The breast or bottle? Women's infant feedings choices in a subsequent birth after a previous Caesarean Section

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ABSTRACT

Objective
The objective of the study was to explore, from mothers' perspectives, the experiences and decision-making associated with a subsequent birth following a Caesarean Section (CS) of which feeding their newborns was a specific focus. This article presents the sub-set of findings on infant feeding choices.

Design
A qualitative methodological framework, utilizing descriptive phenomenology.

Setting
A maternity hospital in Brisbane, Australia.

Participants
Twenty women who had given birth at Redland Hospital after experiencing a previous CS were invited to participate.

Data Collection Techniques
Tape recorded interviews were conducted six weeks postpartum.

Results
The findings identify that mothers fell into three different attitudinal groups regarding their decision-making with respect to feeding their newborn. The first perspective was based on a strong commitment to breastfeeding, which was often maintained in the face of quite significant difficulties. The second perspective was a complete refusal to breastfeed and a clear decision to bottle feed made prior to the birth and adhered to irrespective of alternative advice or persuasion. The third perspective was an initial desire to breastfeed that was easily thwarted by difficulties. The findings emphasise the importance of facilitating for CS births an environment that promotes bonding and breastfeeding by ensuring, where possible, that there is no separation of mother and baby after the birth, maximum opportunity for skin-to-skin contact, time for the mother to breastfeed the baby in the period immediately after the birth and no supplementation of breastfeeding with formula.

Conclusions
The success of the midwife or maternity nurse in relation to supporting breastfeeding was, in part, impacted on by the mother's pre-determined approach to feeding the newborn. Breastfeeding support for attitudinal groups one and three were most likely to be successful, while the second group was refractory to nursing breastfeeding assistance.

INTRODUCTION

The benefits of breastfeeding for the health and emotional well-being of children, and the health of mothers, have been well documented (Day 2004). The medical and sociological literature overwhelmingly supports and encourages breastfeeding wherever possible. This is an issue of recognised global significance, with the position of the World Health Organisation (2008) as follows:

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breastfed (1) for the first six months of life to achieve optimal growth, development and health (2). Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

In Australia, breastfeeding is an issue of national significance, although the states and territories have varied in their translations of this recommendation. In Queensland, the current State Government (Queensland Health) recommendation is that babies be breastfed exclusively for the first six months of life, with family foods introduced at this age in addition to continued breastfeeding to at least 12 months and after that for as long as mutually desired (QH 2008).

Yet despite these clear recommendations and guidelines, the chances of an Australian infant receiving optimum nourishment in their first years of life is presently less than one per cent.[1] Grille (2005) argues the global retreat from breastfeeding is one instance in which evolution in parenting has gone backwards. This is concerning, given the documented benefits of breastfeeding for both infants and their mothers and thus the association between full-term breastfeeding and reduced public health costs (Palmer 1988).

This paper presents the findings of research which explored the experiences and decisions, from mothers' perspectives, of feeding their newborns following a birth subsequent to a birth by Caesarean Section (CS). The findings identified mothers as being of one of three pre-disposed approaches with respect to feeding their newborns. It is anticipated that an understanding of these different attitudinal groups will enhance midwives' ability to tailor their care of such mothers in the initial post-partum period insofar as such care pertains to assisting mothers with the feeding of their infants.

METHODS

The Research

The study was conducted by a senior research fellow at the Central Queensland University (CQUniversity) in association with the then Director of Obstetrics and Gynaecology at Redland Hospital (Hospital), Queensland. The study was funded by a Hospital/CQUniversity Industry Grant.

Aims and Objectives

The aim of the research was to explore from the mothers' perspective the experience and process of decision-making associated with a subsequent birth after a previous CS. The focus on the birth experience included the topic of feeding the newborn. The findings from the study are rich and dense and will be published separately as a number of articles. The findings presented in this article are from the data that describes the mothers' experience with feeding their baby following the birth. The objective in presenting these findings and identifying different attitudinal groups, is to enhance midwives' ability to tailor their assistance of mothers with feeding their infants in the initial post-partum period.

Methodology

Descriptive phenomenology was chosen as the theoretical framework as it underpins a research method that explores the 'lived experience' of people from the 'inside' perspective of the individuals involved in the experience (Holloway

[1] The Australian Bureau of Statistics has documented that only one per cent of children are breastfed until two years of age (ABS 2003). This is the minimum length of time that is considered 'full term' breastfeeding by the World Health Organisation (WHO 2008).

2008). As Spiegelberg (1975) explains, descriptive phenomenology is the 'direct exploration, analysis, and description of particular phenomena, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation'. In this case, the phenomenon is mothers' lived experience with regard to the experience and decision-making associated with delivery and newborn feeding for a subsequent birth following a CS. As inductive, phenomenological, qualitative work, the reporting of findings is based on a commitment to the participants' point of view with the researcher playing the role of co-participant in the discovery and understanding of what the realities are of the phenomena studied (Sorrell and Redmond 1995; Streubert and Carpenter 1995).

Participants

Twenty women who gave birth at a maternity hospital in Brisbane were invited to participate in the study in June 2008. Women were eligible to participate if they had experienced a Caesarean Section subsequent to this pregnancy. The sub-section of findings presented in this article are from interviews with all of the 20 women, conducted in June 2008, six weeks after the subsequent birth. Of these 20 women, two had vaginal births (VBAC), two attempted VBAC and 16 chose elective CS (EC).

The participants were enrolled through the Project Officer for the study who was under contract with CQUniversity and thus independent of the Hospital. The mothers were notified of the study by a letter from the Head of the maternity department. The Project Officer was provided by the hospital with a list of mothers who fitted the criteria, along with their telephone numbers. The participants were consecutively enrolled from this list, through an initial telephone call, followed by the Project Officer providing written Project Descriptions of the project and an invitation for voluntary participation in the research. At this stage signed consent forms from the participants were collected and enrolment occurred. There was no screening of participants. Prior to interviewing, participants were again informed of their ethical rights (e.g., informed consent, confidentiality, right to withdraw). Ethical consent to conduct the study was obtained from the CQUniversity Human Research Ethics Committee and the HREC of the Hospital. Participants were verbally informed of their rights in research and written consent was obtained for participation in the research.

Demographics

Prior to this last birth experience, 13 women had experienced an emergency CS and seven had an EC. At the time of the interview, 17 mothers had two children, one mother had four children and two mothers had three children. All participants were either married or in a de-facto relationship at the time of birth. The participants' mean age was 32 years, with an age range of 26 to 38 years. All of the women lived in the geographical catchment area of the Hospital.

Interviews

The data collection was conducted through an iterative, phenomenological, qualitative research methodology using open-ended interviews conducted at the time and location of each participant's choice (Holloway 2008). The interviews were conducted by a psycho-social researcher employed by CQUniversity and thus independent of the Hospital. The interviews were informed by the principles of 'phenomenological reflection' as outlined in the work of Van Manen (1990). The line of questioning included the techniques of probing, paraphrasing and silence to explore each participant's experience. The interviews lasted for approximately one hour and were audio-recorded. The interviews were transcribed verbatim by a research assistant independent of the Hospital.

Analysis

The language texts were then entered into the QSR NUD*IST computer program and analysed thematically. All of the participants' comments were coded into 'free nodes' which are category files that have not been pre-organised but are 'freely' created from the data. Thus the data analysis is driven by all of the participants' insights, not by selected pre-assumptions of the coders. The research team did not mediate the findings but rather developed code titles that directly reflect the participants'

statements ensuring the final analysis directly describes the phenomenon (birth decision-making) from the participants' perspective. The coding was established by an experienced qualitative researcher and completed by a team of research assistants who have extensive experience coding qualitative data. There was complete agreement on the coding and emergent themes. The list of codes was then transported to a Word Computer Program (Word XP) and organised under thematic headings. The findings presented in this article are from the data that describes the mothers' experience with feeding their baby following the birth.

FINDINGS

The women's descriptions about their experience of feeding their newborn are easily divisible into three attitudinal groups. The first set of descriptions provided are from women who were strongly motivated to achieve a vaginal birth and to breastfeed and were prepared to overcome early difficulties with establishing feeding. The second set of descriptions are from mothers who prior to the birth were determined not to breastfeed, with this position maintained irrespective of professional or other advice. The third group initially attempted breastfeeding but quickly elected to artificially feed their baby after the birth when faced with obstacles. For clarity, the statements from the different groups will be presented separately. In order to enrich the presentation of findings, the mode of birth of the mother making the statements will be indicated as follows - elective Caesarian (EC); initially tried for VBAC but ended in emergency Caesar (TVBAC); Vaginal Birth After Caesarean (VBAC).

Group 1 - Strong desire to breastfeed

The mothers in the first group strongly expressed views that they considered breastfeeding a positive experience that helped to address a sense of disappointment associated with a birth by CS. Such mothers attained satisfaction from breastfeeding, as the following response demonstrates:

- (TVBAC) And I'm back at work now but I'm still feeding so I'm really happy that I can do that [breastfeeding]. Yes, so if nothing else I have that. So I'm happy about that [laughs].

The mothers in this group expressed their satisfaction with the provision of help and support for breastfeeding and found the initial assistance from midwives at the hospital very helpful:

- (TVBAC) Yes I'm still feeding. Yes, [the midwives were] really good and they didn't mind coming to help me with how to put her on and show me exactly how it worked. It was good, yeah.

In comparison to the reports of bottle feeding mothers, provided below, who preferred ease and convenience, the stories of the breastfeeding mothers were characterized by perseverance and a continuing commitment to breastfeeding. An appreciation of the support of midwives in initiating breastfeeding was evident. These characteristics are summed up in the following statement:

- (TVBAC) Ah, no, they [midwives] did help. I had a lot of attachment issues too. Like either I wasn't attaching him properly or he couldn't attach - you know how their mouths are so little. And of course my nipple was so big that, yeah, there was a lot of problems with that. And I had like bleeding, sore sort of nipples. But I persevered, we got there eventually [laughs].

There were descriptions from this group of mothers of being well-informed on the topic of breastfeeding. Associated with this was an expressed disappointment that hospital staff did not emphasise enough the negative impact of a CS on breastfeeding; for example:

- (VBAC) I've just read so much... But there's certain things that sometimes, I guess, like breastfeeding issues that they don't often tell you it can be harder to do when you've had a caesarean.

For this group of mothers, a key factor in their consideration of how to feed their newborn is what is best for their baby. The following comment is indicative of the sentiments of this group in this regard:

- (VBAC) Certainly, it is about giving your baby a better chance.

Group 2 - Decision not to breastfeed from the start

There were many mothers who made clear and definite statements that they did not even entertain the idea of breastfeeding. As the following examples demonstrate, for these mothers their intent was always to bottle feed:

- (EC) Yes I did decide right from the start that I would go straight to the bottle with this baby.
- (EC) Yes I did indicate that I wanted to bottle feed from the beginning this time and I felt so much happier this time round.

As can be seen by the following description, for these women the decision is final and not subject to what they perceive as pressure to breastfeed, even from close friends or family, as the following responses exemplify:

- (EC) But they [friends] just did say 'do you not want to try? Are you sure you don't want to try and breastfeed them'. You know, every day I was having to say, 'No, you know, I've made my mind up'.
- (EC) My mother-in-law had a bit of chip about the breastfeeding. But she couldn't help herself. She's a bit like that. I just ignore her [laugh].

Some mothers in this group reported that electing to artificially feed their infant did not diminish their self-esteem in their mothering role:

- (EC) And I haven't felt insignificant or less of a woman because of it [bottle feeding]. That sort of thing never bothered me, I've been lucky there. I know it gets to a lot of women... But, no, it didn't get to me.

However, some mothers perceived that others who believed in breastfeeding may not be approving of their approach and this impacted upon them:

- (EC) ... you can be really made to feel like you've got to breastfeed. Some people made me feel like I was copping out of it or I should go through that feeling tired [this mother primarily associated breastfeeding with feelings of tiredness].

The mothers from this group did not appreciate any pressure from the midwives to breastfeed, as one participant stated:

- (EC) They said to me 'oh your son is ready for a feed' and they popped him on me. I said 'no, no I'm bottle feeding' and the midwife said 'don't you mean artificial feeding?' I just thought, 'oh well who are they to tell me what to do anyway really'.

Similarly, another participant stated:

- (EC) And I also wanted to bottle feed, not breastfeed so I had that rammed down my throat from nursing and medical staff as well which really annoyed me.

Group 3 - Quickly turned to bottle feeding when faced with obstacles

The third group of mothers were initially motivated to try breastfeeding but elected to cease breastfeeding when they found bottle feeding easier. The general sentiments in relation to the importance of opting for the easier process expressed by this group are summarised by the following response:

- (EC) But I just gave up the ghost in the end and I thought 'na, it's not worth it', not fair on her [toddler] and it's not fair on me... [toddler] running around while I'm trying to breastfeed her. And it was just too much easier to put her [newborn] on the bottle.

This group of mothers communicated a sense of lack of knowledge about breastfeeding:

- (EC) I think that was because I didn't know how to look after my breasts and such things I suppose.

When they experienced the common problems associated with establishing breastfeeding such as blisters or bleeding nipples and concerns about quantity and quality of milk supply, the response to these problems was not to persevere but rather to change to the easy option of bottle feeding. As one participant stated:

- (EC) But he just wasn't getting enough, my milk wasn't coming through. And then they suggested to me that I could keep trying and trying and trying and eventually it will come through. But because it was very stressful. Just put him on the bottle.

Like other mothers, some mothers in this group were given inappropriate advice about breastfeeding, lacked support from family, or were encouraged by family members to give up breastfeeding for the 'easier' option of bottle feeding.

There was a clear message from this group of mothers that breastfeeding was not enjoyable:

- (EC) Then trying to get me to breastfeed and in the end I, after a few days, put him on the bottle. I didn't enjoy any of it.

Some of the third group of mothers who discontinued breastfeeding at an early stage reported that the midwives were helpful in their approach to breastfeeding, for example:

- (EC) They did help me with the breastfeeding and I did breastfeed for the five days.

However, most were very negative about the perceived pressure they felt from the midwives to breastfeed:

- (EC) And you know they do push sometimes. So everywhere you look - you walk into hospital everywhere you look posters: 'Breast is Best'. And you know pictures of the babies feeding. And how you're supposed to do it. They give you big manuals on how to do it. And it's like 'oh gee it's very daunting'. Some nurses are great, they'll say 'it's your choice'.

It was reported, to avoid the pressure of midwives, some mothers initially breastfeed in hospital and changed to artificial feeding immediately upon discharge:

- (EC) I think a lot of mothers breastfeed in the hospital purely so they don't have to listen to it. You know what I mean? A few of my friends have come out of hospital or breastfed for the two weeks and then 'oh stuff this' and put 'em [baby] on a bottle.

Others avoided the midwives' assistance:

- (EC) I don't know what happened but something went wrong so I just gave up in the end. I didn't consult nurses or midwives or anyone 'cause they all try and get you to breastfeed too much.

Some participants indicated that, although preferring breastfeeding, the midwives could be accommodating of bottle feeding mothers:

- (EC) They're [midwives] are a lot better about it. They are a lot more accommodating now than when I had my first child. They sort of refused to help me back then. Whereas now they were more likely to assist me if I needed it.

Bottle feeding seen as easier and more convenient option

For mothers in the second and third groups, bottle feeding was preferred on the basis that it was seen as easier and more convenient for the mother:

- (EC) Much, much easier I think because I was a bit more in control... I wouldn't be battling away trying to feed him while I was tired with stitches.

Reasons proffered by the mothers as underpinning their consideration in this regard included the belief that conditions ranging from tiredness to post-natal depression were less likely to be suffered, physical discomfort associated with breastfeeding and ease in management of young siblings. As one participant explained:

- (EC) See so many mums really struggling with their [breast] feeding and just being so tired and crying and getting depressed [after a vaginal birth]. I didn't want that with a two year old around. I guess I just took the approach that I knew was going to cause the least problems and was comfortable.

For another participant, bottle feeding allowed the mother to take 'breaks' from their infant more easily and thus minimised tiredness:

- (EC) ... but you know if I was tired I could drop him off somewhere with a bottle and just say: 'I need a break'.

Factors associated with the experience of a CS that impact on breastfeeding

The mothers listed a number of factors associated with the Caesarian experience which interfered with breastfeeding. These factors were brought about by the medicalised nature of a CS birth, which precluded the mother from engaging in a more 'natural' birth experience of which breastfeeding was part. First was the delay in putting the baby to the breast for the first time:

- (EC) I couldn't feed him obviously for a very long time until I was completely myself kind of thing. So I don't think he got fed until the second day at the hospital.

As another mother stated, the delay in putting the infant to the breast, coupled with the separation from the baby, was seen as contributing to problems with establishing breastfeeding:

- (EC) Probably had an effect mainly I felt because it was... I couldn't breastfeed. Like I tried to breastfeed, I thought that maybe if he would have been put up on me straight away I might have been able to have the skin-to-skin contact and he might have been able to breastfeed.

Secondly, by the time the baby was given to the mother for the first breastfeed, the baby was in a stressed state:

- (EC) ... and I tried to feed her but she was screaming so [laugh]...

Thirdly, during the initial separation from the mother after the birth, the baby could have already been bottle-fed elsewhere:

- (EC) They put her in a humidicrib. I was going to try and breastfeed but because she'd had a bottle by the time she got to me, which was the nighttime, she didn't want to breastfeed.

If there is a long enough delay the mother will be engorged with milk interfering with the first time attachment:

- (EC) She didn't want to feed, I was too hard. It's like I was hard.

Many mothers stated that they bottle-fed both of their children born by CS as their milk did not 'come in':

- (EC) 'Cause I haven't been able to breastfeed with either of them either. My milk just hasn't come in and they just need food so I put 'em on a bottle.

DISCUSSION

The insights provided by the participants are easily divisible into three approaches as regards mothers' decision-making with respect to feeding their newborn. The first perspective is based on a strong commitment to breastfeeding, which is often maintained in the face of quite significant difficulties. The second perspective is a complete refusal to breastfeed and a clear decision to bottle feed made prior to the birth and adhered to irrespective of alternative advice or persuasion. The third perspective is an initial desire to breastfeed that is easily thwarted by difficulties. The overarching consideration for the latter two approaches is the ease and convenience of bottle feeding for the mother. This identification of the existence of different, pre-determined approaches as regards maternal decisions about feeding infants resonates with research by Sheehan, Schmied and Cooke (2003), who explored through qualitative research the baby-feeding decisions of a group of Australian women prior to birth. The authors found that women based antenatal decision on how to feed their newborns on a variety of sources and could be classified into the following four thematic groups: 'assuming I'll breastfeed'; 'definitely going to breastfeed'; 'playing it by ear' and 'definitely going to bottle feed'. The research reported in this article builds on this work with the presentation of findings of research on a more specific group, being mothers who had previously birthed by CS. Our research identifies the existence of three key groups, with the overarching considerations articulated by mothers in determining their fit within each group that of 'ease' and 'convenience' on one hand and what is perceived to be best for their baby on the other. While the findings demonstrate that decisions about the mode of birthing were often directly related to

a prior birth experience, preferences with respect to the mode of feeding their newborn was more innate - the participants did not link their decisions and experiences with feeding their newborn to their prior birth experience.

Breastfeeding is seen as a positive experience for the first group of mothers and the satisfaction with natural feeding goes some way to addressing any sense of disappointment experienced at not being able to deliver the baby vaginally. It is interesting to note that this group of mothers was committed to achieving, where possible, a natural birth, as demonstrated by the fact that all women in this group either attempted or achieved a VBAC.

Recent qualitative research by Beck and Watson (2008) has established that the mode and experience of birthing by the mother can result in starkly different outcomes with respect to feeding their infants. For some, a traumatic or medicalised birth can crystallize a strong commitment to breastfeeding, whilst for others such a birth curtails breastfeeding attempts and results in artificial feeding of their infants. For women in the former group, a perceived 'failure' to birth vaginally led to a resolve to do something 'right', with descriptions provided by such mothers of their tenacity to succeed at breastfeeding linked to 'proving' themselves as mothers (Beck and Watson 2008, p 232-233). Establishing a successful breastfeeding relationship was considered a way to 'make amends' with their baby after a difficult arrival and helped mothers to mentally heal from a difficult or disappointing birthing experience (Beck and Watson 2008, p 233).

The support of midwives with establishing breastfeeding is appreciated by this first group of mothers. Characteristically, the first group of mothers show perseverance in the face of obstacles associated with establishing breastfeeding, including such experiences as milk supply and attachment problems and associated blistering and bleeding of the nipples. These mothers are likely to be well informed about breastfeeding and bonding and a key consideration guiding their decision-making is their perception of what is best for their newborn.

Research by Manhire et al (2007), found that birth by CS has a negative physical effect on breastfeeding but that this can be overcome by persistence and commitment on the part of the mothers. The mothers in the first group identified in the study demonstrated such tenacity. In assisting such mothers, it is of paramount importance that resources are invested in ensuring they receive adequate information, assistance and support in creating an environment conducive to bonding with their infant and establishing a successful breastfeeding relationship. Particular attention should be directed to assisting such mothers to lessen the impact of or overcome obstacles to breastfeeding created by CS births, for example, facilitating initial skin-to-skin contact, allowing the mother time to feed her baby for the first time and assisting breastfeeding where physical limitations brought about by a surgical delivery may pose difficulties.

The second group of mothers made firm decisions to bottle feed before the birth of their child by CS. This decision was often made and adhered to in the face of pressure from friends, relatives and/or health professionals to breastfeed. Satisfaction with breastfeeding is not valued by this group of mothers who express a sense of ease with bottle feeding. Any pressure to breastfeed is not appreciated by mothers with this approach and they spoke very negatively about and expressed intolerance of any comments by midwives that affirmed the importance of breastfeeding. The mothers comprising this group demonstrated their refractory attitudes to breastfeeding and the fact that such attitudes are deeply ingrained and resistant to alternative persuasion, whether from family, friends or health professionals. Strategies designed to promote breastfeeding are least likely to succeed with this group.

The third group of mothers typically engaged in initial attempts to breastfeed in the early hours or days after birth. However, any obstacles were quickly seen as a reason for changing to bottle feeding. This group of mothers described obstacles associated with the process of establishing breastfeeding including lack

of knowledge about the process, lack of enjoyment with breastfeeding, blistering and bleeding of the nipples, problems with establishing their milk supply, a sense of not having a sufficient quantity or quality of breastmilk to offer their baby, infant distress created by breastfeeding problems and lack of support from family members. In contrast to breastfeeding mothers there was not a sense of satisfaction associated with mastering the art of natural feeding and a lack of concern about any disapproval associated with bottle feeding. Some of the third group of mothers appreciated the help of midwives who supported their initial breastfeeding attempts, but most expressed negative feelings about receiving pressure to breastfeed. Descriptions of experiences from this group of mothers indicate that some will avoid contact with midwives, hide the fact that they are bottle feeding or convert to bottle feeding upon leaving the hospital. The findings pertaining to this group resonate with research by McFadden et al (2007), which found that low breastfeeding rates can be attributed in part to deficits in breastfeeding knowledge, including ignorance about national breastfeeding guidelines and policies. The work of Dykes and Griffiths (1998) also resonates with this group, as they stress the significance of socio-cultural influences in determining modes of infant feeding.

The mothers described obstacles associated with the birth experience of a CS including factors such as the delay in placing the newborn to the breast, separation from and lack of initial skin-to-skin contact with the newborn, the distressed state of the baby after the experience of a Caesar, the baby being given a bottle in the nursery prior to being presented to the mother and engorgement of the mother's breasts from delay in contact.

Beck and Watson (2008) reported descriptions from some mothers in their study who considered breastfeeding to be a further physical violation after a traumatic birth, with breastfeeding imposing further physical pain on the mother. Other birth-related impediments to breastfeeding were considered to be perceived inadequate milk supply, distressing 'flashbacks' from the birth and a sense of being 'distanced and detached' from their infant.

Research shows that these factors can, in most cases, be relatively easily overcome with provision of appropriate information, assistance and support at the critical time. Such obstacles are not unique to mothers who have birthed by CS, but are reported as usual problems associated with the initial breastfeeding of an infant irrespective of the mode of birthing. As the findings reveal this group is the most vulnerable to persuasion in either direction as regards the feeding of their infant, it is critical that factors dissuading this group of mothers from breastfeeding their infants be addressed if breastfeeding rates are to improve in Australia. Recent research has confirmed that the vast majority of Australian mothers should be able to breastfeed their infants, providing the existence of conditions amenable to establishing a successful breastfeeding relationship. Their published statement on this issue is as follows (WHO 2008):

Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production.

Some of the barriers to breastfeeding posited by the mothers as physical issues, such as low milk supply, are in fact most often attributable to sociological and environmental influences rather than physical bodily attributes, such as prolonged separation after birth, lack of opportunity for skin-to-skin contact, facilitating time for the mother to breastfeed the baby in the period immediately after the birth and supplementing breastfeeding with formula. Such practices were reported to be the norm by participants in the study, yet are not consistent with the recommendations of leading expert bodies including the Academy of Breastfeeding Medicine (2003), the American Academy of Pediatrics (2005), the American College of Obstetricians and Gynecologists (2007), the Association of Women's Health, Obstetric and Neonatal Nurses (2000), the International Lactation Consultant Association (1999) and the World Health Organisation (1998). Rather, these bodies are uniform in their calls for the universal promotion of skin-to-skin contact and 'rooming-in' and their

opposition to the routine separation of mother and infant after birth. Indeed, Dykes and associates (Dykes 2002; Dykes and Williams 1999) have recorded the important influence of Western biomedical science in the construction of an 'inadequate milk syndrome' or 'perceived breast-milk inadequacy' amongst lactating mothers.

Drawing on expert recommendations, Crenshaw (2007) reports that the final care practice, of six care practices that support normal birth recommended by Lamaze International, must be that there is no separation of mother and baby, with unlimited opportunities for breastfeeding. She encourages women to, wherever possible, arrange for a birthing experience that excludes routine separation of mother and infant, facilitates early and frequent skin-to-skin contact and encompasses 'rooming-in' of mother and baby (Crenshaw 2007).

RECOMMENDATIONS

The authors acknowledge and respect the present recognition in the medical and sociological literature of the desirability of increasing the present rates of exclusive breastfeeding in Australia. With a view to increasing the incidence of exclusive breastfeeding in Australia, there are a number of key factors that emerge from the findings that can be addressed. The key recommendation is that an understanding of the three different attitudinal groups can be used to inform strategies midwives use in supporting breastfeeding. Such knowledge can be used to reinforce the sensitive care that is needed to support mothers' efforts to breastfeed - sensitive care based on a partnership that respects the different experiences and perspectives that mothers bring to their approach to infant feeding. This is consistent with recent research by Schmied et al (2008), which emphasised the crucial need to listen to each woman and their needs and tailor midwifery care to meeting these individual needs if effective hospital-based postnatal care is to be provided.

From a practice perspective, this requires, for the first group of mothers (those with a strong commitment to breastfeeding), support and information to reinforce their decision and practical assistance to overcome any early breastfeeding difficulties encountered by the mother, particularly those that have arisen as a consequence of the birthing experience.

For the second group of mothers (those with a strong aversion to breastfeeding), respect for their decision, expressed by minimal intervention, is reported to be most helpful. The findings establish that this group is likely to be refractory to persuasion to breastfeed.

For the third group of mothers (those with an initial desire to breastfeed that is easily thwarted by difficulties), midwives can assist by providing information, both as to the benefits for mother, child and society to be gained by breastfeeding as well as the potential difficulties to be encountered and ways to overcome such difficulties. Practical assistance to overcome any early breastfeeding difficulties encountered by the mother, particularly those that have arisen as a consequence of the birthing experience, is of paramount importance. It is in this group that the most energy may need to be invested if positive outcomes are to be achieved.

It must be emphasised that most of these factors are of critical importance in the period immediately after the birth, during the mother's stay in hospital and, for the first and third attitudinal groups, it is important that efforts are made to engage the mother in discussion and to support the mother in establishing a successful breastfeeding relationship prior to the mother's discharge from hospital. For the mothers in this study who have experienced a CS it is essential to build a birth situation that promotes bonding and breastfeeding by ensuring where possible that there is no separation of mother and baby after birth, maximum opportunity for skin-to-skin contact and time for the mother to breastfeed the baby in the period immediately after the birth, and no supplementing breastfeeding with formula.

CONCLUSION

The findings presented in this paper identified three attitudinal groups with respect to mothers' approaches to feeding their newborns. It is anticipated that an understanding of these different

attitudinal groups will enhance midwives' ability to tailor their breastfeeding support for mothers during the initial post-partum period.

REFERENCES

Academy of Breastfeeding Medicine Protocol Committee: Chantry, C., Howard, C. and McCoy, R. 2003. Clinical protocol #5: Peripartum breastfeeding management for the healthy mother and infant at term. Academy of Breastfeeding Medicine: New York.

American Academy of Pediatrics (AAP). 2005. Expert workgroup on breastfeeding: Breastfeeding and the use of human milk. *Pediatrics,* 115(2):496 - 506.

American College of Obstetricians and Gynecologists (ACOG). 2007. Committee on Health Care for Undeserved Women and Committee on Obstetric Practice. Special report from ACOG: Breastfeeding: Maternal and infant aspects. *ACOG Clinical Review,* 12(1):1S - 16S.

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). 2000. Evidence-based clinical practice guidelines: Breastfeeding support: Prenatal care through the first year. AWHONN: Washington DC.

Australian Bureau of Statistic (ABS). 2003. Report: Breastfeeding in Australia, 2001, released 17 September 2003.

Beck, C. and and Watson, S. 2008. Impact of birth trauma on breast-feeding: A tale of two pathways. *Nursing Research,* 57(4):228-236.

Crenshaw, J. 2007. Care practice #6: No separation of mother and baby, with unlimited opportunities for breastfeeding. *Journal of perinatal education,* 16(3):39-43.

Day, J. (ed.). 2004. Breastfeeding Naturally. 2nd edition. Australian Breastfeeding Association: Victoria.

Dykes, F. 2002. Western medicine and marketing: Construction of an inadequate milk syndrome in lactating women. *Health Care for Women International*, 23(5):492-502.

Dykes, F., and Griffiths, H. 1998. Societal influences upon initiation and continuation of breastfeeding. *British Journal of Midwifery,* 6(2):76-80.

Dykes, F., and Williams, C. 1999. Falling by the wayside: A phenomenological exploration of perceived breast-milk inadequacy in lactating women. *Midwifery*, 15(4):232-46.

Grille, R. 2005. Parenting for a Peaceful World. Longueville Media: New South Wales.

Holloway, I. 2008. A-Z of Qualitative Research in Healthcare. 2nd Edition. Blackwell Publishing: Oxford, UK.

International Lactation Consultant Association (ILCA). 1999. Evidence-based guidelines for breastfeeding management during the first 14 days. ILCA: Raleigh, NC.

Manhire, K., Hagan, A. and and Floyd, S. 2007. A descriptive account of New Zealand mothers' responses to open-ended questions on their breast feeding experiences. *Midwifery*, 23(4):372-381.

McFadden, A., Renfrew, MJ., Wallace, LM., Dykes, F., Abbott, S., Burt, S., and Kosmala-Anderson, J. 2007. Postnatal. Does breastfeeding really matter? A national multidisciplinary breastfeeding knowledge and skills assessment. *MIDIRS Midwifery Digest,* 17(1):85-8.

Palmer, G. 1988. The Politics of Breastfeeding. Pandora: London.

Queensland Health (QH). 2008. http://www.childcomm.qld.gov.au/pdf/publications/reports/snapshot2005/snapshot_2005_5_health_partA.pdf, accessed 10.02.08.

Schmied, V., Cooke, M., Gutwein, R., and Homer. C. 2008. Time to listen: Strategies to improve hospital-based postnatal care. *MIDIRS Midwifery Digest,* 18(4):547-52.

Sheehan, A., Schmied, V., and Cooke, M. 2003. Australian women's stories of their baby-feeding decisions in pregnancy. *Midwifery*, 19(4):259-66.

Sorrell, J., and and Redmond, G. 1995. Interviews in qualitative nursing research: Differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing*, 21(6):1117-1122.

Spiegelberg, H. 1975. Doing Pphenomenology. Nijhoff: The Hague.

Streubert, J., and and Carpenter, D. 1995. Qualitative Research in Nursing: Advancing the Humanistic Imperative. J. B Lippincott Company: New York.

Van Manen, M. 1990. Researching Lived Experience. State University of New York Press: Ontario.

World Health Organisation (WHO). 1998. Evidence for the 10 steps to successful breastfeeding. WHO: Geneva, Switzerland.

World Health Organisation (WHO). 2008. Official website: http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/index.html, accessed 10.02.08.