

**WORKING IT OUT:  
NEW MOTHERS' EXPERIENCES OF  
LEARNING TO BREASTFEED**

Submitted by

**Danielle Gleeson B. App. Sc (Nursing), Grad. Dip. Mid., IBCLC**

A thesis submitted in partial fulfilment of the requirements of the degree of  
Masters of Midwifery (Research)

School of Nursing & Midwifery  
Faculty of Health Sciences



Australian Catholic University  
Research Services  
Locked Bag 4115  
Fitzroy, Victoria 3065  
Australia

**Date of Submission: 5/12/2011**

## STATEMENT OF AUTHORSHIP AND SOURCES

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required).

Signed



Danielle Gleeson 2/12/11

## ACKNOWLEDGEMENTS

I would like to thank the many people who played an important role in the development of this thesis, most importantly the women who participated in the study. Thank you for sharing the stories of your journey into early breastfeeding and motherhood.

To my principal supervisor, Dr. Karen Flowers, for your endless patience and understanding. Your expertise, advice and support have constantly guided me through this long journey and helped me to become a researcher in my own right. Thank you for helping me to grow.

To Amanda Carter, Teoni McHale and Dr. Sue Kildea for assisting in the supervision of this thesis. You have each had so much to offer and without each of you this thesis would not have been possible.

Last, but certainly not least, I would also like to thank my family and friends for their continued support, in particular my husband Jacques, for becoming a full-time Dad in the months prior to submission of this thesis; yes, we are a team! Also, to my two beautiful boys Isaac and Jesse for accepting that Mummy had to be away for such long hours. Jesse, you missed many of your own breast feeds while Mummy worked to try to help other breastfeeding Mums and babies in the future. I would also like to thank Dad, Irma, Nikki, Ann, Donna, Mary, Jane, Kerry, Jenny and Claire for your constant encouragement. Mary, I *'Niked it'*.

*For Karli*

*1973 - 2005*

*A breastfeeding mother and devoted friend*

*You gave the world so much love and you are truly missed*

## **ABSTRACT**

### ***Background***

Midwives in Australia are the most likely health care providers for new mothers in the early postpartum period, a time where many new mothers are trying to initiate breastfeeding. This period is often a difficult time for new mothers learning to breastfeed, resulting in them seeking support from midwives and other sources. Therefore, midwives are in an opportune position to provide early breastfeeding support. Several studies have examined new mother's experiences of receiving breastfeeding support; however, there is minimal literature on mothers' experiences of receiving this support from midwives.

### ***Aim***

The aim of this study was to explore new mothers' experiences of receiving breastfeeding support from midwives. The study's objectives were to identify, describe and explain the role of the midwife in supporting new mothers to breastfeed, the factors that influenced new mothers' experiences of receiving breastfeeding support from midwives and the impact of midwifery practices on new mothers' experiences of receiving breastfeeding support.

### ***Methods***

A Grounded Theory approach was used for this study, using in-depth interviews of six new mothers in a large public and private maternity hospital in Brisbane, Australia. This method enabled the study to not only identify the mothers' experiences but, additionally, to describe and explain them. Schatzman's dimensional analysis framework was applied in discovering the core category and clarifying the relationships between other categories and the core in theory generation.

### ***Results***

The key finding of this study was that new mothers face a complex and multi-faceted journey in early breastfeeding that can be significantly influenced by their experiences of receiving breastfeeding support from midwives. The findings further show that the mothers' abilities to access midwifery breastfeeding support to learn breastfeeding and solve breastfeeding problems have a direct influence on their feelings of success or failure and how they reach a point of resolution about breastfeeding, including the ongoing method of feeding they choose. Through their stories, the new mothers have asked for midwives to invest time in them, building a partnership, recognising them as individuals and providing emotional support. They have also asked for midwives to better prepare them for the realities of breastfeeding and the problems they may face. Finally, they have requested that midwives help them to overcome those problems by offering responsive, consistent and appropriate support.

Findings from this research add to the body of knowledge concerning midwifery breastfeeding support and new mothers' experiences of learning to breastfeed. The recommendations of this study and their implications for practice, education and research offer midwives, and other key stakeholders in the provision of maternity care, achievable strategies, which have the potential to dramatically improve the overall experience of first-time breastfeeding mothers.

## TABLE OF CONTENTS

Statement of Sources.....	ii
Acknowledgments .....	iii
Abstract .....	iv
List of Tables.....	viii
List of Figures.....	ix
<b>CHAPTER ONE: INTRODUCTION.....</b>	<b>1</b>
AIMS/OBJECTIVES .....	2
SIGNIFICANCE.....	2
BACKGROUND OF THE RESEARCHER.....	3
BACKGROUND.....	5
History of breastfeeding.....	5
Industrialisation and medicalisation.....	7
Women as consumers of maternity care.....	10
Models of maternity care.....	11
Breastfeeding: the optimal nutrition source for infants.....	12
Australian National Breastfeeding Strategy 2010-2015.....	14
Baby Friendly Health Initiative.....	14
Breastfeeding rates in Australia.....	14
Inconsistent breastfeeding definitions.....	16
OUTLINE OF THE THESIS.....	17
SUMMARY.....	19
<b>CHAPTER TWO: LITERATURE REVIEW</b>	
INTRODUCTION.....	20
SEARCH STRATEGIES.....	22
NEW MOTHERS' EXPERIENCES OF BREASTFEEDING.....	23
THE NEED FOR BREASTFEEDING SUPPORT.....	25
DEFINITIONS OF BREASTFEEDING SUPPORT.....	25
THE SUPPORTIVE RELATIONSHIP.....	28
PRACTICAL SUPPORT.....	30
THE SILENT CONSPIRACY (Expectations of breastfeeding).....	31
REALITY OF BREASTFEEDING.....	34
THE TIMING OF BREASTFEEDING EDUCATION.....	36
DETRIMENTAL BREASTFEEDING SUPPORT.....	38
Conflicting advice.....	38
Unsolicited provision of formula and pacifiers.....	40
Rough handling.....	41
Lack of midwives' time.....	42
OTHER SOURCES OF BREASTFEEDING SUPPORT.....	45
RESEARCH METHODOLOGIES.....	46
SUMMARY.....	49
<b>CHAPTER THREE: METHODOLOGY.....</b>	<b>51</b>
INTRODUCTION.....	51
RESEARCH APPROACH.....	52
GROUNDING THEORY.....	53
GROUNDING THEORY METHODS.....	55
Constant comparison.....	55

	(v)
Theoretical sampling.....	56
Theoretical sensitivity.....	57
DATA COLLECTION.....	58
SAMPLING.....	59
Inclusion criteria.....	62
Recruitment .....	63
THEORETICAL SATURATION.....	66
DATA SOURCES.....	66
Interview data.....	66
Memo recording.....	66
DATA STORAGE AND MANAGEMENT.....	67
DATA ANALYSIS.....	67
Memoing.....	72
Data analysis software.....	72
Dimensional analysis.....	76
Discovering the core category.....	78
Theoretical saturation.....	79
Refining the theory.....	80
ETHICAL ISSUES.....	82
RIGOUR.....	83
Credibility.....	84
Dependability.....	85
Confirmability.....	86
Transferability.....	86
SUMMARY.....	87
<b>CHAPTER FOUR: RESULTS.....</b>	<b>88</b>
INTRODUCTION .....	88
PERSPECTIVE.....	91
WORKING IT OUT.....	91
CONTEXT.....	91
Decision to breastfeed.....	92
Knowing.....	93
Unknowing.....	95
Hospital environment.....	97
Summary of contextual categories.....	98
CONDITIONS.....	99
Midwives spending time.....	100
Barriers to midwifery breastfeeding support.....	102
Other sources of support.....	104
Problems.....	105
Summary of conditional categories.....	107
PROCESS.....	108
Seeking support from midwives.....	108
Seeking support from other sources.....	109
Emotional upheaval.....	110
Learning to breastfeed.....	111
Solving problems.....	112
Summary of process categories.....	114
CONSEQUENCES.....	115
Feeling successful.....	115

	(vi)
Feeling a failure .....	116
Resolution.....	117
Ongoing method of feeding.....	119
Summary of consequence categories.....	122
SUMMARY.....	123
<b>CHAPTER FIVE: DISCUSSION.....</b>	<b>124</b>
INTRODUCTION.....	124
ANTENATAL EXPECTATIONS VS POSTNATAL REALITY.....	125
Recommendation 1.....	130
SPENDING TIME.....	130
Recommendation 2a.....	133
Recommendation 2b.....	133
NOT SPENDING TIME.....	133
Recommendation 3.....	135
Recommendation 4.....	137
Recommendation 5.....	138
TIMING OF BREASTFEEDING SUPPORT.....	138
Recommendation 6.....	139
Recommendation 7.....	139
PRACTICES THAT SUPPORT BREASTFEEDING.....	140
Encouragement.....	140
Advice.....	141
Recommendation 8.....	142
Practical support.....	143
Recommendation 9.....	144
PRACTICES THAT DO NOT SUPPORT BREASTFEEDING.....	145
Recommendation 10.....	148
Recommendation 11.....	148
Normalising and dismissing.....	149
Recommendation 12.....	151
Recommendation 13.....	151
Recommendation 14.....	152
EMOTIONAL SUPPORT.....	152
Recommendation 15.....	155
SUMMARY OF RECOMMENDATIONS.....	155
IMPLICATIONS OF THIS STUDY.....	159
Implications for clinical practice.....	159
Implications for midwifery education and training.....	161
Implications for organisations and management.....	163
Implications for future research.....	165
LIMITATIONS.....	167
SUMMARY OF DISCUSSION .....	168
<b>CONCLUSION .....</b>	<b>168</b>
<b>APPENDICES.....</b>	<b>170</b>
Appendix 1: Participant Letter and Consent.....	170
Appendix 2: Ethics Approval.....	174
<b>REFERENCE LIST .....</b>	<b>177</b>

**LIST OF TABLES**

<b><u>Table</u></b>	<b><u>Title</u></b>	<b><u>Page</u></b>
Table 2.1	Summary of elements of key studies	47
Table 3.1	Theoretical sampling guide	62
Table 3.2	Sampling	65
Table 3.3	Generation of open codes	69
Table 3.4	Generation of initial categories	70
Table 3.5	Summary of analytical process used	81
Table 5.1	Summary of recommendations	156
Table 5.2	Categorisation of recommendations	159

**LIST OF FIGURES**

<b><u>Figure</u></b>	<b><u>Title</u></b>	<b><u>Page</u></b>
Figure 3.1	NVivo tree node structure	73
Figure 3.2	Beginning matrix utilising Schatzman's dimensional analysis framework	77
Figure 3.3	Concept map: WORKING IT OUT	78
Figure 4.1	Matrix showing development of categories around the core category	89
Figure 4.2	Full explanatory matrix showing categories and their properties	90



**CHAPTER 1: INTRODUCTION**

**CHAPTER 1 - INTRODUCTION**

New mothers who have chosen to breastfeed often face difficulties in the early postpartum period (Kelleher, 2006; Nelson, 2006). Without adequate support to overcome these difficulties, they may decide to discontinue breastfeeding. In Australia, midwives are the most likely health care providers for new mothers in the early postpartum period (Department of Health and Ageing [DOHA], 2009). Therefore, midwives are in an opportune position to provide early breastfeeding support. Several studies have examined new mothers' experiences of receiving breastfeeding support, however, there is minimal literature to describe their experiences of receiving this support from midwives. Instead, these studies provide information on how mothers experience breastfeeding support offered by family, friends, peer supporters or health professionals in general. Furthermore, many related studies have been conducted in the United States of America (USA), where models of maternity care differ markedly from those in Australia, as midwives are often not the primary health care providers.

This study, using a Grounded Theory approach, examines, in more detail, the complex social and emotional experiences of mothers when receiving breastfeeding support from midwives. Knowledge gained through this research will assist midwives to develop a more effective partnership with new mothers toward a positive breastfeeding experience. This research aims to expand the current knowledge base of the midwives role in the provision of breastfeeding support by asking the question: What are the experiences of new mothers when receiving breastfeeding support from midwives? The findings from this study will assist midwives to better understand the experiences of new mothers when receiving breastfeeding support and to develop support strategies that better meet their needs. This chapter introduces the study, aims, background and significance.

## CHAPTER 1: INTRODUCTION

### **Aim/Objectives**

This study aims to explore new mothers' experiences of receiving breastfeeding support from midwives. The study's objectives are to identify, describe and explain:

- the role of the midwife in supporting new mothers to breastfeed
- the factors that influence new mothers' experiences of receiving breastfeeding support from midwives
- the impact of midwifery practices on new mothers' experiences of receiving breastfeeding support

### **Significance**

Breastfeeding is the optimal source of nutrition for infants and provides numerous health benefits for both the mother and baby (WHO, 2007). Many benefits of breastfeeding are dose-related, that is, increased duration and exclusivity equal improved benefits (Petryk et al, 2007; Thorsdottir et al, 2005). Australian statistics on breastfeeding demonstrate that a large proportion of women cease breastfeeding within first three months of birth (Australian Bureau of Statistics, 2007a; Australian Institute of Family Studies, 2008), well before the recommendations of six months exclusive breastfeeding and at least 12 months of partial breastfeeding (Australian Health Ministers Conference [AHMC], 2009; NHMRC, 2003). Although women give numerous reasons for stopping breastfeeding, research shows that many of these reasons are amenable to intervention from health professionals (Hauck, Fenwick, Daliwal, Butt & Schmied, 2011; Lewallen et al., 2006).

Positive breastfeeding support from health professionals is consistently associated with increased duration and exclusivity of breastfeeding (Britton, McCormick, Renfrew, Wade &

## CHAPTER 1: INTRODUCTION

King, 2007; Hannula, Kaunonen & Tarkka, 2008). For this reason it is important to explore the role of the midwife to identify the support that new mothers find both helpful and detrimental in the early breastfeeding period.

A review of the literature has identified numerous studies on mothers' experiences of breastfeeding and receiving breastfeeding support from various health professionals. The current knowledge on this topic, however, fails to examine the midwife's role in the provision of breastfeeding support. Many of the relevant studies on women's experiences of breastfeeding support lack currency in that they were published prior to the year 2000, before the introduction of continuity of care models, such as midwifery group practices, that allow midwives to care for women up to six weeks after the birth of her baby. Furthermore, the research was often conducted in countries with different care models and primary care providers. It is difficult to assess whether these findings are applicable to the current breastfeeding experiences of Australian women, suggesting a need for more Australian-based research on this topic. Findings from this research will add to the body of knowledge concerning midwifery breastfeeding support. These findings may be utilised to improve clinical practice, midwifery education and assist in the implementation of models of care that enhance the provision of breastfeeding support. Furthermore, providing midwives with feedback on women's experiences of the support they offer may encourage midwives to further reflect on their support practices.

### **Background of the researcher and study setting**

During my thirteen years as a midwife I have practiced in numerous clinical units in two large metropolitan hospitals in South-East Queensland, Australia. The larger of these hospitals was a tertiary referral hospital and became the setting for this study. This setting was unique in that it had both public and private maternity facilities co-located and attracted women from diverse social,

## CHAPTER 1: INTRODUCTION

cultural and economic backgrounds. Additionally, this hospital offered the opportunity to recruit women from various maternity care models with both obstetric and midwifery lead carers. Care models included non-continuity models such as traditional hospital care by midwives and obstetric staff, models offering partial continuity in the antenatal period such as GP shared care, midwifery-led antenatal care and private obstetric care, and a full continuity of care model through the midwifery group practice.

Despite the diversity of these women and the models of maternity care they chose, it has become clear to me that almost all first time mothers require breastfeeding support. More importantly, I observed that the mothers who were successful in their attempts to breastfeed were more likely to report that they received effective breastfeeding support from midwives compared to those women who were experiencing breastfeeding problems.

Over time I have become increasingly passionate about breastfeeding and recognise that breastfeeding is far superior to any other source of nutrition for infants under six months of age. This passion led me to become a lactation consultant almost eight years ago and I have worked in private practice, providing lactation support, for some of that time. On many occasions women have made comments to me such as “oh now I get it... nobody ever explained it like that” or “I didn’t want her to just shove baby on the breast” and “I didn’t get the help I needed”. This led me to reflect on my own breastfeeding support practices. While these comments expressed that women have particular breastfeeding support needs and wishes, they presented abstract concepts that required clarification. When I asked women what support they found helpful they would often describe a story of their encounters with a particular midwife rather than list particular support measures. It occurred to me that in order to examine what effective breastfeeding support was, I would need to ask new mothers about their experiences and analyse their stories of receiving such support.

## CHAPTER 1: INTRODUCTION

During the past eight years I have also been working in the field of midwifery education. Students often ask questions about how to support breastfeeding mothers. While I am able to give them evidence-based advice on physical aspects such as attachment and positioning, I find it difficult to present them with evidence based information about new mothers' experiences of receiving breastfeeding support and what mothers want from such support. This predicament prompted me to search for information on the topic of mothers' experiences of midwifery breastfeeding support. I found that there was minimal evidence on which to base such advice and, as such, I have often resorted to presenting anecdotal information. In order to promote and support breastfeeding, midwives, as the most likely professional supporters of early breastfeeding, need evidence-based information to underpin such support. This realisation was the impetus for me to commence this study on new mothers' experiences of midwifery breastfeeding support.

### **Background**

The purpose of this section is to present the background to the study which includes the history of breastfeeding in Australia, the effects of industrialisation and medicalisation, women as consumers of maternity care, models of maternity care, the benefits of breastfeeding, the Australian National Breastfeeding Strategy, national breastfeeding rates and breastfeeding definitions. The information provided explains breastfeeding in terms of its history, culture, statistics and its presence in national and international strategic health plans. The first contextual topic to be explored is the history of breastfeeding in Australia.

### ***History of breastfeeding***

The natural source of nutrition for human infants, as mammals, is human breast milk. However, throughout history women have substituted their own breast milk through wet-nursing, and, through bottle feeding the milk of other mammals (Van Esterik, 2008). Wet-

## CHAPTER 1: INTRODUCTION

nursing; allowing another lactating woman to feed the infant, was commonly practised in Australia up to the late nineteenth century. Wet-nurses were employed for the upper classes and lactating female inmates were utilised to feed orphaned and motherless infants. Wet-nurses and fresh cow's milk were expensive leading the poor, who did not breastfeed, to hand-feed their infants with normal family foods, condensed milk and pastes of grated grain and water (Lewis, 1980).

The first commercially available breast milk substitute was developed by Swiss chemist, Henri Nestlé, in 1867 (Nestlé, n.d.). In the 1880s and 1890s powdered milks and foods by Nestlé, and companies such as Horlicks, began to appear in Australia and were considered suitable for infants over six months of age (Lewis, 1980). Research of school children in the early 1900's found that children who had received these and other breast milk substitutes were twice as likely to show signs of rickets than children who were breastfed for the first six months (Sutton, as cited in Lewis, 1980)<sup>1</sup>. Other studies had shown that diarrhoea was most common in non-breastfed infants, particularly in the summer when food hygiene was most compromised (Lewis, 1980)<sup>2</sup>. Around the same time the infant welfare movement, originating in Sydney, began to spread the message to mothers that good mothercrafting and breastfeeding were the best preventers of infant mortality. Over the following 20 years, from the turn of the century to the 1920s, infant mortality began to rapidly decrease (Smith, 1993). It has been debated whether this was due to the improved education for mothers on mothercrafting and breastfeeding or the improving living standards of the time (Smith).

By the 1930s other large pharmaceutical companies such as Glaxo began to produce infant formula; then referred to as humanised milk (Bryder, 2009). Infant formula was then readily available to the public and the marketing of formula continued to increase (Van Esterik,

---

<sup>1</sup> Despite numerous attempts, the primary sources of these studies were unable to be located.

<sup>2</sup> Despite numerous attempts, the primary sources of these studies were unable to be located.

## CHAPTER 1: INTRODUCTION

2008). At the same time breastfeeding rates, which had remained quite stable until this time, began to steadily decline despite the infant welfare movement (Smith, 1993). It is difficult to ascertain how significant a role infant formula played on the decline in breastfeeding rates as numerous other factors were beginning to impact on the family unit and childcare in Australia. These will now be discussed.

### ***Industrialisation and medicalisation***

The movement of birth and early mothering into hospitals has taken women away from their traditional networks of support and has hindered the development of the 'embodied knowledge' of breastfeeding and the commitment to breastfeeding that can be seen among women who have witnessed breastfeeding as a normal mothering event (Griffiths et al., 2005). The 1970s, when many of today's new mothers were born or were young children, was a time of significantly low breastfeeding rates in Australia (Lester, 1994). So it could be assumed that many new mothers of today were not breastfed and/or did not commonly witness an infant being breastfed while they were growing up. This, in turn, would have increased new mothers' lack of knowledge related to breastfeeding and increased their breastfeeding support needs.

Industrialisation of the Australian family has also seen mothers become more isolated from their traditional support structure, often requiring mothers to juggle childrearing and employment with little support (Department of the Environment, Water, Heritage and the Arts [DEWHA], 2009). During World War I, Australian women were expected to primarily keep the home and care for the children. They were permitted to join voluntary organisations in aid of the war effort but were discouraged from working in paid jobs (DEWHA). With rapid industrialisation in the 1920s and 1930s (Baker, 2001) and the need for Australian women to take up paid jobs during World War II (DEWHA), the Australian family began to change. More and more women and mothers went to work, with many continuing to work after the

## CHAPTER 1: INTRODUCTION

war (Baker). Women were often expected to resign from employment when they became married or pregnant, but by the 1960s it was quite common for mothers to be in paid employment (Baker).

The increase in the number of employed mothers in Australia was followed by an increasing need for childcare. The Commonwealth Child Care Act of 1972 saw the provision of funding for extended-hours child care for all families allowing more women to juggle motherhood and work (Commonwealth of Australia, 2002). Many child care facilities began to accept infants from six weeks of age, a time when breastfeeding is still being, or has very recently been, established. The association between returning to work and the cessation of breastfeeding is strong (Guendelman et al., 2009, Scott, Binns, Oddy & Graham, 2006) and may have played a role in the rapid fall in Australian breastfeeding rates during the 1960s (NHMRC, 2003). Between 1983 and 2003 the number of mothers employed rose by more than 21 percent for partnered mothers and 18 percent for sole mothers (ABS, 2003). More recent statistics from 2007 show that over half (51.4%) of Australian mothers of children under four years of age were employed.(ABS, 2009).

Despite the fact that most Australian mothers work outside the home, they continue to be responsible for the largest proportion of unpaid domestic work in their homes (ABS, 2009; Burgess, Henderson & Strachan, 2007). This changed role for mothers has lead to numerous images depicting mothers literally juggling such items as a baby, a briefcase and a vacuum cleaner (iStockphoto, 2012; Vectorstock, 2011). In reality, the role of the modern Australian mother has become increasingly difficult and is likely to have impacted on mothers' ability to breastfeed for the recommended time frames.

As responsibilities became greater for the mother, the Australian fertility rate declined. In 1961 the total fertility rate (TFR), which gives an average of the number of children per



## CHAPTER 1: INTRODUCTION

mother, was 3.5 babies per woman (ABS, 2008). This rate continued to decline until the 1980s but has remained quite steady over the past twenty years with 2010 data showing the total fertility rate (TFR) of 1.89 babies per woman (ABS, 2010a). The ABS contributes much of the rapid decrease in the TFR to the increase of women undertaking education and the workforce and greater access to abortion and contraception. Women are also delaying childbearing with the median age of the mother at childbearing increasing from 27.3 years (1985) to 30.7 years (2007) in the past 22 years (ABS, 2010b).

The size of family units has also dwindled over the last century through the decline in the number of extended families. This change is significant as it would have resulted in reduced access to support for the breastfeeding mother. In 2001 only 4.2 percent of Australian children living with a parent lived in an extended family household (Australian Institute of Family Studies [AIFS], 2004). Statistics do, however, demonstrate that a modified extended family has developed that extends beyond the front door (AIFS). These families maintain close and supportive relationships despite not dwelling in the same household.

A study in 1996 illustrated that members of a modified extended family are particularly supportive when children are young with fifty percent of mothers with young children seeing their own mother at least weekly. These rates are slightly lower but still significant for seeing their fathers (38%) and siblings (34%) at least weekly (Millward, 1996). Another study of Australian families found that 65.5% of parents provided emotional support to their grown children (de Vaus, 2002). These statistics infer that while members of a mother's extended family are likely to live separately from her they are very likely to be providing emotional support, particularly when her children are young. Research has demonstrated that emotional support is an important factor in overall breastfeeding support (McInnes & Chambers, 2008; Sheehan, Schmied & Barclay, 2009).

## CHAPTER 1: INTRODUCTION

In comparison to Australian mothers of the late twentieth and early twenty-first centuries, mothers of today are more likely to be educated and juggling paid work, mothering and unpaid domestic work in the home. They are more likely to have their first child later in life and will often have between one and two children. They are less likely to be living in extended family groups but will often still have supportive relationships with members of their extended family. It is important for midwives to understand the dynamics of the modern Australian family as these factors impact on their support needs. For example, mothers returning to work may need information on expressing and storing breast milk and extended family members who have a close supportive relationship with the mother may be included in breastfeeding support sessions to assist them to support the mother post-discharge.

### ***Women as consumers of maternity care***

Women in Australia are beginning to have a voice about maternity care and are asserting that they need access to choice and quality midwifery care (Hirst, 2005, Reiger, 2006). In 2004 a Queensland review of maternity services was undertaken to examine the services available for pregnancy, birthing and postnatal care and recommended strategies for enhancing choices in these services for women (Hirst). Over 200 Queensland maternity consumers responded to the review, calling for changes to the way in which maternity care was delivered, including improved choices and access to care, improved information for consumers and access to midwifery continuity or care models (Hirst).

The Maternity Coalition (MC) is a national maternity consumer advocacy umbrella organisation representing maternity consumers in Australia (MC, 2011). In 2002 the MC released the National Maternity Action Plan (NMAP) which outlined the need for major maternity reform in Australia, and the strategies for achieving this reform. Some of the key suggested areas for reform outlined in the NMAP were for alternatives to the medical model

## CHAPTER 1: INTRODUCTION

in maternity services, access to midwifery continuity of care models and philosophical approaches that place women and their families at the centre of care (MC). The MC continues to drive these reforms through consumer action, including the lobbying of government to support the necessary changes (MC). In effect, maternity consumers are actively challenging the barriers to comprehensive midwifery practice. Women are beginning to have more of a voice in the reform of all facets of maternity care and are demanding that care is responsive to their needs. This study offers women an opportunity to have a voice regarding the provision of breastfeeding support. The stories of their experiences provide information that can be used to guide changes to care that will allow for positive changes in the provision of this support.

***Models of maternity care***

Another important contextual factor in the area of breastfeeding support relates to the models of care available for Australian women throughout the birthing continuum. The options for maternity care in Australia can be separated into public care, consisting of GP or midwife shared care and midwifery models of care, and private care, consisting of care with a private obstetrician or midwife. A significant proportion of maternity care in Australia is provided in tertiary, rather than primary care settings (DOHA, 2009) with the large majority (97.3%) of women in Australia birthing their babies in hospital settings (DOHA). Birth centre births make up a further 2%, with only 0.3% of mothers birthing their baby at home with a private midwife (Australian Institute of Health and Welfare [AIHW], 2009). Most women (55%) have their antenatal care in a public hospital. In this model, midwives are most likely to provide the majority of care in collaboration with obstetricians and other medical specialists where appropriate. Private obstetricians provide 30% of antenatal care, with the remaining 15% of care delivered by a GP (DOHA). Both public and private models of care provide options for continuity of care such as caseload midwifery and midwifery group practices; however

## CHAPTER 1: INTRODUCTION

women continue to have limited access to these models (DOHA). In all models of care, midwives are the most likely providers of postnatal care (DOHA) and, thus, are in an opportune position to promote breastfeeding as the optimal source of infant nutrition to new mothers.

### ***Breastfeeding: the optimal nutrition source for infants***

Breastfeeding is recognized as the optimal form of infant feeding, offering numerous health benefits to both the infant and mother (House of Representatives, 2007; World Health Organisation [WHO], 2002, WHO 2007). Much research has been conducted to study the physical, psychological and economical benefits of breastfeeding; with each showing that breastfeeding is superior to any other method of infant feeding and provides benefits in each of the areas studied.

One of the more pertinent benefits of breastfeeding is the reduction in infant mortality, related to the reduced rates of gastrointestinal and respiratory infections in breastfed infants (Gartner et al., 2005; Kramer, et al., 2001; Ladomenou, Moschandreas, Kafatos, Tselentis & Galanakis, 2010; WHO, 2007). Whilst the reduction in infant mortality is greater in developing countries where sanitation and hygiene are poor, the benefits do extend to more developed countries to a smaller degree (Chen & Rogan, 2004).

Breastfeeding has also been shown to significantly reduce infant morbidity (Gartner et al., 2005; Kramer, et al., 2001). As mentioned previously, the incidence of diarrhoeal illnesses and respiratory tract infections are reduced by breastfeeding. Another common infection shown to be significantly reduced in breastfed infants is otitis media (Ladomenou et al., 2010; Rovers, Schilder, Zielhuis, & Rosenfeld, 2004; WHO 2009). Breastfeeding has also been associated with a reduced risk for many chronic diseases such as asthma and allergies (Karen et al., 2009; Verhasselt, 2008), type 2 diabetes (Owen, Martin, Whincup, Smith, &

## CHAPTER 1: INTRODUCTION

Cook, 2006; Schack-Neilsen & Michaelsen, 2006; WHO 2009), hypertension (Martin, Gunnell & Davey Smith, 2005), obesity (Mayer-Davis et al., 2006; WHO 2009) and numerous childhood cancers (Martin et al.).

The WHO (2007) has confirmed a link between breastfeeding and cognitive development but suggest that it is difficult to ascertain whether these benefits result from the nutritional properties of breast milk or the mother-infant bonding that takes place during breastfeeding. Other studies have confirmed the link between breastfeeding and improved intellectual and motor development (Petryk, Harris & Jongbloed, 2007; Thorsdottir, Gunnarsdottir, Kvaran & Gretarsson, 2005). These links persist even after adjustment of results for potential confounders. Dose-response relationships have been consistently identified (Petryk et al, 2007; Thorsdottir et al, 2005) highlighting the advantages of exclusive and prolonged breastfeeding.

Maternal health benefits from breastfeeding have also been identified. An immediate benefit of breastfeeding shortly after birthing is the reduced risk for postpartum haemorrhage (Chua, Arulkumaran, Lim, Selamat, & Ratnam, 1994; WHO, 2009). Longer term benefits include a reduction in the risks of breast cancer (Gajalakshmi et al., 2009), cervical cancer (Okamura et al., 2006; WHO) and ovarian cancer (Danforth et al., 2007; WHO).

Breastfeeding has an additional economic benefit that extends beyond just the family of the breastfed infant. The costs associated with feeding (Waltemyer, 2008) and providing health care (Cattaneo et al., 2006) to formula-fed infants is significantly higher than those associated with breastfed infants. Additionally, significant environmental costs related to formula production, transport and metal and paper waste are associated with formula feeding (Gartner et al., 2005).

## CHAPTER 1: INTRODUCTION

Given the proven benefits of breastfeeding for both the mother and baby it critical that new mothers receive adequate and effective support in learning to breastfeed. The ability to successfully breastfeed provides far better health outcomes than just optimal nutrition for the newborn. Assisting mothers to successfully breastfeed becomes an investment in the long term health of mothers and babies and the environment in which they live. In view of these benefits to the health of Australia, the Australian government has developed a national strategy to improve breastfeeding rates in Australia.

### ***Australian National Breastfeeding Strategy 2010-2015***

In 2007, a parliamentary inquiry into the health benefits of breastfeeding, titled *The Best Start*, was undertaken and provided an overwhelming argument for improving Australia's breastfeeding rates (House of Representatives, 2007). In 2009, in response to the inquiry, the Australian Health Ministers Conference announced the Australian National Breastfeeding Strategy 2010-2015. The Strategy outlines 15 goals for increasing the percentage of exclusively breastfed babies up to six months of age and the continuation of breastfeeding with complimentary foods to one year and beyond. (AHMC, 2009). The goals focuses are towards improved cultural acceptance and valuing of breastfeeding, improved education and support for breastfeeding mothers, provided by both health professionals and the wider community, improved breastfeeding education for health professionals and an increase in the number of health services with breastfeeding policies in place, with an overarching aim of improving breastfeeding rates (AHMC, 2009).

### **Baby Friendly Health Initiative**

The Baby Friendly Health Initiative (BFHI) was developed by the World Health Organisation (WHO) in partnership with UNICEF in 1991. The purpose of this initiative was to provide support to health facilities in the implementation of practices that "protect, promote and

## CHAPTER 1: INTRODUCTION

support breastfeeding” and to provide accreditation to those facilities that met certain practice criteria (WHO & UNICEF, 2009, p.1). These practices are outlined in the ten steps to successful breastfeeding that were developed in 1989 (WHO & UNICEF) and the 7 Point Plan for a Baby Friendly Community (UNICEF, 2011). Since its introduction, over 20 000 health facilities have been awarded BFHI accreditation (WHO & UNICEF, 2009).

The BFHI was introduced in Australia in 1993 and is governed by the Australian College of Midwives (ACM) (BFHI Australia, 2012). In 2012 there were 77 Australian health facilities with BFHI accreditation, with 16 of these located in Queensland (BFHI Australia, 2012). Approximately 30% of Australian babies are born in BFHI accredited hospitals, however BFHI Australia aim to increase this rate to 100% (BFHI Australia, 2012).

### ***Breastfeeding rates in Australia***

Up until the 1930s breastfeeding had been the norm for infant feeding in Australia (NHMRC, 2003), however breastfeeding rates began to decline in the 1930s (Smith, 1993). The 1960s were associated with the lowest breastfeeding rates in Australia's history, with Victorian rates showing that only fifty to sixty percent of mothers breastfed at hospital discharge and only twenty one percent were still breastfeeding at three months (NHMRC, 2003). These low rates continued into the early 1970s, when many new mothers of today were being born, until breastfeeding rates began to rise in the second half of that decade (Lester, 1994). By the early 1980s, Australia had breastfeeding rates of eighty five percent at discharge and fifty five percent at three months (NHMRC, 2003).

The WHO (2002) and the National Health and Medical Research Council of Australia [NHMRC] (2003) recommend exclusive breastfeeding for at least six months for maximum nutritional and health benefits. The NHMRC set breastfeeding targets for the following 10 years which aimed for eighty percent of mothers to be fully breastfeeding their infant at six

## CHAPTER 1: INTRODUCTION

months. The most recent data show that breastfeeding duration and rates in Australia fall well below these recommendations. The Australian Bureau of Statistics (ABS) reported data collected from the 2004-2005 National Health Survey which indicated that only 52% of infants were receiving any breast milk by four to six months of age (2007a). More specifically, research conducted by the Australian Institute of Family Studies [AIFS] (2008) found that only 14% of infants are fully breastfed at six months of age.

This disparity in reported breastfeeding rates may be related to inconsistent definitions of breastfeeding in Australian research and statistics collection. The AIFS set a specific definition of exclusive breastfeeding (2008) while the ABS reported on any breastfeeding and only used one child per family as a representative for all (2006). The lack of an accurate definition of breastfeeding often results in breastfeeding rates appearing more positive than they are as infants fed once per day can be classified as breastfeeding despite the fact that their primary nutrition source may be infant formula or family foods. The low rates reported in the 1970s are likely to have been significantly lower if exclusive breastfeeding had been consistently defined and the indicator reported.

***Inconsistent breastfeeding definitions***

Data collection of national breastfeeding rates in Australia is infrequent and poorly described in that it lacks an appropriate or standardized definition of breastfeeding and relies on the recall of women over several years. Questions from the 2004-2005 National Health Survey determined whether the child, aged 3 years or less, had ever been breastfed and whether they were currently being breastfed (ABS, 2006). The survey lacked an adequate breastfeeding definition. Additionally, data was only collected on one child from the family, chosen at random (ABS), further reducing the accuracy of data collected.



## CHAPTER 1: INTRODUCTION

The use of an international, standardised breastfeeding definition would allow researchers to provide, access and review consistent data related to the state of breastfeeding internationally. Lobbok and Krasovec (1990) produced a schema for breastfeeding definition in which breastfeeding was categorised as either full, partial or token. The World Health Organisation (WHO, 1991) met the following year to formulate a similar breastfeeding definition. The defined categories of breastfeeding were exclusive, predominant, full, complimentary and non-breastfeeding.

A review of 26 Australian studies reporting on exclusive breastfeeding (Binns, Fraser, Lee & Scott, 2009) found that only half of these used a definition of exclusive breastfeeding that was consistent with the WHO definition (1991) or Lobbok and Krasovec's definitions (1990). The significance of the findings of studies that do not define breastfeeding in a manner consistent with these definitions is difficult to determine, confirm and compare.

For this current study, the definition used for exclusive breastfeeding is the mother providing the baby with breast milk only via the act of breastfeeding without the use of a nipple shield. Other feeding methods identified in this study include breastfeeding with a nipple shield, giving expressed breast milk by any means, artificially feeding with infant formula, and combination feeding breast milk and formula.

### **Outline of the thesis**

Chapter One, presented an overview of this study about new mothers' experiences of receiving breastfeeding support from midwives. The study's aims and objectives were presented along with the significance of the study for midwives, mothers and babies. This chapter also presented the background to the study and the significance of this study.

## CHAPTER 1: INTRODUCTION

Chapter Two presents the literature surrounding breastfeeding and breastfeeding support. The benefits of breastfeeding are presented along with historical and current data regarding breastfeeding in Australia. New mothers' need for breastfeeding support is examined along with the most likely sources of such support. Strengths, weaknesses and gaps in the available literature are identified and key themes in the literature are summarised, providing further justification for the study.

Chapter Three presents Grounded Theory (GT), the qualitative methodological approach chosen to research new mothers' experiences of receiving breastfeeding support from midwives, and the symbolic interactionism underpinning this method. Included in this chapter is a description of the GT approach used for this study and the rationale for choosing this method. Furthermore, this chapter provides explanation of the sampling methods used for this study and the site from which the new mothers were recruited. Ethical considerations and rigour are also addressed.

Chapter Four presents the results of this study. The results are presented in the form of an explanatory matrix outlining the core category of WORKING IT OUT and its relationship to each of the other categories that emerged during the study. A further explanation of these categories and their properties act to tell the story of new mothers' experiences of learning to breastfeed and receiving breastfeeding support.

The final chapter, chapter five, presents a discussion and reflection on the findings, how they relate to the literature and the contribution they make to the professional body of knowledge on breastfeeding support. This chapter also discusses the implications of the study for midwives supporting new mothers to breastfeed, including recommendations for practice, education and further research. The limitations of this study are also presented, followed by a conclusion to the thesis.

## CHAPTER 1: INTRODUCTION

### **Summary**

This chapter has presented the rationale for the study by highlighting the importance of midwifery breastfeeding support for new mothers and proposes that there is a need for further evidence on how midwives can best support new mothers while they are learning to breastfeed. The next chapter examines and evaluates existing research on the many facet of breastfeeding support including the sources, types and timing of this support. Mothers' expectations of breastfeeding support are examined as well as their need for, and experience of, this support. The mother-midwife partnership is examined and related to the provision of breastfeeding support. Additionally, literature is examined related to the way breastfeeding support is defined by different groups and what the literature defines as detrimental breastfeeding support.

CHAPTER 2: LITERATURE REVIEW

**CHAPTER 2 - LITERATURE REVIEW**

**Introduction**

The purpose of this chapter is to present a synthesis of the literature that was reviewed prior to and following data collection and analysis in this study of *new mothers' experiences of receiving breastfeeding support from midwives*. The initial literature review was conducted to explore and critique literature relating to the study topic and to demonstrate a need for the study. Further reviews of the literature served to update the literature related to the concepts identified in the initial review and support the analysis and discussion of the study findings.

The timing of an in depth literature review in Grounded Theory research is controversial with developers Glaser and Strauss having different views on the need to conduct an initial literature review and how the literature is used by the researcher (McGhee, Marland & Atkinson, 2007). Glaser (1992) argued that reviewing the literature too early could lead the researcher to have pre-conceived ideas and then to force the data into these pre-conceived categories rather than to let the concepts emerge from the data inductively. In contrast, Strauss and Corbin, believed that an early literature review assisted the researcher to develop questions, understand where to best gather data, and to be more aware of the researcher's pre-existing ideas and the complexities in the settings where data are being collected (1990). In this study, an early in-depth literature review was conducted in 2004, prior to commencing the study, to identify and critique existing studies related to midwifery breastfeeding support and justify the need for the study. Furthermore, the literature review increased theoretical sensitivity by increasing awareness of my personal beliefs relating to the topic and encouraging me to challenge these beliefs.

The initial literature review focused on a broad range of topics related to women's experiences of breastfeeding support, particularly literature pertinent to the context of

## CHAPTER 2: LITERATURE REVIEW

Australian breastfeeding mothers and breastfeeding support. Further reviews of the literature, conducted in 2009 and 2011, served to update the literature surrounding breastfeeding support and, in many cases, further support the findings of studies in the earlier review.

Numerous themes emerged from the literature on breastfeeding support. However very few of the studies focus on *midwifery* breastfeeding support, instead examining the role of health professionals in the provision of this support. The themes covered within the literature have been synthesised and are discussed under the following 10 headings:

- New mothers' experiences of breastfeeding
- The need for breastfeeding support
- Definitions of breastfeeding support
- The supportive relationship
- Practical support
- The silent conspiracy (expectations of breastfeeding)
- Reality of breastfeeding
- The timing of breastfeeding education
- Detrimental breastfeeding support
- Other sources of breastfeeding support

The first two of the themes, new mothers' experiences of breastfeeding and the need for breastfeeding support, analyse literature that examines the current breastfeeding experience for mothers and highlight that mothers are calling for more effective breastfeeding support. The following three themes, analyse the literature that focuses on what constitutes support and, more specifically, midwifery breastfeeding support. The literature focuses on defining breastfeeding support and its elements. The following two themes, the silent conspiracy (expectations of breastfeeding) and reality of breastfeeding, present the literature that focuses on new mothers' expectations of breastfeeding and the mismatch between these

## CHAPTER 2: LITERATURE REVIEW

expectations and the realities of breastfeeding, supporting that mothers are unprepared for breastfeeding and thus, require midwifery breastfeeding support. An analysis of the literature exploring the timing of breastfeeding education, as a method of support, is also presented. The theme labelled detrimental breastfeeding support incorporates an analysis of literature that examines practices of midwives and other health professionals that mothers find unhelpful to their breastfeeding efforts. The final theme, other sources of support, analyses the literature that focuses on the support offered by other health professionals, family, friends and peers. Particular attention is given to the literature surrounding peer breastfeeding support and the elements that cause it to be so highly rated by mothers.

Several topics that were identified in the initial review have received significantly less attention in recent literature. These topics were kept in the review as they are likely to still represent issues of importance to breastfeeding mothers today. These topics are defining breastfeeding success, the need for practical support, the realities and drawbacks of breastfeeding, conflicting advice and rough handling. Further literature relating to concepts that emerged during data analysis is included in the discussion chapter.

### **Search strategies**

Literature was sought from the electronic databases of MEDLINE, CINAHL, INFOTRAC, EBSCOhost and the Cochrane Library. The search terms used for breastfeeding were "lactat\*", "breastfeed\*", "breast feed\*" and "infant feed\*". The search terms used for support were "help", "educat\*", "care", "inform\*", "assist\*", "promot\*", "advice" and "support\*". Each of these terms was searched again with the added search term "midwife\*" to find articles that were likely to include information on midwifery breastfeeding support. Abstracts of articles were viewed to determine the suitability of articles. Levels of research evidence were not set as limits in searching as many of the studies of interest were qualitative and, thus, not rated

## CHAPTER 2: LITERATURE REVIEW

on evidence hierarchies. Of those studies that were quantitative, preference was given to those with the highest levels of evidence as defined by the NHMRC's evidence hierarchy (2008) such as systematic reviews and randomised-control trials (RCT). Peer-reviewed sources were used wherever possible. As previously stated, current literature was considered to be that which was no greater than eight years old. Subsequent reviews sought to update literature, however, in some cases, more recent studies were not identified.

The reference lists of key articles were screened for further sources that had not been identified in the initial searches. Further searching of journal indexes and Google Scholar was carried out for those journals not included on the electronic databases. In addition, the Australasian *Digital Theses* Program database was searched for unpublished theses on the research topic.

**New mothers' experiences of breastfeeding**

Numerous Australian studies over that last 8 years have focussed on mothers' experiences of breastfeeding and breastfeeding cessation, and found that, for many mothers, there is a mismatch between the expectations and realities of breastfeeding (Burns, Schmied, Sheehan & Fenwick, 2010; Hauck & Irurita, 2003; Hauck, Langton & Coyle, 2002; Hall & Hauck, 2007; Larsen, Hall & Aagard, 2008; Sheehan, Schmied & Barclay, 2009; Scott et al., 2006). This mismatch has remained a consistent focus in the literature over the past eight years. Such a mismatch may leave new mothers feeling surprised, disillusioned and wondering what went wrong.

Breastfeeding problems are one of the most common reasons for breastfeeding cessation in the early postpartum period (Brand, Kothari & Stark, M, 2011; ILCA, 1999 & Scott et al, 2006). Both the NHMRC (1996) and ILCA (1999) recommend providing anticipatory guidance for breastfeeding problems to allow women to be equipped with the knowledge and

## CHAPTER 2: LITERATURE REVIEW

skills to problem-solve if breastfeeding difficulties arise. Women who are provided with realistic guidance find breastfeeding a less confronting and disappointing experience (Schmied, Sheehan & Barclay, 2001) and may be less at risk for early breastfeeding cessation (Scott et al., 2006).

One of the more confronting findings from breastfeeding research is that women who experience early breastfeeding cessation are often left with significant feelings of guilt and/or distress (Cooke, Schmied, & Sheehan, 2007; Hegney, Fallon & O'Brien, 2008; Kelleher, 2006) with women expressing that they would have liked to have breastfed for longer (Graffy & Taylor, 2005; Hamlyn, 2002; McLeod, Pullon, & Cookson, 2002). Lewallen et al. (2006) explored the relationship between breastfeeding support and early breastfeeding cessation and found that many of the reasons for early cessation are amenable to health care intervention. With a greater understanding of new mothers' breastfeeding support needs, midwives may be able to have a positive impact on breastfeeding rates and duration.

The initiation and prolonged duration of breastfeeding is often the goal of health professionals in measuring breastfeeding success. Furthermore, success measures often relate to the physical and technical components of latching and milk transfer (Mulder, 2006). In contrast, women often measure the success of breastfeeding on their own experiences and their infant's contentment (Hauck & Irurita, 2003). The literature shows that, although many mothers find health professionals supportive of breastfeeding, many others discuss practices which are detrimental to their breastfeeding experiences (Hegney et al., 2008; Sarasua, Clausen & Frunchak, 2009; Schmied, Sheehan, McCourt, Dykes, Beake & Bick, 2008; Sheehan et al., 2009). The literature has failed to explore this experience from the perspective of receiving *midwifery* breastfeeding support, demonstrating a limited understanding of mothers' experiences of midwifery breastfeeding support and further justifying the focus of this current study.



## CHAPTER 2: LITERATURE REVIEW

**The need for breastfeeding support**

Many new mothers who choose to breastfeed face both physical and psychological difficulties in the early postpartum period (House of Representatives, 2007; Kelleher, 2006; Nelson, 2006). Without adequate support to overcome these difficulties, many decide to discontinue breastfeeding (Britton, McCormick, Renfrew, Wade & King, 2007; Gilmour, Hall, McIntyre, Gillies & Harrison, 2009). Conversely, support given to breastfeeding mothers is positively associated with an increased duration and exclusivity of breastfeeding (Britton et al., 2007; Henderson & Redshaw, 2010). Therefore, it is important for midwives to question how they can further support new mothers in their attempts to breastfeed. Again the literature reviewed focuses on breastfeeding support from various sources, including health professionals, doctors, peers and family members. It is therefore difficult to ascertain how midwifery breastfeeding support impacts on the experience of difficulties in the postnatal period and mothers' abilities to overcome them. This study seeks to answer this question by questioning mothers about midwifery support specifically.

**Definitions of breastfeeding support**

Often studies related to breastfeeding support fail to define what is meant by the term 'support'. The difficulties in defining the term support can be illustrated by the abundance of definitions available in published dictionaries. For example, yourdictionary.com (2011) provides nine definitions of support including "to give courage, faith, or confidence to; help or comfort" and the Merriam-Webster online dictionary (2009) includes fourteen definitions including to "assist, help", to "maintain" and to "advocate". In the literature, the term support is often interchanged with terms such as encouragement, care, help, promotion, education and advice.

## CHAPTER 2: LITERATURE REVIEW

When the relationship between support and health are investigated, the literature discusses support in terms of social support. Social support is normally broken down into four types of support. The initial three types, emotional, instrumental or tangible, and informational support (House, 1981; Uchino, 2004; Wills, 1985), feature in the varying definitions of social support. The fourth type has been identified as appraisal (House, 1981) or companionship (Uchino, 2004; Wills, 1985). Emotional support refers to the provision of empathy, caring and love. Instrumental support involves the direct provision of practical, tangible assistance. Informational support is the giving of information and advice for addressing problems, and appraisal support is the provision of feedback and encouragement (House, 1981). Each of these types of support feature strongly in the literature surrounding breastfeeding support.

Guided by Grounded Theory, 30 definitions of social support found in academic literature were critically reviewed by Williams, Barclay and Schmied (2004). The authors identified a number of categories including ideas related to relationships, social ties, time and timing, supportive resources, impact of support, intentionality of support, the recognition of support requirements, perceptions of support, satisfaction with support, actual support and characteristics of the provider and recipient of the support (Williams et al.). Of the 30 definitions identified, the authors concluded that only two could be used with any confidence. The definitions identified were those developed by Gottlieb (1978) and Coffman and Ray (2002). Gottlieb's definition identified four overarching classifications of support which they labelled "emotionally sustaining behaviours", "problem-solving behaviours", "indirect personal influence", and "environmental action" (p. 108) within which 26 helping behaviours were further identified. The definition of social support proposed by Coffman and Ray focused on the concept of "mutual intentionality" (p. 538) which included such attributes as caring, respecting and believing in one another, and required each person to be there for one another, sharing information and doing for the other person. According to Williams et al., these two definitions were developed using a "qualitative and contextualised approach"

## CHAPTER 2: LITERATURE REVIEW

(p.958); an approach that the authors contended is the most effective for the development of definitions of social support for use in research and practice. These definitions show that support is a complex and multi-faceted concept that cannot be simply defined.

Breastfeeding support is often defined by its elements. In a review of professional support for breastfeeding, the interventions constituting breastfeeding support were observation, guidance, communication, encouragement, information and technical assistance (Hannula, Kaunonen & Tarkka, 2008). Sheehan et al. (2009) used mothers' descriptions of positive support behaviours and inverted negative support behaviours to provide a list of positive breastfeeding support. Positive support consisted of "emotional support, acknowledgement, approval, being available, providing practical support, staying with you, being sensitive and being flexible" (p. 146).

The above definitions of support vary in that some describe the elements of the supportive interaction, others describe attributes of the provider of support while others describe supportive practices. Many definitions seem to provide only a part of the whole, while the definitions by Gottlieb (1978) and Coffman and Ray (2002) provide more complete definitions that incorporate the interplay of the supportive interaction, the supporter and behaviours and practices that constitute support. These definitions are most appropriate in guiding midwifery practice as they reflect both the actions and complex interpersonal interactions necessary for support.

Breastfeeding support may be considered from both the views of health professionals and mothers.. In 1989 WHO/UNICEF issued a joint statement titled Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services which described the elements of breastfeeding support, focusing on health care practices that can support

## CHAPTER 2: LITERATURE REVIEW

breastfeeding (WHO/UNICEF, 1989). A summary of these elements can be found in The Ten Steps to Successful Breastfeeding within the publication.

It seems appropriate for those who receive support to contribute to its definition through their stories of the interactions, behaviours and practices that constitute support. The literature provides many descriptions from mothers that could further contribute to defining support. Mothers' definitions of breastfeeding support are often interwoven in their stories and dialogue rather than formally announced, and are often described in relation to their experiences of receiving such support. This is illustrated in comments by new mothers in Sheehan et al. (2009) such as "when you have someone who sits with you and persists with you, which I had... it makes it easier" (p. 142) and "I needed to hear that because it reassured me in what I was thinking" (p. 144). An Australian study (Cooke & Stacey, 2003) asked new mothers to rate the importance of various forms of postnatal support. The forms of breastfeeding related support that fell under the categories of practical assistance, information and advice and emotional support were rated as very important or essential by all new mothers (Cooke & Stacey). This suggests that there are similarities in how women and health professionals define breastfeeding support. However, the forms of support offered for rating were preselected by the researcher and did not allow the participants to comment on other forms of support they may have deemed important.

For the purpose of this research, the definition of support proposed by Coffman and Ray (2002) is adopted as it seems to incorporate all of the elements of support that mothers identified in the literature.

### **The supportive relationship**

A number of the definitions of support illustrated the importance of interpersonal interactions and the development of supportive relationships. Mothers have confirmed that the

## CHAPTER 2: LITERATURE REVIEW

development of relationships with health professionals is critical for support to occur. In a descriptive study of 182 mothers, Hoddinott and Pill (2000) reported that women highly valued the formation of relationships with health professionals and distinguished between those who really seemed to care from those who were more impersonal. In a synthesis of research exploring the concept of care for high risk childbearing women, Berg (2005) concluded that a well established relationship between the mother and midwife was essential in allowing the midwife to perform genuine caring. Likewise, an ethnographic study of the cultures, beliefs and practices of free standing birth centres led Walsh (2006) to claim that the development of a good relationship between the mother and midwife allowed women to feel supported in their transition to the role of new mother.

Care provided by health professionals that women found supportive of breastfeeding was examined by Schmied, Beake, Sheehan, McCourt and Dykes (2011) in a metasynthesis of qualitative studies on breastfeeding support. Having a trusting relationship in which the midwife was there for the mother, took time, was empathetic, encouraging, responsive and shared the experience with the mother were highly valued by mothers (Schmied et al.). The authors termed this care "authentic presence" and found that it allowed for more appropriate support which was perceived by mothers to be more effective (p.51).

Care has been identified by mothers as an important part of breastfeeding support (Dykes, 2005; Gill, 2001; Raisler, 2000). Three ethnographic studies illustrated the importance of care through the inclusion of quotations that were transcribed verbatim from interviews and focus groups. The use of quotations as raw data allows the reader some confirmation of the post-analysis findings. When women in Raisler's (2000) study were asked how their peer counsellors differed from health professionals in supporting breastfeeding they replied "she's more personal", "she really cares" and "she never talks down to you like sometimes a health professional might...you can tell if somebody is really interested..."(p.258).

## CHAPTER 2: LITERATURE REVIEW

Mothers also used the word 'caring' to describe those who had offered positive breastfeeding support. This was demonstrated in a study of the encounters between midwives and breastfeeding mothers (Dykes, 2005). One mother commented on her encounters with a particularly "caring" midwife as follows, "(She) has really helped me, building my confidence by praise and saying, 'You're doing fine'... She knew exactly what was going on. She spends time with you." (p.248). Each of these studies were conducted outside of Australia, pointing to a need for Australian research into the relationship between mothers and midwives and the role it plays in breastfeeding support.

### **Practical Support**

Studies reviewing mother's experiences of receiving breastfeeding support from health professionals have enabled mothers to declare their learning needs quite clearly. A resounding call from women for more practical, apprentice-style learning opportunities for breastfeeding was repeated throughout the literature. This requirement was well articulated in a U.K. study by Graffy and Taylor (2005). The authors sampled 654 postpartum mothers, who completed a questionnaire six weeks after the birth of their baby. The study's purpose was to examine mothers' perceptions of the breastfeeding support they had received. Findings showed that the type of support consistently rated as the most helpful for mothers was having someone demonstrate to them how to position and attach the baby to the breast. One of the women in the study expressed her wish for this practical support when she stated "I wanted someone to sit down with me and show me what to do" (p.182).

The teaching of practical techniques by health professionals was also considered supportive by the mothers in a phenomenological study of 19 first-time breastfeeding mothers from the US (Phillips, 2011). The mothers in this study wanted practical support to assist them with skills, such as positioning their baby to the breast, and believed this type of support was

## CHAPTER 2: LITERATURE REVIEW

necessary for them to gain the necessary skills to be able to breastfeed on their own (Phillips). Gill (2001) labelled breastfeeding support as information, encouragement, and interpersonal support. Although mothers in this study valued written and verbal support, they, again, requested more practical support, with a theme of “show me, don’t tell me” arising from their comments. Further studies provided women’s comments on the negative experience of being told what to do rather than assisted to breastfeed (Bondas-Salonen, 1998; Raisler, 2000).

The focus on the hands-off technique for breastfeeding support may be confusing midwives, leading them to believe that they should restrict their teaching to purely written and verbal methods. However, the need for breastfeeding demonstration is illustrated by Hoddinott and Pill’s study (2000) where mothers asked to be shown how to breastfeed rather than asking a midwife to handle their breasts. Further research in Australia is required to ascertain the experiences of mothers in receiving different styles of breastfeeding support.

### **The Silent Conspiracy (Expectations of breastfeeding)**

Studies exploring mothers’ experiences of breastfeeding and breastfeeding cessation have found that, for many mothers, there is a mismatch between the expectations and realities of breastfeeding. Such a mismatch may leave new mothers feeling surprised, disillusioned and wondering what went wrong. It is a time when many mothers first become aware of their need for breastfeeding support in order to overcome the problems they face. As this mismatch becomes evident for most mothers in the early breastfeeding period (Larsen, Hall & Aagaard, 2008), midwives are the most likely providers of this support. The role of midwives in assisting new mothers through this critical time needs to be further explored and will be an area of focus for this current study.

## CHAPTER 2: LITERATURE REVIEW

Antenatal expectations of breastfeeding and the discourse of breastfeeding as natural have been found to strongly influence mothers' breastfeeding confidence (Larsen et al., 2008) according to the findings of a metasynthesis of seven qualitative studies on mothers' breastfeeding experiences. The authors discuss the discourse of breastfeeding as natural as the mother's belief that breastfeeding will happen easily and her inability to foresee the potential demands of learning to breastfeed. The studies included in this metasynthesis came from a variety of western countries including Australia and the U.K, suggesting that this discourse is likely to shape the expectations of mothers in Australia.

A recent Australian Grounded Theory study (Sheehan et al., 2009) provided insight into 37 mothers' experiences of early breastfeeding and breastfeeding support. Again, the mothers discussed that they did not expect breastfeeding to be as difficult as it was. Many mothers in this study believed they had not received honest information to prepare them for the realities of breastfeeding and illustrated this with comments such as "people don't sort of talk about problems" (p.144) and "I guess people don't really want to tell you too many bad stories" (p.144). This lack of honest information caused the mothers to blame themselves when problems arose. Through qualitative data collection methods, this study allowed the mothers to talk about their experiences of feeling unprepared and to provide examples and explanations for this. Although the data were from a smaller cohort of mothers than Larsen et al.'s study (2008), the data are rich; telling a story that is difficult to misconstrue. This study strengthens the notion that new mothers are unprepared to face the difficulties of early breastfeeding and need early breastfeeding support to overcome such difficulties.

In line with the findings in Sheehan et al. (2009) was a theme labelled the "conspiracy of silence" that arose in a survey of 79 first-time mothers in Australia (McVeigh, 1997, p335). McVeigh reported that mothers' written comments regarding postpartum experiences focused around the unpreparedness for mothering experienced by the women surveyed.



## CHAPTER 2: LITERATURE REVIEW

Comments such as “No one told me...” (p.341) or “Why didn’t somebody tell me...” (p.341) further illustrated this experience. The terms “nobody” or “somebody” may point to the fact that women view the need for this information from a social context rather than from midwives specifically. There is a need to question mothers about how midwives can provide support that better prepares them for the realities of breastfeeding. The need for preparatory breastfeeding support will be further explored with mothers in this current study.

An Australian phenomenological study (Harris, Nayda & Summers, 2003), using in-depth conversational interviews of six postpartum mothers, reported that mothers perceived that both people in their social network and professionals had downplayed discussions regarding breastfeeding management issues. Harris et al. also discussed the “conspiracy of silence” (p.25) and believed that new mothers often had a limited awareness of the complex nature of the postnatal period which promoted feelings of failure when problems arose. One mother discussed this ‘silence’ from her friends by saying “they painted a picture that was wonderful. A baby was no problem.” (p.25). This literature demonstrates how a lack of awareness of the complex nature of breastfeeding can have negative emotional consequences for mothers when the realities of breastfeeding become apparent. This strengthens the idea that new mothers need to be supported to be better prepared for breastfeeding and the breastfeeding problems they may face to limit their self perceptions of failure when problems do occur.

The breastfeeding expectations of another group of Australian mothers were found to be dynamic; based on both their own expectations and their changing knowledge and beliefs influenced by their current experience, health professionals, media, literature and the opinions of others (Hauck & Irurita, 2003). With so many sources of breastfeeding information for mothers-to be, there is a need for women to receive evidence-based and realistic information about breastfeeding prior to its initiation. This current study will further explore the types of information that women want in preparation for breastfeeding.

## CHAPTER 2: LITERATURE REVIEW

The findings of the preceding two Australian studies reflect a cultural practise of not discussing breastfeeding problems with other women. Both the NHMRC (1996) and ILCA (2005) recommend providing anticipatory guidance for breastfeeding problems. Midwives are perfectly positioned to provide breastfeeding guidance in the antenatal period, particularly in regards to providing information on how to breastfeed and overcome common breastfeeding problems. The ILCA (2005) reports breastfeeding problems are one of the most common reasons for breastfeeding cessation in the early postpartum period (ILCA, 2005; Scott et al, 2006). Women who are provided with realistic anticipatory guidance find breastfeeding a less confronting and disappointing experience (Schmied et al., 2000) and may be less at risk for early breastfeeding cessation (Scott et al., 2006).

### **Reality of breastfeeding**

The unpreparedness of women for breastfeeding problems and inconveniences is closely ensued by the reality that breastfeeding is a complex, and often difficult process and new mothers require support to solve the problems they encounter. The following literature further explores mothers' experiences of the realities of breastfeeding.

The reality of breastfeeding problems was illustrated in an Australian longitudinal cohort study (Cooke, Schmied & Sheehan, 2007) which explored 449 women's breastfeeding experiences to determine links between maternal distress, breast feeding problems and cessation and maternal role attainment with breastfeeding. Over half of the women (51%) reported experiencing breastfeeding problems and 86% of the mothers stopped breastfeeding earlier than they had initially planned. These results are limited to the setting of the research being in one Australian city, however the large scale to which the mothers experienced a negative breastfeeding reality is concerning. This current study will further

## CHAPTER 2: LITERATURE REVIEW

explore new mothers' experiences of the realities of breastfeeding and ask them to evaluate the role of midwives in supporting them to overcome breastfeeding difficulties.

The expectation that breastfeeding was not easy was not enough to protect mothers from the mismatch between breastfeeding expectations and realities. Hauck, Langton and Coyle (2002) used phenomenology to study the lived experience of breastfeeding difficulties in 10 Australian mothers. The women in this study expressed "shock and disbelief" (p.6) at the reality of breastfeeding problems. Some of the mothers in this study had expected that breastfeeding would not be easy but, despite this, found they were unprepared for the realities they faced. It is worthy to note that half of these women were nurses, with four also being midwives. It is assumed that, at least, the midwives in this study held a high level of breastfeeding knowledge. Although the professions of these four women may have contributed to bias within this study, it is valuable in suggesting that increasing women's knowledge of breastfeeding problems alone is not adequate in providing effective support throughout this period of realization. Interestingly, women in another study commented that too much information added to the stress they experienced (Schmied et al., 2000). This study will ask mothers how midwives can support them to be better prepared for the realities of breastfeeding. The findings will assist midwives to provide preparatory support that is considered most appropriate by mothers in preparing them to breastfeed.

Further experiences that mothers in several studies did not anticipate were those of fatigue (Hall & Hauck, 2007; Philips, 2011), isolation (Gill, 2001; Hall & Hauck, 2007; McVeigh, 1997), pain (Hall & Hauck, 2007; Hauck, Fenwick, Dhaliwal & Butt, 2011; Raisler, 2000), disorganisation (Raisler, 2000), confusion (Hauck et al., 2002), exposure (Harris et al., 2003; Hoddinott & Pill, 1999; Raisler, 2000), resentment towards their baby (Harris et al., 2003) and feeling tied down (Hall & Hauck, 2007; Hauck et al., 2011; Phillips, 2011). Although the findings of so many negative experiences may be concerning, they enable midwives to better

## CHAPTER 2: LITERATURE REVIEW

understand mothers' breastfeeding experiences and to use this knowledge to better prepare them to support mothers through this time of upheaval and realisation. The sources used to create this list of concerns are primarily studies conducted in other countries, reflecting a gap in the literature related to the breastfeeding experiences of Australian mothers. The findings from this current study will provide further evidence of the breastfeeding experiences of mothers in Australia.

### **The timing of breastfeeding education**

The provision of information, advice and education have been identified as components of support (Coffman & Ray, 2002). Most new mothers have a significant amount to learn about breastfeeding and midwives in postnatal inpatient areas have little time for teaching (Schmied et al., 2011). Research often raises the debate of whether or not antenatal breastfeeding education is effective. Three extensive reviews of the benefits of antenatal education continue the debate. A Cochrane systematic review (Britton et al., 2009) explored the findings of 34 randomised controlled trials, involving 27 385 mother-infant pairs, to assess the effectiveness of different types, timing and providers of breastfeeding support interventions on breastfeeding duration. When assessing the timing of support, the authors concluded that the effect on breastfeeding duration in studies containing an antenatal element of breastfeeding support was not significant. In contrast, there was significant effect on breastfeeding duration in studies using only postnatal breastfeeding support (Britton et al., 2009).

An evaluation of the effect of antenatal breastfeeding education on the duration of breastfeeding was undertaken in another Cochrane systematic review of 14 studies including 6932 women (Lumbiganon, Martis, Laopaiboon, Festin, Ho, & Hakimi, 2011). Breastfeeding education during pregnancy appeared to increase the duration of breastfeeding however the

## CHAPTER 2: LITERATURE REVIEW

effects were small. The authors concluded that the small effect, coupled with the fact that the included studies were of a poor quality, resulted in an inability to make any resultant recommendations related to antenatal breastfeeding support (Lumbiganon et al.). The effectiveness of prenatal and postnatal interventions on breastfeeding duration was examined in a systematic review of 37 experimental studies, involving 20 253 participants (de Oliveira, Camacho & Tedstone, 2001). In contrast to the conclusions of Britton et al. (2004) and Lumbiganon et al., the authors of this study found that interventions containing prenatal or combined prenatal and postnatal elements were more effective than those containing a postnatal element alone. These findings are consistent with those of another study on the effects of antenatal breastfeeding education. Su et al. (2007) conducted a randomised control trial of 430 women in Singapore to investigate the effects of both antenatal education and postnatal support strategies on the rates of exclusive breastfeeding at various time intervals, up to six months. The study found that both antenatal education and postnatal support strategies were related to a significantly increased duration of exclusive breastfeeding.

The findings of these three reviews are mixed with no strong evidence as to the value of antenatal breastfeeding education. They give strength to the notion that breastfeeding education alone may not be enough to prepare mothers for the realities of breastfeeding. Other antenatal breastfeeding support elements, combined with education, may prove more effective in preparing mothers for breastfeeding. This current study will ask mothers to describe their preparation for breastfeeding and evaluate how the antenatal breastfeeding support they received impacted on their breastfeeding experiences.

## CHAPTER 2: LITERATURE REVIEW

**Detrimental breastfeeding support**

Although the literature shows that mothers find health professionals supportive of breastfeeding, practices which can be detrimental to their breastfeeding experiences have also been identified in research studies. The following section analyses the literature that identified detrimental breastfeeding support such as conflicting advice, the unsolicited provision of formula or pacifiers, rough handling and a lack of midwives' time.

**Conflicting advice**

Advice, in the forms of teaching, counselling and giving information, is an important component of support (Coffman & Ray, 2002) and is required by mothers as a strategy for building their knowledge about all aspects of breastfeeding (Sheehan et al., 2009). The experience of receiving conflicting advice emerged frequently and consistently throughout the literature (Cooke & Stacey, 2003; Hailes 2000; Hauck, Graham-Smith, McInerney & Kay, 2011; Hoddinott & Pill, 2000; McInnes & Chambers, 2008; Schmeid et al., 2011; Smith, 2003). Mothers found this conflicting advice "more disconcerting than comforting" (Smith, 2003), and a challenge to discern between contradictory recommendations (Hauck et al., 2011; Hoddinott & Pill, 2000). Some mothers even employed strategies to keep different advisors happy by feigning acceptance of the advice (Hoddinott & Pill, 2000). Mothers also described that breastfeeding advice found in information that is readily accessible to them was also conflicting (Bridges, 2007; Smith, 2003).

Consistency of midwifery advice was examined through 284 Australian mothers' evaluations of postnatal midwifery support (Cooke & Stacey, 2003). Through a self-report questionnaire, over 25% of all mothers reported that midwives had not provided consistent advice, although more than 95% of these mothers had, antenatally, highlighted consistency as a requirement for postnatal support. The authors of this study improved the generalisability of results by

## CHAPTER 2: LITERATURE REVIEW

recruiting women from three different hospitals with different models of care (Cooke & Stacey, 2003). This finding suggests that midwives may be offering advice to mothers that is unsupportive of their attempts to breastfeed.

Mothers' experiences of receiving conflicting advice about breastfeeding were examined in an Australian study, using a qualitative exploratory design (Hauck et al., 2011). The mothers' descriptions showed that, in addition to advice that was obviously inconsistent or contradictory, they viewed conflicting advice as including advice that was provided in a manner that was not caring or empathetic and reflected disparate views with those of the mother. The authors suggested that midwives could minimise conflicting advice by changing the way advice is delivered; ensuring it demonstrates a caring, empathetic and woman-centred approach. This type of approach aligns with both Coffman and Ray's definition of support (2002), which encourages a mutual relationship that is caring and empathetic, and the findings of the literature previously presented on supportive relationships.

Variations in midwives' knowledge of breastfeeding may contribute to women's experiences of conflicting breastfeeding advice (Cantrill, 2003). Cantrill's study of 1105 Australian midwives' breastfeeding knowledge used a breastfeeding knowledge questionnaire (BKQ) with a 100% correct score equalling fifty five points. Correct answers were based on current evidence. The mean score of the respondents was 48.15 with a range of 16-55. The large range of scores may reflect the varying levels of evidence-based knowledge held by Australian midwives. The response rate was only 31%, which may have represented those midwives who were more interested in breastfeeding, and possibly had different knowledge levels than those of the non-responders (Cantrill, 2003).

A number of Australian studies have confirmed mothers' experiences of conflicting advice over a period of eight years, demonstrating that this is an ongoing problem that may affect

## CHAPTER 2: LITERATURE REVIEW

the mothers in this current study. This study will allow mothers the opportunity to voice their concerns about any practice that is seen as detrimental to breastfeeding support. If conflicting advice is raised as an area of concern for the mothers, further enquiries could be made to explore the effect of conflicting advice on mothers' experiences of breastfeeding. Giving mothers the opportunity to voice their concerns on this topic will enable midwives to identify particular areas of concern and collaborate in their efforts to provide effective and consistent breastfeeding support.

***Unsolicited provision of formula and pacifiers***

Another practise of health professionals identified as unsupportive of breastfeeding is the provision of formula and pacifiers without the mother's consent (Tender et al., 2009) or advising women to supplement without medical indication (Semenic, Loiselle, Gottlieb, 2008; Tender et al., 2009). This practice is contradicted by the WHO/UNICEF Ten Steps to Successful Breastfeeding statement (WHO/UNICEF, 1998) and the National Health and Medical Research Council (2003). A North American literature review (Dennis, Hodnett, Gallop & Chalmers, 2002) of different strategies for promoting positive breastfeeding behaviours found that the practice of formula supplementation is strongly associated with an increased risk for early breastfeeding cessation. By supplementing breastfeeds, midwives also give women less opportunity to learn breastfeeding and are less inclined to provide breastfeeding support (Auerbach, 2000).

Mothers complained of health professionals supplementing their babies with formula in hospital without any consent from them in a US study (Tender et. al, 2009). In a survey ascertaining why babies were supplemented with formula in hospitals, 20% of mothers responded that they were not given any reasons as to why their baby had received formula supplementation. Raisler (2000) noted formula supplementation without consent as the most



## CHAPTER 2: LITERATURE REVIEW

common complaint from women who participated in focus groups for her qualitative study of low-income mothers' breastfeeding experiences. The comment of one woman clearly illustrated her lack of consent: "They gave her a bottle without even waking me up to ask me...I had made it specifically clear...I want this baby completely breastfed.". It appears that Australian research has, thus far, failed to effectively assess whether this is also a local problem.

***Rough handling***

Another area of concern identified in research studies over the past decade for mothers was the rough handling they experienced when their babies were assisted to the breast. Women vividly described this practice with comments such as "they were just grabbing (my) boob and throwing it in (the baby's) face" (Hoddinott & Pill, 2000, p.228) and "they would just take my child's head and push him right on my breast...he couldn't breathe" (Raisler, 2000, p.256). Barclay et al. (1997) suggested that rough handling can make the embodied experience of becoming a mother more difficult, confusing and damaging to women's self-esteem. Schmied et al. (2011) commented that mothers often experienced health professionals' attempts at a hands-on approach to breastfeeding support as "intrusive and rough", with the breast being treated as just a "feeding implement" (p.57). A more embodied way of providing practical support was seen by mothers as support that was offered sensitively and empathetically and within a developed relationship between the mother and health professional (Schmied et al.). The majority of these studies were over ten years old suggesting that this topic has received less attention in recent literature. Through mothers' in-depth stories of their experiences of receiving breastfeeding support, this current study will be able to ascertain whether this experience remains an issue for mothers today.

## CHAPTER 2: LITERATURE REVIEW

***Lack of midwives' time***

A further detrimental factor for breastfeeding mothers is the perceived lack of time midwives have to provide breastfeeding support. An ethnographic study of the encounters between breastfeeding mothers and midwives in two UK postnatal wards presented the issues of time from both the midwives' and mothers' views (Dykes, 2005). The discussions in this study centred on the theme of "taking time and touching base" (p. 245). The time constraints experienced by the midwives in this study were described by one midwife as follows: "There isn't the time needed to help women let alone give them appropriate breast-feeding support. You can't do that when you're busy" (p.245). Dykes found that women were often well aware of the busyness their midwives which is confirmed through comments such as "they seem to be pressured, panicking and anxious" (p.245) and "The midwives seem to be spread very thinly and they don't have much time" (p.245). As a result of this awareness, the mothers were less likely to ask for help, tending to struggle on themselves.

Although midwives' concerns with time pressures have been documented, it was the mothers who expressed the most concerns with time limitations in the literature. Women wanted health professionals to stay with them at least for the entire length of the first feed (Graffy & Taylor, 2005; Gill, 2001; Hoddinott & Pill, 2000; Scott & Mostyn, 2003). However, women did not blame the health professionals themselves, but rather their daily routines, for their busyness (Hauck et al. 2011, Schmied et al., 2011; Scott & Mostyn, 2003). The effect of early hospital discharge on breastfeeding duration is uncertain (Dennis, 2002); however, what is certain is that shorter stays give midwives less time to counsel breastfeeding mothers.

The current literature regarding the lack of time for breastfeeding support stems from other countries that have different disciplinary care models, hospital stays and community follow-up programs to those available in Australia. Further research is required to determine how

## CHAPTER 2: LITERATURE REVIEW

time factors are perceived by Australian mothers and midwives. The following section analyses literature on alternate sources of breastfeeding support.

### **Other sources of breastfeeding support**

Midwives play a primary role in the provision of early breastfeeding support, however, it is evident throughout the literature that new mothers continue to draw strongly from other sources for this support such as partners, family, peers and other health professionals (Clifford & McIntyre, 2009; Britton et al., 2007). There is also a significant amount of literature on mothers' experiences of receiving peer breastfeeding support. Examining this literature can assist in identifying knowledge that can inform the current study and can be applied to the work of midwives in the provision of breastfeeding support.

The various effects of breastfeeding support provided by partners, family and friends is illustrated in an Australian phenomenological study of 10 women's' experiences of breastfeeding difficulties. Hauck et al. (2002) used the term 'encouragement', to describe advice that was supportive to mothers in their efforts to continue breastfeeding, and 'encumbrances' to describe advice that was non-supportive to mothers in their efforts to breastfeed. Women in this study described encouragement as emotional support and hands-on assistance given by partners, their mothers and other mothers as important and valuable. In contrast, encumbrances were described as advice that opposed their breastfeeding efforts such as family and friends encouraging them to bottle-feed, conflicting advice and advice overload. Mothers' descriptions of supportive and non-supportive advice from sources other than midwives closely align with the advice considered supportive and non-supportive from midwives. This demonstrates that findings from studies related to other sources of breastfeeding support may be able to be applied to the experience of midwifery breastfeeding support.

## CHAPTER 2: LITERATURE REVIEW

Sources of breastfeeding support were explored in an extensive literature review undertaken by Clifford and McIntyre (2009). The review found that mothers had numerous sources of breastfeeding support including their husbands or partners, family and friends and peers, through both formal and informal networks. The health professionals identified as supporting mothers to breastfeed included midwives, doctors, lactation consultants, nurses and other health professionals (Clifford & McIntyre). The review showed that peer supporters were particularly highly rated by mothers and were considered to be effective in providing breastfeeding support. Mothers expressed that they felt more able to be open with peer supporters and felt less rushed than they did with health professionals. The latter of these findings confirms the previously presented findings that mothers do not want to feel that there is a lack of time for breastfeeding support.

A confiding and supportive relationship with peers is closely related to mothers' ability to cope in the postnatal period (Hoddinott & Pill, 1999). In Hoddinott and Pill's qualitative study of infant feeding, mothers wanted to receive a range of advice from women they trusted, who had recent mothering or breastfeeding experience. One participant in this study commented "I would love at my antenatal classes to have met with a woman that had problems breastfeeding...I wasn't prepared" (p.560). These findings suggest mothers' needs for a role-model and reflect those previously mentioned regarding mothers' needs for apprentice-style learning.

A Cochrane systematic review (Britton et al., 2007) explored the effectiveness of varying types of breastfeeding support. When reviewing lay support, that is support given by non-professionals, the authors found that the cessation rate for women who were exclusively breastfeeding was significantly less for women who received lay breastfeeding support or a combination of lay and professional support than for those who received professional support

## CHAPTER 2: LITERATURE REVIEW

alone. This high-level evidence points to a need for the inclusion of lay breastfeeding support programs within Australian maternity services.

An Australian study (Kruske, Schmeid & Cooke, 2007) of 193 mothers confirms that peer support combined with professional support delays the cessation of breastfeeding in exclusively breastfeeding mothers. This retrospective study compared the breastfeeding duration of mothers who attended a program of combined peer and professional support (child health nurses) with those of mothers who attended individual appointments with child health nurses. The study concluded that exclusively breastfeeding mothers attending the combined program were more likely to still be breastfeeding at eight weeks than those mothers who did not receive peer support. This study, being a retrospective chart audit, was limited in that the groups were not randomised and women had self-selected into the peer support group. These women may have been more motivated to breastfeed and, thus, more likely to choose a program that seemed to offer greater support (Kruske et al., 2007). Nevertheless, this data offers promising evidence that the success of peer support programs in other countries is likely to be repeated in the Australian context.

Peer breastfeeding counsellors differed from other providers in the support they offered by offering more time, home visits and individualized support, according to the mothers in a US study of their breastfeeding experiences (Raisler, 2000). By sampling low-income, breastfeeding women the researcher hoped to gain an insight into how these women succeeded to breastfeed despite belonging to a demographic group in which breastfeeding was uncommon. Mothers' response rates to questions regarding interactions with their breastfeeding peer counsellors were higher than for any other question asked. They responded with praise for their breastfeeding peer counsellors for being "knowledgeable and experienced, responding promptly to distress calls, and acting personal and caring" (p.257).

## CHAPTER 2: LITERATURE REVIEW

The author concluded that health professionals should utilise breastfeeding peer counsellors as allies in increasing breastfeeding rates among low-income mothers (Raisler, 2000). The weakness of this study was that all participants sampled were successful in breastfeeding, which may have limited findings by excluding those who were unsuccessful and possibly less supported.

The literature shows that the impact of family, friends and peers on breastfeeding support for mothers is substantial and mothers' experiences of receiving this support are often similar to their experiences of receiving such support from midwives. Additionally the literature has highlighted that mothers highly value peer breastfeeding support as support that is more caring, less rushed and better allows for the development of a relationship than support from health professionals. Research should question whether these qualities are also valued when applied to the situation of midwifery breastfeeding support.

### **Research methodologies**

A summary of the methodologies and limitations of the key research studies cited in this review is now presented. Evaluating these elements assisted in identifying the most effective methodology for this research. Additionally, it assisted in identifying gaps in the current literature, further confirming the need for this current study.

## CHAPTER 2: LITERATURE REVIEW

Table 2.1: Summary of elements of key studies

Study	Methodology	Focus of breastfeeding support	Limitations
Britton, McCormick, Renfrew, Wade & King, 2007	Systematic review of quantitative trials	<ul style="list-style-type: none"> <li>The effect of breastfeeding support on breastfeeding duration</li> </ul>	<ul style="list-style-type: none"> <li>Support difficult to define due to large number of studies using different definitions</li> <li>Did not focus on midwifery breastfeeding support</li> </ul>
Cooke, Schmied, & Sheehan, 2007	Quantitative- Analysis of survey data	<ul style="list-style-type: none"> <li>Relationship between maternal distress and maternal role attainment, breastfeeding problems and breastfeeding cessation</li> </ul>	<ul style="list-style-type: none"> <li>Unable to determine causality</li> <li>Influence of breastfeeding support not able to be determined</li> </ul>
Cooke & Stacey, 2003	Mixed method- Content analysis	<ul style="list-style-type: none"> <li>Content related to first breastfeed in midwifery textbooks</li> </ul>	<ul style="list-style-type: none"> <li>not related to mothers experiences of breastfeeding support</li> <li>did not include numerous aspects of breastfeeding support</li> </ul>
Dykes, 2005	Qualitative- Critical ethnographic approach	<ul style="list-style-type: none"> <li>encounters between midwives and breastfeeding mothers in a postnatal ward</li> </ul>	<ul style="list-style-type: none"> <li>Not Australian</li> <li>Limited geographical area</li> <li>Possible Hawthorne effect</li> </ul>
Gill (2001)	Qualitative- Ethnography	<ul style="list-style-type: none"> <li>Breastfeeding support from health professionals in postnatal wards – perceptions of mothers and maternal-child health nurses</li> </ul>	<ul style="list-style-type: none"> <li>Not Australian</li> <li>Possible Hawthorne effect – researcher employee/peer to nurses</li> <li>Midwives were not the providers of support</li> </ul>
Graffy & Taylor, 2005	Qualitative- Thematic analysis	<ul style="list-style-type: none"> <li>Women's perspectives of breastfeeding information, advice and support</li> </ul>	<ul style="list-style-type: none"> <li>Not Australian</li> <li>Unable to differentiate between sources of support</li> </ul>

## CHAPTER 2: LITERATURE REVIEW

			<ul style="list-style-type: none"> <li>• Did not focus on midwifery breastfeeding support</li> </ul>
Hauck & Irurita, 2003	Qualitative- Grounded Theory	<ul style="list-style-type: none"> <li>• Expectations of breastfeeding</li> <li>• Incompatible expectations of others related to weaning</li> </ul>	<ul style="list-style-type: none"> <li>• Did not focus on midwifery breastfeeding support</li> <li>• Some mothers interviewed about experiences with previous children – significant time lapse</li> </ul>
Hauck, Langton & Coyle, 2002;	Qualitative – Phenomenology	<ul style="list-style-type: none"> <li>• Lived experience of breastfeeding difficulties</li> <li>• Breastfeeding support from health professionals</li> </ul>	<ul style="list-style-type: none"> <li>• 5 of 10 mothers were nurses/midwives</li> <li>• all participants had tertiary education</li> <li>• women sampled had all experienced substantial breastfeeding difficulties</li> <li>• Did not focus on midwifery breastfeeding support</li> </ul>
Hoddinott & Pill (2000)	Qualitative- Grounded Theory and discourse analysis	<ul style="list-style-type: none"> <li>• Breastfeeding advice from health professionals</li> </ul>	<ul style="list-style-type: none"> <li>• Not Australian</li> <li>• Did not focus on midwifery breastfeeding support</li> </ul>
Larsen, Hall & Aagard, 2008	Metasynthesis of qualitative studies	<ul style="list-style-type: none"> <li>• Factors affecting maternal confidence that result in breastfeeding cessation</li> </ul>	<ul style="list-style-type: none"> <li>• Only one Australian study included</li> <li>• Did not focus on midwifery breastfeeding support</li> </ul>
Raisler (2000)	Qualitative- Ethnography Content analysis	<ul style="list-style-type: none"> <li>• Breastfeeding experiences of low-income mothers</li> </ul>	<ul style="list-style-type: none"> <li>• Not Australian</li> <li>• Did not focus on midwifery breastfeeding support</li> <li>• Researcher identified as midwife</li> </ul>
Schmied, Beake, Sheehan, McCourt and Dykes (2011)	Metasynthesis of qualitative studies	<ul style="list-style-type: none"> <li>• Mothers' perceptions and experiences of breastfeeding support</li> </ul>	<ul style="list-style-type: none"> <li>• Did not focus on midwifery breastfeeding support</li> <li>• Difficult to ascertain definitions of support used in included studies</li> </ul>
Sheehan, Schmied & Barclay, 2009	Qualitative- Grounded Theory constructionist approach	<ul style="list-style-type: none"> <li>• Mothers' experiences of early breastfeeding support</li> </ul>	<ul style="list-style-type: none"> <li>• Single geographic location</li> <li>• Did not focus on midwifery breastfeeding support</li> </ul>



## CHAPTER 2: LITERATURE REVIEW

A qualitative research methodology was used in the majority of key studies enabling the researchers to conduct a deep exploration of the topic of breastfeeding support from the perspective of the mother and, at times, the providers of breastfeeding support. As this study seeks to explore new mothers' experiences of receiving breastfeeding support from midwives, a qualitative method would seem most suitable to ensure that the mothers are able to tell their stories and discuss the topics that are important to their individual experiences.

This summary illustrates a number of gaps in the literature. The most pronounced is that most of these studies examined breastfeeding support provided by health professionals and peers and did not focus on midwifery breastfeeding support, justifying the need for this current study. The design of this study, which is presented in the next chapter, ensures that data are collected early to reduce the influences of other sources of support and questions that focus on the mothers' experiences of receiving support from midwives. As many of the key studies were conducted outside Australia, this study will add to the body of knowledge on *Australian* mothers' experiences of receiving midwifery breastfeeding support.

### **Summary**

This literature review examined both current and previous literature related to breastfeeding and breastfeeding support. Australian and international literature on breastfeeding support was reviewed and a number of themes were identified and examined including definitions of breastfeeding support, new mothers' need for and experience of breastfeeding support, factors of positive and detrimental breastfeeding support, new mothers expectations and experiences of breastfeeding, the supportive relationship and other sources of breastfeeding support.

## CHAPTER 2: LITERATURE REVIEW

The current knowledge on the topic of breastfeeding support is often derived from studies conducted in other countries more than eight years ago, does not adequately define support and focuses on support from health professionals as a group, rather than midwives. It is difficult to assess whether the findings of such research is applicable to the current breastfeeding experiences of Australian women. A summary of the research limitations of key studies justifies the need for this current research and a qualitative methodology for this study. In adding to the current knowledge base and focusing on the role of midwives as breastfeeding supporters, this research poses the question: *What are the experiences of new mothers when learning breastfeeding from midwives?* The next chapter will discuss the methodology used for this research study.

CHAPTER 3: METHODOLOGY

**CHAPTER 3: METHODOLOGY**

**Introduction**

This chapter presents the research design and methodology used for this study of new mothers' experiences of receiving breastfeeding support from midwives. Included in this chapter is a description of the qualitative approach to research, the Grounded Theory (GT) approach used for this study, including the symbolic interactionism underpinning this method and the rationale for choosing this method.

The research question that initially directed the study was: *What are the experiences of new mothers when receiving breastfeeding support from midwives?* The objectives of the study are to identify, describe and explain:

- the role of the midwife in supporting new mothers to breastfeed
- the factors that influence new mothers' experiences of receiving breastfeeding support from midwives
- the impact of midwifery practices on new mothers' experiences of receiving breastfeeding support

As the study progressed, the focus evolved to encompass the women's experiences of learning to breastfeed, with the emergence of the core process of WORKING IT OUT.

This chapter provides an in-depth account of the study design, and justification of the sampling methods, data collection and analysis. The data analysis processes are described using examples of memos, codes, a concept map and a storyline. The ethical considerations to protect

## CHAPTER 3: METHODOLOGY

the participants are also addressed. The criteria for rigorous GT research are applied in evaluating the research and the limitations are outlined.

### **Research Approach**

Various qualitative research methods are available to researchers. The research question and objectives should guide the researcher in the selection of the appropriate qualitative method (LoBiondo-Wood, 2010). The research approach to this study was considered in relation to the approach that best fit the purpose. This study focuses on the experiences of new mothers when receiving breastfeeding support from midwives. As human experience is the focus, a qualitative research approach is best suited to this study.

Qualitative approaches aim to discover the experience of the situation from the informant's point of view and to answer questions that focus on social experience, how it is created and how it gives meaning to human life (Denzin & Lincoln, 2011). The literature review presented in Chapter two demonstrates that there is little evidence on the experience of new mothers receiving breastfeeding support from midwives. Qualitative research is useful when the viewpoint and experiences of those being studied are not well known or understood (Polit & Beck, 2008). In improving this understanding, the nature of qualitative enquiry encourages detailed and rich descriptions to emerge for explaining phenomena within the social world (Denzin & Lincoln, 2011).

The literature review also shows that qualitative methodologies are commonly used in the field of midwifery research, particularly when studying the experiences of women in pregnancy and motherhood. Several studies have shown that Grounded Theory is one such methodology which is particularly useful for gaining rich descriptions of the basic social processes surrounding becoming a mother (Hauck & Irurita, 2003; Hoddinott & Pill, 2000;

## CHAPTER 3: METHODOLOGY

Sheehan, Schmied & Barclay, 2009). These GT studies used in depth interviewing to allow women to provide detailed stories of their experiences related to breastfeeding and new motherhood and demonstrate the suitability of the GT method in exploring women's experiences and support GT as the methodology for this study.

Grounded Theory (GT) has its theoretical underpinnings in symbolic interactionism (Denzin & Lincoln, 2011). GT is emergent and, therefore, is useful when there is limited prior research of a topic, as it allows the research to be informed by the data. GT encourages the researcher to remain open minded and allow findings about the real social problems related to the situation being studied to emerge from the data rather than being explicated or forced. In allowing emergent findings, theoretical principles are discovered rather than predetermined (Bryant & Charmaz, 2007). GT uses a systematic approach to data collection and analysis for the purpose of increasing the understanding of social and psychological phenomena through the generation of explanatory theory (Bryant & Charmaz). In this case the phenomenon was women's' experiences of receiving breastfeeding support from midwives. The GT approach allowed me to view the situation of receiving midwifery breastfeeding support from the perspective of the participants. Furthermore, this method encouraged me to work beyond just identifying mother's experiences but additionally to describe and explain those experiences.

### **Grounded Theory**

Grounded Theory is a social research method developed by sociologists Barney Glaser and Anselm Strauss (1967) who advocated for the development of theory from research that was grounded in data rather than the deduction of hypotheses from a known theory (Charmaz, 2006). Their purposes for developing GT included an attempt to "strengthen the mandate for generating theory, to help provide a defence against doctrinaire approaches to verification, and to reawaken and broaden the picture of what sociologists can do with their time and

### CHAPTER 3: METHODOLOGY

efforts.” (Glaser & Strauss, 1967, p.7). They believed GT to be a practical method of generating meaningful and respectable theory to explain basic social processes (Glaser & Strauss).

The basic underpinning of GT lies in symbolic interactionism (Denzin & Lincoln, 2011). Symbolic interactionism was a term first coined by sociologist Herbert Blumer in 1937, describing the belief that humans behave towards things in response to the meanings those things have to them. Furthermore, symbolic interactionism focuses on the social and behavioural roles of people as they interact with one another (Bryant & Charmaz, 2007).

Glaser (1992) illustrated the relationship between GT and symbolic interactionism most clearly, stating that the assumption of GT is that humans actively shape the world in which they live through the process of symbolic interaction and that life is characterized by variability, complexity, change and progress. Strauss (1987) also addressed this assumption stating that change is a feature of social life that needs to be accounted for through attention to social interaction and social process and that interaction, processes and social change are best understood by grasping the actor's viewpoint.

This study focuses on new mothers' symbolic interactions while learning to breastfeed. This method of enquiry allows the researcher to explain these interactions which include social interactions with the midwives providing breastfeeding support and with other sources of support, and describe the processes and meanings of other interactions during the experience of learning to breastfeed. Most importantly, this method of enquiry allows the researcher to generate theory based on an understanding of the overall experience of learning to breastfeed or establishing an alternate feeding method and its meaning for new mothers.

**Grounded Theory methods**

Unlike most experimental studies, where a set sample size is determined and recruited, and data are collected prior to the commencement of data analysis, GT is a cyclic and ongoing process in which concurrent sampling, data collection and data analysis are undertaken until theoretical saturation occurs (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The researcher samples one set of data and then analyses it before sampling the next set. This method is based on three major principles central to GT which are constant comparison, theoretical sampling and theoretical sensitivity. These are described below.

***Constant comparison***

Central to GT is the principle of constant comparative analysis, in which new data are constantly compared with existing data to find links and categories and allow the emergence of theory (Bryant & Charmaz, 2007). This method of data analysis allows the researcher to examine a phenomenon by providing a system in which to analyse large amounts of raw data in order to build understanding and, eventually, theory (Strauss & Corbin, 1998).

Constant comparative analysis requires the researcher to take one segment of data and compare it to all other segments of data. Through questioning, the researcher looks at what makes each segment different and/or similar to other segments of data. These segments can be words, sentences paragraphs, memos or other data. The concepts that emerge become the “building blocks” for the theory (Strauss & Corbin, 1998, p.102).

This analysis, utilizing constant comparison, is known as coding. Coding in classic GT has three stages. The first of these is open coding which involves a “word-by-word, line-by-line analysis” (Grbich, 1999, p.176) of the transcript. By comparing words or lines to find similarities and differences, the researcher begins to group the data allowing the emergence of initial categories.

## CHAPTER 3: METHODOLOGY

A core category is then identified (or discovered) and forms the central point around which all of the other categories are focussed.

This process of limiting the focus to the core category occurs through selective coding. In this stage, coding is delimited to working only with categories relating to the core category. Delimitation continues through theoretical sampling, which allows the collection of data that are relevant to the emerging theory (Bryant & Charmaz, 2007). Constant comparison of the data continues throughout this stage until the point of theoretical saturation; when no new categories or properties are emerging. Through this process of selective coding; linking the categories around the core category, a theory emerges (Glaser & Strauss, 1967).

Theory emergence is most visible in the final stage of coding known as theoretical coding. Theoretical coding allows conceptualisation of the relationships between the substantive codes in order to “weave the fractured story back together again” (Glaser, 1978, p.72). Theoretical coding is integrative in that it lends form to the existing codes and allows the researcher to tell an analytic story that is coherent and theoretical (Charmaz, 2006).

### ***Theoretical Sampling***

Theoretical sampling is a technique used by the researcher, after analysing the most recent data, to decide what data to collect next and how to sample it. This process is guided by the emerging theory in that the researcher continually adjusts sampling to ensure the data collected is relevant to the theory (Glaser & Strauss, 1967). Constant comparative analysis and theoretical sampling occur concurrently. Constant comparison guides theoretical sampling in that it generates the themes, concepts and categories on which the sampling is based. Literature may also inform initial theoretical sampling reached (Strauss & Corbin, 1998).



## CHAPTER 3: METHODOLOGY

Theoretical sampling continues until theoretical saturation has been reached (Strauss & Corbin, 1998). Theoretical saturation is the point at which further sampling does not add any new data and the data already collected is rich and complete (Munhall, 2011). For this reason, the amount of data sampled and/or collected is not defined at the beginning of the research process.

### ***Theoretical Sensitivity***

The insight that a Grounded Theory researcher has about the subject being studied and the extension of this insight through immersion in the research data is known as theoretical sensitivity (Strauss & Corbin, 1998). It enables the researcher to be inductive in their thinking and to develop specific data into more abstract forms, allowing the development of theory from their observations (Heath & Cowley, 2004; Schreiber, 2001).

The researcher's theoretical sensitivity takes them from being the researcher to becoming the theorist as well. It is their thoughts, ideas and experiences that interplay with the data to generate theory (Glaser & Strauss, 1967). Without theoretical sensitivity the researcher could only present the data collected rather than make sense of it.

Theoretical sensitivity encourages the researcher to become aware of how their own background may have shaped their personal beliefs and to constantly challenge personal theories or biases against the data (Schreiber & Stern, 2001). This ensures that the emerging theory will be truly grounded in the data which, in turn, improves the rigor of the study.

After the initial development of GT, Glaser and Strauss worked separately and their thoughts on the GT methodology evolved in different directions. Strauss began working with another sociologist, Juliet Corbin, and together they described a more structured approach to the GT method and asserted that GT should be verificational and legitimately influenced by the

## CHAPTER 3: METHODOLOGY

researcher's existing ideas (Strauss & Corbin, 1990). Glaser continued with a more purist approach insisting that preconceptions must be avoided as they could pollute theory generation (1992).

The GT approach initially drawn upon for this study was the GT described by Glaser and Strauss (1967). During theoretical coding this approach then shifted to the GT of Strauss and Corbin (1998) with the modification of using Schatzman's dimensional analysis framework (Schatzman, 1991). An explanation of this approach and justification for this shift is presented later in this chapter.

### **Data Collection**

GT allows for varying data sources such as people, documents and the researcher's own experiences (Strauss & Corbin, 1998). Data may consist of written observations, such as field notes and theoretical memos, and recorded interactions, such as video, audiotaped interviews and transcriptions. Further data may be sourced from the literature available on the research topic (Byrne, 2001). For the purpose of theory generation, data used in GT should be rich. According to Charmaz (2006), "rich data are detailed, focused and full" (p.14). Therefore, conducting interviews with new mothers was the most fitting way to collect rich data for this study.

The primary data used for this study consisted of data collected during semi-structured, in-depth interviews with individual mothers. This method of data collection is common in GT research (Streubert, Speziale & Carpenter, 2007). In-depth interviewing is well suited to exploratory research methods that are theory-building; where the researcher seeks to gain an understanding of the field and develop a theory around it (Minichiello, Aroni & Hays, 2008). These interviews were conducted with each mother in their home and were

## CHAPTER 3: METHODOLOGY

audiotaped for the purpose of data extraction and, initially, word by word analysis. Interviews were between one and two hours in length depending on the depth of the data that was being gathered and the new mother's eagerness to discuss her experiences.

Interviews were conducted within four weeks of the participant's hospital discharge. Conducting the interviews within this time frame allowed participants to effectively recall their experiences and decreased the effect of other health professionals' influences on participants' experiences of breastfeeding support. Research on the memory of stressful events has demonstrated that recollection fades over time (Waldenstrom, 2003), with a five to twelve percent decline in the ability to recall events per month passed (Thirsted, 1998). In addition, memories can be altered by post event input, thus effecting a person's reporting of the event (Waldenstrom, 2004).

Questions used in the interviews were based on a broad range of topics gathered from findings of current related literature. The researcher utilised some open-ended questions whilst still allowing "the flexibility to probe and explore areas that seem appropriate to the individuals concerned" (Rees, 2003, p. 128). The use of an aide de memoire assisted the researcher in maintaining focus during the interviews. Examples of questions asked include:

- Tell me about your experience of receiving breastfeeding support from midwives at the hospital?
- What were your expectations of the breastfeeding support that you would receive from midwives?

### **Sampling**

The first participant was sampled using purposive sampling; that is they were selected purposefully because they had the experience that was being examined (Holloway & Wheeler, 2010). Purposive sampling is based upon the knowledge the researcher currently has about the

### CHAPTER 3: METHODOLOGY

target population. Using this knowledge, the researcher selects participants who are considered typical of the target population or those who can provide rich data on the phenomenon under study (Haber, 2010).

This study excluded women I had cared for during the course of my clinical duties as it was thought that this may cause the women to feel obliged to consent or provide data that was considered 'pleasing' to me. As a qualified midwife and lactation consultant, I was able to effectively identify those mothers who required ongoing psychological, physical or breastfeeding support during the interview. After the interview, I informed the mothers that I was a midwife and lactation consultant and offered breastfeeding support to the women who had described having ongoing problems then the options of receiving support. I also offered these mothers the option of being referred to another health professional for support. Two of the mothers accepted my offer of breastfeeding support and this support was given immediately after the interview. No mothers chose to be referred or were assessed as requiring referral. This aligns with the ethical principles of this study explained later in this chapter.

Once initial data were collected theoretical sampling, as described earlier, guided the remainder of the data collection. This switch in sampling techniques is required in GT to ensure that data collected are relevant to the emerging theory (Glaser & Strauss, 1967). The analysis of data from the first interview assisted in identifying a participant for the following interview who would provide the opportunity to gather data which may validate relationships between concepts and categories or limit their applicability. Theoretical sampling required the selection of interview participants who could provide the insights most useful for developing further understanding of the topic at that point of the research process (Rees, 2003). It also necessitated that interviews were adapted throughout the research process to focus on emerging themes and categories that arose

### CHAPTER 3: METHODOLOGY

(Holloway & Wheeler, 2010). Theoretical sampling continued until theoretical saturation was reached.

For maximum variation, data were gathered from a range of first-time mothers who had initiated breastfeeding. Sampling for maximum variation allowed me to determine whether common themes or patterns were occurring across the variation. Additionally, maximising variation in the data allowed dense development of category properties and delimited the scope of the theory (Yee, 2001). A theoretical sampling guide was designed as a checklist for recruiting participants to ensure that the range of characteristics that could influence new mothers' experiences were included. Variables that were sought for maximum variation, as identified in the literature, included:

- a) age
- b) care-mode (i.e. public/private)
- c) ethnicity
- d) level of education

The theoretical sampling guide, in the form of a table, is shown on the following page.

## CHAPTER 3: METHODOLOGY

Table 3.1: Theoretical sampling guide

Variables	Participant 1	Participant ....
Age Range in years: <ul style="list-style-type: none"> <li>• 18-24</li> <li>• 25-31</li> <li>• 32-38</li> <li>• 38-45</li> </ul>		
Model of care: <ul style="list-style-type: none"> <li>• Public</li> <li>• Private</li> </ul>		
Ethnicity (e.g.) <ul style="list-style-type: none"> <li>• Caucasian</li> <li>• Asian</li> <li>• Aboriginal or Torres Strait Islander</li> <li>• Middle Eastern</li> </ul>		
Education Level: <ul style="list-style-type: none"> <li>• Primary</li> <li>• Secondary</li> <li>• Tertiary</li> <li>• Post-graduate</li> </ul>		

***Inclusion Criteria***

Participants invited to participate in the study met the following criteria:

1. First time mother
2. Baby was singleton, term and healthy
3. Breastfeeding was commenced
4. Mother was English-speaking
5. Mother was 18 years or older
6. Mother was psychologically and physically capable to participate in the interview

## CHAPTER 3: METHODOLOGY

First-time mothers were sought as they had not previously experienced breastfeeding or received postpartum breastfeeding support. This limited the possibility of previous experiences of breastfeeding support influencing the experience being studied. Primiparous mothers are more likely to require postnatal midwifery support related to infant feeding according to an Australian study (Cooke & Stacey, 2003) of 228 mothers' postnatal support needs. The two items that related to infant feeding were assistance for feeding and information regarding feeding. One hundred percent of primiparous mothers indicated they had required support for both items, while multiparous mothers required support for these items at with 72% and 65% indicating these needs respectively (Cooke & Stacey).

***Recruitment***

To recruit mothers for this study, midwives on the postnatal wards at a metropolitan tertiary hospital, where I was an employee, were provided with information regarding the inclusion criteria and preferred variables of the participants. Midwives were asked to contact me, a midwifery educator, when a potential participant was identified. After several weeks without notification of any potential participants I chose to undertake the identification procedure myself. To facilitate this, I went to the postnatal wards of the hospital, and looked at the patient boards which contained information related to each of the mothers' parity, age, feeding choice and diagnosis. Based on this information, I selected a mother and then checked her hospital chart to ensure she met all of the eligibility criteria. Lastly, I sought advice from mother's allocated midwife to ensure that approaching the woman for recruitment was appropriate at that time.

After confirming suitability I approached the new mother, introduced myself as a researcher with an interest in breastfeeding, provided an information letter and consent form and explained that I would give her time to read the information and return later that day to answer any questions and find out whether she would like to participate. A copy of the Information Letter and Consent form

### CHAPTER 3: METHODOLOGY

are provided in Appendix 1. Upon returning to the new mother, and receiving confirmation of her willingness to participate, I obtained written consent from the mother.

Initial identification of participants was relatively easy, however this became more difficult as I began theoretically sampling while aiming to sample for maximum variation. Women in the 18-24 year age range were reluctant to be involved in the study and significant time passed before the first participant with this attribute was recruited. Non-Caucasian women were also less likely to want to participate. One Indigenous mother agreed to consider participating but decided against it after a day of consideration. Unfortunately, all other Indigenous women approached declined to participate. Through much persistence, significant variation of participants was achieved as demonstrated in the table below.



## CHAPTER 3: METHODOLOGY

Table 3.2: Sampling

6 participants

	'Ann'	'Rhonda'	'Lilly'	'Susan'	'Soko'	'Jessica'
Age Range In years:  18-24 25-31 32-38 38-45	25-31	25-31	18-24	38-45	32-38	18-24
Model of care:  Public Private	Private	Public	Public	Private	Private	Public
Ethnicity (e.g.)  Caucasian Asian Indigenous Middle Eastern	Caucasian	Caucasian	Pacific Islander	Caucasian	Asian	Caucasian
Education Level:  Primary Secondary Tertiary Post-graduate	Tertiary	Secondary	Primary	Tertiary	Secondary	Secondary

## CHAPTER 3: METHODOLOGY

### **Theoretical saturation**

The number of participants required for a GT study cannot be predetermined. The focus of sampling in GT is on rich data rather than numbers. The point at which the researcher stops sampling for any given category is the point of theoretical saturation. Theoretical saturation is the point at which further sampling adds no new data, the same data are being repeated and the researcher is able to fully develop the properties of the category (Glaser & Strauss, 1977); the point at which the data collected is rich and complete (Munhall, 2011). In this study theoretical saturation was reached after five interviews however a sixth participant was sampled to confirm this saturation.

### **Data sources**

#### ***Interview data***

Interviews were audio-taped and subsequently transcribed. Transcriptions were imported into NVivo7, a computer-assisted qualitative data analysis program allowing electronic data which was more easily stored and analysed. While written data were the primary type of data used for analysis, audio data was often replayed to ensure emphasis, sarcasm, humour and emotion were taken into account. Transcriptions were also checked against corresponding audio data for correctness.

#### ***Memo recording***

Memos were recorded throughout the data collection and analysis phases and included thoughts, questions, discoveries and insights from the analysis. The recording and storing of memos for later comparison against the data promotes theoretical sensitivity (Heath & Cowley, 2004.,

## CHAPTER 3: METHODOLOGY

Charmaz, 2006) as it assists the researcher to identify and define categories and their relationships to each other throughout the data analysis process, encourages constant comparison and acts as a reminder of thoughts and ideas that may otherwise have been forgotten (Glaser & Strauss, 1967).

### **Data storage and management**

Computer-assisted qualitative data analysis software (CAQDAS) was utilised to assist with data storage and management. CAQDAS allows the researcher to “simultaneously save valuable time and increase the quality of analytical output” (Wickham & Woods, 2005, p.699). The program NVivo was chosen as it allowed data to be stored, analysed, compared and manipulated with relative ease. Reports were easily exported to email format and distributed to my supervisors to assist in communicating research progress and memos were able to be linked to data sources for easy revision whenever required. Specific information on how NVivo assisted in each stage of data analysis will be presented later in this chapter.

### **Data Analysis**

The analysis of qualitative data requires the researcher to explore and organise data to find relationships between each part (Polit & Hungler, 2004). In GT this exploration and organisation is based on the process of constant comparative analysis, introduced earlier in this chapter. Constant comparative analysis is designed to assist the researcher to generate a theory from their research that is “integrated, consistent, plausible, (and) close to the data...” (Glaser & Strauss, 1967, p.103); “...a theory that accounts for much of the relevant behaviour.” (p. 30).

For theory generation, data collection and analysis must occur simultaneously. That is, data analysis (constant comparison) guides the researcher to adjust the sampling (theoretical

### CHAPTER 3: METHODOLOGY

sampling) to ensure that the data collected is relevant to the theory (Glaser & Strauss, 1967). This meant that transcription of the first interview, before subsequent interviews, was the point at which data analysis commenced. Sampling for the subsequent interviews was based on data from analysis of previous interviews. This was a cyclic process that occurred throughout data analysis.

Constant comparative analysis consists of four distinct stages. The first of these is involved with the comparison of incidents applicable to each category (Glaser & Strauss, 1967). After importing the first interview transcript into the NVivo 7 "Sources" section (QSR International, 2006) I commenced open coding. Open coding involved coding the data line-by-line into as many categories, and properties of categories, as possible. Line-by-line analysis is necessary in ensuring full theoretical coverage of the data and ensuring it is well grounded (Glaser, 1978).

In searching the data for meaning Glaser (1978) advises the researcher to ask the following questions of the data;

- "What is this data a study of?" (p. 57)
- "What category does this incident indicate?" (p. 57)
- "What is actually happening in the data?" (p. 57)

The purpose of these questions is to keep the researcher theoretically sensitive, that is able to make sense of the data by making connections, identifying patterns and establishing relationships between each data segment (Glaser, 1978). By asking these questions I was encouraged to analyse each piece of data from various perspectives that I may not have otherwise thought about. This ensured that the data's meaning emerged through the labelling of appropriate codes and discouraged the forcing of data into pre-conceived categories.

Below is an example of a data segment from the first interview and its corresponding open codes.

## CHAPTER 3: METHODOLOGY

Table 3.3: Generation of open codes

Data	Open codes generated
<i>"I mean, I know you have to <b>battle on by yourself</b> and, you know, because you're <b>going home</b> and you've got to be <b>independent</b> but, yeah, sometimes you just <b>expect a little bit more</b> I think."</i>	<ul style="list-style-type: none"> <li>• working it out for myself</li> <li>• persistence</li> <li>• going home</li> <li>• working it out for myself</li> <li>• expectations vs reality</li> </ul>

As more interview data were collected the codes were clustered to develop the categories and their properties. Although data were being coded to some categories more than others, and those categories seemed to better fit the research question, all data and codes were regarded as important at this point. Open coding identified 113 initial categories. Examples of the emergence of two categories during open coding are shown below, incorporating the use of data, codes and memos.

## CHAPTER 3: METHODOLOGY

Table 3.4: Generation of initial categories

Data segment examples	Open codes generated	Memo/s	Category
<p><i>"I think if they had <b>more time to spend with you</b>... yeah, it would be more beneficial"</i></p> <p><i>"the most beneficial thing is if they <b>spend time</b> with you"</i></p> <p><i>"you could have more <b>one on one time</b>"</i></p> <p><i>"she was willing to <b>spend time</b>"</i></p> <p><i>"in the ideal world they'd probably just <b>spend more time</b> with you"</i></p> <p><i>"the midwives that just seemed to <b>spend a lot more time</b> with me and stay with me for a little while"</i></p>	<ul style="list-style-type: none"> <li>• spending time</li> <li>• more time</li> <li>• time with you</li> </ul>	<p>Again, the mention of time. Lack of time spent on giving support as a negative and spending time as a positive. It seems that mothers are wanting midwives to invest more time in providing breastfeeding support. I wonder how much time is considered adequate. Is it dependant on the situation? Is it just until the mother feels confident or is the investment of time from the midwife, despite the outcome, a positive thing? What does the mother want the midwife to spend the time doing?</p> <p>Another mention of time here. Spending time giving support was considered helpful. The difference with this code is that support was given so time was a positive thing. The other two codes i.e. lack of time and delayed support were about not getting support. Therefore time was a negative thing.</p>	Midwives spending time

## CHAPTER 3: METHODOLOGY

<p><i>"it seemed a bit <b> rushed</b>"</i></p> <p><i>"because, really, of that time factor... just the fact that you're <b> not getting the time</b> with the staff"</i></p> <p><i>"Where as, with the <b> time constraints</b> within the hospital that just doesn't seem feasible"</i></p> <p><i>"I think <b> if they had more time</b> to spend with you..."</i></p>	<ul style="list-style-type: none"> <li>• lack of time for support</li> <li>• workload – busyness of midwives</li> </ul>		<p>Barriers to midwifery breastfeeding support</p>
---	---	--	--

## CHAPTER 3: METHODOLOGY

**Memoing**

During coding, I had numerous moments of realisation where a relationship or concept suddenly became clear or a question became apparent. When this occurred I would stop coding for a moment and record my thoughts. This process of memoing (Glaser & Strauss, 1967) was utilised from the very early stages of analysis and was continued throughout the process. The NVivo 7 software allowed me to link memos to nodes, text or to store them beside the data. In the early stages these memos related to the names I gave to categories, my ideas about how categories may be connected and my thoughts about future sampling. An example of a memo written during open coding of the first interview is given below:

Memo titled "Who's time?" linked to tree node "Time Invested"

*The free nodes attached to this parent node mention both time invested by the mother and midwife. Time invested by the midwife relates to providing breastfeeding support and is described as a positive thing. Time invested by the mother relates to waiting for support and the time actually breastfeeding and is described as a negative thing. So it seems that time invested by others is positive and time invested by the mother is negative. Is this just a coincidence and the negative and positive aspects relate to the actual activity or is time invested always negative according to the giver of that time?*

Memos became a part of the data being analysed in that they assisted in interpreting the data and recording ideas that could be used at a later time to assist further comparison and analysis. Further memos are included in the remainder of this chapter to demonstrate how they assisted in the open coding process and the delimiting of the theory during selective coding.

**Data analysis software**

The use of the NVivo 7 software assisted in the open coding process by allowing text segments to be selected and coded as a "node" (QSR International, 2006). NVivo 7 allowed the



## CHAPTER 3: METHODOLOGY

identification of both free nodes and tree nodes. Several of the tree nodes were assigned as categories and some of the free nodes were assigned to the properties of each category. Nodes were displayed in a tree-like structure and could be collapsed or expanded as required. By double-clicking on a node, each coded data segment for that node was displayed. Editing of nodes was simple and allowed nodes to be moved, merged, copied, created and deleted. NVivo 7 kept a log of structural changes to the node trees and thus enabled a virtual paper trail. An example of a segment of the node tree-structure is shown below.

Figure 3.1: NVivo tree node structure

The screenshot displays the NVivo 7 interface. At the top, a 'Tree Nodes' table lists nodes and their associated sources and references. A callout box labeled 'Category' points to the 'Working it out' node. Below the table, the 'Acceptance' node is selected, and its properties are shown. A callout box labeled 'Property' points to the 'Acceptance' node. At the bottom, a list of references is displayed, with a callout box labeled 'Data segment' pointing to the text of Reference 2.

Name	Sources	References
Working it out	0	0
Acceptance	2	6
Doing it myself	1	5
Doing it right	4	15
Response to not being able to breastfeed	1	1

**Acceptance**

Reference 1 - 0.26% Coverage  
I mean, I was feeling relatively good within myself and felt that I'd given it, you know, my best go, my best shot

Reference 2 - 0.12% Coverage  
I mean now I feel fine but not sort of at the time...

Reference 3 - 0.47% Coverage  
and that baby was, you know, it wasn't going to be detrimental to the baby, that she'd survive on the formula feeding, just seeing her content and gaining weight and, you know, looking healthy and happy

Reference 4 - 0.11% Coverage  
I think it's just the process that you go through

## CHAPTER 3: METHODOLOGY

The second stage of the constant comparative method involves the “integration of categories and their properties” (Glaser & Strauss, 1978, p.108). This integration is enabled by the comparison of incidents to properties of categories in order to determine how they relate to each other. For example, during this stage of coding the workload and busyness of the midwife had been identified as a property of the category *barriers to midwifery breastfeeding support*. Data from further interviews revealed the codes of *mother hears other buzzers* and *mother feels guilty requesting support*. Constant comparison allowed for questioning of the relationship between these codes, the category *barriers to midwifery breastfeeding support* and its properties. Whilst these codes were also compared to other categories and properties it became clear that the mothers hearing other buzzers contributed to their perceptions of the workload and busyness of the midwives and had the consequence of causing mother to feel guilty requesting support. Thus these codes and properties were all considered properties of the category *barriers to midwifery breastfeeding support*. Through this process, categories and their properties began to have more meaning and a story started to develop, demonstrating that the constant comparative method was allowing the emergence of a theory.

“Delimiting the theory” (Glaser & Strauss, 1967, p. 110) was the third stage of the constant comparative method of analysis. The constant comparative process allowed the identification of codes that were related and, after thorough questioning of each, these codes were subsequently linked together. On some occasions the codes were merged as it was found that two or more codes had the same meaning. On other occasions codes became the property of a category or a category itself. For example, a previously labelled code, *lack of time for support*, was considered to mean the same as the code *workload/staffing/busyness* and was, thus, integrated into a single property of the category *barriers to midwifery breastfeeding support*. When a category emerged it was compared to other categories and codes to identify any relationships between them. It is these categories that become the building blocks for the emergent theory (Glaser, 1978).

## CHAPTER 3: METHODOLOGY

After five interviews were conducted and data were becoming more theoretically saturated, some codes continued to stand alone with little data saturation. These codes were deemed to be theoretically defunct in that they did not seem to fit the emerging theory (Glaser, 1978). They were eventually disregarded reducing the number of codes but with each remaining code fitting with the incidents they were representing.

At this stage of data analysis, following the GT method described by Glaser and Strauss (1967), coding becomes theoretical. However, initial attempts to construct theory from the positivist perspective, where I tried to separate myself entirely from the data, felt uncomfortable and caused a period of “analytic interruptus” (Lofland, 1970) where I was unable to move forward with analysis of the data. The following memo illustrates the difficulties I encountered:

*After a meeting with my supervisors I am aware that I have been too scared and cautious about developing a storyline for fear of then forcing the codes in to fit my story rather than the story of the women. I need to see this as a work of art and get more creative. I need to find a way to conceptualise the data. I need to spend some time thinking about what is really happening here. What is the storyline? Does it fit every new mother's experience?*

At this point I changed to the method of GT described by Strauss and Corbin (1990) as it offered a more structured approach to the stage of analysis. So, instead of moving toward theoretical coding I began to use axial coding (Strauss & Corbin) to make connections between the categories that had emerged in the open coding phase. It became apparent that I had already begun axial coding of data in that I had already been comparing and merging categories with one another. Strauss and Corbin suggest the use of a coding paradigm for axial coding, that includes conditions, context, actions and consequences (Strauss & Corbin). I chose to use an alternative model which was Schatzman's dimensional analysis framework (Schatzman, 1991).

## CHAPTER 3: METHODOLOGY

**Dimensional analysis**

Dimensional analysis is a methodological approach that allows the grounding of theory in qualitative research (Schatzman, 1991). For the analysis of data from this current study, the dimensional analysis framework provided an overarching paradigm that allowed for the recommencement of analysis and guided the process of theory building. Schatzman explains that the ability of the framework to guide analysis is one of the primary benefits of dimensional analysis. This, in turn, allows for a second benefit, in that analytical processes are made explicit as the researcher is able to demonstrate the processes used to generate theory from data (Schatzman).

In Schatzman's model, dimensional analysis reflects the normal cognitive processes of a person as they try to understand a phenomenon. This can be reflected in how a person tells a story in that the objects and events within the story are designated as the context or a condition to the actions or interactions that are central to the story or situation. Alternatively they may be presented as a consequence of these actions or interactions (Schatzman).

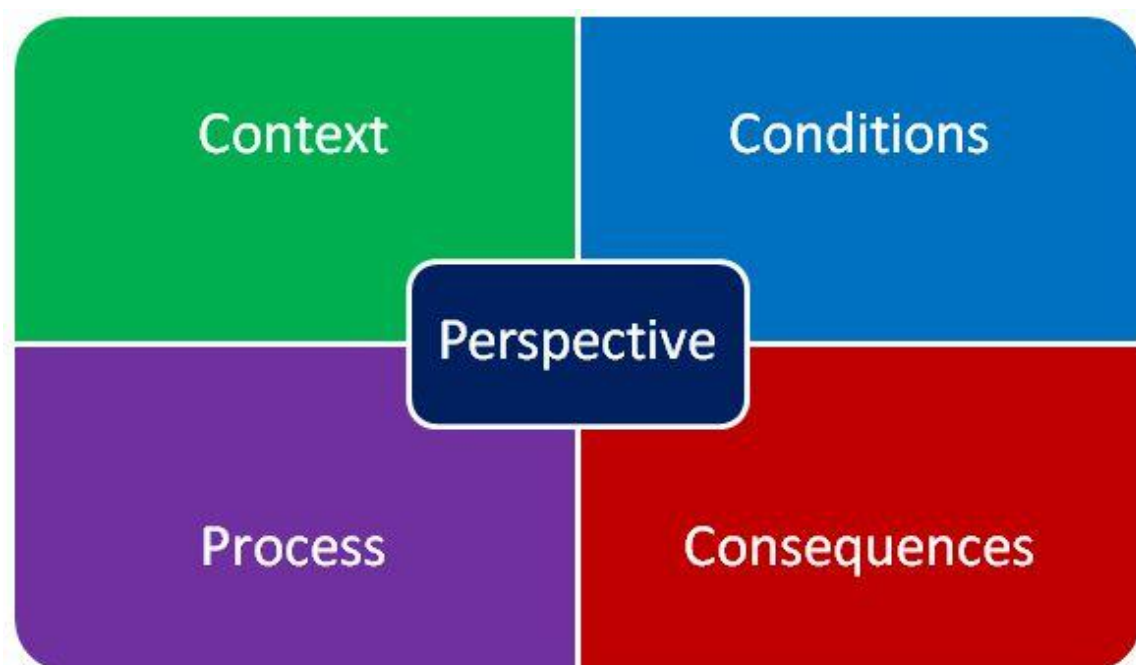
In the initial stage of dimensional analysis the objects or aspects of the story are discovered and become dimensions and their properties. Open coding had followed an almost parallel process to the dimensionalising process described by Schatzman, in which the researcher asks "what *all* is involved here?" (1991, p. 310). The analytical process of open coding had provided the dimensions and properties required for moving on to the explanatory phase of dimensional analysis. An explanatory matrix is used in dimensional analysis as a framework for the analysis of data. As with the components of a story, the components of the explanatory matrix are context, conditions, processes, consequences and perspective. In explaining the phenomenon, the researcher designates the dimensions and their properties as a part of the context, conditions, processes or consequences. The context is the environment or situation in which the participants

## CHAPTER 3: METHODOLOGY

experience the phenomenon. The conditions have an impact on the phenomenon by facilitating, hindering or otherwise influencing the phenomenon's actions and interactions, known as processes. The consequences are the outcomes of the actions and interactions (Kools, McCarthy, Durham & Robrecht, 1996).

The perspective is the central dimension of the phenomenon that relates to all of the other dimensions. Each dimension is trialled as the perspective and the other dimensions are redesignated in response. Finally, one of these is chosen as the perspective because it provides the most logical and consistent explanation for the relationship between itself and the other dimensions and their designation within the matrix (Schatzman, 1991). This dimension becomes the central or core component of the story.

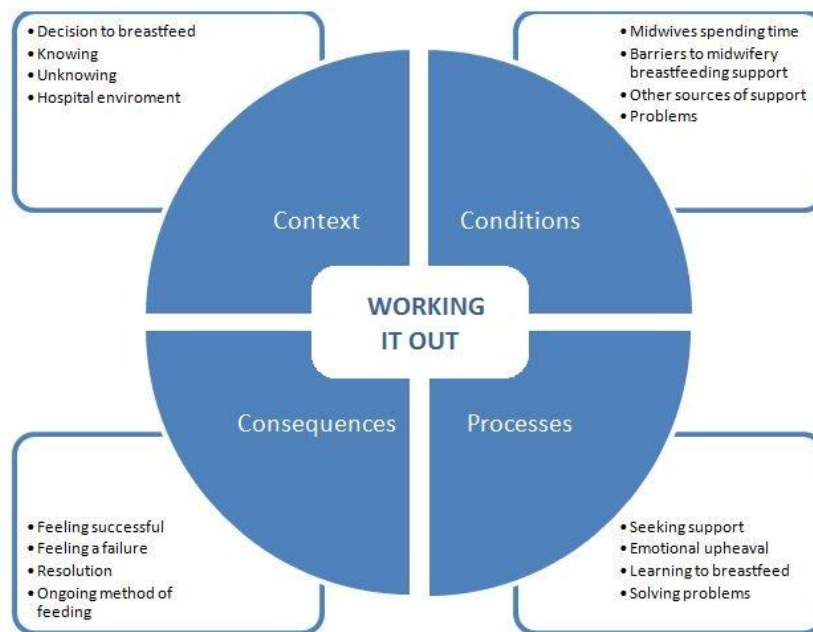
Figure 3.2: Beginning matrix utilising Schatzman's dimensional analysis framework



***Discovering the core category***

The identification of a core category and the relating of other categories to the core is identified as a process of selective coding by Strauss and Corbin (1990). In this final stage of coding, after the constant comparing of categories within the explanatory matrix, it was found that the category WORKING IT OUT was central to new mothers' experiences of receiving midwifery breastfeeding support. WORKING IT OUT was tested as the core category to ensure that all other categories related to it. This testing occurred through a number of means such as the writing of storylines, which will be discussed under the heading of memos, and the drawing of concept maps to see how the core category related to the other categories. An example of a concept map of the relationship of categories around the core category WORKING IT OUT is shown below.

**Figure 3.3:** Concept map: WORKING IT OUT



For this study, a final interview was conducted as a method of testing the core category and the relationship of the other categories against it. This interview did not add any new data, but served to confirm WORKING IT OUT as the core category and confirm that the storyline reflected the

## CHAPTER 3: METHODOLOGY

experience of new mothers receiving midwifery breastfeeding support. Below is an example of an earlier storyline:

Storyline 1

*The new mothers in this study were motivated to breastfeed because they wished to do the right thing for their babies and be good mothers. Midwives in the antenatal setting and other people around them had spoken of the benefits of breastfeeding. Before their babies were born, the new mother expected that breastfeeding would come naturally and that she and her baby would know what to do. When the baby was born the new mothers found themselves in a position of not knowing how to breastfeed their babies and looked to midwives for help with learning to breastfeed. Some new mothers actively sought support from midwives by buzzing for assistance and asking questions. Other new mothers were passive, waiting for the midwife to offer and provide breastfeeding support. These new mothers went through a process of working out how to feed their baby. When the support given by midwives was considered by the new mother as helpful, the mother seemed to be able to work it out quickly and without struggle or stress and found learning to breastfeed a positive and rewarding experience. If the mother received no support or support that was not considered helpful she took longer to work it out, experienced struggle, sought the support from friends, family and other health professionals and found learning to breastfeed a negative experience. These mothers experienced stress, guilt and a changed perception of their ability to be a good mother overall.*

At this point of the data analysis I was not entirely sure that WORKING IT OUT was the core category but it can now be seen that this storyline assisted in the process of identifying it as the core category.

**Theoretical Saturation**

The researcher continues to collect and analyse data until the data is rich and complete and sampling does not add any new data (Munhall, 2011). This is referred to in GT as the point of theoretical saturation (Glaser & Strauss, 1967). In this study, theoretical saturation became evident at the fifth interview; however a sixth interview to confirm the emerging theory also confirmed that theoretical saturation had occurred.

## CHAPTER 3: METHODOLOGY

***Refining the theory***

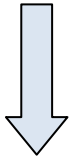
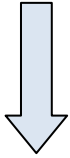
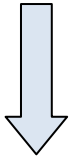
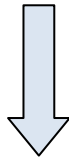
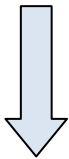
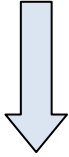
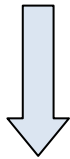
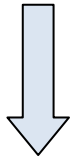
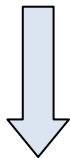
The process of refining the theory involves reviewing the theory for gaps, inconsistencies, poorly developed categories and over-developed categories (Strauss & Corbin, 1990). Strauss and Corbin suggest that the researcher should review the theory sensing for anything that doesn't seem right. The developing theory for this current study seemed to flow well but the category labelled *problems*, which was dimensionalised as a condition, contained both conditional and process properties. For this reason the process of problem solving was not adequately addressed in the storyline. Further analysis and checking of data resulted in the formation of a new process category labelled *solving problems*. The properties of the category *problems* that were process properties became properties of *solving problems*. The theory was further validated by providing the storyline to friends of the researcher who had recently breastfed. These mothers all agreed that the storyline reflected their own experiences of receiving midwifery breastfeeding support. This further analysis and checking of the storyline resulted in a more refined theory. This theory will be described in the following chapter.

A summary of the processes of analysis used for this study is presented in the following table:



## CHAPTER 3: METHODOLOGY

Table 3.5: Summary of analytical process used

Constant comparison	Glaser & Strauss (1967)	Strauss & Corbin (1990)	Coding for this study
<p><b>Comparing incidents applicable to each category</b> (Comparing incidents to incidents) CODES</p>  <p><b>Integration of categories and their properties</b> (Comparing incidents to properties of a category) CONCEPTS</p>  <p><b>Delimiting the theory</b></p>  <p><b>Writing the theory</b></p>	<p><b>Open/Substantive coding</b> (procedure for developing categories of information)</p>  <p><b>Theoretical coding</b> (Procedure for conceptualising how open/substantive codes relate to each other to develop a theory)</p>	<p><b>Open coding</b> (procedure for developing categories of information)</p>  <p><b>Axial coding</b> (procedure for interconnecting the categories)</p>  <p><b>Selective coding</b> (Procedure for building a story that connects the categories, choosing a core category and producing theory)</p>	<p><b>Open coding</b></p>  <p><b>Attempted theoretical coding</b></p>  <p><b>Shifted to axial coding</b> using <b>Schatzman's dimensional analysis framework</b></p>  <p><b>Selective coding</b></p>

## CHAPTER 3: METHODOLOGY

### **Ethical Issues**

The ethical principles applied to this research were guided by the NHMRC's National Statement on Ethical Conduct of Research Involving Humans (1999 & 2009). I gave particular consideration to the vulnerability of new mothers and the potential emotional risk involved in discussing their breastfeeding experiences. I also considered the fact that I was recruiting mothers at my place of employment and was mindful that I did not recruit any mother who I had cared for as a midwife or lactation consultant. These considerations were reflected in the inclusion criteria and research design which ensured a minimal potential for physical, legal, financial or psychological harm. It did not contain interventions, treatments or therapeutic techniques and participants were not from any particularly vulnerable groups. The participants were physically and mentally competent to give informed consent. This resulted in the research being categorised as minimal risk.

Ethical approval for this study was sought and given from the Australian Catholic University (Human Research Ethics Committee) at which the researcher is a student. Additional approval was sought and given from the Mater Health Service's Human Research Ethics Committee as the women who participated in the study were recruited from this health service.

Consent was obtained after a thorough explanation of the study and the opportunity to ask questions had been provided. All participants in this study provided informed consent and signed a consent form prior to the commencement of data collection. The women were assured that their care would not be affected by their decision to accept or decline involvement. Participants were also informed that they could withdraw consent at any stage of the research without consequence. Additionally, participants were informed that their

### CHAPTER 3: METHODOLOGY

identity would remain confidential during all stages of the research process through the use of a pseudonym.

The pseudonym, given to each participant, was utilized throughout the data collection, analysis and reporting stages of the research. Any identifying data, such as the consent forms, were stored separately from other data. All data, including paper, audio and electronic, were securely stored in a locked filing cabinet. De-identified data were saved to a password protected computer hard drive.

#### **Rigour**

“One of the main challenges in qualitative data analysis is to ensure that the voice of the other is heard and allowed to enter into dialogue with pre-existing understandings.” (Ezzy, 2002, p.xiii).

Rigour in GT refers to numerous aspects of the research that allow trustworthiness, defined by Schwandt (2007) as the quality of the research and its findings that make the research noteworthy to its readers. The basic strategies for ensuring rigour relate to the researcher being able to clearly identify the decisions surrounding the research method, sampling techniques, analytical and interpretive processes and ethical considerations as well as to maintain a comprehensive audit trail which clearly identifies these factors (Mays & Pope, 1995).

Theoretical sensitivity helped me to develop effective research questions. From my experience of conducting an early literature review, rather than encouraging the forcing of data into pre-conceived categories, this process encouraged me to discover what was not yet known about the topic in question. I have remained mindful of Glaser's views related to the forcing of data and have taken steps to maintain reflexivity, that is “thoughtful, conscious

## CHAPTER 3: METHODOLOGY

self awareness" (Finlay, 2002, p. 532) such as the keeping of theoretical memos to ensure I constantly questioned how my knowledge and thoughts impacted on the data.

Four criteria for establishing trustworthiness in qualitative research were identified by Lincoln and Guba (1985) as credibility, dependability, confirmability and transferability. These criteria, and a description of how this research adhered to each, are outlined below:

### ***Credibility***

Credibility refers to the confidence the researcher has in the truth, accuracy and soundness of the data and their interpretations of the same (Lincoln & Guba, 1985). Credibility of data was enhanced in this research by collecting it first hand from participants through an interview process. Data was comprised of the mothers' experiences and feelings and could be questioned and verified at the time of its collection. Theoretical sampling ensured that data were collected from participants of varying ages, ethnicity, educational levels and models of care. This ensured that the emerging theory was not specific to any particular socioeconomic or cultural group.

Additionally, through theoretical sampling, I endeavoured to recruit participants who had differing experiences. This increased the likelihood that data encompassed a variety of aspects and experiences within the phenomenon being studied which increases credibility (Graneheim, & Lundman, 2004). Furthermore, but not initially apparent, the feeding outcomes of the participants were varied at the end of the study period, confirming that the participants' experiences were likely to have been quite different.

Transcribed digital recordings ensured that the data was authentic and not subject to my ability to recall the interview content. Where a transcriber was hired, I personally checked each word within the transcription against the original audio recording. During each stage of

## CHAPTER 3: METHODOLOGY

coding the recordings and transcripts of each interview were reviewed many times to ensure that the true meanings of the data were interpreted.

I utilised digital audio to record field memos in my car as soon as an interview had concluded to ensure my initial thoughts and ideas were captured. These field notes included observations, questions, ideas, themes and labels that I was able to access later for comparison with other data. The immediate capturing of these memos ensured that these data were not forgotten over time or later confused as applying to another participant or interview.

### ***Dependability***

Dependability refers to the stability, or reliability, of data over time and through changing conditions (Marshall & Rossman, 2011). Peer examination can allow the researcher to establish dependability by assisting them to draw dependable inferences from the data (Marshall & Rossman). As this research was part of the work required for a Masters degree, three research supervisors became such peers. The supervisors were consulted regularly throughout each stage of the research process, providing me with the opportunity to present data and subsequently compare interpretations, discuss findings in detail and to be guided in using GT correctly. Each of these added to the dependability of the research.

The keeping of records that detail the research process such as the nature of decisions and the data and reasoning behind these decisions can enhance dependability (Chiovitti & Piran, 2003). The use of the program NVivo has enabled such records to be kept and utilised throughout the processes of data coding and theory generation. In doing so it allowed a clear and detailed audit trail to develop, improving the likelihood that another researcher could replicate the study in the future.

## CHAPTER 3: METHODOLOGY

### ***Confirmability***

Confirmability is concerned with assuring the data, interpretations and outcomes of the study truthfully represent the information provided by the participants in the context of the study rather than the researcher's perspectives, biases or motivations (Polit & Beck, 2006). The primary operational technique for ensuring confirmability in qualitative research is the maintenance of an audit trail (Marshall & Rossman, 2011). As described under the heading "Dependability", a clear and detailed audit trail of this research was maintained, aided by the use of CAQDAS; NVivo.

Audiotaping of interviews added to the audit trail maintained for this study and allowed regular rechecking of interview data to ensure the true meaning of what was said by participants was not lost during transcription. Thought was given to the participant's mood, tone, emphasis on words and body language. Field memos were recorded and incorporated into the analysis. This enhanced the confirmability of the research by promoting more honest interpretation of the data.

### ***Transferability***

Transferability refers to the generalisability of the data, or the applicability it may have to other settings or groups (Polit & Beck, 2006). The primary technique for improving the transferability of qualitative research is the use of thick description (Miles & Huberman 1994; Lincoln & Guba 1985). The GT techniques of theoretical sampling and constant comparison used in this research facilitated transferability as they encouraged sampling that gathered "the widest possible range of information for inclusion in the thick description" (Lincoln & Guba, p.316).

### CHAPTER 3: METHODOLOGY

The thick description is utilised by the reader to ascertain whether data are applicable to other contexts. The researcher's responsibility is to provide a sufficient enough description for this to be achieved rather than to come to such conclusions themselves (Lincoln & Guba 1985). Data from this study that contributed to a thick description included demographic data, audio and transcribed interview data, field and theoretical memos, codes and a dimensional analysis framework. Further data adding to the thick description will be this thesis which details each part of the research process.

In summary, rigour was maintained throughout the research process through the consideration and application of the principles of credibility, dependability, confirmability and transferability and the associated strategies described above.

#### **Summary**

This chapter has described the qualitative methodology of GT and how the processes of the GT method were applied to the data collection and analysis of in this study. The shift in GT methods described by Glaser and Strauss (1967) to the methods described by Strauss and Corbin (1990) was justified. Application of Schatzman's dimensional analysis framework for analysing the data in this study was also justified. Examples of memos, codes, a concept map and a storyline were provided to illustrate the analytical process. Finally, an explanation of how the researcher maintained rigour and high ethical standards was provided. The following chapter presents a detailed explanation of the findings of this research.

## **CHAPTER FOUR: RESULTS**

### **Introduction**

This chapter presents the results of this study. The previous chapter explained the GT methodology and how it assisted the development of categories, properties, a core category and, eventually theory. This chapter explains these findings in detail.

The aim of this study was to explore new mother's experiences of receiving breastfeeding support from midwives. Although midwifery breastfeeding support was the initial focus of the study and became a category of the theory, it did not prove to be the central theme. The core category and perspective that emerged from the study is WORKING IT OUT which encompasses the point that each of the new mothers reached despite their differing experiences of receiving midwifery breastfeeding support.

The factors that influenced the new mothers' experience of WORKING IT OUT were categorised into contexts, conditions, processes and consequences in accordance with Schatzman's dimensional analysis framework (1991) as explained in the previous chapter. WORKING IT OUT emerged not only as the endpoint or destination for the mothers in this study but reflected the journey of each mother in the study.

All new mothers reached a point of WORKING IT OUT and each went through similar steps and processes to arrive at this point however their experiences of these processes varied according to the breastfeeding support they received and their ability to solve the breastfeeding problems they faced. WORKING IT OUT does not necessarily refer to successful breastfeeding, but to the entire process and a critical point the new mothers reached in their experiences of early mothering regardless of the feeding outcome.



## CHAPTER 4: RESULTS

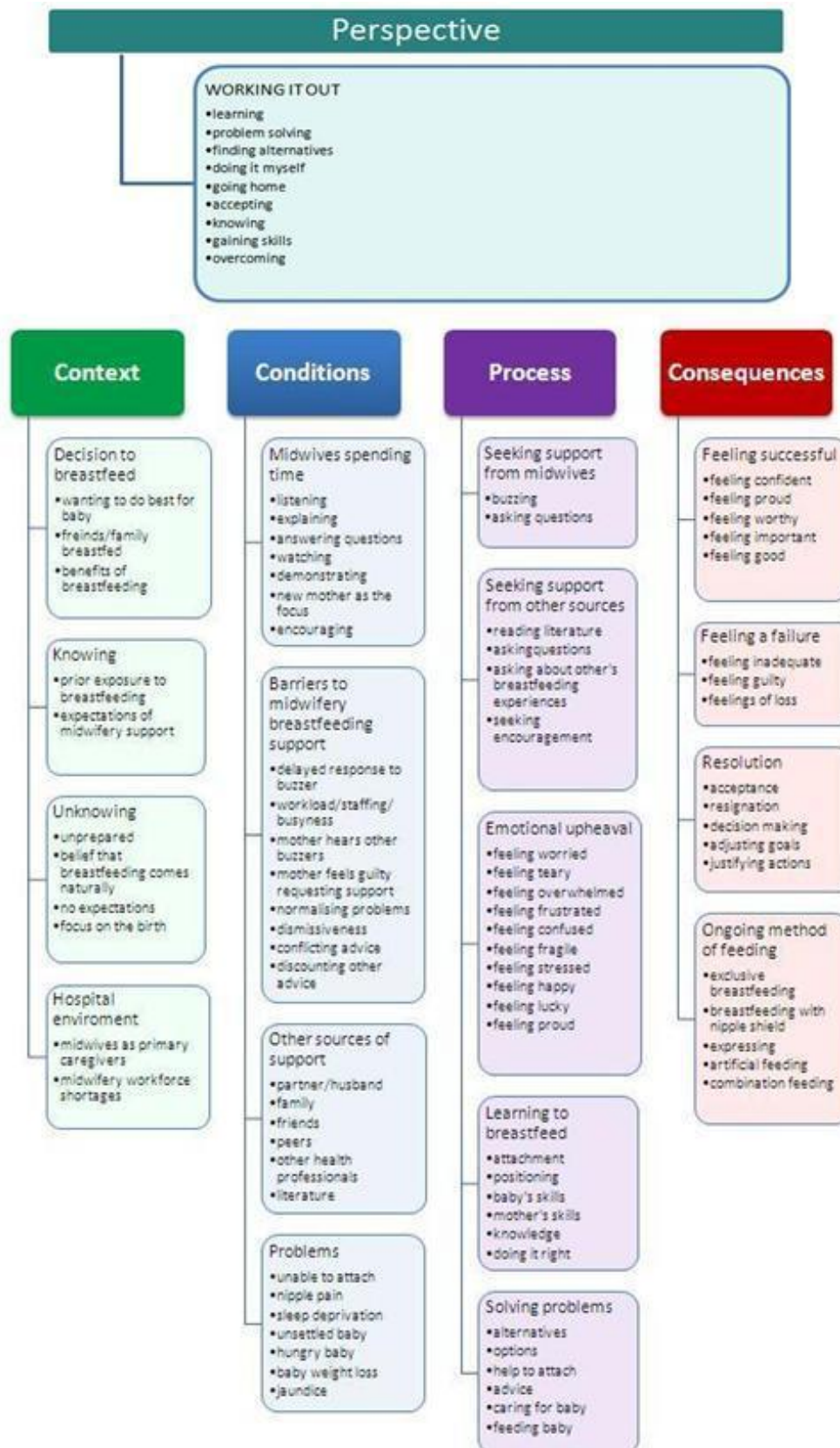
The results of this study are presented visually in Figure 4.2 according to Schatzman's Dimensional Analysis framework. The context, conditions, processes and consequences are placed around the perspective or core category of WORKING IT OUT to demonstrate that each relates to it as the core category. Each of these elements and categories are presented in this chapter supported by verbatim quotes from the data to further illustrate the mothers' experiences.

**Figure 4.1:** Matrix showing development of categories around the core category



The above diagram applies Schatzman's dimensional analysis framework (Schatzman, 1991) and shows the relationships of categories to the core category of WORKING IT OUT. The diagram below provides more detail with the properties of each category listed.

Figure 4.2: Full explanatory matrix showing categories and their properties



## CHAPTER 4: RESULTS

An explanation of the inter-relationships between each of these categories, properties and the core category of WORKING IT OUT is presented below.

**PERSPECTIVE:****WORKING IT OUT**

WORKING IT OUT emerged as the core category in this study encompassing the point that each of the new mothers reached despite their differing experiences of receiving midwifery breastfeeding support. The category of WORKING IT OUT emerged not only as the endpoint or destination for these mothers but embraced each contextual element, condition, process and consequence of the matrix as though it mapped out the journey each mother took. In the following quotes, the mothers discuss how they worked through breastfeeding difficulties to a point of feeling better about their experience and infant feeding outcomes:

*Ann: Um... well I don't know. I suppose it just seemed to happen quite quickly. I got home, I have the support of family and friends just reinforcing that I was doing the right thing and that baby was, you know, it wasn't going to be detrimental to the baby, that she'd survive on the formula feeding, just seeing her content and gaining weight and, you know, looking healthy and happy. I think it's just the process that you go through.*

*Susan – She slept a lot better as soon as I started thinking about what I would tell someone else to do she started sleeping and was more, I guess I was more relaxed. I thought oh this is so easy why didn't we think about doing this beforehand... so I started doing what I thought I should do and she just settled down a lot more, more quiet times, I actually got to read my book occasionally.*

The following section on context sets the scene for the new mothers' experience of WORKING IT OUT.

**CONTEXT:**

Context refers to the environment, setting and circumstances surrounding the process of new mothers receiving breastfeeding support from midwives and ultimately WORKING IT

## CHAPTER 4: RESULTS

OUT. It emerged from the data that the contextual categories important to WORKING IT OUT were the *decision to breastfeed*, the new mothers' knowledge of breastfeeding; categorised as *knowing* and *unknowing*, and *the hospital environment*. A description of each of these categories, their properties and links to other dimensions of the theories are presented below.

***Decision to breastfeed***

The decision to breastfeed is one of four contextual categories within the theory of WORKING IT OUT and reflects the mothers' reasons to breastfeed their babies. The mother's decision to breastfeed was part of the context of WORKING IT OUT in that it provided the motivation for each of the new mothers to breastfeed. The new mothers had set themselves a goal of breastfeeding successfully. The situations they faced and the activities they engaged in affected their ability to reach this goal. In turn, the ability or inability to reach this goal resulted in the varying feelings and outcomes. Despite the decision to breastfeed, reaching the goal of successfully breastfeeding was not imperative to WORKING IT OUT as are explained later in this chapter.

The mothers in this study described numerous factors that had influenced their decision to breastfeed. Several of the mothers made the decision believing it was best for their baby's health, for example, the following quotes demonstrate the mothers' understanding that breastfeeding would strengthen their babies' immune systems and/or protect them from illness:

*Ann: You know, with the breastfeeding there is that closeness... you know that you're giving your baby, you know, the best possible chance with the breast milk.*

*Susan: I wanted to give her at least some antibodies... if that was all I could manage".*

## CHAPTER 4: RESULTS

*Soko: I was reading some books about, you know, breastfeeding... and it is the best way to feed baby... and the books said also if I feed him my breastmilk, um, he gets, um, he won't get sick for about six months.*

Information or encouragement from others also played a role in the mothers' decision to breastfeed. This information and encouragement came from various sources including friends, family and midwives. Lily, a young mother, had initially decided not to breastfeed but commented that she had changed her mind because of her mother's influence:

*Lily: My Mum, she was telling me to breastfeed... she was saying that breastfeeding is much, much better than the bottle... she said it's good for the baby to have the breastfeeding, like... it's for life or something.*

Rhonda found that encouragement from a midwife in the antenatal period was helpful in giving her the confidence to try to breastfeed as described in the following quote:

*Rhonda: Whenever I left when I was talking about breastfeeding or whatever, she always made me feel reassured that, um, that I would be able to breastfeed... that your bodies are made for this... I felt like, um, that I could handle whatever comes about. She was probably the best support out of anyone I spoke to".*

New mothers' prior knowledge of breastfeeding is also likely to have influenced their decision to breastfeed.

### **Knowing**

The category of *knowing* relates to the mothers' knowledge prior to the experience of learning to breastfeed. Each of the new mothers in this study arrived at motherhood with varying amounts of information about breastfeeding and prior exposure to breastfeeding. This category reflects the new mothers' perception of the knowledge they had rather than identifying only their actual knowledge. The new mothers' knowledge came from various sources and experiences and was not always correct.

## CHAPTER 4: RESULTS

*Knowing* was important to the process of new mothers WORKING IT OUT in that it influenced both their decision to breastfeed and their expected and actual breastfeeding support needs. This, in turn, impacted on the ways in which they sought support during the process of WORKING IT OUT. The category of *knowing* was also closely related to the conditions and consequences of WORKING IT OUT in that it set up each new mother's expectations about learning to breastfeed, thus, influenced their emotional responses to the experience. When the new mothers were asked about their prior knowledge of breastfeeding, several expressed that this knowledge came from exposure to breastfeeding mothers. The breastfeeding experience of those mothers impacted on the new mothers' beliefs and expectations as illustrated in the following data segments:

*Researcher: How did you learn about breastfeeding?*

*Susan: I guess from friends that were doing it at the time. Yeah just basically from friends and what they tell me to do, tell me what they were doing, just seeing them doing it, it seemed so easy.*

*Soko: I definitely wanted to breastfeed but, um, some friends have a trouble... um, didn't make much milk and they went to formula as well. My friends always had trouble like feeding the baby every one hour... baby was always crying and... yeah having so much trouble. I had another friend, she had a sore nipple. So I was a little bit concerned...*

*Rhonda: I think just because I've been around my friends kids for like the last five years... they're all young and there was always one on the way that, um, you sort of just listen to their stories and um, sort of, I had a general gist of it...*

On other occasions the women had actively sought out information from sources such as books, the internet and lactation consultants. The mothers found this type of information enhanced their knowledge as they describe through the following comments:

*Ann - Well I'd seen a lactation consultant prior to the delivery...quite a few weeks prior, and I'd read the books so... I mean I was sort of feeling confident from that perspective.*

## CHAPTER 4: RESULTS

*Rhonda: Um... I just looked up internet and magazines and reading books... like that one there (points to Sheila Kitzinger's "Pregnancy and Childbirth" book) which I've gone back to already since having him so...*

*Susan - I did a lot of reading, it is amazing what you forget... I went back to the book afterwards and thought I must have read this chapter but I completely forgot about it but I have a breastfeeding made easy book, and that made all perfect sense but it's not so grand when your milk doesn't come in. So I did read... but it's experience and I am a very visual person and I learn a lot more from seeing things being done rather than reading.*

While the new mothers' knowledge assisted to prepare them for their experience of learning to breastfeed, their knowledge deficits, often unknown to them until they began learning to breastfeed, heightened their feelings of unpreparedness. Most of the new mothers found that their expectations of WORKING IT OUT were far different to the realities of the situation. The next category articulates their lack of knowledge and the mismatch between their expectations and reality.

### ***Unknowning***

In contrast to *knowing*, the category *unknowning* relates to the new mothers' lack of information, preparation and expectations about breastfeeding. Similarly to *knowing*, *unknowning* was important to WORKING IT OUT in that it directly influenced the new mothers' expectations of breastfeeding, their expectations of the support they would receive from midwives and formed the basis for their actual breastfeeding support needs. This, in turn, influenced how the new mothers sought breastfeeding support and their ability to solve problems and ultimately learn how to breastfeed.

It emerged from the data that the mothers were often unaware of their need for support which resulted in several of the new mothers not seeking support until a problem arose. The following comment was echoed by several of the new mothers:



## CHAPTER 4: RESULTS

*Jessica: I really had no idea, it was just the whole pregnancy and birth and afterwards process, I've just rolled with it, it's like, I didn't really have any expectations on it. I had no... didn't know what to expect, and didn't know what was going to happen*

Similar to *knowing*, this *unknowing* caused a wide gap between the new mothers' expectations of learning to breastfeed and the reality of WORKING IT OUT. This gap caused mothers to experience an emotional upheaval as they came to terms with the difficulties they faced. Susan felt her friends had prepared her for some of the difficulties of breastfeeding but found she was not at all prepared for the emotional side of the experience as she explained in the following data segment:

*Susan: Intellectually you know but emotionally it doesn't matter what you know. I certainly didn't imagine that I would have all the emotional upheaval that I have had.*

The mothers often thought their lack of knowledge was related to their focus on the labour and birth and inability to see past those events as described in the following quotes:

*Rhonda: I was kind of a bit blind in that regard. I think you just get so excited by the fact that you're going to have a baby, you don't actually think about the after stuff.*

*Ann: With regards to the breastfeeding, you know, I didn't have a lot of concern, you know, I just maybe thought it would be a lot easier and... yeah... it was more the fear of the unknown, the fear of the delivery that really concerned me.*

*Soko: No I didn't think about breastfeeding at all. I was always, you know, always thinking about labour (laughs) and nothing after that... so when it happen it's quite... always, you know, feeding him and it's quite time consuming (laughs)... It was a bit of a surprise, yeah.*

One of the factors that may have hindered the new mothers' motivation to seek further knowledge about breastfeeding was their belief that breastfeeding would come naturally and that the process of learning to breastfeed would be relatively easy. The following quotes highlight these beliefs:



## CHAPTER 4: RESULTS

*Ann: You know, you sort of think oh well I can do it, you know, it will be easy and... yeah I think the natural thing is just, well...you know? It's supposedly a natural thing so the baby should just easily attach.*

*Rhonda: I thought they'd just, you know, sort of, you know, they'd learn how to suck...I didn't realise that it could be all over the place.*

*Soko: I didn't study much about breastfeed. I thought that just happens right away but it didn't.*

The data segments above illustrate not only the new mothers' lack of awareness of what they did not know about breastfeeding but, paradoxically, an unknowing of this lack of knowledge. Each of the mothers was surprised to find that there was a large amount she didn't know about breastfeeding which resulted in a gap between expectations and reality. Most of the new mothers had not expected to face the practical difficulties or the emotional upheaval that they did during the process of learning to breastfeed. The realisation of their lack of knowledge was significant to the new mothers' experiences of learning to breastfeed as it highlighted to them their need for support in their journey towards WORKING IT OUT. This, in turn, altered how they sought that support.

The new mothers in this study initially realised their support needs within the first one to three days following the births of their babies, while they were in hospital. This timing meant that the hospital environment was a key contextual factor in their journey to WORKING IT OUT.

### ***Hospital Environment***

The contextual category *hospital environment* refers to environmental factors within the hospital that affected new mothers' abilities to access breastfeeding support. Factors within the *hospital environment* determined who provided breastfeeding support to new mothers and the situations in which they were able to provide such support. These situations directly

## CHAPTER 4: RESULTS

impacted the amount and perceived quality of support the new mothers received which, in turn, influenced the process of WORKING IT OUT and the outcomes of this process.

Midwives were the primary postnatal carers and, as such, were the primary source of breastfeeding support for new mothers. Midwives were heavily relied upon for breastfeeding support; however, this study was conducted during a time of midwifery workforce shortages. This was described by new mothers as an environmental factor that had a negative impact on midwives' abilities to spend time providing breastfeeding support; a condition of WORKING IT OUT:

*Susan: I think that I probably was too concerned about the nurses (midwives) and their workload than getting someone to watch me... I just think they need more staff there. It's just too frantic.*

*Ann: I can understand that the ward is so busy and, you know, there's a lot of people to attend to. Just the fact that you're not getting the time with the midwives, you know, you might be better off at home*

The above quotes demonstrate that new mothers recognised the workload issues for midwives and considered the shortage of midwives an overall barrier to midwifery breastfeeding support. Specifically, it was seen to impact negatively on the actions and interactions of WORKING IT OUT such as *seeking support from midwives, learning to breastfeed* and *solving problems*. These categories are further explained under the heading of 'Process' later in the chapter.

### **Summary of contextual categories**

The above description and explanation of the context of WORKING IT OUT; has shown how each of the categories of *the decision to breastfeed, knowing, unknowing* and *hospital environment* is linked to the overall perspective of WORKING IT OUT. The ways in which these contextual factors are woven through the conditions, processes and consequences of

## CHAPTER 4: RESULTS

WORKING IT OUT are varied. The decision to breastfeed provided the motivation for the new mothers to learn to breastfeed and gave them a goal of working breastfeeding out. The women's knowledge and lack of knowledge about breastfeeding influenced their expectations, support needs, support seeking behaviours and emotional responses to the experience. The hospital environment determined that midwives were the primary source of breastfeeding support, whilst midwifery workforce shortages were considered by new mothers as responsible for many barriers to this support.

These contextual factors described the setting in which the new mothers were experiencing the journey of early breastfeeding and WORKING IT OUT. The conditions or circumstances of WORKING IT OUT are examined below.

### CONDITIONS:

Conditions refer to the circumstances in which the new mothers were WORKING IT OUT. The conditions that emerged from the data were *barriers to midwifery breastfeeding support*, *other sources of support*, *midwives spending time* and *problems*. The first three conditions relate directly to breastfeeding support and highlight the importance of this support as the mothers learnt how to breastfeed and solved breastfeeding problems. Breastfeeding support was defined by the mothers, regardless of its basis in evidence.

Each of the conditions had a direct influence on both the processes and consequences of WORKING IT OUT as they influenced the mothers' support seeking behaviours and their emotional responses to the experience of WORKING IT OUT. Breastfeeding support was important to the mothers in overcoming breastfeeding problems and had a significant effect on their experience of WORKING IT OUT. Women who believed that they received the

breastfeeding support they required described their experience more positively than those who felt their support needs were often unmet.

Each of the conditions are described and explained below.

### ***Midwives spending time***

*Midwives spending time* refers to the midwives investing time with the new mothers to provide personalised breastfeeding support. *Midwives spending time* emerged as a significant condition of WORKING IT OUT in that it facilitated new mothers to work breastfeeding out sooner by assisting them to solve problems and gain the knowledge and skills required in *learning to breastfeed*. Additionally, it provided the new mothers with the opportunity to discuss their emotions and feelings surrounding the experience of WORKING IT OUT.

The mothers spoke very positively of the midwives who spent time with them as the following remarks confirm:

*Susan: ...these two (midwives) spent more time and I got more out of them because they managed to spend more time with me and, so, that's probably very valuable.*

*Ann: I think the most beneficial thing is if they spend time with you... the midwives that just seemed to spend more time with me and come to me when I buzzed and then watch me put her on and stay with me for a little while, you know, they seemed to make the difference.*

*Jessica: I had a really bad night and one of them (a midwife) just came and sat with me for a bit...which was really good... it was nice having someone to sit in there with us making sure, double checking he was attached properly and offering suggestions on how to make each of us a bit happier.*

*Soko: She (the midwife) spent the time with me with the breastfeed. She was really good and she just showed me the position and also how to hold him. She spent about... maybe... half an hour. Well that (breastfeeding) take a long time to get used to and, you know, it's not like five minutes lesson to do it....*

## CHAPTER 4: RESULTS

After initial interviews identified *midwives spending time* as important to new mothers, further questions were asked to ascertain the types of support the midwives provided while spending time. Further data revealed that when the midwives spent time they watched, listened, explained, answered questions, demonstrated, encouraged, sat down, gave one on one attention and the mother felt she was the focus. This is summarised well in the following quote:

*Susan: I guess the ideal midwife would sit with you, explain about caring for your baby... Watch you breastfeed, spend some time... The ideal person would be to listen, to explain.....*

*Midwives spending time* in providing breastfeeding support to new mothers emerged as one of the most significant conditions of WORKING IT OUT. It provided the mothers with a more positive experience of WORKING IT OUT, facilitated problem solving and allowed them the opportunity to discuss their thoughts and feelings related to the experience of WORKING IT OUT. This research did not set out to find a link between breastfeeding support and feeding outcomes, and this would be impossible with the sample size utilized. It did emerge from the data, however, that the women in this study who described having a midwife spend time with them were able to reach the point of WORKING IT OUT sooner and with less emotional upheaval than those who did not believe they had received the midwives attention. These mothers were also more likely to choose *exclusive breastfeeding* as their *ongoing method of feeding*.

In contrast to the *midwives spending time*, some of the new mothers talked about feeling there was a lack of time spent by the midwives in helping them to breastfeed. The women discussed numerous factors that they perceived as barriers to midwives spending such time. These and other *barriers to midwifery breastfeeding support* are described below:

***Barriers to midwifery breastfeeding support***

*Barriers to midwifery breastfeeding support* emerged as a condition that encompassed those factors that new mothers described as hindering both the provision and reception of midwifery breastfeeding support. The barriers labelled *delayed response to buzzer*, *workload/staffing/busyness*, *mother hears other buzzers* and *mother feels guilty requesting support* were linked to the contextual factor of *midwifery workforce shortages* as they focussed on the busyness of midwives and the ward environment. They were also not conducive to the condition of *midwives spending time*.

Several of the mothers commented that the midwife would arrive to answer the buzzer long after the need for support had arisen:

*Ann: On a number of occasions it was 45 minutes to an hour before anyone would even pop their head in... so by that time the feed was nearly over...*

*Susan: If they've gone for an hour, well you've finished feeding by then... they're not there now to see it, to witness it...*

The perception that the midwives were busy caused some of the mothers not to seek midwifery support:

*Soko: I just thought if I ring the bell, maybe they might be too busy. I can partly hear the babies crying and the beeping sounds to calling the midwife and I thought ooh they might be a bit busy and I was a bit hesitate to do that...*

*Susan's husband (who interjected during interview): I think one of Susan's problems was she felt guilty about taking up too much of the midwives time... and I think that's what part of the problem was feeding (baby). I think she should have realised that you know they were there for her as well not just for to sort think oh well I don't want to take up too much of their time because they've got other people to look after.*

The mothers who did not receive breastfeeding support when they required it were less able to initiate the processes of *solving problems* and *learning to breastfeed*. This had several

## CHAPTER 4: RESULTS

negative outcomes, which are described under *consequences*, and caused a delay in WORKING IT OUT.

The barriers of *normalising problems*, *dismissiveness*, *conflicting advice* and *discounting other advice* accounted for midwifery breastfeeding advice that was described by new mothers as unsupportive. Ann tried to seek information on expressing after she had trouble breastfeeding but felt that the midwife dismissed her attempts to solve a problem:

*Ann: ...the expressing... that was just sort of, you know, when I mentioned that, it was just disregarded. She just said there's no point in doing that... Some of them were just a bit dismissive and didn't fully appreciate where I was coming from...*

Other mothers' comments illustrated that some midwives had normalised breastfeeding problems:

*Lily: My nipple was very sore. They (midwives) said it's supposed to be like that... might take a couple of weeks and then over.*

*Susan: ...she said that's normal... so I just thought that's normal and didn't mention anything. So the next morning I just happened to mention it and they said oh no that's not good.*

Susan's comment also represents the final two barriers of *conflicting advice* and *discounting other advice*. Several of the new mothers in this study described these practices as unsupportive:

*Ann: Everybody had a different way of showing you things and sort of different ideas. Maybe they were being helpful suggesting you try different ways of doing things but in the end it's just exhausting... you know, the inconsistencies with the approach of the staff...*

*Rhonda: ...cause I read that when your breasts get sore, you're doing it wrong. And they were quite adamant that whoever said that is a bit silly.*

Ann and Rhonda differentiated conflicting advice from offering alternatives; the latter of which they believed was supportive of breastfeeding:

## CHAPTER 4: RESULTS

*Ann: ...maybe if just more alternatives were offered to me in the hospital it might have made a difference.*

*Rhonda: So just sort of trying out different things that they've told me... that sort of helped... It was good to hear all the options.*

Each of the above mentioned barriers to midwifery breastfeeding support impeded the mothers' ability to *learn to breastfeed* and *solve problems*. Mothers' responded to these barriers by feeling an *emotional upheaval* and by *seeking support from other sources*. These processes often led to negative consequences and a delayed journey to WORKING IT OUT. The *other sources of support* are explored below.

### ***Other sources of support***

All of the new mothers in this study identified other sources of support. These sources were described as positive and assisted the mothers in WORKING IT OUT by helping them in *solving problems*, *learning to breastfeed* and dealing with the *emotional upheaval* that some of the mothers encountered.

Many of the mothers described their *husband* or *partner* as being an important source of emotional and practical support:

*Susan: He (husband) was just saying that it would get better and we'd be fine and she was fine and she was getting fed and just trying to make things better... I have been very lucky that he's been very supportive.*

*Rhonda: (Husband) has been good. He's been doing most of the getting up and I just sort of lay in bed and feed him lying down.*

Supportive actions assisted the new mothers in WORKING IT OUT. Lily, who had been combining breast and bottle feeding, described the support provided by her *family*:

*Lily: I'm staying with my parents and my sister and my brother... all of them...when I was, like, busy doing something, make him a bottle to give him a feed. And then when, other time, he wouldn't sleep, they just stand up and carry him.*



## CHAPTER 4: RESULTS

*Friends and peers* were also a common source of support:

*Rhonda: ...most of my friends have got babies now so their experiences are more recent and they just... tell me what they experience and what they read*

*Susan: I had a bit of a meltdown on that evening and lucky I've got a friend and she came over and kinda settled me down. Luckily she was on five days off, so she came, she came for a couple of days.*

In addition to the mostly lay support of family and friends, mothers described more expert advice from *other health professionals* and *health literature*:

*Ann: I just went to my GP the day after I was discharged and um, yeah, she was very supportive.*

*Soko: I was reading some books about breastfeeding... I think same information from books and also the midwives.*

These other sources of support were sometimes only called upon if the new mother encountered problems that were not solved with midwifery breastfeeding support or the mother felt she was unable to access midwifery support. The problems the new mothers in this study encountered are further explored below.

### **Problems**

All of the new mothers in this study experienced some perceived problems with breastfeeding. Many of the problems arose for the mothers due to their *unknowing* of how to effectively breastfeed. These problems had to be overcome before the mothers could reach the point of WORKING IT OUT. Often the mothers did not expect to have such problems and this resulted in the mothers feeling an *emotional upheaval*. On all occasions problems motivated the mothers to seek support from midwives or other sources.

The extent of such problems varied greatly between the women, however being *unable to attach* baby to the breast was a problem experienced by them all.

## CHAPTER 4: RESULTS

*Ann: I was having problems with attachment because the nipple was ridged and blistered and so forth.... So I knew myself that this... this wasn't working properly.*

*Rhonda: I thought maybe it hurt so much because he seemed to suck his bottom lip in behind his top gum line so I'm thinking maybe he doesn't have as big a reach as some would, so I thought maybe that is why it might be hurting.*

The comments from Rhonda and Susan show how being *unable to attach* baby often led to pain. Four of the new mothers identified significant *nipple pain* as a problem they faced:

*Susan: I thought her attaching would be painful anyway but she took a long time to learn to attach onto my left breast, the right one was fine but the left one was always an issue and she'd just clamp on the nipple and that really hurt, so I really dreaded the thought of her drinking on that side, she's a lot better now, I've learnt to attach her better.*

For Ann, the pain became unbearable and she eventually decided to stop breastfeeding:

*Ann: In the end it was just the pain of the blistering and the cracking, sore nipples and so forth that sort of led me to think I just can't, you know, proceed with this any longer.*

Jessica's use of the term "wreck" was synonymous to the *emotional upheaval* that the new mothers felt as part of the process of WORKING IT OUT:

*Jessica: ...by the end of it, I was a wreck cause I was so sore but I'm working out strategies to deal with that too... I was teary cause I was so sore but we um, just happened to find some nice cream that actually works.*

This *emotional upheaval* was more significant if the new mother had faced breastfeeding *problems*. Emotional upheaval is dimensionalised as a process within the explanatory matrix and is further explored later in this chapter.

Another problem that caused significant *emotional upheaval* was *sleep deprivation*. The new mothers spoke of their babies being *unsettled* and *hungry* in the first few days. They felt they were unable to get adequate sleep because of the demands placed upon them by their babies:

## CHAPTER 4: RESULTS

*Susan: ... that night when I had no sleep, all I wanted was four hours straight sleep, that was all I would have wanted but I couldn't get it because there was no-one to look after her.*

*Rhonda: ...that's probably the hardest thing in the evening, when he's sort of like that (acting hungry) and you are starting to get tired, that it's harder to deal with.*

*Ann: You're sleep deprived; you're just feeling exhausted... I just thought how am I meant to sleep when I've got this screaming baby?*

The final two problems that the new mothers recounted related to the baby's physical wellbeing. These problems were identified as *baby weight loss* and *jaundice*. Susan felt particularly guilty when her baby had lost a little over ten percent of her birth weight by day three of life:

*Susan: I just felt really bad that I had done that to her, that I had starved my baby, that I'd hurt her... and that she'd lost all this weight and how was I going to get my boobs, um you know, the milk going ...*

Problems were often related to the contextual category of *unknowing*. The new mothers had a belief that breastfeeding would come naturally and were *unprepared* for the problems that many of them experienced. Whilst the nature of the problems the new mothers faced varied, their responses were more consistent. Due to the *unknowing*, each of the new mothers responded to problems by seeking support from midwives and seeking support from other sources. Solving problems became a significant step in the journey to WORKING IT OUT and will be further explored as a process category later in the chapter.

### **Summary of conditional categories**

The categories described above were conditional to WORKING IT OUT. When the new mothers in this study were able to access breastfeeding support through *midwives spending time* or *other sources of support*, they reached the point of WORKING IT OUT sooner and the journey was described as positive. Barriers to midwifery breastfeeding support and

## CHAPTER 4: RESULTS

problems had the opposite effect in that they caused a delay in WORKING IT OUT and tainted the journey negatively, regardless of the feeding outcome.

The conditions described above shaped the actions and interactions of the mothers in WORKING IT OUT. These are identified as processes within the matrix.

### **PROCESS:**

Process refers to the actions and interactions the mothers participated in on their journey to WORKING IT OUT. The processes of *learning to breastfeed* and *solving problems* were actions taken by the mother with the aim of successful breastfeeding. The category *emotional upheaval* outlined the feelings mothers experienced in their attempts to solve the problems they faced while learning to breastfeed. Other processes were *seeking support from midwives* and *seeking support from other sources*; both of which were interactions initiated by the mothers in an effort to access breastfeeding help from others.

### ***Seeking support from midwives***

Midwives, as the primary health care providers for postpartum women, were considered by mothers as an important source of breastfeeding support. The mothers in this study actively sought midwifery breastfeeding support by *buzzing* for assistance and *asking questions* about breastfeeding.

*Rhonda: ...they just kept checking every time I'd ring the buzzer... just like if I had questions they were quite happy to answer anything... If I didn't know something they gave me the information.*

*Jessica: I buzzed if I needed them (midwives)... I wasn't too sure of what I was doing so I just called and they showed up and that was fine.*

*Lily: He was crying and I can't stop him... I was asking the midwife to bring something like a little container (to express into). I ask them (when) my nipple was very sore.*

The mothers also sought support from other sources as described below.

### ***Seeking support from other sources***

The category *seeking support from other sources* relates to the actions taken by the mothers to access support other than that provided by midwives. These actions included *asking questions* and, more specifically, *asking about other's breastfeeding experiences*. Rhonda and Susan spoke of their friends providing this support:

*Rhonda: ...speaking to my friends with kids is also a great help... just (questions) like how many days before the milk comes in and... having small breasts and wondering whether you're even going to have any milk and stuff like that.*

*Susan: I rang this friend... and she came over and kind of settled me down and you know... you'll be right, you'll get through this.*

*Ann: I got home, I have the support of family and friends just reinforcing that I was doing the right thing... just being reassured that what you're doing is fine.*

As the quotations from Susan and Ann showed, interactions with others also assisted the mothers in *seeking encouragement* with breastfeeding. Statements from others that reassured or reinforced the mothers' actions assisted in decreasing the *emotional upheaval* and were, thus, valuable in assisting the journey to WORKING IT OUT.

The other common source of support in the form of information and advice came from breastfeeding literature. Literature was often sought when other advice was not solving mothers' breastfeeding problems as Ann explains:

*Ann: I'd just have to try to push on myself and get this right. I'd get the books out and I'd look at the posters on the wall and just try and work it out myself.*

Rhonda sought information from varying sources:

*Rhonda: I just looked up internet and magazines and books... those books sort of had stories and questions that were about things that I was wondering about myself.*

Seeking support from other sources assisted women to gather information and receive reassurance. This improved women's abilities to solve problems and feel good about their decisions. This support, and the support from midwives, was an important factor in the journey to WORKING IT OUT. Without support women had a more negative experience of breastfeeding and were more likely to suffer a significant emotional upheaval.

### ***Emotional upheaval***

The category *emotional upheaval* accounts for the feelings the new mother experienced on her journey to WORKING IT OUT. The extent of the feelings took the new mothers by surprise as Susan articulates in the following quote:

*Susan: I certainly didn't imagine that I would have all the emotional upheaval that I had even though you know about the hormone levels and everything and you hear women talking about their emotions being all over the place.*

The majority of these feelings were negative and came about after women experienced *problems* they were unable to solve due to their inability to access the appropriate breastfeeding support. These feelings were *feeling worried, feeling teary, feeling overwhelmed, feeling frustrated, feeling confused, feeling fragile and feeling stressed*. For Jessica, *pain was the instigator for feeling teary*:

*Jessica: ... the first day back, it was kinda by the end of it, I was a wreck because I was so sore. I was teary cause I was so sore.*

Jessica's term 'wreck' described the point of emotional upheaval where mothers became aware of being overwhelmed by emotions. Susan referred to this point as a meltdown:

*Susan: ... she wasn't feeding properly when we left. I was a bit stressed about all that. Had a bit of a meltdown that evening.*

Ann described the interrelatedness of emotions and how one lead to another:

## CHAPTER 4: RESULTS

*Ann: ... by the end of it I think I was totally confused... and then it (confusion) just leads to feeling stressed... just stressed and frustrated. I thought it would be a little bit easier and it was just difficult so maybe that just adds to the frustration, and then you become stressed. By the end of it (trying to master attachment and positioning) I just felt exhausted, frazzled, depressed and yeah, just thought this is never going to work.*

In contrast to the experience Ann described above, the mothers also described positive feelings; *feeling happy, feeling lucky and feeling proud*. These positive feelings were brought about by success with breastfeeding. Lily described *feeling proud* when she was able to breastfeed her baby.

*Lily: It was funny to me because I was thinking oh my gosh I feed the baby. I was proud.*

Positive feelings often overtook negative feelings as mothers worked through *solving problems* and came closer to the point of WORKING IT OUT.

*Susan: I felt vulnerable, really vulnerable. When she woke up it struck terror in me that I wasn't going to feed her properly. I am much more relaxed about it now because I think oh well I'll just give her a bottle if I've got nothing left.*

The *emotional upheaval* experienced mothers was proportionate to the number of *problems* faced and the ability to solve those problems. *Solving problems* was an important part of the process of *learning to breastfeed*.

### ***Learning to breastfeed***

*Learning to breastfeed* was an easily identified category in the process of working it out as all of the mothers had made an initial *decision to breastfeed*. The mothers in this study did not know how to breastfeed and required support from the midwives and others in learning this new skill. The category of *learning to breastfeed* related to *knowledge* and skills focused around *attachment* and *positioning*. The mothers described these skills as both the *mother's skills* and the *baby's skills*. In the following quote, Soko focused on her own skills:

## CHAPTER 4: RESULTS

*Soko: Well, ah, the first time I didn't, of course, I didn't know what the good position and also how to hold him and stuff like that but my midwife, the one... she spent the time with me with the breastfeed... she was really good and she just showed me the position and also how to hold him and I didn't know he have to suck the breast... not the nipple, but the whole lot and, um, of course that time it was a bit hard for me to adjust the right position.*

In contrast, Susan described the breastfeeding skills her baby was developing:

*Susan: ...she took a long time to learn to attach onto my left breast, the right one was fine but the left one was always an issue and she'd just clamp on the nipple and that really hurt, so I really dreaded the thought of her drinking on that side, she's a lot better now...*

The mothers sought assistance with the development of *positioning* and *attachment* skills and were anxious to ensure they were *doing it right*. An affirmation of such was usually sought from the midwives:

*Ann: I was wanting more people (midwives) just to come and supervise me... check that I was doing things properly myself. You need positive reinforcement. It's a good thing you know, cause it's coming from a professional person and it's just more.... reaffirmation that you're doing it right.*

*Rhonda: I found them to be really reassuring that I was doing the right thing... because I thought I was doing it wrong but they just kept checking so that was good.*

While *learning to breastfeed*, with an emphasis on *doing it right*, the majority of the mothers encountered breastfeeding problems. *Solving problems* became an important part of the journey to WORKING IT OUT and influenced the *ongoing method of feeding*.

### **Solving problems**

*Solving problems* constitutes all of the methods employed by both the mothers and midwives to overcome breastfeeding problems. This category includes finding *alternatives* and *options*, getting *advice*, getting *help to attach* and having someone feed the baby formula or care for the baby if the mother was unable to breastfeed correctly or breastfeeding was not



## CHAPTER 4: RESULTS

solving another problem such as an unsettled baby. *Solving problems* was a critical step in the process of WORKING IT OUT for each of the new mothers. An inability to solve *problems* resulted in a greater *emotional upheaval* for mothers and a longer journey to WORKING IT OUT.

In attempting to overcome problems the mothers sought support from the midwives and others. Soko received *help to attach* her baby to the breast.

*Soko: Well that (breastfeeding) take a long time to get used to... but I have to know what the right position... I had to spend some time for like what's the right position, you know, how to hold him and stuff like that so... some midwife came in and if I was holding him a bit, um, too leaned forward, wasn't the right position, she just told me to push him in and just lean back and she show me, just quickly.*

Jessica described how learning to solve specific problems gave her tools for future problem solving:

*Jessica: ... he used to go sleep half way through a feed... and then they, I think one of them (midwife) gave me strategies on keeping him awake during the feed, like playing with his hand and stuff so, and that was pretty much enough... It was kinda like an extra tool in my toolkit sorta thing. It was a kinda relief that there was something else to do that wasn't a huge deal, yeah*

Being provided with *alternatives* and *options* was also described by some of the mothers as an effective method of *solving problems*.

*Rhonda: ... especially with the really bad blisters... I didn't have any of those... that nipple cream stuff or anything like that... so I went out and got that and... like that wasn't enough so then I went and got this thing (points to nipple shield).... and that's been... made it a lot easier... just sort of trying out different things that they've told me, you know, that they've liked or whatever. That's sort of helped.*

Susan felt that her friends provided *alternatives* and *options* for feeding but the midwives did not. She thought that information about complimentary feeding should have been provided to her by the midwives.

## CHAPTER 4: RESULTS

*Susan: ... they (friends) said if you try one thing and it doesn't work, try something else. Don't get too hung up about breastfeeding. Whereas you get taught breast is best in hospital but there's not a lot of information given to you about bottle feeding. I think they (midwives) really need to teach about other ways of feeding.*

Susan's comment demonstrates that *solving problems* was not purely dedicated to breastfeeding. Other methods of *solving problems* focussed on ensuring the baby was settled and fed by another means if breastfeeding was unsuccessful. Lily found this type of problem solving was offered by both midwives and, in the latter quote, family members:

*Lily: ...on the time that he's crying and acting like he's very hungry... and I was trying to put my breast to him, he doesn't want it and (mimics turning away). That night they (midwives) gave me a container (for expressing) and one bottle. I was asking them because I feel guilty... feel sorry for him because he's very hungry.*

*Lily: ...when, other time, he wouldn't sleep, they (family members) just stand up and carry him.*

The mothers' ability to solve problems was dependant on her knowledge and the support she received from midwives or others. The ability to solve problems impacted on the mothers' overall experience of learning to breastfeed. *Solving problems* was critical for the mothers in being able to continue to breastfeed.

### **Summary of process categories**

The categories described above reflect the processes of WORKING IT OUT. These categories demonstrate the importance of the mothers *seeking support* as an action toward *learning to breastfeed* and a strategy for *solving problems*. All of the mothers also underwent an *emotional upheaval* in which they experienced positive, negative or a combination of such feelings. These influenced the mothers' decisions about an ongoing method of feeding; a prerequisite to WORKING IT OUT. These decisions were not only a consequence of the process of WORKING IT OUT but also its context and conditions. Consequences are further explored below.

### **CONSEQUENCES**

Consequences encompasses the feelings, decisions and actions that were a result of the mothers' experience of WORKING IT OUT. This experience was influenced by a combination of the context, conditions and process described above. Each of the mothers reached a point of resolution as the journey of WORKING IT OUT neared its destination. Additionally, through necessity, each of the mothers decided upon an ongoing method of feeding.

The feelings described as consequences were both positive; *feeling successful*, and negative; *feeling a failure*. Some of the mothers experienced only positive or negative feelings while others experienced a combination. These feelings are detailed below.

#### ***Feeling successful***

The consequence of *feeling successful* was a positive feeling that encompassed *feeling confident*, *feeling proud*, *feeling worthy*, *feeling important* and *feeling good*. These feelings were the result of *solving problems* and *doing it right* which, in turn, were influenced by the breastfeeding support the mothers received.

*Learning to breastfeed with support* and success in *solving problems* resulted in the mothers *feeling confident*. Positive reinforcement from the midwives was particularly helpful in building confidence in the mothers as described in the following quotes:

*Susan: I was confident because they said, you know, that I was doing so well so early on...*

*Rhonda: She (midwife) always made me feel reassured that I would be able to do it (breastfeed)... so I found that to be... as if I could handle anything... that I could handle whatever comes about.*

## CHAPTER 4: RESULTS

*Ann: ...when you have midwives that are supportive... it boosts your confidence... they make you feel like you're doing something right, something worthwhile... Some people just seem to have the ability to make you feel that you're important.*

Ann's quote reflects the feelings of worthiness and importance that some of the mothers expressed about being able to breastfeed their babies. For Lily, successful breastfeeding resulted in her *feeling proud*.

*Lily: I was thinking oh my gosh I feed the baby... I was proud.*

*Feeling successful* was consistently the result of successful breastfeeding and was, thus, more likely to be associated with breastfeeding as the *ongoing method of feeding*. In contrast, feeling a failure was less likely to be associated with ongoing breastfeeding.

### ***Feeling a failure***

The consequence of *feeling a failure* encompasses the negative feelings associated with an inability to *solve problems* and unsuccessful breastfeeding. These feelings included *feeling inadequate*, *feeling guilty* and *feelings of loss*.

Most of the mothers believed that breastfeeding would come easily and an inability to breastfeed caused mothers feelings of inadequacy:

*Ann: Well you just feel a bit inadequate and you feel a bit stupid because you're thinking it's such a simple thing, it should be natural, I should be able to do this myself.*  
*Susan: I felt useless. I felt totally useless on the Friday and just cried and cried and cried and thought what have I done, this is such a horrible thing that I've done. I thought I'm not a very good mother.*

Susan's quote above demonstrates her feelings of inadequacy as well as the experience of *feeling guilty* after a midwife told her that her baby had become dehydrated. Guilt surrounded the feelings of not being able to meet the baby's needs. This is further demonstrated in Lily's quote below:

## CHAPTER 4: RESULTS

*Lily: ...that night he was crying and I can't stop him... and I was trying to put my breast to him and I feel guilty... feel sorry for him cause he's very hungry.*

Ann described how the inability to breastfeed brought with it feelings of guilt and loss as the expectation of being able to breastfeed was replaced with an opposing reality:

*Ann: It's supposedly a natural thing so the baby should just easily attach... you just don't think about all the problems that might occur... Something that you really hoped you could do, you can't, so yeah, it's a bit of a loss in a sense. You know, you don't have that closeness maybe... and then you know that you're giving your baby the best possible chance with the breast milk so I suppose you're feeling a bit guilty... yeah.*

It has been demonstrated that the ability or inability to breastfeed led mothers to *feel successful* or *feel a failure*. Additionally, it had a significant impact on how each mother reached a *resolution* regarding ongoing infant feeding.

### **Resolution**

*Resolution* describes another consequence that occurred in response to the experience of WORKING IT OUT. Each of the mothers reached a point of *resolution* about their breastfeeding experience and their *ongoing method of feeding*. As with each of the categories under the heading of *consequences*, the category *resolution* could be linked back to the *context, conditions and process of WORKING IT OUT*. For example, the differences in the ways each mother reached a *resolution* were a direct consequence of her ability or inability to breastfeed. This, in turn, related to the mothers' *knowing* and *unknowing* about breastfeeding (context), the breastfeeding support she received (condition), the emotions she experienced (process) and the ability to learn to breastfeed, solve problems and seek support (process).

For the mothers who received early breastfeeding support, reaching a resolution was a simple process which involved *acceptance* and *decision making* to continue breastfeeding.

## CHAPTER 4: RESULTS

*Rhonda: I don't really know what I expected but they gave me all the help that I needed so I couldn't ask for any more and, um, they didn't give me any less so I was quite happy... I'm glad that I'm definitely, um... I chose to breastfeed over bottle feed.*

*Soko: ...the first midwife was really helpful for the breastfeed so... I was quite confident when I came home and, ah, I sort of knew with the breastfeed, I was pretty comfortable... and I thought oh yeah this is it, yeah... and happy, feel happy about it.*

In contrast, the mothers who felt they had not received the support they needed reached a *resolution* quite differently. Reaching a *resolution* often took longer as the mothers struggled for longer with the processes of WORKING IT OUT, such as *learning to breastfeed*, *seeking support* and *solving problems*. For some of the mothers, *resignation* and *adjusting goals* was a prerequisite to reaching a resolution.

*Ann: ...it's just overwhelming ... something that you really hoped you could do you can't. I just felt exhausted, frazzled, depressed and yeah just thought this is never going to work. I was in a fragile state and I'd made up my mind that, you know, I was just going to put her on formula. In the end it was just the pain of the blistering and the cracking, sore nipples and so forth that sort of led me to think I just can't, you know, proceed with this any longer. You feel you just sort of have no other option.*

Susan's comment below illustrates the relief that came with adjusting goals, despite the fact that her preference was for breastfeeding.

*Susan: I am much more relaxed about it now because I think oh well I will just give her a bottle if I've got nothing left. Some days she has no comp feeds at all, other days she does. I would prefer to just breastfeed.*

Ann had concerns about what others would think about her decision to bottle feed. This resulted in Ann *justifying actions* surrounding her feeding decisions and eventually accepting the thoughts and judgements of others.

*Ann: You feel a bit like a quitter, you know, because people just think that you should have persisted... there's that guilt and people sort of, you know, make you feel guilty. It's one of the first things people ask you is if you're breastfeeding, but you just have to be strong, sort of overcome that. I mean, I was feeling relatively good within myself and felt that I'd given it, you know, my best go, my best shot...but um... yeah, I think you just have to be strong and just be ready for the response that you might get.*

## CHAPTER 4: RESULTS

Reaching a resolution related to infant feeding was critical to the process of WORKING IT OUT. Until a resolution was reached, the mothers continued, and sometimes struggled, with the processes of learning to breastfeed, seeking support, and solving problems. The point of resolution was always accompanied by the mothers making a firm decision about the ongoing method of feeding.

### ***Ongoing method of feeding***

*The consequence ongoing method of feeding* refers to the varying methods of feeding the mothers had decided upon at the point of reaching a resolution in the process of WORKING IT OUT. The feeding methods included *exclusively breastfeeding*, *breastfeeding with a nipple shield*, *expressing*, *artificial feeding* and *combination feeding* (breast and artificial). The chosen method of feeding most often reflected the ability or inability of mothers to access breastfeeding support and solve problems. The mothers who believed they had received the breastfeeding support they needed to solve their breastfeeding *problems* were more likely to continue breastfeeding than those that did not.

Jessica had chosen to *exclusively breastfeed* as an *ongoing method of feeding*. This reflected her description of being able to access breastfeeding support and solve *problems*.

*Jessica: It (breastfeeding support from midwives) was it good, like um, when I had questions, when I started they just sort of took over and said what to do, ... once we got back into the room and started the next day they sort of came in and were helpful and showed me what to do and ... yeah ... I think it was supportive, that's what I needed.*

Soko also described a positive experience of *learning to breastfeed* and accessing midwifery support.

CHAPTER 4: RESULTS

*Soko: Well, ah, the first time I didn't, of course, I didn't know what the good position and also how to hold him and stuff like that but my midwife, the one... she spent the time with me with the breastfeed... she was really good and she just showed me the position and also how to hold him and I didn't know he have to suck the breast... not the nipple, but the whole lot and, um, of course that time it was a bit hard for me to adjust the right position. She was just, just tell me, you know, fix that way or move that way or like that. So that bit really helped.*

Soko had returned to work two weeks after her baby was born and was both breastfeeding and expressing for this reason.

Rhonda was discharged from hospital breastfeeding after receiving some support from the midwives to correct attachment. Rhonda also told of a positive experience in receiving breastfeeding support from the midwives.

*Rhonda: I actually thought it was really good... like he didn't feed at first and I found them to be really good... they were all really helpful. I didn't find any problems at all. I found them really really good. By the time when my nipples we're starting to get sore... um, I found them to be really reassuring that um... I was doing the right thing... they just kept checking on me everytime I'd ring the buzzer... to check like if he was attached properly or um, just to help get him on. I couldn't... at first I was having troubles getting him on. Obviously he probably didn't know what he was doing either so... but by the end there it was good... yeah.*

Rhonda continued to have sore nipples after discharge so she decided to continue breastfeeding with a nipple shield after a friend advised her about them.

Lily had commenced exclusive breastfeeding but began to give top-up formula feeds while in hospital as her baby was not settling after his feeds. Lily had received some support from a midwife on one occasion when her baby did not settle.

*Lily: ...that night he was crying and I can't stop him and I was asking the nurse (midwife) if they, um, they bring something like a little container to... (mimics expressing) but it was only one time. Like, on the time that he's, like, he's like crying and acting like he's very hungry... and I was trying to put my breast to him... he doesn't need it and like (mimics baby turning away)... Yeah and that night they*



## CHAPTER 4: RESULTS

*(midwife) gave me a container (for expressing) and one bottle (of formula). I was asking them because I feel guilty... feel sorry for him cause he's very hungry. He was a lot happier (after having formula).*

Lily also told the midwife that she was experiencing pain when breastfeeding. The midwife told Lily that the pain was normal for the first two or so weeks of breastfeeding. This made Lily feel better about the pain and she did not feel the need to request further support with this. Lily chose *combination feeding* with both breastfeeding and formula feeding as her *ongoing method of feeding*.

Susan was also *combination feeding* at the time of her interview and was continuing this as the *ongoing method of feeding*. Susan had received some limited support with attachment but encountered *problems* prior to discharge, with her baby's weight and urine output decreasing significantly. The paediatrician diagnosed her baby as dehydrated and ordered formula top-up feeds. Susan reflected that she was unsure of the correct breastfeeding techniques as she had not received enough breastfeeding support from the midwives due to them being busy and understaffed.

*Susan: You would walk out into the hallway and you wouldn't see anyone and there would be buzzers going off left, right and centre and you just think oh you poor buggers and, um you know, they would say they would come back in a minute and it might be an hour, hour and a half... if they've gone for an hour well you've finished feeding by then and hopefully settled the baby and everything so, um, yeah, they're not there now, to see it, to witness it and that's probably a bit of what happened as well, you know a universal problem with staffing.*

Ann had received some midwifery breastfeeding support for nipple pain and difficulty attaching baby to the breast. She described some of this support as helpful and positive but expressed that it was often confusing and unsupportive. At other times Ann, like Susan, had encountered difficulties in accessing midwifery breastfeeding support due to the business of the midwives.

## CHAPTER 4: RESULTS

*Ann: They would tell me to buzz so most times I would... well probably every time I would press the buzzer and on a number of occasions it was 45 minutes to an hour before anyone would even pop their head in to see me...so by that time the feed was nearly over and you know I was none the wiser I would take her off and I would still have the same problem that I'd been having. So... well other times the midwife would come in and say yeah the attachment looks fine but then I'd take her off and I'd still have the same problem, the nipple would be really ridged and blistered. So I knew myself that this... this wasn't working properly. They just sort of didn't know how to go about, you know, improving things.*

Ann believed that *artificial feeding* had become the *ongoing method of feeding* by necessity rather than choice. The experience of *learning to breastfeed*, *solving problems* and *seeking support from midwives* had been a negative one and left her feeling that she would not attempt to breastfeed any subsequent children she may have.

*Ann: Well at this point I just wouldn't bother with the whole breastfeeding thing at all because it just had me so stressed.*

The mothers in this study all chose to breastfeed initially. The *ongoing method of feeding* chosen by the mothers at the point of *resolution* was directly influenced by their ability to seek breastfeeding support and solve breastfeeding problems. Those mothers who believed they had received the support they required to solve the breastfeeding problems they encountered were more likely to continue *exclusive breastfeeding* when compared to those mothers who described difficulties in accessing support and *solving problems*.

### **Summary of consequence categories**

The categories dimensionalised as consequences were the feelings and actions that resulted from the new mothers' experiences of WORKING IT OUT. Consequences varied and were dependent upon the mother's ability to seek breastfeeding support and solve problems. Those mothers who were able to access support and solve problems felt successful and easily reached a resolution that led them to choose breastfeeding as an

## CHAPTER 4: RESULTS

ongoing method of feeding. The mothers who were unable to access breastfeeding support, and were therefore less able to solve breastfeeding problems, felt a failure and took longer to reach a point of *resolution*. These mothers were less likely to choose *exclusive breastfeeding* as an *ongoing method of feeding*.

### **Summary**

This chapter has presented the results of this study which explored new mother's experiences of receiving breastfeeding support from midwives. The findings presented revolve around the study's core category of WORKING IT OUT; encompassing both the journey of early breastfeeding and the destination all of the mothers reached despite their differing experiences. The categories that informed the substantive theory of this GT study were dimensionalised and presented under the headings of *perspective*, *context*, *conditions*, *process* and *consequences* using Schatzman's Dimensional Analysis Framework (Schatzman, 1991). The explanatory matrix developed through this framework demonstrated the relationships between the categories and the core category.

The findings of this study show that a new mother's ability to access midwifery breastfeeding support to learn breastfeeding and solve breastfeeding problems has a direct influence on her feelings of success or failure and how she reaches a point of resolution about breastfeeding, including the ongoing method of feeding she chooses. The most effective midwifery breastfeeding support occurred when midwives were seen to be *spending time* providing early breastfeeding support.

These findings and the theory that has been informed by these results will be further discussed in the following chapter and related to current literature and practice.

## **CHAPTER 5: DISCUSSION**

### **Introduction**

This chapter presents a discussion of the findings of this study of new mothers' experiences of receiving breastfeeding support from midwives. These findings will be related to relevant literature and a synthesis of findings and current evidence support recommendations for midwifery practice related to the provision of breastfeeding support to new mothers.

The key findings that emerged from this study (as presented in the previous chapter) were that the new mothers all experienced a journey of WORKING IT OUT where they sought breastfeeding support from midwives in an effort to learn to breastfeed and solve breastfeeding problems. The mothers then reached a point of resolution regarding infant feeding and decided upon an ongoing method of feeding. The mothers who were able to access midwifery support and have a midwife spend time helping them learn to breastfeed were more likely to solve their breastfeeding problems, reach a point of resolution sooner and continue to exclusively breastfeed than those mothers who had inadequate support.

An initial review of the literature, presented in chapter 2, assisted in identifying existing studies related to the topic and justified the need for the study. The literature is further explored in this chapter in relation to the key findings of the study. Findings of recent research are compared with the findings of this current study and confirming or contrasting findings are discussed. This second review of the literature assists in positioning the findings and informs the resultant recommendations for practice, education and further research.

The recommendations from this study focus on the breastfeeding support offered by midwives. Strategies to encourage midwives to spend time in early breastfeeding support are discussed in addition to strategies for overcoming mothers' perceptions that midwives

are busy. Other recommendations focus on the provision of consistent advice and the utilisation of breastfeeding plans for non-continuity models of midwifery care.

### ***Antenatal expectations vs postnatal reality***

The new mothers interviewed in this study all discovered a mismatch between their antenatal expectations of breastfeeding and the postnatal reality of the same. Most of the mothers had believed that breastfeeding would be easy and not pose any significant problems. WORKING IT OUT, the central theme of this study, demonstrates that the mothers were faced with breastfeeding problems and each mother underwent a process of WORKING IT OUT which included at least some of the following actions; *learning, problem solving, finding alternatives, doing it myself, going home, accepting, knowing, gaining skills and overcoming*. These actions formed the dimensions of WORKING IT OUT. The mothers sought support from midwives in these actions.

The mismatch between breastfeeding expectations and reality has been well described in the literature with first-time mothers often lamenting that breastfeeding is portrayed as easy and natural when the reality is that it can be difficult and painful (Burns et.al., 2010; Sheehan et.al., 2009; Hall & Hauck, 2007 & Larsen, Hall & Aagard, 2008). The significance of the breastfeeding expectation and reality mismatch is reflected in a metasynthesis of seven qualitative breastfeeding studies by Larsen et al. (2008), who used the term "shattered expectations" to describe mother's experiences of this mismatch. Their findings revealed that breastfeeding, as natural, was a prominent discourse antenatally which hid the need for mothers to learn a competency. Mothers in this current study were likewise surprised by the workload of breastfeeding and the problems they encountered.

## CHAPTER 5: DISCUSSION

Mothers have called for honesty from health professionals in relation to the entire range of breastfeeding experiences (Sheehan et al., 2009). For mothers in an Australian Grounded Theory study, breastfeeding was often portrayed as easy and uncomplicated but the reality was quite the opposite with the women feeling to blame when breastfeeding went wrong, as a result of not having breastfeeding presented honestly or realistically (Sheehan et al.). The mothers in this current study also revealed that they felt guilty or to blame when they were unable to breastfeed their babies. Honest and realistic anticipatory guidance for breastfeeding could better prepare mothers for breastfeeding difficulties and reduce the incidence of guilt and self-blame among mothers in relation to breastfeeding problems.

New mothers who believed that breastfeeding would come easily and naturally had often given little thought to what they would do if a breastfeeding problem arose. In a recent meta-ethnographic synthesis of 17 qualitative studies of women's breastfeeding experiences, 'expectations and reality' was one of two main themes that emerged from the views of 500 women in six western countries (Burns et al., 2010). This synthesis found that women were mostly unprepared for the need to access support from others, acquire new skills and overcome challenges in order to breastfeed (Burns et al.). This finding confirms the findings from this current study suggesting that the belief that breastfeeding would come easily, led mothers to believe they did not need to prepare or gather knowledge about breastfeeding prior to the experience.

In contrast to the findings of this current study, a descriptive Australian pilot study (Craig & Dietsch, 2010) found that, among ten primiparous women, expectations of breastfeeding problems were high. The mothers in the pilot study were booked into a single private maternity unit and attended specific antenatal breastfeeding education. It is unclear as to whether specific anticipatory education geared toward the expectation of breastfeeding problems impacted on these findings. Another Australian study also found that some of the

## CHAPTER 5: DISCUSSION

participant mothers expected problems in breastfeeding (O'Brien, Buikstra & Hegney, 2008). The majority of mothers in this study (61%) were multiparous. It is possible that mothers who expected breastfeeding problems were those who had previously experienced difficulties with breastfeeding attempts. A re-analysis of the data to separate primiparous and multiparous women's expectations would confirm this possibility. Further research to investigate the antenatal expectations of breastfeeding in a large cohort of Australian primiparous women would assist in ascertaining their overall expectations of breastfeeding problems.

For the women in this current study, breastfeeding expectations were influenced by breastfeeding knowledge. The category of *unknowing* emerged from the mothers' descriptions of expecting breastfeeding to occur naturally in addition to descriptions of unpreparedness, a lack of expectations and a focus on the birth. Of particular importance was the mothers' unpreparedness for experiencing breastfeeding problems. This finding reflects the *unknowing* of women described in other breastfeeding studies (Craig & Dietsch, 2010; Burns et al., 2010). Most of the mothers in this current study had not sought any significant breastfeeding education antenatally, such as the attendance at breastfeeding classes or a visit with a lactation consultant. Some of the mothers had come across brief information about breastfeeding in antenatal classes, pregnancy books or on the internet, but this did not prepare them for the problems they faced.

It is pertinent to question whether midwives are responsible in any part for Australian women's unrealistic breastfeeding expectations. Hall and Hauck (2007) suggest that breastfeeding educational materials aimed at women in the antenatal period emphasize the natural aspects of breastfeeding and convey the message that breastfeeding is easy. While this type of content may encourage the initiation of breastfeeding, it is unlikely to be of assistance in preparing mothers for breastfeeding difficulties. Several of the mothers in this

## CHAPTER 5: DISCUSSION

current study stated that they needed information that better prepared them for the realities of breastfeeding and provided them with solutions for common breastfeeding problems. A meta-synthesis of 31 qualitative breastfeeding studies (Schmied, Beake, Sheehan, McCourt & Dykes, 2011) also found that standardised packages of breastfeeding information did not provide women with the information they required. The women were aware that more detailed information may deter them from feeding, but wanted to have that choice.

The studies cited above and the data gained from this current study were consistent in suggesting that women commonly experienced breastfeeding problems. In fact all of the women in this current study experienced breastfeeding problems to some degree. Mothers defined problems as those events/actions that hindered the progress of WORKING IT OUT. The problems experienced included the common complaint of nipple pain, an inability to correctly attach baby to the breast, an unsettled or hungry baby and nipple damage. One mother in this study believed that her baby's dehydration and weight loss were direct consequences of her ineffective breastfeeding technique as the following quote demonstrates:

*Susan: I just felt really bad that I had done that to her, that I had starved my baby, that I'd hurt her... and that she'd lost all this weight and how was I going to get my boobs, um you know, the milk going ...*

The incidence of breastfeeding problems was quantified in a longitudinal study of 556 Australian women (Scott & Colin, 2002), which set out to describe the problems mothers experienced with breastfeeding over the first six months post-partum. At discharge from hospital, 82.6% of the mothers had experienced one or more breastfeeding problems, with over half experiencing sore or cracked nipples. The incidence of problems was highest during the inpatient period and decreased significantly over time (Scott & Colin). A more



## CHAPTER 5: DISCUSSION

recent Australian study (Hauck, Fenwick, Dhaliwal, Butt & Schmied, 2011) has confirmed the high incidence of breastfeeding problems in the postpartum period. Of the 1105 primiparous women who responded to self-report questionnaires, 75.6% reported that they had experienced breastfeeding problems. These surveys captured data from mothers' first 10 postpartum weeks so the timing of these problems cannot be confirmed, but are likely to have decreased in frequency over time as the data from Scott and Colin suggest.

Women who experience problems are significantly more likely to cease breastfeeding, and the more problems experienced the more likely cessation is (Hauck et al., 2011). Of the women in Hauck et al.'s study who experienced no problems, only 1.9% ceased breastfeeding compared to 18.8% who experienced one problem, and 29% who experienced four or more problems. Furthermore this study found a further likelihood of breastfeeding cessation among primiparous women who reported unhelpful hospital midwives. It would be helpful to further research whether the women who had breastfeeding problems were the same women who reported unhelpful hospital midwives. This link would confirm the findings from the current study that show that women who did not receive adequate breastfeeding support were more likely to experience breastfeeding problems.

The findings from this current study confirm those expressed in current literature, that new mothers are likely to experience breastfeeding problems and are ill-prepared for the common realities of such. A balanced and realistic expectation of breastfeeding, including the natural and innate nature of the partnership between mother and infant, the common requirement for professional breastfeeding support, the possibility of breastfeeding problems and a toolkit of potential solutions would limit the disillusionment experienced by many new mothers. The following recommendation is based on the assumption that the antenatal

## CHAPTER 5: DISCUSSION

provision of realistic breastfeeding education and anticipatory guidance for solving breastfeeding problems would reduce the mismatch between new mothers' breastfeeding expectations and realities.

### Recommendation 1

It is recommended that midwives provide written and practical antenatal breastfeeding education that realistically prepares new mothers for the experience of early breastfeeding, their need for breastfeeding support and the potential for various breastfeeding problems. Education outcomes should include assisting mothers to gain the knowledge and skills required to identify and solve common breastfeeding problems.

### ***Spending time***

The word 'time' featured prominently in women's discussions surrounding their early breastfeeding experiences and emerged recurrently during data analysis. Two areas of focus around time emerged; time **for** breastfeeding support and time **of** breastfeeding support. The women in this current study spoke mostly of the time for breastfeeding support in relation to the time midwives invested in the same.

Two categories emerged during data analysis that related to time for breastfeeding support. The first category was *midwives spending time*. The mothers in this study believed that *midwives spending time* providing breastfeeding support was critical to their ability to breastfeed successfully. Data analysis raised the question of whether time itself was most important or whether it was what the midwife did during that time. Further questioning of the mothers in relation to actual time spent by the midwife and the support offered during that time revealed that the time spent varied greatly from ten minutes to thirty minutes or more. It became clear that it was the actual support provided while the midwife invested time that

## CHAPTER 5: DISCUSSION

made the view of time spent so positive. The support offered, while midwives spent time, included *listening, explaining, answering questions, encouraging, watching, demonstrating* and having the *new mother as the focus*. For the mothers in this study, *midwives spending time* was synonymous with midwives providing positive breastfeeding support. In a Grounded Theory study of mothers' expectations and experiences of infant feeding support, (Sheehan, Schmied & Barclay, 2009) three properties of positive support emerged. Two of these were "being available" and "staying with you", both aligning closely with the concept of the midwife spending time with women. Women's views focused on the value of the midwives being present rather than what they actually did during that time.

'Being present' was a term used by one of the mothers in this current study when she spoke of the *midwives spending time*. 'Presence' is a term well-defined in nursing and midwifery literature. Pembroke and Pembroke (2008) used an integration of philosophical reports and women's personal reflections to offer insight into the concept of 'presence' in midwifery. They found that one of the two focal concepts of midwifery presence was availability, adding "to be available to the woman involves listening to her and following her lead" (p.325). Being available and listening were also identified as important aspects of support to the mothers in this current study. *Listening* emerged as a property of *midwives spending time*. A recent meta-synthesis of women's perceptions and experiences of breastfeeding support found that breastfeeding support occurs along a continuum from "authentic presence" to "disconnected encounters" (Schmied, et.al., 2011, p. 51). Authentic presence described the care given by peers or professionals that mothers found supportive and was made up of seven themes: "being there for me", "empathetic approach", "taking time/touching base", "providing affirmation", "being responsive", "sharing the experience" and "having a relationship" (p. 54). The category of *midwives spending time* was confirmed by Schmied et al. with each of its

## CHAPTER 5: DISCUSSION

properties featuring in the descriptions of authentic presence and facilitative style, occurring at the 'supportive' end of the continuum.

The idea that spending time was not as much about the time as about how the time was utilised was confirmed by Kennedy, Andersen and Leap (2010) who used interpretive phenomenology to explore the meaning of midwifery presence. They suggested that "merely placing a midwife with a woman during her labour does not guarantee improved outcomes" (p.109) and found that presence is multi-factorial. This notion aligns with the findings of this study that *midwives spending time* is not about time alone but about how that time was used to support the mother. The concept of presence is similar to that of 'with woman'; a term that is quoted as the original meaning of the word midwife (Merriam-Webster, 2011). Like 'presence' and *midwives spending time*, 'with woman' encompasses so much more than mere physical presence.

The characteristics of midwifery presence were described by the mothers in a recent Swedish study in terms of what these mothers wanted from breastfeeding support. Bäckström, Wahn and Ekström (2010) used content analysis to study the experiences of both mothers and midwives in relation to breastfeeding support. Although they did not use the term presence, the mothers' descriptions of wanting support as unique individuals, to be listened to and to have more time from the midwives in supporting their breastfeeding are those characteristics commonly associated with midwifery presence. Likewise, these characteristics are those consistently reported to occur within continuity of midwifery care models (Brook & Barnes, 2001; Williams, Lago, Lainchbury & Eagar, 2010; Fereday, Collins, Turnbull, Pincombe & Oster, 2009; Sandall, Page, Homer & Leap, 2008) which leads to the assumption that breastfeeding support would be enhanced within these models, and leads to the following recommendation:

## CHAPTER 5: DISCUSSION

Recommendation 2a

It is recommended that maternity care organisations give preference to continuity of care models that facilitate midwifery presence through the building of midwife-mother partnerships and woman-centred care enabling continuity of carer to extend into the postnatal period.

Much of the research focussed on the role of presence in midwifery is focussed on the intrapartum period. The meta-synthesis by Schmied et al. (2011) provided important data on the importance of presence for breastfeeding mothers. Further research focussing on midwifery presence for breastfeeding support could give added credit to the valuable role it plays in the provision of early breastfeeding support.

Recommendation 2b

It is recommended that further research is conducted to explore the role of midwifery presence in the provision of breastfeeding support.

***Not spending time***

It was not surprising that the second category, *Barriers to midwifery breastfeeding support*, had properties relating to midwives not spending time. The first property within this category was labelled *delayed response to buzzer*. The mothers frequently described situations in which they had sought midwifery breastfeeding support by pressing the buzzer, but had not received a response in a timely manner. The mothers complained that they had often finished breastfeeding their babies by the time the buzzer was attended. Like the mothers in this study, Schmied et.al. (2011) found that mothers blamed this more on the work environment than on the health professionals themselves. This data formed the basis of the second property, *workload/staffing/busyness*.

## CHAPTER 5: DISCUSSION

The property *workload/staffing/busyness* emerged from the mothers' comments that midwives looked busy and stated they were busy and understaffed. A synthesis of 47 qualitative papers, on breastfeeding support, found that concerns about time pressures were consistently raised by (McInnes & Chambers, 2008). The authors suggested that perceptions of busy staff could result in the mothers feeling reluctant to ask for help. Perceptions of busy staff and a general lack of encouragement may result in reluctance to ask for help. In line with the views of McInnes and Chambers, the mothers in this current study described that they heard many buzzers (property - *mother hears other buzzers*) which led them to believe that the midwives must be busy answering to other women's requests for support. In response to these observations the *mothers felt guilty requesting support* for themselves. For the husband of one woman in this study, this was believed to be the cause of her inability to solve breastfeeding problems and the subsequent dehydration of her baby as he describes in the following quote:

*"I think one of Susan's problems was she felt guilty about taking up too much of the midwives' time... and I think that's what part of the problem was feeding (baby). I think she should have realised that you know they were there for her as well not just for to sort think oh well I don't want to take up too much of their time because they've got other people to look after."*

This finding was confirmed by Schmied et al. (2011) who described that the mothers with this perception tended to quietly struggle on by themselves.

After the interviews for this current study were conducted, the hospital where the women were recruited underwent a major redevelopment. A new patient call system was implemented that sent pages to each woman's allocated midwife. Midwives set their pagers to vibrate to ensure women were not disturbed by pager alerts. The call system was

## CHAPTER 5: DISCUSSION

programmed to escalate an unanswered call by sending an alert to an allocated buddy midwife. It was observed that buzzers seemed to be answered in a more timely fashion and the perception of busyness seemed to decrease for both midwives and mothers. This conclusion and the evidence surrounding mothers' reported perceptions of the busyness of midwives leads to the following recommendation:

### Recommendation 3

It is recommended that those involved in the management and design of maternity care settings give consideration and preference to those factors that limit the perception of busyness, such as silent or pager-style patient call systems, the positioning of utility and station areas so that they are out of the direct line of vision of mothers and a preference toward non-shared or paired rooms over four or six bedded bays for the accommodation of mothers, so that mothers witness less of midwives' work.

The perception that midwives were too busy to offer breastfeeding support was again described in Schmied et al.'s (2011) continuum of breastfeeding support under the themes of "communicating temporal pressure" and "they don't give you time". The authors presented the category of "disconnected encounters" (p. 57) which included the factors that were considered the least supportive for mothers learning to breastfeed.

Mothers' perceptions of the midwives being too busy to offer breastfeeding support were justified by midwives in several Australian studies. Cooke, Cantrill and Creedy (2009) accessed data from a national survey of Australian midwives related to their practice supporting the first breastfeed. The midwives identified limitations to breastfeeding support imposed by their workloads and the apparent higher priorities of other clinical matters. Gilmour, Hall, McIntyre, Gillies and Harrison's (2009) descriptive study of factors associated with early breastfeeding cessation reiterated this. Australian midwives in this study also

## CHAPTER 5: DISCUSSION

revealed that they were sometimes too busy to provide breastfeeding support for mothers in hospital. Again, they blamed workloads and competing priorities such as the needs of mothers post-caesarean as impacting on their ability to provide breastfeeding support. Another Australian study (Rayner, Forster, McLachlan, Yelland & Davey, 2008) sought the views and experiences of midwives providing postnatal care in Victorian hospitals through questionnaires and interviews. They found that midwives were dissatisfied with their ability to provide postnatal care, including breastfeeding support. The midwives identified organisational barriers such as a reduced postnatal stay, staffing issues and the busy and chaotic nature of the wards as time limiting and, thus, barriers to the provision of support.

The results of this current study and the current literature clearly identify that mothers and midwives value time for midwifery support and believe that not enough time is currently available for its provision. This raises the question of what can be done to allow more time for midwifery breastfeeding support? The health dollar allows little flexibility of mother to midwife ratios within postnatal wards so changes to hospital midwifery care need to focus on the redistribution of midwifery time to allow more time for breastfeeding support and midwifery presence.

A program being implemented by the United Kingdom's (UK) National Health Service (NHS) is currently redesigning the way in which nurses and midwives work on inpatient wards. The program titled 'Releasing time to care', otherwise known as the 'Productive ward', focuses on changing the way tasks are viewed and carried out to ensure they are necessary, efficient, less wasteful and improve patient care and satisfaction (Wilson, 2009). Simple measures such as redesigning work areas, improving communication, reducing disruptions and revising the frequency of routine procedures has resulted in a 20% increase in the time allowed for direct patient care (Wilson). This program has been so successful that 80% of Trusts across England have registered to implement it within their organisations (Wilson).



## CHAPTER 5: DISCUSSION

A revised version of this program is currently being implemented within several units, including a maternity unit, in a Queensland Health hospital and has likewise witnessed a significant improvement in the time available for direct patient care (Caddick, 2011, Personal communication). Programs with outcomes such as these are promising for enabling midwives more time for the provision of breastfeeding support.

#### Recommendation 4

It is recommended that providers of postnatal care, particularly those located in hospitals, implement a program that evaluates and redesigns the work of postnatal midwives to ensure it is effective and efficient. Tasks that are wasteful, ineffective or inefficient should be rethought and redesigned to allow a better distribution of time for direct midwifery care and breastfeeding support.

A lack of time for midwifery breastfeeding support can lead to mothers experiencing rushed and unhelpful interactions (Schmied et al., 2011). The findings of the meta-synthesis conducted by Schmied et al. align closely with this current study's category *Barriers to midwifery breastfeeding support* and its properties of *workload/staffing/busyness* and *mothers feel guilty requesting support*. Furthermore, it describes how busyness and a lack of time can negatively affect the support given. The mothers in this study also described this link. These descriptions lead to the emergence of properties within the category of *Barriers to midwifery breastfeeding support* that described the unsupportive practices of *normalising problems, dismissiveness, conflicting advice* and *discounting other advice*.

The findings of this study along with the findings of a large meta-synthesis confirm both the importance of *midwives spending time* providing breastfeeding support and the negative consequences of a lack of time given for the provision of this support. Interestingly, although the word 'time' is used consistently in women's discourse surrounding breastfeeding support

## CHAPTER 5: DISCUSSION

it seems that it is as much about the midwifery presence offered during the time invested as the minutes and hours. This finding gives rise to the following recommendations:

**Recommendation 5**

It is recommended that midwives receive education on midwifery presence and the ways in which they can enhance their presence while providing breastfeeding support e.g. listening, using verbal and non-verbal language that portrays availability and presence, ensuring that time spent providing breastfeeding support is woman-focused.

***Timing of breastfeeding support***

The second theme related to time was the timing of breastfeeding support. Experiences with breastfeeding in the early hours and days of life have a significant influence on the likelihood and exclusivity of continued breastfeeding (Britton, McCormick, Renfrew, Wade, & King, 2007). Whilst the timing of breastfeeding support was not an area of focus for this study, data revealed mothers receiving support in the first 24 hours of breastfeeding seemed to quickly solve problems, were more likely exclusively breastfeed and reached a point of *WORKING IT OUT* sooner than those mothers who did not receive this early support. It is important to note that the mothers in this current study did not speak of 24 hours, but rather the first night and day, day and night or similar. The period of 24 hours has been chosen to quantify their descriptions.

A search of the literature revealed an abundance of information and research related to support of the first breastfeed and breastfeeding support during the mothers' postpartum stay in hospital. Definitions of early breastfeeding support vary greatly with most referring to either the first breastfeed or the first four to six weeks. Only one study (Kervin, Kemp &

## CHAPTER 5: DISCUSSION

Pulver, 2010) was identified that examined breastfeeding support within the first 24 hours, among other timing landmarks. This study used a cross-sectional method to analyse the impact of the type and timing of breastfeeding support on mothers' behaviours. Only 15.2% of mothers reported receiving any practical breastfeeding help, other than that provided at birth, in the first 24 hours. Fifty-five percent of the mothers felt that the health care team could have provided more breastfeeding support in this period. Less than half of the women interviewed (47%) felt that health care staff had positive attitudes toward breastfeeding in their first 24 hours postpartum, despite the fact that this was found to positively influence breastfeeding behaviours. The authors of this study did not present data related to the effects of practical breastfeeding support within the first 24 hours other than that associated with the first breastfeed.

Further research on the timing of breastfeeding support is required to ascertain the significance of this support at different chronological landmarks in the early postnatal period, with an emphasis on the first 24 hours. Findings which confirm that support in the first 24 hours can decrease early breastfeeding problems could guide busy midwives to be more strategic in their allocation of time for breastfeeding support with a greater focus on those mothers who are in the first 24 hours postpartum. This approach may result in mothers requiring less time beyond this period as problems are more likely to have been averted.

### Recommendation 6

It is recommended that midwifery workload allocations prioritise time for the provision of breastfeeding support in the woman's first 24 postnatal hours.

### Recommendation 7

Further research is undertaken to explore the relationship between breastfeeding support given in the first 24 hours and the rate of breastfeeding problems experienced.

**Practices that support breastfeeding**

Data from this study provide valuable information on the practices that mothers find supportive of breastfeeding. The importance of the midwife being present for the mother and investing time for breastfeeding support has been discussed. The other practices that mothers identified as most supportive of breastfeeding will now be explored further and related to the current evidence surrounding breastfeeding support. These include encouragement, advice and practical support.

Each of the mothers in this study discussed the positive effects of receiving encouragement about breastfeeding from midwives. Encouragement came in the form of positive reinforcement about what the mother was doing and comments that demonstrated that the midwife believed the mother could successfully breastfeed. This encouragement instilled confidence and helped the mothers to persevere with their breastfeeding attempts.

***Encouragement***

Encouragement has been consistently identified in the literature as being supportive and confidence building for breastfeeding mothers. McInnes and Chambers (2008) reported that mothers found those health professionals that were helpful were more likely to provide encouragement; described as praise and building the mother's confidence. In contrast, unhelpful health professionals projected a lack of belief in the mother's ability to breastfeed. In addition to encouragement being considered helpful by mothers, it has been shown to have a positive impact on exclusive breastfeeding rates. Data from a large population-based survey of 2824 mothers on English maternity care (Henderson & Redshaw, 2010) showed a 13% increase in exclusive breastfeeding for those women who reported receiving active

## CHAPTER 5: DISCUSSION

support and encouragement from health professionals. Another study (Graffy & Taylor, 2005) sought to gather 654 English mothers' views on how breastfeeding support could be improved through a qualitative analysis. "Reassurance and encouragement" (p.183) was identified as one of the five major components of breastfeeding support. The authors suggested that these were particularly valuable because the mothers were unprepared for the realities of breastfeeding and lacked confidence in their ability to breastfeed. Schmied et al. (2011) also suggested that reassurance and encouragement be provided in response to mothers' lack of confidence. Furthermore, they discussed the need for encouragement to be provided in a sensitive and effective manner rather than to create a pressure to breastfeed. Encouragement was further identified as one way in which health professionals could demonstrate "authentic presence" despite limited time and continuity (Schmied et.al, 2011, p. 58). The findings of this study are pertinent as time constraints were considered as a barrier to breastfeeding support by all of the women in this current study. The ability to demonstrate midwifery presence through the simple act of providing encouragement needs to be promoted to midwives as it can be achieved at almost any time and without significant time investment,

**Advice**

Another important aspect of breastfeeding support identified by the mothers in this current study related to the information and advice offered about breastfeeding. This advice was provided in the form of explanations and answers to mothers' questions and was helpful in addressing the *unknowing* and unpreparedness of these first time mothers. Advice has been identified as supportive for breastfeeding in many studies (Schmied et al., 2011; Henderson & Redshaw, 2010; Backstrom et al., 2010; Graffy & Taylor, 2005). Advice and information was supportive if it was consistent (Henderson & Redshaw, 2010; Gilmour et. al, 2009;

## CHAPTER 5: DISCUSSION

Sarasua, Clausen & Frunchak, 2009; McInnes & Chambers, 2008), realistic (Schmied et al., 2011) and individualised (Schmied et al.; Backstrom et al.; Graffy & Taylor).

Women in this current study also told of the topics they wanted midwives to provide advice on, which were attachment of baby to the breast, the timing and duration of feeds, and their current breastfeeding problems. These topics were in line with those described by Backstrom et al. (2010) who described that women considered breastfeeding support as adequate when it contained information about breastfeeding timing, breastfeeding techniques and damaged nipples. Likewise, Graffy and Taylor (2005) found that the advice women found most helpful addressed specific breastfeeding concerns such as the timing and duration of feeds, positioning, expressing, and treatments for sore nipples and engorgement. These studies confirm the findings of this current study; that women are particularly interested in information on solving common breastfeeding problems.

However, several of the women facing breastfeeding problems in this current study stated that they wanted midwives to offer them alternative ways to breastfeed to address their specific problems. These alternatives related to attachment, positioning, frequency of feeding and nipple shield use. The women were quite clear about the difference between the midwife offering advice on alternatives and giving conflicting advice. Alternatives were seen to be individualised to women's needs and helpful in solving their breastfeeding problems. Conflicting advice was seen as much the opposite and will be explored later in the chapter. Mothers' calls for advice to assist them in solving breastfeeding problems give rise to the following recommendation:

### Recommendation 8

It is recommended that midwives give mothers breastfeeding advice that includes information on a range of alternative methods for breastfeeding and for dealing with

## CHAPTER 5: DISCUSSION

breastfeeding problems to allow mothers to find the methods that best suit their individual needs. These alternatives are presented to women as a tool kit of strategies for future use rather than inconsistent advice.

***Practical support***

The final supportive practice that will be explored in this section is practical support. Practical support has been identified as positive breastfeeding support recurrently in the literature (Phillips, 2011; Schmied et al., 2011; Backstrom et al., 2010; Henderson & Redshaw, 2010) however the features that define practical support vary markedly. For the mothers in this current study, practical support consisted of both hands-off support; demonstrating and hands-on support; physical guiding and assisting. One midwife demonstrated positioning techniques by holding the baby herself. Another midwife demonstrated to a mother how to shape her breast for attaching the baby. Schmied et. al (2011) use the term “instrumental” support (p. 54) to encompass the practices of observing, demonstrating and providing practical help for breastfeeding mothers. Schmied et. al describe this support as being responsive to the mother’s needs rather than a narrow concept of feeding support. The need for practical breastfeeding support to be responsive to the mother’s unique needs was reiterated by the women in Backstrom et al’s study (2010). Several of the women in this current study wanted hands-on practical support, particularly in the first 24 hours of breastfeeding.

Hands-on practical assistance occurred when a midwife placed her hands on a mother’s hands to help guide the baby to the breast or attached baby to the mother’s breast herself. Such practical support is illustrated in the following quote:

## CHAPTER 5: DISCUSSION

*Susan: In the beginning they were helping me attach her to me so they would actually do it on to me so I could see how they managed to get her on.*

The mothers in this study described hands-on practical support positively and did not feel at any time that the support offered was rough or intrusive. This finding aligns with the findings of a phenomenological study of the lived experience of 19 first-time breastfeeding mothers (Phillips, 2011), who considered hands-on help as an essential component of a successful breastfeeding experience. "Show me, don't tell" was the major theme that arose from the descriptions of breastfeeding support from mothers in an ethnographic study (Gill, 2001). Although more recent studies have examined practical breastfeeding support, the women in Gill's study were particularly clear in their articulation of their need for practical support. The mothers in this study wanted to be shown how to position themselves and their babies for breastfeeding, how to attach their babies to the nipple, how to stimulate suckling, how to remove the baby from the breast and how to use a breast pump. They were clear that they needed more than just explanations of how to do these things (Gill).

Findings related to the practices that support breastfeeding show that new mothers need a variety of support methods to be offered by midwives to meet their needs. This conclusion leads to the following recommendation:

### Recommendation 9

It is recommended that midwives offer breastfeeding mothers a variety of support methods including informational (advice), emotional (encouragement), hands-off (demonstrating) and hands-on practical support. Midwives collaborate with mothers to discover the support types that will best support the mother's learning style and learning needs.



***Practices that do not support breastfeeding***

In contrast to the practices that support breastfeeding, the mothers in this current study also identified practices that were unsupportive of their efforts to breastfeed. These practices were less of a barrier overall to breastfeeding than the mother's inability to access breastfeeding support, but added to mothers' frustrations and inability to solve their breastfeeding problems. For some of the mothers in this study, the only contact they had with midwives in relation to breastfeeding was considered unsupportive with one mother stating she felt she would have done better at breastfeeding with no breastfeeding support from the midwives at all compared to the unsupportive 'help' she received.

The unsupportive practice most commonly described by the mothers in this study related to *inconsistent advice*. *Inconsistent advice* occurred when midwives provided mothers with breastfeeding information or guidance that was conflicting or incompatible with advice she had previously received. The mothers in this study felt that some midwives did not seem interested in the advice the mother had already received and were insistent that the mother change her practices to align with their own advice. Additionally, some midwives were reported to discount the advice of other midwives and health professionals, leaving the mother confused and lacking confidence in midwifery breastfeeding support overall.

A contributing factor for inconsistent advice may relate to midwives' knowledge of breastfeeding. Cantrill, Creedy and Cooke (2004) reported on the breastfeeding knowledge of a large sample ( $n = 1105$ ) of Australian midwives who had responded to a Newborn Feeding Ability Questionnaire (NFAQ). Questions assessed knowledge related to newborn feeding ability. The mean score was 85.94 from a possible total score of 110. Scores varied markedly with a range of 40 to 110. Whilst some areas of knowledge scored higher than

## CHAPTER 5: DISCUSSION

others, there were demonstrated knowledge deficits in all areas. This study also sought to determine midwives' management of the first breastfeed through self-reports. A strong association was identified between midwives' knowledge of newborn feeding ability and their reported practice managing the first breastfeed. The authors recommended that midwives be encouraged and supported to incorporate evidence-based research into their practice. They further suggested that research is required to identify the areas of knowledge deficit among midwives that contribute to the provision of conflicting advice (Cantrill et.al.).

The particular breastfeeding topics that are most likely to be associated with mothers' complaints about conflicting advice have received little attention in research, with most studies confirming the existence of conflicting advice rather than identifying its characteristics. Two recent Australian studies offer insight into the characteristics of conflicting advice from the perspective of breastfeeding mothers (Hauck, Graham-Smith, McInerney & Kay, 2011; Schmeid et al., 2011). Hauck et al. used a qualitative exploratory design to question 62 Western Australian mothers about their experience of conflicting advice and how it affected their breastfeeding experience. The women were asked to provide an example of when they had received conflicting advice and their responses offered a unique insight into the common topics for which conflicting advice was offered. The topic areas identified by Hauck et al. were positioning, the use of nipple shields, demand feeding and the interpretation of infant sleeping/settling issues related to breastfeeding. Schmeid et al. also identified positioning as a topic for which conflicting advice was offered in their metasynthesis of women's experiences of breastfeeding support. In addition, attachment, supplemental feeding, the timing and length of feeds, and milk supply were also identified as topics. The identified topic areas could be a focus in further research related to midwives' breastfeeding knowledge.

## CHAPTER 5: DISCUSSION

It is pertinent to question whether a reduction in conflicting advice may be assisted by improving midwives' knowledge of breastfeeding. Whilst this question has not been clearly answered, research has shown that interventions aimed at increasing the breastfeeding knowledge of health professionals can improve breastfeeding knowledge, attitudes and reported confidence in practice (Khoury, Hinton, Mitra, Carothers & Foretich, 2002; Watkins & Dodgeson, 2010). A review of 14 intervention studies confirmed this when the authors sought to determine the effect of interventions to increase breastfeeding knowledge, self-confidence and evidence-based behaviours of health professionals (Watkins & Dodgeson). Their findings clearly showed that educational interventions were successful in improving health professional's breastfeeding knowledge and, in turn, promoted positive breastfeeding attitudes. One of the included studies showed that staff did not have improved knowledge scores post-intervention but showed a significant increase in the appropriateness of the breastfeeding support they offered (Ingram, 2006). Knowledge scores were assessed pre and post-intervention but attitude scores were only assessed pre-intervention (Ingram). This same effect of an intervention on breastfeeding knowledge and practice was demonstrated by Barnes, Cox, Doyle and Reed (2010) who set out to evaluate a practice-development initiative to improve breastfeeding rates. Their findings were that staff knowledge was not increased by the intervention, however it facilitated the implementation of practices that were more closely aligned with current evidence-based practices (Barnes et al.). It would be helpful to know whether these findings were related to improved breastfeeding attitudes post-intervention. Such a link could influence the design of breastfeeding education for health professionals to ensure that an objective of improving breastfeeding attitudes of health professionals receives equal attention to improving breastfeeding knowledge.

The importance of breastfeeding attitudes among health professionals was recently highlighted by Australian mothers (Hauck et al., 2011) in a study of women's perceptions of

## CHAPTER 5: DISCUSSION

conflicting advice on breastfeeding. The mothers in this study described conflicting advice as including advice that was too generic and not individualised to their particular needs, did not take into account their thoughts and feelings, was given based on the agenda of the midwife or organisation, was not explained adequately and was provided with an uncaring and unsympathetic manner. Similarly, Sheehan et al.'s (2009) study found that directive advice was very similar to conflicting advice and was deemed by mothers to be unsupportive and confusing. Each of these descriptions demonstrate an influence of midwives' breastfeeding attitudes on the support they provided to women. This aligns to several of the mothers' comments in this current study about the "unhelpful" midwives not seeming to care about breastfeeding or the breastfeeding experiences of the mothers themselves and giving priority to their own views of what was best for the mothers.

### Recommendation 10

It is recommended that future research further explores the role that breastfeeding attitudes of health professionals play in mothers' experiences of conflicting advice.

### Recommendation 11

It is recommended that midwives attend breastfeeding education sessions that focus on evidence-based lactation content, strategies for common breastfeeding problems, and activities that encourage midwives to reflect on their breastfeeding attitudes and identify attitudes that may hinder the provision of effective breastfeeding support.

***Normalising and dismissing***

Mothers' descriptions of midwives giving generic advice and making "blanket statements" about their breastfeeding issues (Hauck et al., 2011, p.159) closely align with another two practices that do not support breastfeeding identified in this current study. These practices were labelled *normalising problems* and *dismissiveness* and described the mothers' experiences of midwives seemingly discounting their breastfeeding problems and need for breastfeeding support. Like the women in Hauck et al.'s study, the women in this current study felt that the midwives often did not acknowledge or dismissed their individual situations and provided generic advice that did not address their problems. According to Hauck et.al., this apparent lack of understanding of the woman's individual needs could be addressed through improved listening and communication between the mother and midwife, a thorough assessment of the woman's breastfeeding situation and the provision of individualised advice.

The failure for midwives to understand mothers' individualised needs for breastfeeding support has been described by Schmied et al. (2011) as a reductionist approach. In the reductionist approach the midwife does not listen or ask but rather presumes and tells. This approach results in women being given information in an ineffective manner and feeling confused and undermined rather than supported (Schmied et al.). Indeed, the mothers in this current study confirmed that they often felt confused as a result of non-individualised and non-caring advice.

Another property that emerged as unsupportive to mothers' breastfeeding efforts was midwives *discounting other advice*. The mothers in this study complained that midwives often discounted other midwives' or health professionals' advice by ignoring it, disagreeing with it or discrediting the original source. Mothers felt frustrated and confused when the

## CHAPTER 5: DISCUSSION

midwife told them that what they were doing was wrong and directed them to try something that was inconsistent with previous advice received. This was particularly frustrating for the mother if the previous strategies were working and sometimes led the mothers to “secretly do their own thing” when the midwife left the room. Possibly the most damaging aspect of midwives *discounting other advice* was the resulting lack of confidence and trust the mothers had in the midwives’ knowledge and abilities around the provision of breastfeeding support. These findings align with the comments of Hauck et al. (2011) who suggest that health professionals’ credibility is being jeopardised by conflicting breastfeeding advice as women begin to lose confidence and question the advice being given. Additionally, this lack of confidence may impact those midwives who do possess the appropriate knowledge and skills and use them to provide effective breastfeeding support.

It is fitting to also question whether midwives have insight into the common complaint of inconsistent and conflicting advice from mothers. The midwives who were informed about this study consistently predicted that inconsistent advice was a theme likely to emerge from the data. This could signify local professional insight with regards to inconsistent breastfeeding support. Research shows that this insight extends beyond local boundaries. Midwives views about conflicting and inconsistent advice were explored among North-American nurses by Nelson (2007), using an existential-phenomenological approach. The maternal-newborn nurses in this study overwhelmingly agreed that the breastfeeding support they offered was often perceived as inconsistent by both new mothers and themselves. The midwives described breastfeeding support as a dynamic and “multidimensional process with relational, contextual and situational components” (p.29). They also commented that mothers needed to be given different advice because different strategies worked for different mothers. This comment aligns with those of the mothers in this current study who clearly articulated their need for alternative breastfeeding strategies to

## CHAPTER 5: DISCUSSION

be offered as described under the heading of practices that support breastfeeding.

Conversely, this comment does not align with the previously mentioned practice of offering generic, non-individualised advice. Overall, it would seem that mothers are asking for individualised, evidence-based and reasoned advice and alternatives to be offered that complement any successful strategies and current plans that are in place.

The description of qualities of breastfeeding support discussed above gives rise to the suggestion that the unsupportive practices of conflicting advice, discounting others advice, normalising problems and dismissiveness could be reduced significantly within models that provide continuity of care. Research shows that improved communication, working in partnership and individualised assessment and care are provided in continuity of care models (Fereday et al., 2009; Sandall et al., 2008). Of additional benefit is the reduction of the number of caregivers resulting in the provision of consistent advice. This assumption is supported by McInnes and Chambers (2008) in their qualitative synthesis of women and health professional's views of breastfeeding support. The authors reported less conflicting advice where continuity of care was provided. This gives rise to the following recommendations:

### Recommendation 12

It is recommended that preference is given to continuity of care models that reduce inconsistency of breastfeeding advice through the reduction of the number of midwives a mother sees throughout the birthing continuum and the development of an effective mother-midwife partnership

### Recommendation 13

It is recommended that midwives working in non-continuity or team models of care communicate and document breastfeeding support and subsequent breastfeeding plans

## CHAPTER 5: DISCUSSION

thoroughly and, wherever possible, access this information prior to each contact with a breastfeeding mother.

### Recommendation 14

It is recommended that further research related to breastfeeding advice ensures a clear differentiation between 'inconsistent' or 'conflicting' advice and offering 'options' or 'alternative' advice. Such research seeks mothers' opinions on how advice can be presented to ensure it works with mothers' breastfeeding attempts rather than against them.

### ***Emotional support***

One of the key findings of this study was that all of the mothers experienced some form of emotional upheaval in their journey to WORKING IT OUT. Recent research in the area of maternal distress suggests that all new mothers experience distress in the transition to motherhood in response to feelings of isolation, altered roles and feeling depleted (Emmanuel & St John, 2010). The distress experienced by the mothers in this current study was intensified by breastfeeding problems and an inability to access effective breastfeeding support. Whilst some of the emotions experienced were positive such as happiness and pride, others were of a negative nature such as feeling frustrated, confused, teary, fragile and stressed. Some of the mothers reported interactions with midwives in which they felt emotionally supported and these experiences were associated with positive emotions. However, these did not emerge as commonly as the comments about the mothers feeling unsupported emotionally and the resulting negative emotions experienced. These findings are supported by those of Burns et al. (2009) in a meta-synthesis of womens' experiences of breastfeeding. Like this current study, Burns et al. found that appropriate breastfeeding support was one of the key factors expressed by the mothers who described experiencing



## CHAPTER 5: DISCUSSION

positive emotions and connected encounters in breastfeeding. Conversely, those mothers who described experiencing negative emotions and disconnected encounters were far more critical of the level of breastfeeding support they received.

The assumption that mothers' experiences of emotional upheaval can be positively influenced by connected encounters of breastfeeding support leads to the question of how support can be improved to support mothers through this experience. The mothers in this current study felt that the midwives lacked the motivation or time to be present and to provide emotional support. The benefits of continuity of midwifery care have previously been discussed and can be applied in a likewise manner to the situation of emotional support in that this model of care allows time for the formation of effective relationships and listening and responding to women's needs (Sandall et al., 2008). Postnatal home visiting is another strategy that has been shown to allow for the better provision of emotional support due to less time (Bailey, 2010; Kronborg, Væth, Olsen, Iversen and Harder, 2007). The women in Bailey's study expressed that they preferred home visiting to clinic visits as they felt more relaxed and less rushed, and there was more time for the health visitor to answer their questions. This finding strongly aligns with findings of this current study; that women highly value the investment of time by the midwife or health professional for the provision of breastfeeding support.

Peer support is another strategy shown to improve the provision of effective emotional support for breastfeeding mothers (Moran, Dykes, Burt & Shuck, 2006; Wade, Haining & Day, 2009). A Cochrane systematic review of breastfeeding support found that peer support, whether or not combined with professional support, has been consistently shown to decrease breastfeeding cessation rates (Britton et al., 2009), however the authors did not make any link to the role of emotional support in this relationship. Another study focusing on the role of psychosocial postnatal support confirmed that emotional support also significantly

## CHAPTER 5: DISCUSSION

decreases breastfeeding cessation rates, however, this support was provided in the form of postnatal home visits with a health practitioner rather than a peer (Kronborg et al., 2007).

The relationship between peer breastfeeding support and emotional support was confirmed by Moran et al. (2006) who explored the similarities and differences in the approaches of midwives and peer breastfeeding supporters. The authors concluded that peer supporters placed a greater emphasis on the provision of emotional support than midwives (Moran et al.). This finding was confirmed by McInnes and Chambers (2008) who found that peer supporters placed more emphasis on emotional support and the need to elicit the mothers' own knowledge and check her understanding.

The women in this current study had little opportunity to receive emotional support due to the busy nature of the hospital postnatal wards and the lack of continuity of caregivers. Two of the mothers received a single postnatal home visit and one of the mothers stated that this was a very supportive encounter with the midwife. In hindsight it would have been beneficial to further question this mother about the specific qualities of the visit and whether the availability of time and emotional support contributed to her positive view of this encounter.

Mothers in this study and current research consistently identified that time, presence and emotional support are critical to the mother having a positive experience of breastfeeding support. This finding strengthens the idea that peer breastfeeding supporters would have a positive influence on new mothers' experiences of *learning to breastfeed* and *WORKING IT OUT*. Peer supporters could offer non-rushed and individualised emotional support.

The Australian Breastfeeding Association (ABA) is one such group that offers peer breastfeeding support to mothers (ABA, 2011). Whilst they strive to ensure women are aware of the services they offer, many women remain unaware or do not access their services within the early postnatal period. The findings of this current study show that new

## CHAPTER 5: DISCUSSION

mothers need emotional support for breastfeeding very early in the postnatal period. Maternity care providers can improve the access mothers have to peer breastfeeding support by collaborating with such groups as the ABA, or implementing alternative peer support models, that encourage early peer support. This leads to the following recommendation:

### Recommendation 15

It is recommended that maternity care providers collaborate with current providers of peer breastfeeding support, or implement new models of peer support, that are available to all breastfeeding mothers. It is recommended that such models include the initiation of peer support relationships in the antenatal period to encourage access to this support in the first 24 postnatal hours.

### ***Summary of recommendations***

In response to the findings of this study of new mothers' experiences of midwifery breastfeeding support from midwives and current related evidence, fifteen recommendations have been proposed. A summary of these recommendations is presented in table 5.1 below. The implications of these recommendations for clinical practice, education, management and future research are discussed in the next section of this chapter.

**Table 5.1: Summary of recommendations****Recommendation 1**

It is recommended that midwives provide written and practical antenatal breastfeeding education that realistically prepares new mothers for the experience of early breastfeeding, their need for breastfeeding support and the potential for various breastfeeding problems. Education includes assisting mothers to gain the knowledge and skills required to identify and solve common breastfeeding problems.

**Recommendation 2a**

It is recommended that maternity care organisations give preference to continuity of care models that facilitate midwifery presence through the building of midwife-mother partnerships and woman-centred care and these models allow for continuity of carer to extend into the postnatal period.

**Recommendation 2b**

It is recommended that further research is conducted to explore the role of midwifery presence in the provision of breastfeeding support.

**Recommendation 3**

It is recommended that those involved in the management and design of maternity care settings give consideration and preference to those factors that limit the perception of busyness such as silent or pager-style patient call systems, the positioning of utility and station areas so that they are out of the direct line of vision of mothers and a preference toward non-shared or paired rooms over four or six bedded bays for the accommodation of mothers, so that mothers witness less of midwives' work.

**Recommendation 4**

Providers of postnatal care, particularly those located in hospitals, implement a program that evaluates and redesigns the work of postnatal midwives to ensure it is effective and efficient. Tasks that are wasteful, ineffective or inefficient should be rethought and redesigned to allow a better distribution of time for direct midwifery care and breastfeeding support.

**Recommendation 5**

Midwives receive education on the evidence surrounding midwifery presence and the ways in which they can enhance their presence while providing breastfeeding support e.g.

listening, using verbal and non-verbal language that portrays availability and presence, ensuring that time spent providing breastfeeding support is woman-focused.

**Recommendation 6**

Midwifery workload allocations prioritise time for the provision of breastfeeding support in the woman's first 24 postnatal hours.

**Recommendation 7**

Further research is undertaken to explore the relationship between breastfeeding support given in the first 24 hours and the rate of breastfeeding problems experienced.

**Recommendation 8**

Midwives give mothers breastfeeding advice that includes information on a range of alternative methods for breastfeeding and for dealing with breastfeeding problems to allow mothers to find the methods that best suit their individual needs. These alternatives are presented to women as a tool kit of strategies for future use rather than inconsistent advice.

**Recommendation 9**

Midwives offer breastfeeding mothers a variety of support methods including informational (advice), emotional (encouragement), hands-off (demonstrating) and hands-on practical support. Midwives collaborate with mothers to discover the support types that will best support the mother's learning style and learning needs.

**Recommendation 10**

Future research further explores the role that breastfeeding attitudes of health professionals play in mothers' experiences of conflicting advice.

**Recommendation 11**

Midwives attend breastfeeding education sessions that focus on evidence-based lactation content, strategies for common breastfeeding problems, and activities that encourage midwives to reflect on their breastfeeding attitudes and identify attitudes that may hinder the provision of effective breastfeeding support.

**Recommendation 12**

Preference is given to continuity of care models that reduce inconsistency of breastfeeding advice through the reduction of the number of midwives a mother sees throughout the birthing continuum and the development of an effective mother-midwife partnership

**Recommendation 13**

Midwives working in non-continuity or team models of care communicate and document breastfeeding support and subsequent breastfeeding plans thoroughly and, wherever possible, access this information prior to each contact with a breastfeeding mother.

**Recommendation 14**

Further research related to breastfeeding advice ensures a clear differentiation between 'inconsistent' or 'conflicting' advice and offering 'options' or 'alternative' advice. Such research seeks mothers' opinions on how advice can be presented to ensure it works with mothers' breastfeeding attempts rather than against them.

**Recommendation 15**

It is recommended that maternity care providers collaborate with current providers of peer breastfeeding support, or implement new models of peer support, that are available to all breastfeeding mothers. It is recommended that such models include the initiation of peer support relationships in the antenatal period to encourage access to this support in the first 24 postnatal hours.

**Implications of this study**

This research has offered new information and insights into new mothers' experiences of receiving midwifery breastfeeding support and confirmed current research on the topic. The purpose of this section of the thesis is to highlight the implications, the findings and resulting recommendations of this research for midwives, organisations, managers and researchers. The recommendations have been categorised to assist in the identifying the specific implications for each group as outlined in Table 5.2 below.

Table 5.2: Categorisation of recommendations

<b>Categories</b>	<b>Recommendations</b>
Clinical practice	1, 8, 9, 13
Education / Training	5, 11
Management / Organisation	2a, 3, 4, 6, 12, 15
Future research	2b, 7, 10, 14

***Implications for clinical practice***

The recommendations under the category of clinical practice propose actions that midwives can take to improve mothers' experiences of receiving breastfeeding support and to assist these mothers in their journey to *WORKING IT OUT*. Each of these recommendations address concerns raised by mothers in this study and respond to types of support they found most helpful in their journey of learning to breastfeed and *WORKING IT OUT*. The

## CHAPTER 5: DISCUSSION

recommendations provide actions that each midwife can implement in their practice to improve the provision of breastfeeding support in both the antenatal and postnatal periods.

Antenatally, women are poorly prepared for the realities of breastfeeding. They complain that other women and the media do not portray breastfeeding honestly and fail to reveal that breastfeeding problems are likely to occur. In addition, women complain of receiving breastfeeding advice that is also unrealistic or inadequate in preparing them for the realities ahead. This study confirmed that midwives have a role in preparing new mothers for the realities of breastfeeding through antenatal breastfeeding education. Midwives should inform pregnant women that breastfeeding is a learnt skill, requiring the support of others in helping them to work it out. Midwives should discuss common breastfeeding problems such as sore nipples, sleep deprivation, engorgement and an unsettled baby and provide anticipatory guidance in the form strategies for dealing with such 'problems'. This knowledge would decrease mothers' distress and improve their abilities to problem solve when problems do occur. Additionally, mothers would be able to begin to try one or more of these strategies while waiting for a midwife to provide support such as when the ward is busy or post-discharge.

The postnatal focussed recommendations address the findings that mothers need breastfeeding support that is consistent, appropriate and individualised. The mothers in this and other studies complained that breastfeeding support is often inconsistent, inflexible, generic and inappropriate. This type of advice and support left mothers confused and frustrated as they continued on with problems unsolved. Indeed, this type of support often contributed to the problems the mothers experienced. Additionally, the mothers often lost confidence in midwives' knowledge and abilities around breastfeeding.



## CHAPTER 5: DISCUSSION

In order for midwives to provide appropriate, individualised, consistent and flexible care, they need to work to build a partnership with breastfeeding women. A partnership allows the woman and midwife to contribute equally in communications and decision making, ensuring the mother's thoughts and feelings are heard and the support provided addresses her specific needs and issues. Mothers have highlighted their need for varying types of breastfeeding support including informational, emotional, and practical support. In a partnership, women can easily communicate the types of support they need in any given situation and midwives can effectively respond to women's cues for such support.

One way of encouraging partnership and assisting mothers to remain key players in decision making about their breastfeeding support needs is for midwives to develop breastfeeding plans with mothers and to clearly document and communicate these plans. It should be an expectation that each midwife providing breastfeeding support becomes familiar with these plans to ensure future breastfeeding support offers consistency and that changes are justified in relation to the mothers' individual situations. This is of particular importance when care is fragmented and mothers are likely to have contact with several midwives throughout the continuum of care.

The findings of this study indicate that the above changes to practice would significantly improve new mothers' experiences of receiving midwifery breastfeeding support however midwives are encouraged to design and participate in evaluations of such changes to confirm these findings.

### ***Implications for midwifery education and training***

Changes to practice inherently require education to support the change. The findings of this study reveal that midwives often engage in breastfeeding support practices that are

## CHAPTER 5: DISCUSSION

considered unhelpful by new mothers and changes are necessary to improve new mothers' experiences of receiving this support. Education should provide midwives with information about breastfeeding, the practices that mothers find supportive of breastfeeding, breastfeeding problems and problem-solving strategies and the evidence and rationale behind these practices. Such education should be an annual mandatory requirement for all midwives, and be incorporated into midwifery preparatory programs, to ensure midwives are providing mothers with effective, consistent and evidence based support.

Research has indicated that midwives who possess evidence-based knowledge of breastfeeding may be more likely to provide consistent and appropriate breastfeeding support (Cantrill et. al, 2004) and are more likely to have positive breastfeeding attitudes (Watkins & Dodgeson, 2010). Positive breastfeeding attitudes have been associated with the provision of more appropriate breastfeeding support (Hauck et al., 2011) and should, thus, be addressed in midwifery education sessions through the encouragement of reflection and the identification of attitudes that hinder the provision of effective breastfeeding support.

Midwives also need education about midwifery presence, a concept that is relatively new when applied to the situation of breastfeeding support. Midwives could improve breastfeeding support through a better understanding of midwifery presence and the strategies midwives can use for enhancing their presence during the provision of breastfeeding support such as using non-verbal language that portrays availability and interest and asking the mother questions about her needs. Midwives also need to learn about factors that hinder presence such as comments about being busy and body language that suggests impatience. The simple act of clock-watching can send a powerful message to the mother that the midwife does not have the mother as her central focus at that time.

## CHAPTER 5: DISCUSSION

Midwifery education about breastfeeding and breastfeeding support has the potential to significantly improve the experiences of new mothers when receiving breastfeeding support in that it would encourage midwives to change their practices to align with the mothers' descriptions of positive breastfeeding support, specifically support that is consistent, individualised and evidence-based.

### ***Implications for organisations and management***

The majority of recommendations made in response to the findings of this study relate to organisational change. Organisational change refers to the changes required to be instigated by health services, organisations and management rather than midwives themselves. The midwives' role is to rally organisations for such changes to occur as soon as possible in an effort to enhance the breastfeeding support that new mothers receive and, in some cases, their own abilities to provide effective breastfeeding support.

The focus area for organisational change relates to changes that allow midwives and other breastfeeding supporters to spend time with mothers providing breastfeeding support. The mothers' in this study clearly articulated that hospital midwives were often too busy to meet their breastfeeding support needs. Time, or the perception of time spent was identified as the most valuable resource for breastfeeding support by the mothers in this study and strategies are required to overcome the deficiency of this precious resource.

It seems reasonable for the initial response to examine how tasks can be reallocated to allow for more time to be invested into midwifery breastfeeding support. Providers of postnatal care should undertake an observation and evaluation of the work of midwives, particularly those working in ward-based environments, to identify those tasks that are time-consuming, wasteful, inefficient and ineffective and redesign or reallocate them to allow a

## CHAPTER 5: DISCUSSION

better distribution of time for direct midwifery care. This will allow the midwife more time to effectively assess mothers' breastfeeding support needs through communication and the development of a partnership with mothers. Additionally the midwife will be able to demonstrate presence and availability which was seen as synonymous with positive breastfeeding support by the mothers in this study and reduced mothers' reluctance to request support when it was required.

This study found that the mothers' perception of the midwives being too busy to provide breastfeeding support was exacerbated by the constant buzzing of the patient call system and the mothers' witnessing midwives running in and out of ward utility areas. As stated above, this was a significant barrier to midwifery breastfeeding support as mothers often felt guilty asking for support from an already time-pushed midwife. Organisations should consider the redesign of units to incorporate silent or pager-style patient call systems. Silent systems have visual indicators of patient calls and no audible tones for mothers to hear. Pager style systems are effective if set to vibrate and can also be set to escalate unanswered calls so that a buddy midwife is notified that the call has not been answered. These types of call systems can significantly reduce mothers' perceptions of busyness and their reluctance to call on midwives for breastfeeding support. Additionally, the latter system can reduce the time a mother waits for a response to her buzzer by utilising other midwives who may be available. The danger of this system of escalation is that it could increase the possibility of inconsistent advice if the two midwives do not effectively communicate and the mother does not have a breastfeeding plan in place (as per Recommendation 13).

Other environmental factors that should be considered by organisations and hospital planners is the design of postnatal units to ensure that mothers have less visual cues that suggest midwives are busy. Specific examples of designs that could achieve this include the

## CHAPTER 5: DISCUSSION

positioning of utility areas so that they are not in the direct line of vision of mothers in their rooms and the limiting of mothers' rooms to single or paired rooms.

Recommendations for improving the time allocated for midwifery breastfeeding support also relate to models of care. Continuity of care has been shown to increase the time a midwife spends with a mother and to encourage the formation of a positive partnership. Maternity service providers should support such models of care through collaboration with caseload midwives and the support of internal continuity of care models such as midwifery group practices.

Breastfeeding support is available from alternative sources and organisations such, as the ABA, and health service providers should collaborate with these sources of support to ensure that women are aware of them and have early access to them. Such collaboration could significantly increase the number of mothers accessing peer support and, thus, improve the breastfeeding support they receive.

Implementation of the above strategies for health services, organisations and management would improve the time invested in the provision of breastfeeding support for mothers. This, in turn, would improve mothers' experiences of receiving breastfeeding support and ensure that the support provided more closely matched mothers' needs.

### ***Implications for future research***

Findings from this study have highlighted topics that are not adequately addressed within current literature in relation to the timing of breastfeeding support, the delineation between inconsistent advice and offering options, and the role of midwifery presence in the provision of breastfeeding support. The recommendations are for further research to further explore these topics and offer a greater understanding of the same.

## CHAPTER 5: DISCUSSION

The first recommendation is for further research to investigate the relationship between breastfeeding support given to new mothers in the first 24 hours following birth and subsequent breastfeeding problems experienced by the mother. Findings in this current study show that breastfeeding support provided in the first 24 hours was linked to the mothers' improved ability to solve breastfeeding problems thereafter. Current literature discusses breastfeeding support in the context of the early breastfeeding period, which is usually defined as the first six weeks postpartum, or the postnatal inpatient period, which can vary markedly. Such research fails to adequately examine the first 24 hours period in relation to the support received or the outcomes of that support. Further research is required to determine whether the first 24 hour period is more, equally or less significant than other time periods defined more commonly in current research.

The second recommendation is for research to further explore the role of midwifery presence in the provision of breastfeeding support. Much of the research focussed on the role of presence in midwifery is focussed on the intrapartum period. Further research focussing on midwifery presence for breastfeeding support could give added credit to the valuable role it plays in the provision of early breastfeeding support.

The final recommendation for research relates to the need to redefine terminologies that are currently interchanged in research about breastfeeding support and lead to confusion for research participants and those interpreting the research findings. More specifically this recommendation is that future researchers investigating breastfeeding advice differentiate between "inconsistent" or "conflicting" advice and "options" or "alternative" advice. The mothers in this current study spoke of being offered options and alternatives positively; however these terms are often related to, or interchanged with, the terms "inconsistent" or "conflicting", particularly in surveys given to mothers to ascertain positive and negative aspects of breastfeeding support. This research is necessary to decrease the confusion

## CHAPTER 5: DISCUSSION

around the meaning of these terms and to ascertain whether being offered options and alternatives is considered supportive by mothers in future studies.

### ***Limitations***

Whilst the methods of this research were rigorously applied, limitations still exist. The limitations relate to sampling for the most part. The sampling of women who were 18 years and older and spoke English meant that the experience of younger women and those from non-English speaking backgrounds were not represented in the data. These sampling criteria were applied for ethical reasons but may have led to important differences in these women's experiences not being represented. The experience of Indigenous mothers is also not represented in the data due to difficulties in recruiting Indigenous women despite great emphasis being placed on this in recruitment attempts.

The women were sampled from a single maternity hospital which meant they represented a small geographical area and limited models of care. This hospital did offer both public and private care and women were recruited from both models so findings are applicable to the women's experiences within both public and private hospital care. Women were not recruited from continuity of care models. Including such women may have altered the results as research suggests that these women have quite different experiences of midwifery care.

Lastly, a literature review was carried out before data collection commenced as this was a requirement of the research course attached to the Masters program being undertaken by the researcher. Whilst current debate continues about the use of the literature review within Grounded Theory (Glaser, 1992; Strauss & Corbin, 1990), each of the original theorists has warned that an early literature review can reduce the researcher's reflexivity. Whilst all

## CHAPTER 5: DISCUSSION

attempts were made to remain open to the data, some bias toward themes previously discovered may have occurred.

### ***Summary of discussion***

This chapter has presented a discussion of the findings of this study of new mother's experiences of receiving breastfeeding support from midwives, using a Grounded Theory approach. The key findings were discussed in relation to current relevant literature and synthesised to support the recommendations. The implications of this research in relation to clinical practice, education, management and future research have been presented. The limitations of this research study were also identified.

### **Conclusion**

This study of new mothers' experiences of receiving midwifery breastfeeding support has met the objectives of identifying, describing and explaining the role of the midwife in providing breastfeeding support to new mothers, the factors that influence new mothers' experiences of receiving breastfeeding support from midwives and the impact of midwifery practices on new mothers' experiences of receiving breastfeeding support. Beyond the objectives, it has described the rich experience of new mothers through their journey of WORKING IT OUT; the core category of this study. This core category was shown to encompass both a journey and destination for new mothers as they learnt to breastfeed and coped with the problems they faced along the way. WORKING IT OUT has been shown to be a complex, multi-faceted journey that can be significantly influenced by mothers' experiences of receiving breastfeeding support from midwives.

The mothers in this study have called for midwives to offer breastfeeding support that more closely matches their needs. Through their stories, they have asked for midwives to invest time in



## CHAPTER 5: DISCUSSION

them, building a partnership, recognising them as individuals and providing emotional support. They have asked for midwives to assess their individual situations and offer responsive support. They have asked for midwives to better prepare them for the realities of breastfeeding and the problems they may face. Finally, they have requested that midwives help them to overcome those problems by offering responsive, consistent and appropriate support.

Although data collected for this study was collected in 2006, current research shows that the mothers' stories remain true to the experiences of women today. The recommendations of this study and their implications for practice and research continue to be both valid and necessary to ensure new mothers are provided with breastfeeding support that is individualised and effective in meeting their needs. The recommendations offer midwives, and other key stakeholders in the provision of maternity care, achievable strategies that, when implemented, have the potential to dramatically improve the overall experience of first-time breastfeeding mothers.

**APPENDIX 1: Participant letter and consent form**



***Health Services Brisbane Limited***

**INFORMATION LETTER**

<b><i>Title of the study:</i></b>	New Mother's Experiences of Receiving Breastfeeding Support from Midwives
<b><i>Student Researcher:</i></b>	Danielle Gleeson, RN, RM, IBCLC, Ba Sc Nurs, Mater Mothers' Hospital, South Brisbane 4101, Ph: (07) 3840 2855
<b><i>Programme in which enrolled:</i></b>	Master of Midwifery (Research)
<b><i>Supervisor:</i></b>	Karen Flowers RN PhD Australian Catholic University 1100 Nudgee Rd Banyo QLD Ph: (07) 3623 7292
<b><i>Associate Supervisor:</i></b>	Amanda Carter Assistant Director of Education - Clinical Mater Health Services South Brisbane 4101 Ph: (07) 3840 8488

Dear New mother,

Congratulations on the birth of your baby. As a new mother, you have unique experiences that midwives can learn from. For this reason, you are invited to take part in an interview as part of a study on new mothers' experiences of receiving breastfeeding support from midwives.

Your participation will involve an interview in the first two to four weeks after the birth of your baby. The interview will occur in your home or at an alternative location that is agreed upon. During this session you will be invited to describe your experiences of receiving breastfeeding support from midwives. The interview will last approximately one hour and will be audio taped.

If you agree to be involved in this study you may decline to answer particular questions during the interview, stop the interview, or withdraw from the study at any time without consequence for your care at the hospital. Any information supplied by you will remain

APPENDICES

strictly confidential. Your name will be changed to a pseudonym (false name) to protect your identity.

It is anticipated that the findings of this study will be used in assisting midwives to provide breastfeeding support that more closely matches mothers' needs, however there is a possibility that this research may not result in any direct benefits.

Findings of this study may be published in a health-related journal; however, as previously stated, the researcher will ensure your identity remains confidential. Participants will be provided with feedback of the overall outcomes of the study where this is requested.

If you have any questions or concerns regarding the way in which the research is being conducted please contact either myself (on the number above) my supervisor for this study, Karen Flowers on (07) 3623 7292.

This research has been approved by the Australian Catholic University and the Mater Health Service Human Research Ethics Committees.

If you have any query that I or my research supervisor have not been able to satisfy or you have any complaint or concern regarding this research you may phone the Mater Research Secretariat on (07) 3840 1585 or write to the Australian Catholic University Chair of the Human Research Ethics Committee at the following address:

Chair, HREC  
C/o Research Services  
Australian Catholic University  
Brisbane Campus  
PO Box 456  
Virginia QLD 4014  
Ph: (07) 3623 7294  
Fax: (07) 3623 7328

If you agree to participate in the interview, please sign the attached consent form, having read and understood the information given. Please keep the participant copy for your records and return the other copy to the student researcher. Alternatively, you are free to decline involvement without giving a reason for this and without consequence for your care.

Thank you for your interest.  
Danielle Gleeson  
Student Researcher



**Health Services Brisbane Limited**

**CONSENT FORM – Participant's Copy**

**Title of the study:** New Mother's Experiences of Receiving  
Breastfeeding Support from Midwives

**Student Researcher:** Danielle Gleeson

**Supervisor:** Karen Flowers

**Associate Supervisor:** Amanda Carter

I have:

- read and understood the attached information letter
- had any questions or queries answered to my satisfaction
- understood that the interview will be audio-taped
- understood that my name will not be revealed and will not be stored with the interview material
- been assured that I am free to withdraw at any time without consequence
- agreed to participate in the study

I am over 18 years of age and I consent to this interview freely and without persuasion.

Name of Participant: \_\_\_\_\_  
(Print Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_

Signature of Student Researcher: \_\_\_\_\_

Date: \_\_\_\_\_



**Health Services Brisbane Limited**

**CONSENT FORM – Researcher's Copy**

**Title of the study:** New Mother's Experiences of Receiving  
Breastfeeding Support from Midwives

**Student Researcher:** Danielle Gleeson

**Supervisor:** Karen Flowers

**Associate Supervisor:** Amanda Carter

I have:

- read and understood the attached information letter
- had any questions or queries answered to my satisfaction
- understood that the interview will be audio-taped
- understood that my name will not be revealed and will not be stored with the interview material
- been assured that I am free to withdraw at any time without consequence
- agreed to participate in the study

I am over 18 years of age and I consent to this interview freely and without persuasion.

Name of Participant: \_\_\_\_\_  
(Print Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_

Signature of Student Researcher: \_\_\_\_\_

Date: \_\_\_\_\_

**APPENDIX 2: ETHICS APPROVAL**

Australian Catholic University  
Brisbane Sydney Canberra Ballarat Melbourne



Human Research Ethics Committee

Committee Approval Form

**Principal Investigator/Supervisor:** Dr Karen Flowers Brisbane Campus  
**Co-Investigators:** Ms Amanda Carter Brisbane Campus  
**Student Researcher:** Ms Danielle Gleeson Brisbane Campus

**Ethics approval has been granted for the following project:**  
New mother's experiences of receiving breastfeeding support from midwives  
**for the period:** 10 June 2005 to 31 December 2005  
**Human Research Ethics Committee (HREC) Register Number:** Q 2004 05 22

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
  - security of records
  - compliance with approved consent procedures and documentation
  - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
  - proposed changes to the protocol
  - unforeseen circumstances or events
  - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

A handwritten signature in black ink that reads "K. Pashley".

Signed: \_\_\_\_\_ Date: 10 June 2005  
(Research Services Officer, McAuley Campus)



**Mater**  
Health Services Brisbane Limited



**MATER HEALTH SERVICES HUMAN RESEARCH ETHICS COMMITTEE**

3 May 2005

Ms Danielle Gleeson  
9 Ben Vardon Avenue  
Kholo 4306

Dear Ms Gleeson

**Re: New mothers' experiences of receiving breastfeeding support from midwives Ref No. 842M**

I write to advise that the Mater Health Services Human Research Ethics Committee considered your research proposal at its April 27 2005 meeting.

Approval has been granted subject to the following conditions:

- Satisfactory response to SSC questions;
- **Staff Information Sheet:** does the investigator need to be informed when the mother "becomes physically or psychologically unwell" etc or simply that she is no longer available for the study given the recruitment guidelines?
- Does the study need to identify whether the mother has had contact with the Nursing Mothers Support Association prior to interview?
- **Sampling:** The Committee does not understand how the researcher 'select the participants who can provide the insights most useful...' – does this involve some unscientific judgement on the part of the researcher or recruiting staff? Potentially an ascertainment bias?
- **PIS:** Please add a statement such as "if you or your baby develops health problems, you will not be approached for interview even if you have previously given consent"
- Please check English expression / grammar – investigator uses 'effecting' where the context demands 'affecting' and grammar in PIS needs attention.
- **Consent Form:** Please include a line for a witness signature;

*The Committee confirmed it did not need to review this study again and final approval could be granted between meetings.*

The approval will be valid for the duration of the project or three years, whichever is earlier. Please note the following conditions of approval.

- Any departure from the protocol detailed in your proposal must be reported immediately to the Committee.
- When you propose a change to an approved protocol, which you consider to be minor, you are required to submit a written request for approval to the Chairperson, through the Secretary. Such requests will be considered on a case by case basis and interim approval may be granted subject to ratification at the next meeting of the Committee.
- Where substantive changes to any approved protocol are proposed, you are required to submit a full, new proposal for consideration by the Human Research Ethics Committee.
- You are required to advise the Research Secretariat immediately of any complaints made, or expressions of concern raised, in relation to the study, or if any serious or unexpected adverse events occur.

Research Secretariat Room 235 Aubigny Place Ph: +61 7 3840 1585 Fax: +61 7 3840 1571 Email: [Odette.Petersen@mater.org.au](mailto:Odette.Petersen@mater.org.au)  
Mater Misericordiae Health Services Brisbane Limited ACN 096 708 922  
Raymond Terrace, South Brisbane, Queensland 4101 Australia • Phone +61 7 3840 8111 • [www.mater.org.au](http://www.mater.org.au)



F0621 08/03

- 
- Under the *NHMRC National Statement on Ethical Conduct in Research Involving Humans*, research ethics committees are responsible for monitoring approved research to ensure continued compliance with ethical standards, and to determine the method of monitoring appropriate to each project. You are required to provide written reports on the progress of the approved project annually and on completion of the project. The Committee may also choose to conduct an interim audit of your research.

The study may not commence until you have received your final approval letter. (All correspondence should be directed to the Mater Research Secretariat.)

Yours sincerely



Christopher Coyne  
Chairperson  
Mater Health Services Human Research Ethics Committee



REFERENCES

**REFERENCES**

- Auerbach, K. G. (2000). Evidence-Based Care and the Breastfeeding Couple: *Key Concerns*. *The Journal of Midwifery & Women's Health*, 45(3), 205-211. doi: 10.1016/s1526-9523(00)00012-x
- Australian Bureau of Statistics. (2003). *Australian Family Characteristics, June 2003*. Canberra: AGPS Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/234CFF39BDFDFF80CA25745F00168760?OpenDocument>.
- Australian Bureau of Statistics. (2006). *National Health Survey: users' guide, 2004–05*. Canberra: ABS Retrieved from [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/A58E031838C37F81CA257141000F1AAF/\\$File/4363055001\\_2004-05.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/A58E031838C37F81CA257141000F1AAF/$File/4363055001_2004-05.pdf).
- Australian Bureau of Statistics. (2007a). *Health of Children in Australia: A Snapshot, 2004-05*. Canberra: ABS Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/4829.0.55.001Main%20Features12004-05?opendocument&tabname=Summary&prodno=4829.0.55.001&issue=2004-05&num=&view=>.
- Australian Bureau of Statistics. (2008). *Year Book Australia, 2008*. Canberra: AGPS Retrieved from [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/8D6ED0E197FE38A6CA2573E7000EC2AD/\\$File/13010\\_2008.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/8D6ED0E197FE38A6CA2573E7000EC2AD/$File/13010_2008.pdf).
- Australian Bureau of Statistics. (2009). *4102.0 - Australian Social Trends*. Canberra: AGPS Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features40March%202009>.
- Australian Bureau of Statistics. (2010a). *3301.0 - Births, Australia, 2010*. Canberra: AGPS Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/Products/5FB2B59CDDAD3F69CA2579330016741A?opendocument>.
- Australian Bureau of Statistics. (2010b). *1301.0 - Year Book Australia, 2009–10*. Canberra: AGPS Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/0/18394636639EBC1FCA25773700169C60?opendocument>.
- Australian Health Ministers Conference. (2009). *Australian National Breastfeeding Strategy 2010-2015*. Canberra: AGPS Retrieved from [http://www.health.gov.au/internet/main/publishing.nsf/Content/49F80E887F1E2257CA2576A10077F73F/\\$File/Breastfeeding\\_strat1015.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/49F80E887F1E2257CA2576A10077F73F/$File/Breastfeeding_strat1015.pdf).

## REFERENCES

- Australian Institute of Family Studies. (2008). *Growing up in Australia: The Longitudinal Study of Australian Children*. Melbourne: Retrieved from <http://www.aifs.gov.au/growingup/pubs/ar/annualreport2006-07.pdf>.
- Backstrom, C., Wahn, E., & Ekstrom, A. (2010). Two sides of breastfeeding support: experiences of women and midwives. *International Breastfeeding Journal*, 5(1), 20.
- Bailey, S. (2010). Postnatal care: exploring the views of first-time mothers. *Community Practitioner*, 83(12), 26-29.
- Baker, M. (2001). *Families, Labour and Love: Family Diversity in a Changing World*. Vancouver: University of British Columbia Press.
- Barclay, L., Everitt, L., Rogan, F., Schmied, V., & Wyllie, A. (1997). Becoming a mother — an analysis of women's experience of early motherhood. *Journal of Advanced Nursing*, 25(4), 719-728. doi: 10.1046/j.1365-2648.1997.t01-1-1997025719.x
- Barclay, L. M., & Lloyd, B. (1996). The misery of motherhood: alternative approaches to maternal distress. *Midwifery*, 12(3), 136-139. doi: 10.1016/s0266-6138(96)90057-1
- Barnes, M., Cox, J., Doyle, B., & Reed, R. (2010). Evaluation of a Practice-Development Initiative to Improve Breastfeeding Rates. *The Journal of Perinatal Education*, 19(4), 17-23.
- Berg, M. (2005). A midwifery model of care for childbearing women at high risk: genuine caring in caring for the genuine. *The Journal of Perinatal Education*, 14(1), 9-21.
- BFHI Australia. (n.d.). *About BFHI*. Retrieved 13/3/12 from <http://www.babyfriendly.org.au/about-bfhi/>
- Binns, C. W., Fraser, M. L., Lee, A. H., & Scott, J. (2009). Defining exclusive breastfeeding in Australia. *Journal of Paediatrics and Child Health*, 45(4), 174-180. doi: 10.1111/j.1440-1754.2009.01478.x
- Bondas-Salonen, T. (1998). New mothers' experiences of postpartum care — a phenomenological follow-up study. *Journal of Clinical Nursing*, 7(2), 165-174. doi: 10.1046/j.1365-2702.1998.00138.x
- Brand, E., Kothari, C., & Stark, M. A. (2011). Factors Related to Breastfeeding Discontinuation Between Hospital Discharge and 2 Weeks Postpartum. *The Journal of Perinatal Education*, 20(1), 36-44. doi: 10.1891/1058-1243.20.1.36
- Bridges, N. (2007). Ethical responsibilities of the Australian media in the representations of infant feeding. *Breastfeeding Review*, 15(1), 17-21.
- Britton, C., McCormick Felicia, M., Renfrew Mary, J., Wade, A., & King Sarah, E. (2007). Support for breastfeeding mothers. *Cochrane Database of Systematic Reviews*, (1). Retrieved from <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001141/frame.html> doi:10.1002/14651858.CD001141.pub3

## REFERENCES

- Brook, C., & Barnes, M. (2001). Experience-based educational strategies to promote woman-centred midwifery practice. *The Australian Journal of Midwifery*, 14(1), 22-26. doi: 10.1016/s1445-4386(01)80031-8
- Bryant, A., & Charmaz, K. (2007). *The SAGE handbook of grounded theory*. London: Sage.
- Bryder, L. (2009). From breast to bottle: a history of modern infant feeding. *Endeavour*, 33(2), 54-59.
- Burgess, J., Henderson, L., & Strachan, G. (2007). *'I Just Juggle': Work and Family Balance in Australian Organisations*. Hecate.
- Burns, E., Schmied, V., Sheehan, A., & Fenwick, J. (2010). A meta-ethnographic synthesis of women's experience of breastfeeding. *Maternal & Child Nutrition*, 6(3), 201-219. doi: 10.1111/j.1740-8709.2009.00209.x
- Byrne, M. (2001). Grounded theory as a qualitative research methodology. (Brief Article). *AORN Journal*, 73(6), 1155.
- Caddick, S. (2011, 5/10/11). [*Releasing time to care project - Queensland Health*].
- Cantrill, R., Creedy, D., & Cooke, M. (2003). How midwives learn about breastfeeding. *Australian Midwifery*, 16(2), 11-16.
- Cantrill, R., Creedy, D., & Cooke, M. (2004). Midwives' knowledge of newborn feeding ability and reported practice managing the first breastfeed. *Breastfeeding Review*, 12(1), 25-33.
- Cattaneo, A., Ronfani, L., Burmaz, T., Quintero-Romero, S., MacAluso, A., & Di Mario, S. (2006). Infant feeding and cost of health care: A cohort study. *Acta Paediatrica*, 95(5), 540-546.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. Thousand Oaks: Sage.
- Chen, A., & Rogan, W. J. (2004). Breastfeeding and the Risk of Postneonatal Death in the United States. *Pediatrics*, 113(5), e435-439. doi: 10.1542/peds.113.5.e435
- Chiovitti, R. F., & Piran, N. (2003). Rigour and grounded theory research. *Journal of Advanced Nursing*, 44(4), 427-435. doi: 10.1046/j.0309-2402.2003.02822.x
- Chua, S., Arulkumaran, S., Lim, I., Selamat, N., & Ratnam, S. S. (1994). Influence of breastfeeding and nipple stimulation on postpartum uterine activity. *BJOG: An International Journal of Obstetrics & Gynaecology*, 101(9), 804-805.
- Clifford, J., & McIntyre, E. (2008). Who supports breastfeeding? *Breastfeeding Review*, 16(2), 9-19.
- Coffman, S., & Ray, M. (2002). African American women describe support processes during high-risk pregnancy and postpartum. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 31, 536-544. doi: 10.1111/j.1552-6909.2002.tb00078.x

## REFERENCES

- Commonwealth of Australia. (2002). *Commonwealth Support for Childcare: Historical Overview of Commonwealth Support/Policy*. Canberra: AGPS Retrieved from [http://www.aph.gov.au/library/INTGUIDE/sp/childcare\\_support.htm](http://www.aph.gov.au/library/INTGUIDE/sp/childcare_support.htm).
- Cooke, M., Cantrill, R., & Creedy, D. (2003). The first breastfeed: a content analysis of midwifery textbooks. *Breastfeeding Review*, 11(3), 5-11.
- Cooke, M., Cantrill, R. M., & Creedy, D. K. (2009). Midwives' reported practice supporting the first breastfeed. *Maternal & Child Nutrition*, 5(4), 334-346. doi: 10.1111/j.1740-8709.2008.00173.x
- Cooke, M., Schmied, V., & Sheehan, A. (2007). An exploration of the relationship between postnatal distress and maternal role attainment, breast feeding problems and breast feeding cessation in Australia. *Midwifery*, 23(1), 66-76.
- Craig, H. J., & Dietsch, E. (2010). 'Too scary to think about': First time mothers' perceptions of the usefulness of antenatal breastfeeding education. *Women and Birth : Journal of the Australian College of Midwives*, 23(4), 160-165.
- Danforth, K., Tworoger, S., Hecht, J., Rosner, B., Colditz, G., & Hankinson, S. (2007). Breastfeeding and risk of ovarian cancer in two prospective cohorts. *Cancer Causes and Control*, 18(5), 517-523.
- de Oliveira, M. I. C., Camacho, L. A. B., & Tedstone, A. E. (2001). Extending Breastfeeding Duration Through Primary Care: A Systematic Review of Prenatal and Postnatal Interventions. *Journal of Human Lactation*, 17(4), 326-343. doi: 10.1177/089033440101700407
- de Vaus, D. (2002). *Diversity and change in Australian families: Statistical profile*. Canberra: AGPS Retrieved from <http://www.aifs.gov.au/institute/pubs/diversity/DiversityAndChange.pdf>.
- Denis, W. (2006). Subverting the assembly-line: Childbirth in a free-standing birth centre. *Social Science & Medicine*, 62(6), 1330-1340. doi: 10.1016/j.socscimed.2005.08.013
- Dennis, C., Hodnett, E., Gallop, R., & Chalmers, B. (2002). The effect of peer support on breast-feeding duration among primiparous women: a randomized controlled trial. *Canadian Medical Association Journal*, 166(1), 21-28.
- Denzin, N., & Lincoln, Y. (2011). *SAGE Handbook of Qualitative Research* (4th ed.). Thousand Oaks: Sage.
- Department of Health and Ageing. (2009). *Improving Maternity Services in Australia: Report of the Maternity Services Review*. Canberra: Commonwealth of Australia.
- Department of the Environment, Water, Heritage and the Arts (DEWHA). (2009). *Women in Wartime, Culture Portal*. Retrieved 6/7/09, 2009, from <http://www.cultureandrecreation.gov.au/articles/womeninwartime/>
- Dykes, F. (2005). A critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England. *Midwifery*, 21(3), 241-252.

## REFERENCES

- Emmanuel, E., & St John, W. (2010). Maternal distress: a concept analysis. *Journal of Advanced Nursing*, 66(9), 2104-2115. doi: 10.1111/j.1365-2648.2010.05371.x
- Ezzy, D. (2002). *Qualitative Analysis: Practice and Innovation*. Crows Nest: Allen & Unwin.
- Fereday, J., Collins, C., Turnbull, D., Pincombe, J., & Oster, C. (2009). An evaluation of Midwifery Group Practice: Part II: Women's satisfaction. *Women and Birth*, 22(1), 11-16. doi: 10.1016/j.wombi.2008.08.001
- Finlay, L. (2002). "Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*, 12(4), 531-545. doi: 10.1177/104973202129120052
- Gajalakshmi, V., Mathew, A., Brennan, P., Rajan, B., Kanimozhi, V., Mathews, A., . . . Boffetta, P. (2009). Breastfeeding and breast cancer risk in India: A multicenter case-control study. *International Journal of Cancer*, 125(3), 662-665.
- Gartner, L., Morton, J., Lawrence, R., Naylor, A., O'Hare, D., Shanler, R., & Eidelman, A. (2005). Breastfeeding and the Use of Human Milk. *Pediatrics*, 115(2), 496-506. doi: 10.1542/peds.2004-2491
- Gill, S. (2001). The Little Things: Perceptions of Breastfeeding Support. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 30(4), 401-409.
- Gilmour, C., Hall, H., McIntyre, M., Gillies, L., & Harrison, B. (2009). Factors associated with early breastfeeding cessation in Frankston, Victoria: a descriptive study. *Breastfeeding Review*, 17(2), 13-19.
- Glaser, B. (1992). *Emergence Vs. Forcing: Basics of Grounded Theory Analysis*. Mill Valley: Sociological Press.
- Glaser, B., & Strauss, A. (1967). *Discovery of Grounded Theory*. London: AldineTransaction.
- Glaser, B. G. (1978). *Theoretical sensitivity: advances in the methodology of grounded theory*: Sociology Press.
- Gottlieb, B. (1978). The development and application of a classification scheme of informal helping behaviours. *Canadian Journal of Behavioural Science*, 10(2), 105-115.
- Graffy, J., & Taylor, J. (2005). What Information, Advice, and Support Do Women Want With Breastfeeding? *Birth: Issues in Perinatal Care*, 32(3), 179-186.
- Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105-112. doi: 10.1016/j.nedt.2003.10.001
- Grbich, C. (1999). *Qualitative research in health: An introduction*. Sydney: Allen & Unwin.
- Griffiths, L. J., Tate, A. R., Dezateux, C., & Millennium Cohort Study Child Health Group (2005). The contribution of parental and community ethnicity to breastfeeding practices: evidence from

## REFERENCES

- the Millennium Cohort Study. *International Journal of Epidemiology*, 34(6), 1378-1386. doi: 10.1093/ije/dyi162
- Guendelman, S., Kosa, J. L., Pearl, M., Graham, S., Goodman, J., & Kharrazi, M. (2009). Juggling Work and Breastfeeding: Effects of Maternity Leave and Occupational Characteristics. *Pediatrics*, 123(1), e38-46. doi: 10.1542/peds.2008-2244
- Haber, J. (2010). Sampling. In G. LoBiondo-Wood & J. Haber (Eds.), *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice* (7th ed.). Sydney: Mosby.
- Hailes, J. (2000). Support for breastfeeding in the first postpartum month: Perceptions of breastfeeding women. *Breastfeeding Review*, 8(3), 5-9.
- Hall, W. A., & Hauck, Y. (2007). Getting it right: Australian primiparas' views about breastfeeding: A quasi-experimental study. *International Journal of Nursing Studies*, 44(5), 786-795.
- Hannula, L., Kaunonen, M., & Tarkka, M.-T. (2008). A systematic review of professional support interventions for breastfeeding. *Journal of Clinical Nursing*, 17(9), 1132-1143.
- Harris, M., Nayda, R., & Summers, A. (2003). Breasts and Breastfeeding: Perspectives of women in the early months after birth. *Breastfeeding Review*, 11(3), 21-29.
- Hauck, Y., Fenwick, J., Daliwal, S., Butt, J., & Schmied, V. (2011). The Association Between Women's Perceptions of Professional Support and Problems Experienced on Breastfeeding Cessation: A Western Australian Study. *Journal of Human Lactation*, 27(1), 49-57. doi: 10.1177/0890334410386956
- Hauck, Y., Langton, D., & Coyle, K. (2002). The path of determination: exploring the lived experience of breastfeeding difficulties. *Breastfeeding Review*, 10(2), 5-12.
- Hauck, Y. L., Graham-Smith, C., McInerney, J., & Kay, S. (2011). Western Australian women's perceptions of conflicting advice around breast feeding. *Midwifery*, 27(5), e156-e162. doi: 10.1016/j.midw.2010.02.003
- Hauck, Y. L., & Irurita, V. F. (2003). Incompatible Expectations: The Dilemma of Breastfeeding Mothers. *Health Care for Women International*, 24(1), 62.
- Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies*, 41, 141-150.
- Hegney, D., Fallon, T., & O'Brien, M. L. (2008). Against all odds: a retrospective case-controlled study of women who experienced extraordinary breastfeeding problems. *Journal of Clinical Nursing*, 17(9), 1182-1192.
- Henderson, J., & Redshaw, M. (2011). Midwifery factors associated with successful breastfeeding. *Child: Care, Health and Development*, 37(5), 744-753. doi: 10.1111/j.1365-2214.2010.01177.x
- Hirst, C. (2005). *Re-birthing: Report of the Review of Maternity Services in Queensland*. Retrieved from

## REFERENCES

- [http://www.health.qld.gov.au/publications/corporate/maternity\\_report2005/MaternityReview\\_FullDoc.pdf](http://www.health.qld.gov.au/publications/corporate/maternity_report2005/MaternityReview_FullDoc.pdf)
- Hoddinott, P., & Pill, R. (1999). Qualitative study of decisions about infant feeding among women in east end of London. *BMJ*, 318(7175), 30-34. doi: 10.1136/bmj.318.7175.30
- Hoddinott, P., & Pill, R. (2000). A qualitative study of women's views about how health professionals communicate about infant feeding. *Health Expectations*, 3(4), 224-233.
- Holloway, L., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Oxford: Blackwell.
- House, J. (1981). *Work, Stress and Social Support*. Boston: Addison-Wesley.
- House of Representatives Standing Committee on Health and Ageing. (2007). *The Best Start: Report on the enquiry into the health benefits of breastfeeding*. Canberra: AGPS.
- Ingram, J. (2006). Multiprofessional training for breastfeeding management in primary care in the UK. *International Breastfeeding Journal*, 1(9). doi: 10.1186/1746-4358-1-9
- International Lactation Consultant Association. (2005). *Clinical Guidelines for the Establishment of Exclusive Breastfeeding*. Retrieved from <http://www.ilca.org/files/resources/ClinicalGuidelines2005.pdf>
- iStockphoto.com. (2012). *Mon juggling*. Retrieved from <http://www.istockphoto.com/stock-illustration-1949270-mom-juggling.php>
- Karen, M., Chris, M., Kristin, W., Michael, J., Philip, P., Tristram, L., . . . Town, G. I. (2009). Breastfeeding protects against adverse respiratory outcomes at 15 months of age. *Maternal & Child Nutrition*, 5(3), 243-250.
- Kelleher, C. (2006). The physical challenges of early breastfeeding. *Social Science & Medicine*, 63(10), 2727-2738.
- Kennedy, H., Anderson, T., & Leap, N. (2010). Midwifery Presence: Philosophy, Science and Art. In D. Walsh & S. Downe (Eds.), *Essential Midwifery Practice: Intrapartum Care* (pp. 105-123). Oxford: Blackwell.
- Kervin, B., Kemp, L., & Pulver, L. (2010). Types and timing of breastfeeding support and its impact on mothers' behaviours. *Journal of Paediatrics and Child Health*, 46(3), 85-91. doi: 10.1111/j.1440-1754.2009.01643.x
- Khoury, A., Hinton, A., Mitra, A., Carothers, C., & Foretich, C. (2002). Improving breastfeeding knowledge, attitudes, and practices of WIC clinic staff. *Public Health Reports*, 117(5), 453-462.
- Kools, S., McCarthy, M., Durham, R., & Robrecht, L. (1996). Dimensional Analysis: Broadening the Conception of Grounded Theory. *Qualitative Health Research*, 6(3), 312-330. doi: 10.1177/104973239600600302



## REFERENCES

- Kramer, M. S., Chalmers, B., Hodnett, E. D., Sevkovskaya, Z., Dzikovitch, I., Shapiro, S., . . . for the, P. S. G. (2001). Promotion of Breastfeeding Intervention Trial (PROBIT): A Randomized Trial in the Republic of Belarus. *JAMA*, 285(4), 413-420. doi: 10.1001/jama.285.4.413
- Kronborg, H., Væth, M., Olsen, J., Iversen, L., & Harder, I. (2007). Effect of early postnatal breastfeeding support: a cluster-randomized community based trial. *Acta Paediatrica*, 96(7), 1064-1070. doi: 10.1111/j.1651-2227.2007.00341.x
- Kruske, S., Schmied, V., & Cook, M. (2007). The 'Earlybird' gets the breastmilk: findings from an evaluation of combined professional and peer support groups to improve breastfeeding duration in the first eight weeks after birth. *Maternal & Child Nutrition*, 3(2), 108-119.
- Labbok, M., & Krasovec, K. (1990). Toward Consistency in Breastfeeding Definitions. *Studies in Family Planning*, 21(4), 226-230.
- Ladomenou, F., Moschandreas, J., Kafatos, A., Tselentis, Y., & Galanakis, E. (2010). Protective effect of exclusive breastfeeding against infections during infancy: a prospective study. *Archives of Disease in Childhood*, 95, 1004-1008. doi: 10.1136/adc.2009.169912
- Larsen, J., Hall, E., & Aagaard, H. (2008). Shattered expectations: when mothers' confidence in breastfeeding is undermined &#x2013; a metasynthesis. *Scandinavian Journal of Caring Sciences*, 22(4), 653-661.
- Lester, I. (1994). *Australia's Food and Nutrition*. Canberra: AGPS Retrieved from <http://www.aihw.gov.au/publications/aus/afn94/afn94.pdf>.
- Lewallen, L., Dick, M., Flowers, J., Powell, W., Zickefoose, K., Wall, Y., & Price, Z. (2006). Breastfeeding Support and Early Cessation. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(2), 166-172.
- Lewis, M. (1980). The Problem of Infant Feeding: The Australian Experience from the Mid-Nineteenth Century to the 1920s. *J Hist Med Allied Sci*, XXXV(2), 174-187. doi: 10.1093/jhmas/XXXV.2.174
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. London: Sage.
- LoBiondo-Wood, G. (2010). Introduction to qualitative research. In G. LoBiondo-Wood & J. Haber (Eds.), *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice* (7th ed.). Sydney: Mosby.
- Lofland, J. (1970). Interactionist imagery and analytic interruptus. In T. Shibutani (Ed.), *Human nature and collective behavior: Papers in honor of Herbert Blumer* (pp. 35-45). New Jersey: Transaction.
- Lumbiganon, P., Martis, R., Laopaiboon, M., Festin, M., Ho, J., & Hakimi, M. (2011). Antenatal breastfeeding education for increasing breastfeeding duration. *Cochrane Database of Systematic Reviews*. Retrieved from doi:10.1002/14651858.CD006425.pub2
- Marshall, C., & Rossman, G. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks: Sage.



## REFERENCES

- Martin, R. M., Gunnell, D., Owen, C. G., & Davey Smith, G. (2005). Breast-feeding and childhood cancer: A systematic review with metaanalysis. *International Journal of Cancer*, 117(6), 1020-1031.
- Maternity Coalition. (2011). *Maternity Coalition: every woman, every choice*. Retrieved 20/10/11, 2011, from <http://www.maternitycoalition.org.au/home/modules/content/?id=1>
- Mayer-Davis, E., Rifas-Shiman, S., Zhou, L., Hu, F., Colditz, G., & Gillman, M. (2006). Breast-Feeding and Risk for Childhood Obesity. *Diabetes Care*, 29(10), 2231-2237. doi: 10.2337/dc06-0974
- Mays, N., & Pope, C. (1995). Qualitative Research: Rigour and qualitative research. *BMJ*, 311(6997), 109-112. doi: 10.1136/bmj.311.6997.109
- McGhee, G., Marland, G. R., & Atkinson, J. (2007). Grounded theory research: literature reviewing and reflexivity. *Journal of Advanced Nursing*, 60(3), 334-342.
- McInnes, R., & Chambers, J. (2008). Supporting breastfeeding mothers: qualitative synthesis. *Journal of Advanced Nursing*, 62(4), 407-427.
- McVeigh, C. (1997). Motherhood Experiences from the Perspective of First-Time Mothers. *Clinical Nursing Research*, 6(4), 335-348. doi: 10.1177/105477389700600404
- Merriam-Webster. (2011). *Merriam-Webster online dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/midwife>
- Millward, C. (1996). *Aspects of Grandparenting*. Paper presented at the Fifth Australian Family Research Conference, Brisbane.
- Minichiello, V., Aroni, R., & Hays, T. (2008). *In-depth interviewing: principles, techniques, analysis* (3rd ed.). Sydney: Pearson.
- Moran, V., Dykes, F., Burt, S., & Shuck, C. (2006). Breastfeeding support for adolescent mothers: similarities and differences in the approach of midwives and qualified breastfeeding supporters. *International Breastfeeding Journal*, 1(1), 23.
- Mulder, P. (2006). A Concept Analysis of Effective Breastfeeding. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(3), 332-339.
- Munhall, P. (2011). *Nursing research: A qualitative perspective*. London: Jones and Bartlett.
- National Health and Medical Research Council. (1999). *National Statement on Ethical Conduct in Human Research*. Canberra: AGPS.
- National Health and Medical Research Council. (2003). *Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers*. Canberra: AGPS.
- National Health and Medical Research Council. (2008). *NHMRC additional levels of evidence and grades for recommendations for developers of guidelines: Stage 2 consultation*. Canberra:

## REFERENCES

- NHMRC Retrieved from  
[http://www.nhmrc.gov.au/guidelines/\\_files/Stage%20%20Consultation%20Levels%20and%20Grades.pdf](http://www.nhmrc.gov.au/guidelines/_files/Stage%20%20Consultation%20Levels%20and%20Grades.pdf).
- National Health and Medical Research Council. (2009). *National Statement on Ethical Conduct of Research Involving Humans*. Canberra: AGPS.
- Nelson, A. M. (2006). A Metasynthesis of Qualitative Breastfeeding Studies. *Journal of Midwifery & Women's Health*, 51(2), e13-e20.
- Nelson, A. M. (2007). Maternal-newborn nurses' experiences of inconsistent professional breastfeeding support. *Journal of Advanced Nursing*, 60(1), 29-38. doi: 10.1111/j.1365-2648.2007.04373.x
- Nestlé. (n.d.). *Baby Milk Issue Facts: History*. Retrieved 2/7/09, 2009, from  
<http://www.babymilk.nestle.com/History/>
- O'Brien, M., Buikstra, E., Fallon, T., & Hegney, D. (2009). Exploring the Influence of Psychological Factors on Breastfeeding Duration, Phase 1: Perceptions of Mothers and Clinicians. *J Hum Lact*, 25(1), 55-63. doi: 10.1177/0890334408326071
- Okamura, C., Tsubono, K., Niikura, H., Takano, T., Nagase, S., Yoshinaga, K., . . . Yaegashi, N. (2006). Lactation and Risk of Endometrial Cancer in Japan: A Case-Control Study. *The Tohoku Journal of Experimental Medicine*, 208(2), 109-115.
- Owen, C. G., Martin, R. M., Whincup, P. H., Smith, G. D., & Cook, D. G. (2006). Does breastfeeding influence risk of type 2 diabetes in later life? A quantitative analysis of published evidence. *Am J Clin Nutr*, 84(5), 1043-1054.
- Pembroke, N., & Pembroke, J. (2008). The spirituality of presence in midwifery care. *Midwifery*, 24(3), 321-327. doi: 10.1016/j.midw.2006.10.004
- Petryk, A., Harris, S. R., & Jongbloed, L. (2007). Breastfeeding and Neurodevelopment: A Literature Review. *Infants & Young Children*, 20(2), 120-134  
 110.1097/1001.IYC.0000264480.0000227947.0000264416.
- Phillips, K. (2011). First-Time Breastfeeding Mothers: Perceptions and Lived Experiences with Breastfeeding. *International Journal of Childbirth Education*, 26(3), 17-20.
- Polit, D., & Hungler, B. (2004). *Nursing Research: Principles and methods* (7th ed.). Philadelphia: Lippincott.
- Polit, D., & Beck, C. (2006). *Essentials of nursing research: methods, appraisal, and utilization*. New York: Lippincott Williams & Wilkins.
- QSR International. (2006). *NVivo qualitative data analysis software: Version 7*, from  
[http://www.qsrinternational.com/products\\_nvivo.aspx](http://www.qsrinternational.com/products_nvivo.aspx)

## REFERENCES

- Raisler, J. (2000). Against the odds: breastfeeding experiences of low income mothers. *Journal of Midwifery & Women's Health*, 45(3), 253-263.
- Rayner, J., Forster, D., McLachlan, H., Yelland, J., & Davey, M. (2008). A state-wide review of hospital postnatal care in Victoria, Australia: The views and experiences of midwives. *Midwifery*, 24(3), 310-320. doi: 10.1016/j.midw.2006.10.008
- Rees, C. (2003). *Introduction to research for midwives* (2nd ed.). Sydney: Books for Midwives.
- Reiger, K. (2006). A neoliberal quickstep: contradictions in Australian maternity policy. *Health Sociology Review*, 15(4), 330 - 340.
- Rovers, M., Schilder, A., Zielhuis, G., & Rosenfeld, R. (2004). Otitis media. *Lancet*, 363(9407), 465-473.
- Sandall, J., Page, L., Homer, C., & Leap, N. (2008). Continuity of care-what is the evidence. In C. Homer, P. Brody & N. Leap (Eds.), *Midwifery continuity of care: A practical guide*. Sydney: Churchill Livingstone.
- Sarasua, I., Clausen, C., & Frunchak, V. (2009). Mothers' experiences with breastfeeding management and support: a quality improvement study.(Research)(Report). *Breastfeeding Review*, 17(1), 19(19).
- Schack-Nielsen, L., & Michaelsen, K. (2006). Breast feeding and future health. *Current Opinion in Clinical Nutrition & Metabolic Care*, 9(3), 289-296
- Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the rounding of theory in qualitative research. In D. Maines (Ed.), *Social organisation and social process: Essays in honour of Anselm Strauss* (pp. 303-314). New York: Aldine.
- Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2011). Women's Perceptions and Experiences of Breastfeeding Support: A Metasynthesis. *Birth*, 38(1), 49-60. doi: 10.1111/j.1523-536X.2010.00446.x
- Schmied, V., Sheehan, A., & Barclay, L. (2001). Contemporary breast-feeding policy and practice: implications for midwives. *Midwifery*, 17(1), 44-54. doi: 10.1054/midw.2000.0234
- Schmied, V., Sheehan, A., McCourt, C., Dykes, F., Beake, S., & Bick, D. (2008). *Women's perceptions and experiences of breastfeeding support: A meta-synthesis of qualitative research (Review)*. Retrieved June 9, 2009, from Joanna Briggs <https://www.joannabriggs.edu.au/protocols/Protocol208.pdf>
- Schreiber, R., & Stern, P. (2001). *Using grounded theory in nursing*. New York: Springer.
- Schwandt, T. (2007). *The SAGE dictionary of qualitative inquiry*. London: Sage.
- Scott, J., & Colin, W. (2002). Breastfeeding: reasons for starting, reasons for stopping and problems along the way. *Breastfeeding Review*, 10(2), 13-19.

## REFERENCES

- Scott, J. A., Binns, C. W., Oddy, W. H., & Graham, K. I. (2006). Predictors of Breastfeeding Duration: Evidence From a Cohort Study. *Pediatrics*, 117(4), e646-655. doi: 10.1542/peds.2005-1991
- Scott, J. A., & Mostyn, T. (2003). Women's Experiences of Breastfeeding in a Bottle-Feeding Culture. *Journal of Human Lactation*, 19(3), 270-277. doi: 10.1177/0890334403255225
- Semenic, S., Loiselle, C., & Gottlieb, L. (2008). Predictors of the duration of exclusive breastfeeding among first-time mothers. *Research in Nursing & Health*, 31(5), 428-441. doi: 10.1002/nur.20275
- Sheehan, A., Schmied, V., & Barclay, L. (2009). Women's experiences of infant feeding support in the first 6 weeks post-birth. *Maternal & Child Nutrition*, 5(2), 138-150.
- Smith, P. M. (1993). Mothers, Babies, and the Mothers and Babies Movement: Australia Through Depression and War. *Soc Hist Med*, 6(1), 51-83. doi: 10.1093/sochis/6.1.51
- Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. London: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of Qualitative Research: Grounded theory procedures and techniques* (2nd ed.). Thousand Oaks: Sage.
- Streubert Speziale, H., & Carpenter, D. (2007). *Qualitative research in nursing: advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott Williams and Wilkins.
- Su, L., Chong, Y., Chan, Y., Chan, Y., Fok, D., Tun, K., . . . Rauff, M. (2007). Antenatal education and postnatal support strategies for improving rates of exclusive breast feeding: randomised controlled trial. *BMJ*, 335(7620), 596-. doi: 10.1136/bmj.39279.656343.55
- support. (2009a). *Merriam-Webster Online Dictionary*. Retrieved 25/6/09, from <http://www.merriam-webster.com/dictionary/support>
- support. (2011). *yourdictionary.com*. Retrieved from <http://www.yourdictionary.com/support>
- Tender, J., Janakiram, J., Arce, E., Mason, R., Jordan, T., Marsh, J., . . . Moon, R. Y. (2009). Reasons for In-Hospital Formula Supplementation of Breastfed Infants From Low-Income Families. *J Hum Lact*, 25(1), 11-17. doi: 10.1177/0890334408325821
- Thirsted, R. (1998). *The recall of stressful events*. Retrieved from <http://galton.uchicago.edu/~s226/Handouts/samprep.html>
- Thorsdottir, I., Gunnarsdottir, I., Kvaran, M. A., & Gretarsson, S. J. (2005). Maternal body mass index, duration of exclusive breastfeeding and children's developmental status at the age of 6 years. *Eur J Clin Nutr*, 59(3), 426-431.
- Van Esterik, P. (2008). The politics of breastfeeding: an advocacy update. In C. Counihan & P. Van Esterik (Eds.), *Food and culture: a reader* (2nd ed.). New York: Routledge.
- Vectorstock. (2011). *Housewife Vector*. Retrieved from

## REFERENCES

- <http://www.vectorstock.com/royalty-free-vector/housewife-vector-43871>
- Verhasselt, V., Milcent, V., Cazareth, J., Kanda, A., Fleury, S., Dombrowicz, D., . . . Julia, V. (2008). Breast milk-mediated transfer of an antigen induces tolerance and protection from allergic asthma. *Nat Med*, 14(2), 170-175.
- Uchino, B. (2004). *Social Support and Physical Health: Understanding the Health Consequences of Relationships*. New Haven: Yale University Press.
- UNICEF. (2011). *Seven Point Plan*. Retrieved from <http://www.unicef.org.uk/BabyFriendly/Health-Professionals/Going-Baby-Friendly/Community/Seven-Point-Plan-for-Sustaining-Breastfeeding-in-the-Community/>
- Wade, D., Haining, S., & Day, A. (2009). Breastfeeding peer support: are there additional benefits? *Community Practitioner*, 82(12), 30-33.
- Waldenstrom, U. (2003). Women's memory of childbirth at two months and one year after the birth. *Birth*, 30(4), 248-254.
- Waldenström, U. (2004). Why Do Some Women Change Their Opinion About Childbirth Over Time? *Birth*, 31(2), 102-107. doi: 10.1111/j.0730-7659.2004.00287.x
- Waltemyer, C. (2008). Take baby steps to reach breastfeeding goals. *Nursing*, 38(9), 21-22.
- Watkins, A. L., & Dodgson, J. E. (2010). Breastfeeding Educational Interventions for Health Professionals: A Synthesis of Intervention Studies. *Journal for Specialists in Pediatric Nursing*, 15(3), 223-232. doi: 10.1111/j.1744-6155.2010.00240.x
- Wickham, M., & Woods, M. (2005). *The Qualitative Report*. 10(4), 687-702. Retrieved from <http://www.nova.edu/ssss/QR/QR10-4/wickham.pdf>
- Williams, K., Lago, L., Lainchbury, A., & Eagar, K. (2010). Mothers' views of caseload midwifery and the value of continuity of care at an Australian regional hospital. *Midwifery*, 26(6), 615-621. doi: 10.1016/j.midw.2009.02.003
- Williams, P., Barclay, L., & Schmied, V. (2004). Defining Social Support in Context: A Necessary Step in Improving Research, Intervention, and Practice. *Qualitative Health Research*, 14(7), 942-960. doi: 10.1177/1049732304266997
- Wills, T. (1985). Supportive functions of interpersonal relationships. In S. Cohen & L. Syme. *Social support and health* (pp.61-82). Orlando: Academic Press.
- Wilson, G. (2009). Implementation of releasing time to care – the productive ward. *Journal of Nursing Management*, 17(5), 647-654. doi: 10.1111/j.1365-2834.2009.01026.x
- World Health Organisation. (1991). *Indicators for assessing breastfeeding practices*. Retrieved from [http://whqlibdoc.who.int/hq/1991/WHO\\_CDD\\_SER\\_91.14.pdf](http://whqlibdoc.who.int/hq/1991/WHO_CDD_SER_91.14.pdf)
- World Health Organisation. (2002). *The optimal duration of exclusive breastfeeding: A Systematic Review*. Geneva: World Health Organisation.

## REFERENCES

- World Health Organisation. (2007). *Evidence on the long-term effects of breastfeeding: systematic reviews and meta-analyses*. Geneva: World Health Organisation.
- World Health Organisation. (2009). *Acceptable medical reasons for use of breast-milk substitutes*. Geneva: World Health Organisation.
- World Health Organisation, & UNICEF. (1989). *Protecting, promoting and supporting breastfeeding: the special role of maternity services*. Geneva: World Health Organisation.
- World Health Organisation, & UNICEF. (2009). *Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care*. Geneva: World Health Organisation.
- Yee, B. (2001). *Enhancing security: A grounded theory of Chinese survival in New Zealand*. Retrieved from <http://www.bevenyee.com/phd2-1a.html>