Original Article

Using video narratives of women's lived experience of breastfeeding in midwifery education: exploring its impact on midwives' attitudes to breastfeeding

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Abstract

Strong evidence supports the health benefits of breastfeeding contributing to the public health campaign to improve initiation and duration of breastfeeding globally, yet breastfeeding continuation rates are persistently low in the UK. Inadequate support from health professionals appears to be an underlying feature, aggravated by a dearth of professional education that uses a biopsychosocial approach. This paper describes how using women's video narratives of their lived experience of breastfeeding within higher education impacted positively on the attitudes of a group of midwives in relation to supporting breastfeeding women. It reports on the qualitative element of a two-phase sequential mixed methods study where focus group methods generated rich data about how and why the educational intervention altered attitudes. Analysis was thematic. Six major themes emerged, 'listening and learning from real women's experiences'; 'generation of emotions'; 'acquisition of new knowledge and learning'; 'reflection on practice'; 'promotion of independent learning' and 'sharing learning and ideas with peers'. 'Listening and learning from real women's experiences' was central to learning, and was pivotal to attitudinal change, motivating an intense need to improve practice. Findings support the value of using women's video narratives within midwifery education, through their power to integrate affective and cognitive learning, and to promote a transformative learning process. This novel approach brings value-added learning benefits by enhancing the potential to improve attitudes towards supporting breastfeeding women and improving clinical practice.

Keywords: breastfeeding support, midwives, attitudes, education, qualitative methods, focus groups.

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Introduction

It is widely accepted that exclusive breastfeeding for the first 6 months of the baby's life, with breastfeeding continuing until 12 months and beyond, provides considerable benefits to both mother and baby (Kramer & Ritsuko 2002). However, in the UK breastfeeding continuation rates are persistently low with a substantial proportion of mothers giving their babies some-

thing other than breast milk on the first day after birth, less than half of all mothers exclusively breastfeeding at 1 week and only a fifth by 6 weeks (Bolling *et al.* 2007).

Much of the literature suggests that breastfeeding support offered by health professionals can influence both initiation and continuation of breastfeeding (Swanson & Power 2005; Britton *et al.* 2007; Renfrew *et al.* 2005). Indeed McFadden & Toole (2006)

suggested that support from just one midwife can make a considerable difference to a woman's experience of breastfeeding. However, the quality of information and support that women receive will be profoundly affected by the knowledge, skills, expertise and attitudes of individual midwives (Becker 1992). It is no surprise then, that health professionals' attitudes and opinions, described in the literature as 'ambiguous, inconsistent, inaccurate, neutral or negative' actually hamper women's experiences of breastfeeding leading to poor breastfeeding outcomes (Baxter 2006; McFadden & Toole 2006).

Midwives' attitudes about how they support breastfeeding women have been strongly associated with inadequate provision of education, not always underpinned by sound educational theory (Renfrew *et al.* 2005). Becker (1992) related this issue particularly to midwives with more than 10 years of clinical experience. Arguably, this may be associated with the academic level of UK midwifery 'training' before the 1990s with minimal analysis and application of research based evidence (Renfrew 2006; Smale *et al.* 2006), coupled with the medicalized approach to childbirth and infant feeding (Dykes 2002).

It has been recognized that midwives' practice may be influenced more strongly by their own personal bias, subjective beliefs and attitudes about breastfeeding than evidence-based education (Simmons 2002). Indeed, even though midwives might have cognitive knowledge regarding the benefits of breastfeeding, the affective level influenced by embodied, vicarious and work-based experiences will have a greater effect on their attitudes, impacting on clinical practice (Dykes 2006). This suggests that evidence based edu-

cation does not necessarily overcome conflicting and unsupportive practice for breastfeeding women (Henderson *et al.* 2000), but that attitudinal change is also necessary. Bernaix (2000) agreed that the most important predictor of supportive practice for breastfeeding is a combination of knowledge, skills and positive attitude. Thus, Dykes (2006, p. 211) suggested that midwives need to develop supportive practice, by 'reflexively exploring' practice-based experiences in order to amalgamate the four different sources of knowledge.

Sheehan *et al.* (2003) argued that breastfeeding education for health professionals has principally focused on the biophysical factors. This implies that the complex interdependent factors such as the emotional and social aspects of women's lives that impact on breastfeeding success have been ignored. With these issues left untapped, there has inevitably been a lack of understanding about how women feel about their breastfeeding experiences and how midwives can best support their needs (Sheehan *et al.* 2003). Thus, to enhance understanding it is vital to use a biopsychosocial approach including physiological, psychological and socio-cultural influences on breastfeeding (Dykes 2006). It is proposed that these crucial aspects of learning can be incorporated into midwifery education by using research exploring women's lived experiences of breastfeeding published in the literature (Schmied & Barclay 1999; Hoddinott & Pill 2000) or on the Internet (Ryan & Alexander 2007).

The development and research of innovative approaches to learning and teaching relating to breastfeeding is vital if Higher Education Institutes

Key messages

- New perspectives of breastfeeding can be enabled by listening and learning from women's lived experiences of breastfeeding.
- Integrating cognitive with affective learning has the potential to positively change attitudes to support for breastfeeding women.
- Listening and watching women's video narratives has the potential to trigger dissonance promoting a transformative learning process.
- Combining video narratives with guided study is a powerful method of encouraging reflection, resulting in an intense need to improve practice.
- Video narratives of the lived experience of breastfeeding are likely to generate strong emotions in listeners triggering reflexive practice.

are to respond to the UNICEF Baby Friendly Initiative's challenge to meet new educational standards (UNICEF UK 2002) and the demands of the European Commission to improve pre-registration and continuing education (EU Project on Promotion of Breastfeeding in Europe 2004). Thus, the aim of this study was to explore the impact of an educational intervention using women's video narratives of their lived experience of breastfeeding and guided learning material on midwives' attitudes to providing support for breastfeeding women.

Materials and methods

Research design

The educational intervention

Participants were provided with a DVD with video clips of women's narratives of their lived experience of breastfeeding extracted from the Bournemouth University/DIPEX breastfeeding module (Ryan & Alexander 2007). While the socio-economic status of video subjects was not known, video clips were selected to represent diversity of age and ethnicity. Women selected ranged from 22 to 40 years and included English, Scottish, Ugandan, Sri Lankan and French-British. The narratives provided a wide range of experiences relating to midwives' support in the first few hours and days following birth.

Guided study materials in the form of a workbook were designed to engage participants in three different active learning approaches (Hewitt-Taylor 2003). The first was by 'listening and watching' the video clips to enhance communication and critical reasoning skills. The second encouraged 'contextual reflection' using the clips as a trigger to promote critical thinking around practice-based issues involving personal reflection and self-awareness. The third used 'conceptual reflection' to encourage students to explore ideas from various angles and to construct an argument for change within their own practice. A whole day was timetabled within the unit of study to enable participants enough time to work independently to complete the workbook. Debriefing occurred during the focus groups, but formal evaluation

and a further opportunity to debrief was enabled through the standard university 'student unit evaluation'.

A two-phase, sequential mixed methods study was used (Cresswell 2003). The first phase used questionnaires to measure and compare midwives' attitudes towards providing support for breastfeeding women, before and after the educational intervention. The second phase used two focus groups to explore how and why the educational intervention had impacted on the midwives' attitudes. The results of the first phase were limited due to small sample size, thus more emphasis was given to data collection and analysis of the second qualitative phase (Ivankova *et al.* 2006). This decision was corroborated by the richness of data collected during the focus groups, providing depth of meaning to the research question (Holloway & Wheeler 2002). This paper reports on the second qualitative phase.

Setting and participants

This study was undertaken within the context of a post-registration midwifery programme in a University in England. Using a purposive sampling method (Wagstaff 2000), the whole student cohort were invited to participate. All the midwives in the cohort, except one, consented and participated, 11 in total providing enough participants for two focus groups. There was a wide range of midwifery experience within the sample, from 0 to 25 years, and a diverse range and amount of time spent (0–15 h) undertaking breastfeeding-related education within the preceding triennial.

Ethical issues

Permission to undertake the study was gained from the University Research Governance Group and the Lead Midwife for Education. Participants were provided with both written and verbal information, informing them that participation was voluntary and that they were free to withdraw from the study at anytime. Particular emphasis was placed on informing participants that choosing not to participate would

not jeopardize academic progress. Consent was gained by written consent.

Confidentiality was maintained by ensuring restricted access of all data to the research team. This data was coded and destroyed on completion of the study. While participants' words are quoted within publications, alphabetical codes have been used to protect participants' identity.

Data collection using focus groups

Focus groups were selected as the method of data collection for the second phase of the study, because they seek to generate qualitative data that capitalizes on group interaction. This process can empower people to contribute to discourse, who may have been reluctant to be interviewed on their own (Abbott 2002).

Two focus groups were conducted 3 weeks after participants had received the educational intervention and 2 weeks after the allocated day timetabled within the unit of study. Five and six midwives attended each group, respectively. Seven stimulus questions, developed from the study aims and questionnaire results, were used in both focus groups.

Limitations

The principal researcher was a member of the teaching team and known to the participants. The potential for bias and coercion in this relationship was recognized (Litosseliti 2003). Participants could have felt they must please the teacher in what they say, rather than what they really felt. Steps were taken to minimize these effects. The information sheet distributed to all participants emphasized that the researcher would remain impartial, with the added assurance that she would not be involved in marking any of their summative assessments while studying at the University. Participants were informed that the principal researcher would not be functioning as a teacher in the focus group and would therefore listen to the conversation rather than join in. The role of the assistant researcher was crucial here. She recorded all discussions on audio tape and generated field notes including any verbal and non-verbal interactions to

enable subsequent cross-checking with the principal researchers' field notes. The impact of the second researcher was minimized by emphasizing that she was not a midwife or breastfeeding expert and was not present to assess the level of discussion (Litosseliti 2003). After the conclusion of the interviews, the principal and assistant researchers made further field notes together, including capturing first impressions.

The possible impacts of group dynamics and dominant members were also recognized (Stewart & Shamdasani 1990). While it was anticipated that using a group of midwives known to each other may have influenced their responses, not wanting to look foolish or different from one another, the groups appeared to open up and debate issues freely. A degree of familiarity and sharing of group characteristics within educational research is thought to facilitate descriptions of experiences, perceptions, feelings and attitudes through group discussions (Cohen *et al.* 2007). Possibly in this research study it occurred because participants had actually developed trust over the course of the midwifery programme and felt safe within the confines of the focus group. Indeed, the interaction among the group, including everyday language, appeared to be a key feature, giving it a high level of face validity.

While this study aimed to explore how and why midwives' attitudes changed as a result of using the educational intervention, it did not seek to explore behavioural outcomes such as whether improved attitudes actually enhanced support for breastfeeding women with subsequent improvement in breastfeeding outcomes.

Focus group analysis

The data from the focus groups was subjected to thematic analysis (Krueger 1998; Rabiee 2004). Fundamental ideas were grouped together into larger categories to form recurrent themes and theoretical ideas. The data was compared within each group before connecting the major themes of the two interviews together into a thematic framework (Krueger 1998). This process provided validity to findings that were apparent in both groups, at the same time as

highlighting issues that were unusual or specific to one group. The final stage of the analysis entailed 'mapping and interpreting' (Rabiee 2004, pp. 658–659). This involved considering the 'words' and 'context' together with their meanings. The 'specificity', 'frequency' and 'extensiveness' of comments, together with the 'consistency' of participant's opinions, provided an insight as to whether the group discussion itself altered people's views.

Results

Six major themes (numbered) and related subthemes (in italics) emerged from the data. The themes reported in this paper focus on answering the question how and why were midwives' attitudes toward supporting breastfeeding women changed as a result of engaging with the educational intervention. Quotes from participants have been used to illuminate the findings, and to provide an enhanced appreciation of their voiced views and experiences.

1. Listening and learning from real women's experiences

The central theme at the core of the discussion within both focus groups was 'listening and learning from real women's experiences'. This theme appeared to underpin, influence and interconnect with three other major themes, as the process of listening and learning from real women triggered the 'generation of emotions', 'acquisition of new knowledge and learning' and/or 'reflection on practice'. However, none of this seemed possible without the 'promotion of independent learning', which was further enhanced by 'sharing of learning with peers', the final two themes that emerged from the data (Fig. 1).

Seeing women's perspectives

Seeing women's perspectives included areas of practice that for some midwives they admitted they had overlooked. They had become so preoccupied in everyday practice, that they had actually lost sight of what breastfeeding women actually feel and need.

Fig. 1. Visual representation of major themes.

I thought it was really nice to revisit the women and get their perspective on things. I'd forgotten about them in the whole equation. (D) (FGp 1)

Participants realized that their previous practice-based, educational and embodied experiences had not always had the same effect on them. Seeing women's perspectives had provided an opportunity to take a fresh look at breastfeeding. It enhanced their appreciation of what it was like to breastfeed in various circumstances, changing their attitudes and perceptions about support for breastfeeding women.

I've breezed along very much on the same information although I have been to several updates in the course of the years. That did really make me stop and revisit breastfeeding, even though I have breastfed myself, but it really made me look at the women's perspective. And probably then it has made a dramatic difference... I would imagine it has impacted on quite a few of us... (D) (FGp 1)

The realization that some support issues were particularly meaningful to women was further reinforced when participants heard several women talking about the same concerns. Participants considered this beneficial in providing them with a sound rationale for changing their practice to support breastfeeding women more effectively.

I thought it was very positive actually hearing all the women's views together, because most women talked about the same aspect . . . that's obviously important to women, so maybe that is how we should be approaching our practice. (B) (FGp 1)

Gaining feedback

Gaining feedback regarding midwifery support for breastfeeding mothers, by listening to the women's narratives, was considered a valuable learning opportunity, which under normal circumstances, appeared difficult to acquire. Participants realized there were missed opportunities for evaluating their own provision of support from women's perspectives, due to the rapid turnover of cases passing through maternity services. This resulted in enhanced awareness, because in reality, they did not actually know how effective their own support provision was.

Because you don't normally get the feedback . . . especially working in a hospital . . . see the woman, you look after the woman, in whatever way you can to the best of your ability and they're gone. (K)

. . . And you don't know whether you've helped or not. (G) (FGp 2)

Gaining feedback by listening and learning from real women's experiences also provided positive affirmation and reassurance for some participants. They began to appreciate their own contribution to the support for breastfeeding women, alongside the recognition that not all midwives practise in the same way. Comparing the provision of support for women in the video clips with support offered within their own maternity unit enabled further learning. This was considered important for informing future practice change.

It makes us realise how lucky we are, that that's what we do in our unit. (E)

Yeh, because we do that, babies don't go to the resuscitaire, they don't need to . . . and I suppose you always think, that's what happens everywhere else, but . . . we are in the minority. (G) (FGp 2)

Safety vs. choice

The women's narratives had also served as a powerful trigger. Midwives were reminded that, in contemporary midwifery practice, safety vs. choice is a significant issue. Indeed, they realized that mother's preferences were often denied because of an overriding priority of keeping mother and baby safe.

You lose sight of the important things to the mum don't you, you get so . . . caught up on safety, that you lose sight on what's important to mum, and it's reminded us of that, I think. (G) (FGp 2)

It appeared that this overwhelming attitude to 'protect' women from harm, disregarding their individual choices, had not been recognized before. By listening and learning from the women's experiences of breastfeeding, together with a period of reflection, an enhanced appreciation of why and how women make choices about breastfeeding was facilitated. Thus, through the narratives, the 'art' of midwifery was realized providing a more 'woman-centred', holistic perspective of support, rather than only a scientific medicalized approach to care (Anderson & Davies 2004).

It's funny how her priorities obviously lay more with the baby . . . than she was with herself. (F)

And that's her natural instinct immediately as a mother isn't it? (J)

Whereas our natural instinct is to be more concerned with the woman. (F) (FGp 2)

2. Generation of emotions

The strong attitudes of determination portrayed in women, through their narratives, generated emotions in all participants.

Mixed emotions

These emotions were often mixed and included feelings of admiration, sadness and despair, along with an instinctive need to defend the midwifery profession.

I did admire them for their perseverance and their determination . . . I was almost feeling quite defensive, because I felt they were directly criticising the provision . . . that I felt was very sad. (D) (FGp 1)

The emotional aspects of breastfeeding seen and heard in the women's narratives further impacted on how participants responded. It made them consider future support provision for breastfeeding women. Actually seeing women in the flesh, crying and expressing their emotions on a screen had a new and significant meaning. They had not experienced this kind of learning before through conventional methods of education, such as textbooks and lectures. The mediated knowledge gained by the midwives through these 'secondary experiences' appeared to be an important feature of the learning process (Jarvis 2006).

I would say it (opinion) has, it has changed, yeh especially when you see, like that lady crying about it, and getting that emotional about it . . . has sort of reiterated the importance of those . . . initial few minutes . . . (G) (FGp 2)

Feelings of frustration and resentment

For a small number of participants, feelings of frustration and resentment were engendered when their opinions about breastfeeding and priorities in care were challenged by what the women said in their narratives. Subthemes overlapped here with mixed emotions running high because health and safety vs. choice was also an issue.

. . . it wouldn't be considered appropriate to start breastfeeding if the woman's haemorrhaged and they were trying to stabilise the mummy, so . . . I found that quite frustrating watching that. (G) (Gp 2)

Feelings of shock and guilt

Other emotions experienced by participants, generated feelings of shock and sometimes guilt, when they heard about the standards of care and support provided to some women. They had not realized that some outdated practices continued or even existed. The feelings of shock and surprise, however, were not always because the provision of support was incongruent to

their own. For some, hearing women describe their feelings when midwives had handled their breasts was not comfortable listening. The women's narratives appeared to have acted as a trigger, compelling participants to consider their own beliefs about support for breastfeeding women. They realized that what they believed to be helpful to women, was actually perceived by women to be awkward and uncomfortable, providing a negative influence of support. This created feelings of shock as they had never actually realized that what they were doing in practice was disliked by women so much and just how insensitive and 'numb' they had become to women's feelings. Listening to the women's narratives had facilitated genuine insights into women's emotions and feelings of disempowerment and loss of dignity.

It shows how much we take for granted as midwives, because it doesn't give us the right to touch them does it? (J)

. . . Just because you're handling and touching other people's bodies all day everyday, to individual women that can still be a really big big thing. (G)

You'd think that their genitalia would . . . be the worst part wouldn't you. (H)

You would wouldn't you, but it does show how you become numb to it. (G) (FGp 2)

Undertaking the educational intervention had enabled participants to compare the care they currently provide with the care provided in the women's narratives creating a dissonance, or what Jarvis (2006, p. 227) describes as a 'disjuncture'. The dissonance they felt appeared overwhelming, particularly when they realized that they themselves could be 'doing more harm than good'. The women's narratives had made them reflect and 'think' about this attitude. They analyzed, rationalized and internalized their opinions and values before realizing that women's views were more important. The outcome of this process invoked feelings of guilt in some participants, and a desire to avoid this practice in the future.

. . . I almost felt as if I was failing in helping with breastfeeding . . . I mean I don't use a hands on approach unless I feel it's . . . of benefit, but sometimes what we think is of benefit to a woman, is actually doing more harm than good. (F) (FGp 2)

Nevertheless, one midwife defended her practice with a 'protective attitude', believing that the 'hands on approach' was needed to prevent harm and soreness to some mothers.

3. Acquisition of new knowledge and learning

No new knowledge

Participants stated in both focus groups that no new knowledge had been gained from undertaking the educational intervention. However, there was a general agreement that it had encouraged them to revise and consolidate their knowledge and understanding, and in some cases alter their perception of breastfeeding support.

... they were all things I knew, but obviously it has altered my perception. (D) (FGp 1)

Moments of realization and generation of new ideas

Nevertheless, examples of learning were identified by participants as moments of realisation and a generation of new ideas. This occurred when a new concept had been illuminated, or a previous one had been rekindled or reinforced. The women's narratives had acted as triggers, compelling participants to re-assess their former perceptions, beliefs or attitudes about support for breastfeeding women, or to consider a new idea altogether. Indeed, the power of this educational intervention as a transformative learning process (Mezirow 1991), was illustrated with explanations of how participants had considered new ways of supporting breastfeeding women. These discussions led to the realisation in one of the focus groups that actually a good deal of learning had taken place after all.

What one woman said was about being taught to feed laying down, and that's something that I've never actually thought of showing to women, but I know personally helped me no end ... that's something that I will change my practice. ... (G) (FGp 2)

... the skin-to-skin all night long; that had a huge impact on that woman. You know, maybe we should be promoting it more so ... (B) (FGp 1)

Challenging assumptions

This educational intervention further reflected Mezirow's theory of transformative learning (1991) in bringing about new ways of thinking about support for breastfeeding women. The women's narratives had challenged assumptions, which previously participants had never considered. It was not until one midwife engaged with the educational intervention and listened to the women's narratives, that she realized that breastfeeding meant more than nutrition.

I suppose I've just looked at it that it's a means as a source of nutrition for the baby and yes it's nice for the mum because she's knowing, you know, that she's doing what's best for the baby, but, I didn't think it kinda, went as deep emotionally as it, obviously does. (F) (FGp 2)

Prior to the educational intervention some participants appeared to lack awareness of the significance of skin-to-skin contact. The impact that the educational intervention had had on midwives' attitudes to facilitating skin-to-skin at birth became apparent when discussions around this subject dominated both focus groups. One video narrative in particular had stimulated participants in both groups to think about the benefits and practicalities of encouraging skin-to-skin at caesarean section. They had never considered this supportive approach as an option, but during the focus groups they articulated a deep desire to change practice.

I think the women who have had caesarean sections ... certainly if you have worked in the unit for a long time you get so used to the way of doing things, you know, the baby's delivered, it's taken over to the resuscitaire, it's wrapped up in a towel and then given to mum, it's really got me thinking that, yes we should be, you know, giving skin-to-skin contact straight away. There is no reason why not. So, you know, hopefully ... listening to the DVD will improve the level of practice there, and get things all changed. (I) (FGp 2)

Women need to be empowered

A powerful message to most participants occurred with the recognition that women need to be empowered to breastfeed confidently and independently without midwives taking control. This message sug-

gested that positive reinforcement, words of affirmation and encouragement were more important than practical 'hands on' help. The narratives had, as suggested by Carolan (2006), brought fresh insights and new knowledge about how women want to be socialized into their new role as mothers.

Yeh, I think that's what I gained from it, that women want reassurance and praise but they don't really want midwives doing things for them, I think that's what I learnt most . . . (E) (FGp 1)

4. Reflection on practice

Another major theme repeatedly emphasized by participants was the opportunity and importance of spending time on their own, away from clinical practice and the university, in order to reflect on practice.

Reflection on current practice

Indeed, the women's narratives were seen as valuable evidence, which had 'made' participants think, creating opportunities for reflection on current practice.

. . . acknowledging women's experiences as evidence, when we look at evidence bases and you know we get evidence from research, we should actually be using those experiences to form the evidence for our reflection, and that's how we, we grow and learn, so it's very good yeh. (D) (FGp 1)

This process involved areas of practice that they had never thought to reflect on before including entrenched practices and attitudes to breastfeeding that were still apparent in maternity services. It also invoked feelings of frustration with the organisation where they worked. This demonstrated further how the themes interconnected. 'Listening and learning from real women's experiences' had caused a 'generation of emotions' leading to 'reflection on practice' and sometimes 'reflection on practice' caused a 'generation of emotions'. Participants described their thought processes by considering what was good and bad about the women's experiences. This enabled them to make sense of the narratives, before moving on to think about and critically appraise their own practice. This involved self-awareness as they began

to recognize their own shortfalls, or to critically analyze or blame 'the organisation'. It also led them to extend their thoughts by contemplating how they could improve practice, or consider entirely new ways of supporting breastfeeding women. Participants frequently demonstrated reflection on practice in a complete cycle of reflection not unlike Gibbs (1988).

Being away from the hospital environment and away from the study classroom and you are actually on your own and you're thinking about, those women's experiences more intense than you would if you were in a classroom setting maybe. . . . when I was on my own . . . I did reflect on . . . what did I do in practice? How I would improve it, and how I am with the women today? I found it worked better for me. (B) (FGp 1)

Some participants compared traditional with contemporary practice, not necessarily understanding why practice had changed. This suggested they had changed their practice according to the organization's culture rather than understanding the rationale and evidence for the change. This could indicate that perhaps a surface approach to learning had been used previously (Marton & Säljö 1984).

when I trained it was very, you were very pro leaving them, until they initiated breastfeeding themselves, the babies, and that was the . . . philosophy at the time and . . . we've . . . like swung round to be more interventionist more recently, and I don't know . . . why. (D) (FGp 1)

Lack of time and resources

Reflection on practice exposed a hard reality about the culture of 'the organisation', and how restrictive and disempowering working in the maternity services in the UK had become for them. Feelings of frustration and resentment had been triggered by the women's narratives in all of the participants as they felt let down by the NHS, particularly in relation to lack of time and resources.

A strong desire to improve support for breastfeeding women

A strong desire to improve support for breastfeeding women emerged as an outcome of reflecting on prac-

tice. Many participants recognized areas of weakness contemplating positive strategies to enhance women's breastfeeding experiences. Sometimes this reaction was provoked by emotions as previously described.

... and I feel guilty but it's nothing that, I'm doing wrong, it's just ... prioritising, and, you know I just find it hard, infuriating really because ... I do try, but could do better. So my aim is ... to do better. (B) (FGp 1)

Reflection on practice required a high degree of self awareness examining own beliefs, attitudes and values. This enabled personal and professional development as well as considering change in practice.

I think being a little bit stronger on labour ward ... there's always pressure to get the women out of the rooms and onto the postnatal ward ... but I think that there are times when you could say, no, that's really important that woman has time to have skin-to-skin with that baby. (E) (FGp 1)

I think I will personally try in the postnatal period to promote women's independence. I probably instruct a lot whereas I'll probably try to get that lady to be confident, latching her own baby on, spend a bit more time rather than just say, oh here we are we're done, and I can walk away. (D) (FGp 1)

5. Promotion of independent learning

During the focus groups, participants described their individual approaches to using the educational intervention. Indeed none of the other themes would have emerged without the time and space on their own away from the university and clinical practice to listen and learn from the women's experiences and to engage with the workbook.

Valuing flexible learning

Participants valued flexible learning opportunities because they enjoyed the freedom to gain choice and control regarding place, time, pace and method of learning to suit their own lifestyle and individual learning styles.

I will be honest sometimes when I get here (university) after the morning rush, I don't ... tune into anything till about

half eleven. You can pick times that are actually conducive to you, where you're focused, and like ... a lot of you, I did mine in little stages and sort of, doing half an hour at a time, I probably took in a lot more than doing a whole morning of it, so I found it quite beneficial. (G) (FGp2)

Comparisons with conventional approaches to learning

Some participants made comparisons with conventional approaches to learning such as studying in the classroom, or using textbooks. The educational intervention had encouraged a deeper approach to learning than they had previously experienced. It enabled them to work at a higher conceptual level (Marton & Säljö 1984), analyzing the narratives, in order to understand a more holistic view of breastfeeding.

I think sometimes learning in the classroom, you retain so much information ... even despite the tutors ways of trying to deliver it and make it more interesting, after a while you kind of cut off ... and I did know it, but it made me look at it differently by hearing women's experiences ... I thought it was ... a very good way of learning about it for post-registration. (D) (FGp 1)

Guided study to direct learning

However, it was apparent that for most participants, the guided study within the workbook was an essential component of the educational intervention. The women's narratives had triggered emotional responses within participants while the activities in the workbook had encouraged them to reflexively explore their own practice, thus combining affective and cognitive learning together.

You'd want to make sure that the learning requirements were met and I don't know how you could do that just watching it, because we'd all perceive it in a different way and learn different things from it ... there needs to be some direction. (J) (FGp 2)

Self motivation

All the participants agreed that a certain degree of self motivation was required. For some, this motiva-

tion was so 'compelling' that they watched all the video clips and undertook the study material altogether. Others engaged with it over a period of time, finding it beneficial to stop and reflect on each section, before revisiting it again. For a small minority, they were not sure whether they would be stimulated to complete it without further incentives.

6. Sharing learning with peers

The opportunity to share and compare current practice across midwifery services, was not facilitated through the educational intervention, but was a key feature of the focus groups. Discussion and debate over some important issues that had been triggered by the women's narratives enabled participants to challenge each other's assumptions and opinions.

Learning through discussion and debate

While most participants enjoyed working independently, many of them acknowledged that learning through discussion and debate with peers was also necessary to share ideas, and learn from each others' experiences.

Peer support

Peer support was also considered key to preventing the emotional aspects of the women's narratives causing offence and hurt. Hence, the focus groups were regarded as a valuable debriefing process.

... yeh, I think you would really need to come ... back to this environment and then discuss everything like we are doing just now about it. (F) (FgG 2)

Discussion

Out of the six major themes that emerged, 'Listening and learning from real women's experiences', appeared central to the learning process. The findings from this study support Jarvis's (2006) suggestion that while students all learn differently and independently, it is beneficial to initiate learning from a common starting point. Jarvis (2006, p. 226) proposed the use of

'a disjuncture', or dissonance to create a disharmony between the student's past and present perception of an experience, stimulating questions to initiate the learning process. This can be mediated through a 'secondary experience' (Jarvis 2006), which in this study was through the women's video narratives. Thus, 'listening and learning from real women's experiences' had acted as 'a disjuncture' (Jarvis 2006, p. 226), stimulating multiple senses, involving the whole person. This process included for some participants uncomfortable feelings and 'mixed emotions' the 'acquisition of new knowledge' and/or, 'reflection on practice', compelling them to confront their own beliefs, values and attitudes about support for breastfeeding women. It stimulated a learning process that involved at least two of the three domains that Jarvis (2006) described as, 'thought' and 'emotion', with planned 'action', developing from a strong desire to change practice.

Two of the women's narratives within the educational intervention expressed a dislike of midwives handling their breasts, because they found it disempowering. These women's perspectives are supported by evidence in the literature. Dykes (2005) suggests that using a 'hands on' approach can be detrimental to women's confidence. The focus groups revealed that some participants were 'shocked' that women in the narratives objected to a 'hands on' method of support. They were apparently unaware of the detrimental effects on women, despite evidence suggesting that women dislike this approach to care, finding it distressing and embarrassing (Hoddinott & Pill 2000). For these midwives, the experience of seeing and hearing women tell their disempowering stories about midwives handling their breasts, which was different to their own perspective, had acted as a dissonance or 'a disjuncture' (Jarvis 2006, p. 226). This in turn stimulated them to reflect on practice and reconsider this form of support.

This learning process, can also be associated with Mezirow's (1981, p. 7) theory, which suggests that transformative learning occurs when a person is faced with a 'disorientating dilemma', when something unexpected happens that challenges one's own expectations or assumptions. This can be a single isolated event that is challenging in some way, which stimu-

lates critical reflection and self awareness involving the affective, emotional and social aspects of learning (Cranton 2006). By watching and listening to the women's perspectives, midwives' attitudes about having 'control' over the mother and baby had been challenged. Through a process of self awareness and critical reflection, guided by activities in the workbook, the narratives had been a catalyst for considering change in practice.

Critical reflection is at the heart of transformative learning (Mezirow 1991) and 'reflection on practice' was another major theme emerging from the data. Greenhalgh & Hurwitz (1998) suggested that listening to narrative enforces reflection enabling a greater understanding of what has occurred. Indeed, participants in this study felt compelled to reflect on the women's narratives together with their own provision of support for breastfeeding women. This was often triggered by dissonance, 'a disjuncture' (Jarvis 2006, p. 226) or a 'disorientating dilemma' (Mezirow 1981, p. 7) within the midwives' experiences. This dissonance caused a 'generation of emotions' within the participants. Their responses appear to be in line with Gidman's (2007) suggestion that emotional reactions to experiences are particularly pertinent for 'reflection on practice'. This is because they facilitate self awareness and analysis of own thoughts and feelings, enabling the acquisition of new knowledge and ideas. Thus, four major themes emerging from the data suggesting how and why midwives' attitudes had changed, were interconnected and were influenced by one another. 'Listening and learning from real women's experiences' was at the very core, triggering an 'acquisition of new knowledge or ideas' and/or a 'generation of emotions', which in turn, stimulated 'reflection on practice', 'the acquisition of knowledge or more ideas', provoking a strong desire to change practice accompanied by the 'generation' of another set 'of emotions' (Fig. 1).

For the participants in this study, listening and watching the women's narratives was itself a skill, requiring sensitivity and an ability to be receptive to women's perspectives. It involved the use of multiple senses so that not just the women's words were heard, but body language, facial expressions and emotions were also interpreted. This ability appeared funda-

mental in developing communication and critical reasoning skills necessary to enter the woman's world to view different breastfeeding perspectives to their own. Anderson & Davies (2004) stress the importance of developing sensitive, caring attitudes of empathy, understanding, support and responsive communication by combining cognitive and affective domains of learning together. This is considered essential to ensure that the 'scientific' medicalized element of midwifery does not overpower the 'art' of midwifery (Anderson & Davies 2004). This sensitive listening approach enabled participants to gain enhanced understandings about the emotional and socio-cultural meaning of breastfeeding, rather than the biophysical and nutritional processes alone.

Listening and learning from real women's experiences had drawn attention to a stark reality when participants realized that they had actually lost sight of what women want, due to an overwhelming attitude to protect them from harm. The values within the hospital culture of maintaining health and safety were incongruent with the socio-cultural values of women, who wanted, above all, to be kept close to their babies. Seeing the women in the videos tell their emotional stories was very poignant and had 'touched' the midwives, causing many of them to feel emotional as well. The insight gained may well have involved a high degree of emotional intelligence (Goleman *et al.* 2003). It required participants to interpret the women's emotions effectively, alongside developing a deep understanding of their own emotions, including recognizing their own strengths and weaknesses. Arguably this reflection, may lead some midwives to need to 'unlearn' their current beliefs and attitudes (Gould 2003) relating to a medicalized approach to care and the 'power and control relationship' assumed in their midwifery role, enabling them to better support breastfeeding women in the future.

Gaining feedback regarding midwifery support for breastfeeding women had a value-added factor for many participants. It is a useful method of evaluating the efficacy of health care routines, allowing practitioners to make improvements to enhance service users' experiences (Wilcock *et al.* 2003). Participants discussed how they had evaluated what was good and bad about the current level of breastfeeding support

within their own maternity units, and a small minority felt positively reassured. However, most participants experienced feelings of frustration realizing the constraints within the NHS that encouraged routine tasks and procedures reducing the quality of breastfeeding support available.

Many of the participants had initially said that they had not learnt anything new from undertaking the educational intervention. This suggests that the midwives in this study only considered explicit conceptual knowledge as important. The midwives did not immediately realize the implicit emotional and embodied insights that they had gained from listening and learning from the women's experiences. When considering Bloom's taxonomy of educational objectives (Krathwohl *et al.* 1964), it appears that participants had used both the cognitive and affective domains of learning. As they listened to the women's perspectives, they reflected on their own practice, analyzing their actions before appreciating and internalizing a new set of values, which once accepted, required a commitment to change. Indeed, combining the cognitive and affective elements together appeared to enhance a deeper approach to learning (Marton & Säljö 1984), enabling the midwives to engage at higher conceptual levels, causing attitudinal change within these participants.

Participants enjoyed the freedom and control for critical reflection and self awareness in their own time, pace and place. This flexible learning approach is advocated by Hyder (2004) as it enables the student to move away from traditional models of higher education towards a more independent approach to study, creating a sense of autonomy and ownership over learning. However, the focus groups provided a forum for sharing and discussing practice related issues. Thus, it was sometimes difficult to define what learning had been achieved through the educational intervention alone, and what learning had occurred through the exchange of ideas during the focus group. Cranton (2006) suggests that discourse is crucial to the transformative learning process, and that for learning to be complete, a sharing of ideas is also essential. This is also comparable to Laurillard's conversational framework that suggests that to optimize higher levels of learning, the teacher needs to support discursive, adaptive,

interactive and reflective processes to enable students to learn effectively (Laurillard 2002). Therefore, in any future development of the educational intervention, a discussion forum for students to share their learning experiences would need to be included.

Conclusion

This research study supports the benefits of using women's narratives of their lived experience of breastfeeding as part of an educational package within midwifery education, integrating affective and cognitive learning (Krathwohl *et al.* 1964). It has demonstrated its value in promoting a transformative learning process (Jarvis 2006) enhancing the potential to improve attitudes towards support for breastfeeding women. By combining powerful affective and cognitive processes and reflexively exploring practitioners' own practice-based experiences, an intense need to improve practice can be created. Following completion of this study, a web-based resource for pre-registration student midwives has been developed and a post-registration distance learning unit has been validated. Collaborative learning, enabling the exchange of ideas and experiences has been embraced through online discussion forums.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

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