Women's Perceptions and Experiences of Breastfeeding Support: A Metasynthesis

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ABSTRACT: Background: *Both peer and professional support have been identified as important to the success of breastfeeding. The aim of this metasynthesis was to examine women's perceptions and experiences of breastfeeding support, either professional or peer, to illuminate the components of support that they deemed "supportive."* **Methods:** *The metasynthesis included studies of both formal or "created" peer and professional support for breastfeeding women but excluded studies of family or informal support. Qualitative studies were included as well as large-scale surveys if they reported the analysis of qualitative data gathered through open-ended responses. Primiparas and multiparas who initiated breastfeeding were included. Studies published in English, in peer-reviewed journals, and undertaken between January 1990 and December 2007 were included. After assessment for relevance and quality, 31 studies were included. Meta-ethnographic methods were used to identify categories and themes.* **Results:** *The metasynthesis resulted in four categories comprising 20 themes. The synthesis indicated that support for breastfeeding occurred along a continuum from authentic presence at one end, perceived as effective support, to disconnected encounters at the other, perceived as ineffective or even discouraging and counterproductive. A facilitative approach versus a reductionist approach was identified as contrasting styles of support that women experienced as helpful or unhelpful.* **Conclusions:** *The findings emphasize the importance of person-centered communication skills and of relationships in supporting a woman to breastfeed. Organizational systems and services that facilitate continuity of caregiver, for example continuity of midwifery care or peer support models, are more likely to facilitate an authentic presence, involving supportive care and a trusting relationship with professionals. (BIRTH 38:1 March 2011)*

Key words: *breastfeeding, metasynthesis, peer support, professional support, support*

Breastfeeding is universally acknowledged as providing health benefits to both mothers and infants, reducing infant mortality and morbidity, particularly in developing countries, but also in more affluent societies (1). The World Health Organization (WHO), together with the United Nations International Children's Fund (UNICEF), have implemented several initiatives to protect and promote breastfeeding globally (2). Despite these global policies, breastfeeding rates, especially exclusive breastfeeding, remain lower than

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recommended, and are highly variable across different settings (3).

Infant feeding support can come from various sources, including professional and peer support (paid or volunteer) and informal social networks. Both peer and professional support have been identified as important to the success of breastfeeding (4). Research also suggests that poor support may contribute to early cessation of breastfeeding (5–7). Several studies have reported that women expect to seek and receive professional support for breastfeeding in the early postpartum period (7,8), viewing it as a time of learning (9,10). Consistent with this view, health professionals, particularly midwives, also consider breastfeeding "education" to be a significant component of their role (11).

Despite the apparent shared understanding among midwives, lactation consultants, and mothers about the need for support, midwives, lactation consultants, and other health professionals often fail to provide it (5,12–14). Women describe receiving breastfeeding support from professionals in both positive and negative terms (5–7,15). Peer supporters of breastfeeding have been identified as positive role models for women (16,17). Two systematic reviews reported that all forms of extra breastfeeding support demonstrated an increase in initiation (18) and duration of any (partial and exclusive) breastfeeding (4). Lay and professional support together extended duration of any breastfeeding significantly before 2 months (4). The Cochrane Review further concluded that "the relative effectiveness of the intervention components" and women's views should be considered in further trials, suggesting these are two areas that are under explored (4).

For this study we used the term *professional support*, as defined by the Cochrane Review of Breastfeeding Support, meaning support "provided by a variety of medical, nursing, and allied professionals (e.g., nutritionists)" (4). *Peer support* was defined in the Cochrane Review as either voluntary or remunerated. For the purposes of this study, however, we chose Dennis' more descriptive definition of peer support: "The provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor or similar characteristics as the target population" (19, p 329). The term *created social network* indicates that peer supporters are not part of the woman's own informal social network, but are linked with her for the specific purpose of providing support, which in the studies reviewed, is by means of a peer support project or scheme, whether the supporter is paid or not.

The aim of this metasynthesis was to examine women's perceptions and experiences of breastfeeding support to illuminate the components they deem "supportive." A secondary aim was to describe any differences between components of peer and professional support.

Methods

A metasynthesis is a rigorous and analytical process of synthesizing the findings of qualitative research on a particular phenomenon (20). This metasynthesis included studies of both formal or "created" peer and professional support for both primiparous and multiparous breastfeeding women. It excluded studies of family or other informal forms of support for breastfeeding. Studies selected for review were qualitative or qualitative components of larger studies. Studies using a survey design were included if they reported in sufficient detail the analysis of qualitative data gathered through open-ended responses or included a small number of in-depth interviews.

Studies were limited to those published or available in English, in peer-reviewed journals, and undertaken between 1990 and December 2007. The year 1990 was chosen as a cutoff date because that was the year the Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding was first produced and adopted (21). Following on from the Innocenti Declaration in 1990, the Baby Friendly Hospital Initiative (BFHI) was launched in 1991. The BFHI is the most significant internationally structured program to be developed and implemented jointly by WHO and UNICEF as part of the global commitment to protecting and promoting breastfeeding and is based on the Ten Steps to Successful Breastfeeding (2).

The literature search for this review was conducted from October to December 2007 using the following databases: MEDLINE, CINAHL, the Cochrane Library, PubMed, Meditext, Nursing Consult, MIDIRS, PsycINFO, Current Contents, WHO Library Database, Scopus, Science Citation Index, EMBASE, and BMC. Search terms included the following: breastfeeding, qualitative research, breast feeding support, peer support, professional support, post-natal support, postnatal support, volunteer support, lay support, social support, breastfeeding counsellors, lactation consultants, health education, breastfeeding education, and lactation. Figure 1 outlines the review process; of the 254 studies initially identified, 46 relevant abstracts remained. These papers were read in full and eight more were excluded because they were neither original research nor they focused on health professionals' experience.

Thirty-eight articles were assessed using the Joanna Briggs Institute for Evidence Based Nursing-Qualitative Assessment and Review Instrument (22). Seven studies were excluded because they included insufficient qualitative data directly relevant to the review focus.

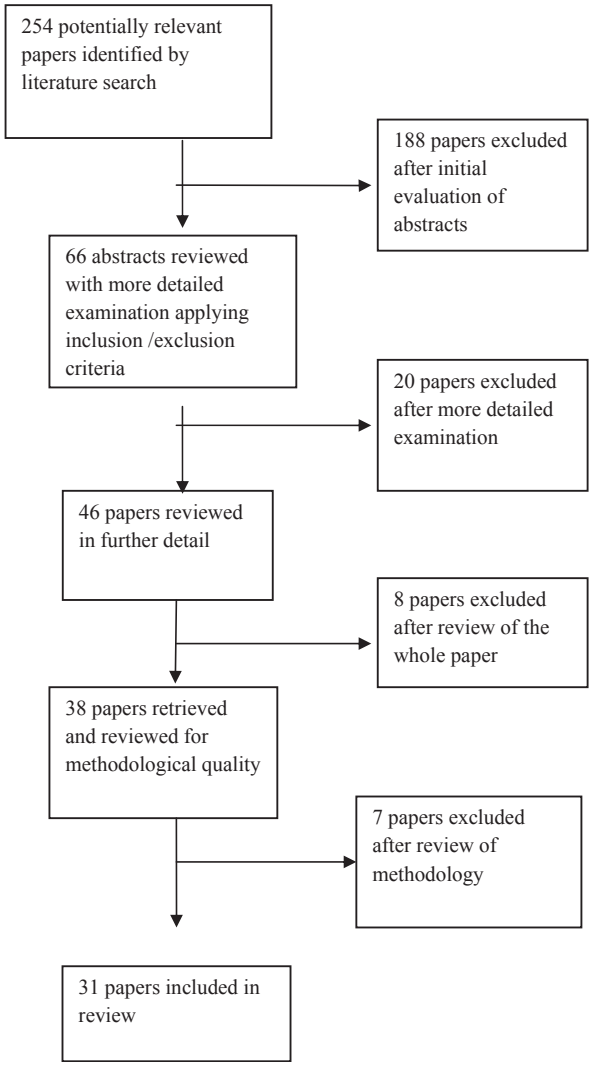

Fig. 1. Breastfeeding support papers selected.

We assessed the remaining 31 studies to be of reasonable quality in terms of clarity, appropriate methodology, credibility, and evidence cited to support the conclusions. The studies included in the metasynthesis are listed in Table 1. Most studies, however, included relatively limited discussion of theoretical or conceptual perspectives, discussion of relevant literature, and reflection on the roles of the researchers.

The number of women who participated in the 31 studies ranged from 8 to 654, but two studies did not report the number of participants. Three studies using structured surveys with open-ended responses had sample sizes of over 150 women, but not all participants provided open-ended responses. Of the remaining 26 studies using only qualitative methods, the median number of women participants was 21, with a range of 8 to 130.

The meta-ethnographic methods of Noblit and Hare (23), particularly reciprocal translation, were used to identify "key metaphors, phrases, ideas, and/or concepts" that are similar across the studies (23), and then to derive concepts that encompass at least two but typically more of the studies being synthesized (24). Further details of the methods of review and synthesis can be obtained from the authors.

Results

The categories and themes that emerged from the synthesis of studies are summarized in Figure 2. Examples of quotations drawn form the original studies to illustrate each theme are presented in Table 2. The categories and themes identified and discussed in the review were found consistently in most of the articles.

The synthesis suggested, first, that support for breastfeeding occurs along a continuum from *authentic presence* at one end, perceived as effective support, to *disconnected encounters* at the other, perceived as ineffective or even discouraging and counterproductive. The synthesis identified, second, a *facilitative approach* versus a *reductionist approach* as contrasting styles of support that women experienced as helpful or unhelpful.

Authentic Presence

The category *an authentic presence* describes care provided by professionals or peers that women found "supportive," and reflects a trusting relationship or connectedness and rapport between the woman and her caregiver, supporter, or both. An authentic presence comprised seven themes (Fig. 2). Providing an authentic presence helps to ensure that support given is appropriate to the woman's needs and enhances its perceived effectiveness.

Being there for me is an important component of an authentic presence, conveying to the woman that the health professional or supporter is available for her when needed in the hospital setting or at home. Studies report that this component can occur even when the midwives and postnatal wards are busy. Not surprisingly, an *empathetic approach* was also integral to an authentic presence, in which women feel any help offered is supportive, rather than undermining, and is enhanced when the health professional or supporter listens in a warm and positive way.

Taking time, touching base involved giving sufficient time to the women, and was important in making women not only feel relaxed, comfortable, and not pressured by rushed professionals, but also for practical reasons. Taking time to sit and observe a feed, offering tips and practical help, and getting to know the woman and her needs were viewed as supportive. Even brief encounters

Table 1. Included Studies

Study	*Methods*	*Participants*
Bailey et al (44), United Kingdom	Semi-structured interviews 1: late pregnancy; 2: 3–9 wk after birth	16 primiparas in low-income areas
Baker et al (45), United Kingdom	In-depth interviews	24 mothers
Beake et al (15), United Kingdom	Interviews with women and professionals; midwife focus group; preimplementation and postimplementation questionnaires; care logs and feeding rates	9 postpartum women; 5 professionals; focus group (14); 33 preimplementation and 11 postimplementation questionnaires
Bowes and Domokos (34), United Kingdom	In-depth interviews	62 Pakistani women, 68 white women, 50 health visitors, 25 general practitioners
Coreil et al (12), United States	Focus groups with women; focus groups and interviews with professionals	Not specified
Cricco-Lizza (46), United States	Participant observation; in-depth interviews	130 black and Hispanic women, 116 children, 20 grandparents, 17 fathers, 11 friends, and 25 other relatives
Dillaway and Douma (47), United States	Focus groups	16 mothers; health care professionals
Dykes (13), United Kingdom	Participant observation; in-depth interviews	61 women; 39 midwives
Dykes et al (30), United Kingdom	Focus groups; interviews	20 teenage mothers
Gill (31), United States	Interviews; observations	8 breastfeeding mothers; 7 nurses
Graffy and Taylor (48), United Kingdom	Open questionnaire	654 women who began breastfeeding
Hailes and Wellard (9), Australia	Focus group interviews	Women 1 mo postpartum
Hall and Hauck (28), Australia	Open-ended question on a questionnaire	203 women at 2 days postpartum; 252 women at 2 wk postpartum
Hauck et al (49), Australia	In-depth interviews	10 women
Hoddinott and Pill (5), United Kingdom	Semi-structured interviews	21 primiparas
Hong et al (29), United States	Interviews	20 married primiparas within the first postpartum month; 15 Caucasian, 4 Hispanic, and 1 Pacific Islander
Ingram et al (50), United Kingdom)	Focus groups with peer supporters; questionnaires with women; breastfeeding rates	22 mothers who attended the group; 6 peer supporters
Kelleher (51), Canada and USA	Semi-structured, in-depth interviews, 1 mo postpartum	52 women—diverse socioeconomic and ethnic backgrounds
Manhire et al (52), New Zealand	Semi-structured survey including some open-ended questions	153 breastfeeding women between 4 mo and 3 yr postnatally
Marshall et al (53), United Kingdom	Observation of interactions with professionals around feeding; in-depth interviews with mothers	158 interactions between women and midwives or health visitors; 22 women interviewed
McFadden and Toole (54), United Kingdom	Focus groups with women	7 focus groups; 35 women living in the sure start area
Meier et al (55), United States	Focus groups with women and peer counselors	3 women's groups of between 5 and 9 women (n = 20), low-income women diverse in ethnicity and age
Memmott and Bonuck (56), United States	Qualitative telephone interviews	21 low-income women (subsample of trial of 382 participants)
Moore and Coty (32), United States	Focus groups with women	8 primigravida women in antenatal and postnatal focus groups, plus 1 woman interviewed alone.
Mozingo et al (6), United States	Interviews	9 women, including 7 primiparas; initiated breastfeeding but stopped within 2 wk

Table 1. (Continued)

Study	*Methods*	*Participants*
Omer-Salim et al (36), Tanzania	Interviews	8 mothers, 0–6 mo postpartum, mixed in ethnicity, educational level and employment
Raine and Woodward (57), United Kingdom	Observation of peer support groups; interviews with women; peer supporter diaries; feeding rates	6 breastfeeding mothers
Raisler J (25), United States	Focus groups with women	7 focus groups, 42 women, diverse in age, ethnicity, location, parity, and feeding method
Scott et al (58), United Kingdom	Focus groups with women	19 mothers in 4 focus groups
Shakespeare et al (8), United Kingdom	In-depth interviews	39 postnatal women
Spear (59), United States	Telephone survey	53 young mothers (13–19 yr) with uncomplicated birth and breastfeeding on hospital discharge

described by Dykes as ''touching base'' were valued by women (13). Women also mentioned that an advantage of peer supporters was that they could spend sufficient time with the woman to make a difference, to provide feedback and tips or information that was centered on the personal needs of the mother and baby. ''Taking time'' also made it easier to ask questions of the supporter or professional (13).

The importance of *providing affirmation*, reassurance, and encouragement was in response to women's lack of confidence whereby many women, across the studies, found the uncertainty and transition of early parenthood challenging. Affirmation involved both affirming that what the women were doing was okay and also about acknowledging what they were experiencing. Listening and responding to women was highly valued. *Being responsive* is very different from offering support that ''presumes and tells.'' It means that professionals or supporters offer timely support or help that suits the woman's needs, and is in keeping with an authentic presence and a facilitative style (see next).

Sharing the experience is a component of the authentic presence in which the caregiver or supporter is prepared to share the experience with the new mother and demonstrates an interest in the woman's perspective. Women especially valued this sharing of personal experiences by the supporter, although care and sensitivity is necessary, according to one study, because experiences are individual.

Having a relationship increases the likelihood of achieving an authentic presence. In this component, the woman has the opportunity to build or to have a relationship with the caregiver or supporter, someone to whom she could relate and share: ''It was like I knew her before'' (25, p 257). Authentic presence is associated with the second category of having a *facilitative style,* which enables learning and results in ''feeling confident'' and able to make one's own decisions.

Facilitative Style

Adopting a *facilitative style* is an approach to health promotion, or helping, that enables people to draw on a range of information and experience and learn for themselves. It emerged consistently across the studies as a positive form of support and was strongly associated with an *authentic presence.* The style and manner in which information, help, and support were offered, was central to women's perceptions of support. A *facilitative style* is similar to what is often described in partnership models (26) and as adult-learning or learner-centered approach to learning, and to the concept of critical pedagogy described by Freire (27). Five themes comprised this component (Fig. 2).

Women wanted *realistic information*. They wanted to hear more about the personal and practical aspects of breastfeeding in a positive but realistic way, including potential challenges and difficulties, and the positive benefits. When information was not realistic, however, positively intended, it was not viewed as supportive, particularly when women encountered difficulties: ''You are told over and over that there is only pain if the baby is not attached properly. Well I am sorry, but I beg to differ'' (28, p 8). Women also want *accurate and sufficiently detailed information*, and in several studies they commented that positive detailed information and practical tips about breastfeeding were really appreciated and encouraging*:* ''(She) made sure that I knew what I needed to know'' (29, p 5).

Study participants appeared to be aware that ''breast is best'' and knew about most benefits. Many wanted

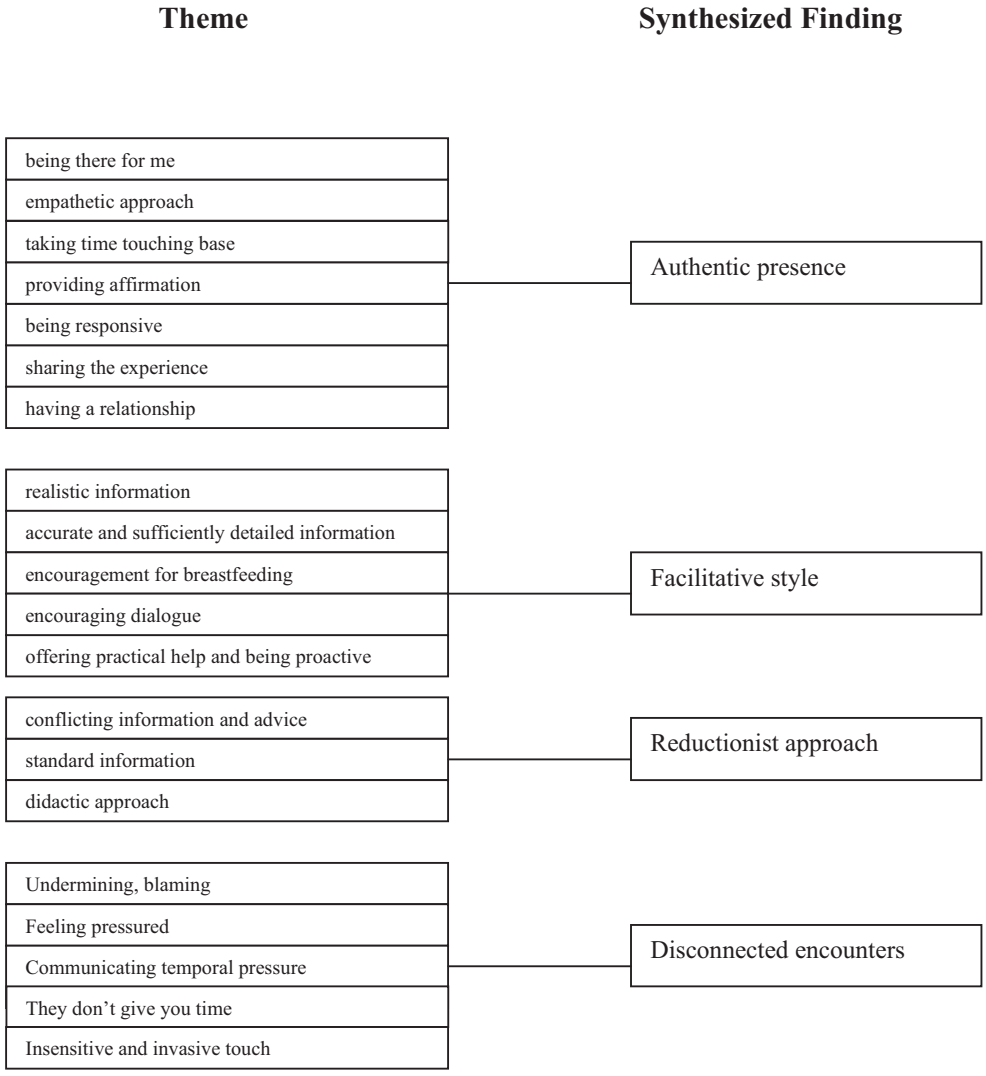

Fig. 2. Summary of analysis and synthesis.

more detailed information about the range of benefits, mechanisms of breastfeeding, and what can help and why. Standardized packages of information, as shown in Table 2, did not provide this information, according to the women. Although aware that giving "full details" may deter women from breastfeeding, women wanted to be the person in control of that decision.

Adopting a facilitative approach involved providing *encouragement for breastfeeding*, but in a sensitive and effective way, rather than creating pressure. Adolescent mothers in general felt that professionals did not really encourage or expect them to breastfeed, and some wanted active and supportive encouragement.

> If they had encouraged me a bit more when I was thinking about putting him on the bottle … like said why don't you give it another day I would have carried on … but they were just well … it's up to you (30, p 396).

A key feature of a facilitative approach is that information is not all one-way but is discursive and interactive, enabling the "learner" to raise topics, ask questions, and discuss issues or concerns. It involves *encouraging dialogue* between the "learner" and the "teacher" or facilitator. Women wanted to be able to give their own views, and in group learning situations such as antenatal education, women liked to discuss and share their views with others.

Practical help is valued and is captured in the comment "show me, don't tell me" (31, p 405). It involves instrumental (practical) and informational support, which is broader than a narrow concept of feeding support, because it is responsive to the woman's needs. It includes observing feeding, demonstrating techniques and approaches that may help, and offering practical help (and tips) that facilitate or enable learning of what is an embodied experience and skill. Women also

Table 2. Examples of Quotations from Articles (Note "Sect" Refers to a Citation from a Web-Based Article)

Categories and Themes	
Authentic Presence	*Examples of Quotations*
Being there for me	• I know she's there for me whenever I want her … I don't know her (peer supporter) but I seem to feel I can rely on her all the time (57, p 213).
Empathetic approach	• Well, I think the, just the … they were so warm … you just felt total trust in the fact they knew what they were talking about, and they knew what I was going through (8, p 256).
Taking time, touching base	• It seemed important to her … she took time to talk to me, asked me questions, and gave me suggestions (29, p 5).
Providing affirmation	• She would just say: "You're doing fine, you're doing fine" when I was thinking that I was doing something wrong (25, p 258).
Being responsive	• I got help when I needed it, and not just about breastfeeding (50, p 115).
Sharing the experience	• Even just sitting there, having a cup of tea while I was trying to feed, was the most help I could want. So I wasn't on my own (8, p 256). • You think nobody understands. It's so nice to have somebody to talk to, because it does encourage you, because they have done it and they will come out and help you (58, p 274).
Having a relationship	• But her coming round is also relationship-based, She's not coming round just to do her duty, she comes to build a relationship and that actually makes you feel comfortable around her, to actually talk to her and open up to her (15, p 41).
Facilitative Style	
Realistic information	• A balanced discussion of the advantages and disadvantages of different feeding options would be most useful … A presentation of both sides—breast versus bottle (12, p 257). • Focusing to a greater extent on how to overcome common difficulties, albeit in an 'it does get better' framework (44, p 244).
Accurate and sufficiently detailed information	• Answer(ing) all my questions for me (25, p 257). • It would have been more helpful if I had information of possible baby behaviours and many different stories on breastfeeding patterns so I would not have been so uncertain for the first days (28, p 792).
Encouragement for breastfeeding	• I am surprised to find that I hardly know any people who breastfed their babies, so it was difficult to have a role model. I feel that more should be done to encourage mothers to breastfeed at parent craft classes (48, p 182).
Encouraging dialog	• They give you a whole bunch of papers then they say, "Here read this." That's your education. I think it would be best if they went over it with you. Just not like you're illiterate, but go over it with you instead of just expecting you to go home and read it (12, p 267).
Offering practical help and being proactive	• It was the first time. We just couldn't seem to get it right. I felt like all thumbs. Then a nurse came in and told me to put his stomach next to mine. She moved him around so he could get my breast. What a difference that made. Such a little thing (31, p 405).
Reductionist Approach	
Conflicting information and advice	• Every single midwife that came in had an entirely different opinion on what to do and it was just, it was far too confusing (53, p 2152).
Standard information	• "They tell you in health talk" "They use medical jargon," and "Her explanations were real technical. I guess I felt a bit rushed" (36, p 123). • There are a lot of things I asked them [nurses] not to do. I know they have rules, but it means a lot to me to do it my way … to feed him when he's hungry, not when they say it's time (31, p 406).
Didactic approach	• No one asked me what I wanted (34, sect. 4.1). • Some aren't interested in what others have told you (13, p 247). • I wasn't ready for her telling me how to express. I wasn't at the stage where I wanted to know about that. I felt that things were going well … she was determined to tell me (13, p 247).

Table 2. (Continued)

Disconnected Encounters	
Undermining and blaming	• I had great difficulty getting him to latch on or suck, and I very much felt the midwives blamed me for this. When I said to one, "It isn't easy," she replied, "Of course it's easy all the other mothers can do it!" (48, p 183).
Feeling pressured	• It's really drummed into people, you know, breastfeeding is best, you shouldn't bottle feed and I just when I changed her over to the bottle I just felt guilty because everyone there's so much hype about breastfeeding and she is just as happy, if not more, on the bottle. You know, I don't think they should drum it into you as much. You know "you should breastfeed." It's your decision, it's up to every individual (5, p 228). • She [health-visitor] said "Well, that's 2 weeks, and she hasn't made up her birthweight. It just means we'll have to take the child to care if you're going to persist with this breastfeeding." I thought that was a terrible thing to say (34, sect. 6.10).
Communicating temporal pressure	• They are so busy, they don't have the time to sit and help you to do it. They really don't. They are rushed off their feet, and are quite harassed, and I was quite willing to give up (34, sect. 4.9).
They don't give you time	• From day one, I thought I would breastfeed, but when I went into the hospital, and I wasn't getting much help, I just thought stuff it … I didn't even know how to start myself, and the nurse showed me once, but after that I still couldn't do it … and I started getting myself depressed and anxious, and I thought "No. I won't be able to cope" (34, sect. 4.12).
Insensitive and invasive touch	• They're trying to grab, grab onto your breast. And trying to get it into his mouth (5, p 123).

appreciate professionals who are proactive, which involves anticipating what a woman may need to know and what type of timely support or help will suit her.

> She really watched the baby and was real intuitive about what was going on. She watched how she fed, and tried to feed, and she could see what was going on, where the others just brought the baby in to me and said, 'Here, it's not working. We'll come back and try again later' (32, p 42).

Reductionist Approach

Contrary to a facilitative style is a *reductionist approach* or style (Fig. 2). Reductionism can be described as the analysis of something into simpler parts or organized systems, especially with a view to explaining or understanding it: the oversimplifying of something complex, or the misguided belief that everything can be explained in simple terms (33). A *reductionist approach* means that information and advice are given in a dogmatic and/or didactic style, which may be related to a personal style and lack of effective training in how to provide "education" or support, but more likely can be attributed to an environment that does not provide opportunities for professionals and supporters to work in facilitative ways. Consequently, a reductionist style tended to be found alongside *disconnected encounters.*

In a *reductionist approach*, information and advice provided by different professionals are more likely to appear conflicting and can cause confusion, distress, and undermine confidence. In most studies, participants described *conflicting information and advice* given in busy clinical situations where care was fragmented with little opportunity for forming relationships. Such conflicting information and advice was given about positioning and latching, supplementation, length and timing of feedings, and milk supply.

Many women also described being given *standardized information* that was not appropriate to their situation (such as telling them what they already knew or missing information that they needed and did not know). In addition, the standardized content related to the way in which information was packaged and offered: "They tell you in health talk," "They use medical jargon," and "Her explanations were real technical. I guess I felt a bit rushed" (6, p 123).

Standardized advice and information is often combined with a *didactic approach*. The reductionist style of interacting with women, means the midwife or nurse is not listening and asking but presuming and telling: "No-one asked me what I wanted" (34). Consequences of this approach appeared to be that many women were not getting the information in an effective way and were often confused or felt undermined rather than supported by it.

Disconnected Encounters

At the other end of the continuum from authentic presence, are *disconnected encounters*, characterized by limited or no relationship and a lack of rapport (Fig. 2). This category was also associated with a *reductionist approach*, and seemed to inhibit learning, leading to

women lacking confidence, and being less likely to sustain breastfeeding. As a result some women then feel guilty and disempowered. No sense of having or building relationships is present: "They just do what they need to do and go. There's no relationship or anything" (15, p 41).

Undermining and blaming was identified in some studies. Women believed that health professionals could undermine their efforts to breastfeed. For some, this action was perceived to be the result of well-intentioned interventions by professionals that did not address the woman's needs, and the help offered was inappropriate. Certain behaviors or styles of interaction could also have a detrimental effect, when comments or giving advice undermined the woman's confidence, rather than encouraging her, sometimes making her feel a sense of guilt and blame. Although a health professional may not intend to provoke guilt, a critical manner or use of words can be perceived this way, especially when women are feeling vulnerable, uncertain, and physically and emotionally tired. Some studies identified women's experience of *feeling pressured* about feeding—experienced both by women who were breastfeeding and who were formula feeding.

In many studies it was common for women to report that staff were simply too busy with other women and tasks to be able to spend the time women needed. Typically, this situation was not perceived as being a fault of health professionals but more a limitation of their work environment. Dykes labeled it *communicating temporal pressure* (13). However, women talked less about feeling rushed when they received care from peer supporters or home-based postnatal care. When women are aware of the pressures on midwives, they tended to struggle on quietly, recognizing that asking for support or information was to request scarce midwifery time; less assertive women tended to be those from lower socioeconomic occupational groups (14).

They don't give you time, along with conveying temporal pressure, describes how when health professionals did not give attention to individual women, and they did not receive help. It was often perceived as rushed and the nature of interactions often as unhelpful:

> From day one, I thought I would breastfeed, but when I went into the hospital, and I wasn't getting much help, I just thought stuff it … I didn't even know how to start myself, and the nurse showed me once, but after that I still couldn't do it … and I started getting myself depressed and anxious, and I thought "No. I won't be able to cope" (34).

Although women strongly valued a "hands-on" proactive approach, attempts by professionals to help in this way were often experienced as intrusive and rough. This *insensitive and invasive touch* meant some women felt as though they were being treated in a disembodied way—as though the breast was just a "feeding implement." In contrast, practical help, such as with latching on the baby, was appreciated if performed sensitively and within the context of a relationship with rapport and empathy.

Discussion

This metasynthesis examined women's perceptions and experiences of breastfeeding support, whether peer or professional, to illuminate the components of support that they deemed "supportive." We argue that support that is perceived positively by women will contribute to wider public health goals (35). Although we included all relevant articles published in English, only one of those retrieved was based in a resource-poor country. The study of Tanzanian women by Omer-Salim et al identified themes that were consistent with those of other studies, despite the difference in health care and social context (36). Most articles came from the United Kingdom or the United States, and so it cannot be assumed that our findings will apply to other countries where the cultural and health care context differs.

Findings of this metasynthesis, particularly the explication of the components of support, are complemented by, and build on, the work of McInnes and Chambers to explain what it means from a woman's perspective to be encouraging or reassuring (37). Both metasyntheses indicate health service support is currently inadequate often because of time pressures and inadequate staffing; however, it is also clear that many health professional practices are unhelpful.

The variation in the nature of the support received suggests that the wider culture, conditions of the profession, and organization and culture of care may all affect the support provided. Authentic presence is facilitated by having a trusting relationship. Organizational systems and services that offer models of continuity of care (e.g., continuity of midwifery care or peer support models) are more likely to facilitate authentic presence because these models foster relationship building. Peer supporters were more likely than professionals to be described as "being there" for women, having a relationship, and sharing the experience.

The category of *disconnected encounters*, and the lack of rapport that characterized it, appeared to be influenced by organizational structure as described by women receiving care in busy fragmented services, where professionals lacked opportunity and motivation to establish a relationship. Added to the challenge for health professionals, however, are staff shortage and duplication or multiplication of tasks, which mitigate against giving time and being with women. Professionals may learn to cope by *conveying temporal pressure* to

women (13,14). Such behavior was not automatic, as in such contexts individual staff sometimes succeeded in conveying an authentic presence, even with more limited time or lack of continuity, because the professional was able to demonstrate ''empathy,'' ''encouragement,'' and ''affirmation.''

The nature of the support offered, whether connected or disconnected, facilitative or reductionist, appeared to influence women's personal confidence in breastfeeding. For women who were feeling less confident or more vulnerable, conflicting and contradictory advice tended to compound difficulty with a further loss of confidence. Women reported feeling confused but also feeling pressured, undermined, blamed, and guilty as a result. These feelings resonated with those of Larsen et al in a metasynthesis that focused specifically on breastfeeding mothers' confidence and the ways in which a lack of confidence resulted in early cessation of breastfeeding (38).

The potential for peer supporters to act as role models was also important particularly, but not exclusively, for adolescent mothers and socially disadvantaged women. The ability of peer supporters to share the experience related both to being able to give time and practical support and being perceived as having more shared experience (16,17,39). Support, which can offer time, continuity, and the encouragement of a ''peer'' may be helpful for many women (15,17,39), not just for those who are identified as demographically less likely to breastfeed.

The findings of our metasynthesis correspond with those of Fenwick et al, who conducted ethnographic research on facilitative and inhibitive nursing actions in an Australian neonatal unit (40). They found that verbal exchanges between a nurse and mother influenced a woman's confidence, sense of control, and feelings of connection with her infant. They identified two types of nursing behavior: the first described as ''facilitative nursing action,'' which women felt helped them to feel connected with their babies; and the second described as ''inhibitive nursing action,'' reflecting a more authoritarian style of approach (40). This research showed that although the development of a trusting relationship is highly desirable, a single encounter in itself can be positive or highly negative to the way a woman feels supported and cared for.

This metasynthesis showed that it is important for supporters to achieve a balance in their approaches: positive but realistic, not over idealistic; encouraging, proactive, and focused on the benefits, but not creating pressure on women to breastfeed and making them feel inadequate or failing if they do not. If women felt they were listened to with empathy and given detailed, realistic information that was centered on their needs, given encouragement and affirmation, they felt supported.

The converse of this, which many women experienced, left them feeling lacking in confidence, guilty, and incapable of breastfeeding. Women seemed to experience not only conflicting advice but conflicting deep-seated messages about breastfeeding. At times, professional supporters in the women's accounts seemed overly zealous, while they often also seemed to lack fundamental confidence in breastfeeding, thus leaving women feeling confused and undermined, rather than helped or empowered to breastfeed.

Although it is not possible from this review to link perception of support specifically with success in initiation and maintenance of breastfeeding, it appears that effective support from a woman's perspective will lead to increased confidence. Other research has demonstrated that confidence and self-efficacy are linked to an increase in breastfeeding (7,41,42). A key methodological problem with some research on effectiveness of support interventions (generally) is that many studies do not assess properly whether intended support is perceived as supportive by recipients themselves. Some evidence from the general literature on social support has reported that support that is not perceived as intended is less likely to be effective or may even be counterproductive (35,43).

This study has important implications for practice. The findings suggest that the current ''institutionalization'' of postnatal care limits opportunities for midwives and lactation consultants to offer an authentic presence and a facilitative style. However, as stated, these qualities may be maximized in some ways, even within institutional settings. The findings add support for the calls for implementation of breastfeeding peer support for women, not only those from lower socioeconomic backgrounds but encompassing the whole spectrum of socioeconomic occupational groupings.

Conclusions

The metasynthesis findings emphasize the importance of person-centered communication skills and of relationships in supporting a woman to breastfeed. Organizational systems and services that facilitate continuity of caregiver, for example, continuity of midwifery care or peer support models, are more likely to facilitate an authentic presence, involving supportive care and a trusting relationship with professionals.

References

1. Hoddinott P, Tappin D, Wright C. Breast feeding. *BMJ* 2008;336(7649):881–887.

2. WHO and UNICEF. *Global Strategy for Infant Feeding and Young Child Feeding*. Geneva: World Health Organisation, 2003. Accessed September 6, 2010. Available at: http://www.who.int/child_adolescent_health/documents/9241562218/en/index.html.
3. Hall Moran V, Dykes F. Complex challenges to implementing the global strategy for infant and young child feeding. In: Dykes F, Hall Moran V, eds. *Infant and Young Child Feeding: Challenges to Implementing a Global Strategy*. Oxford: Wiley-Blackwell, 2009:197–200.
4. Britton C, McCormick FM, Renfrew MJ, Wade A, King SE. Support for breastfeeding mothers. *Cochrane Database Syst Rev* 2007;1:CD001141.
5. Hoddinott P, Pill R. A qualitative study of women's views about how health professionals communicate about infant feeding. *Health Expect* 2000;3(4):224–233.
6. Mozingo JN, Davis MW, Droppleman PG, Merideth A. "It wasn't working": Women's experiences with short-term breastfeeding. *MCN Am J Matern Child Nurs* 2000;25(3):120–126.
7. Sheehan A, Schmied V, Barclay L. Women's experiences of infant feeding support in the first 6 weeks post-birth. *Matern Child Nutr* 2009;5(2):138–150.
8. Shakespeare J, Blake F, Garcia J. Breast-feeding difficulties experienced by women taking part in a qualitative interview study of postnatal depression. *Midwifery* 2004;20(3):251–260.
9. Hailes JF, Wellard SJ. Support for breastfeeding in the first postpartum month: Perceptions of breastfeeding women. *Breastfeed Rev* 2000;8(3):5–9.
10. Nelson AM. A metasynthesis of qualitative breastfeeding studies. *J Midwifery Womens Health* 2006;51(2):e13–e20.
11. Henderson AM, Pincombe J, Stamp G. Assisting women to establish breastfeeding: Exploring midwives' practices. *Breastfeed Rev* 2000;8(3):11–17.
12. Coreil J, Bryant CA, Westover BJ, Bailey D. Health professionals and breastfeeding counseling: Client and provider views. *J Hum Lact* 1995;11(4):265–271.
13. Dykes F. A critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England. *Midwifery* 2005;21(3):241–252.
14. Dykes F. *Breastfeeding in Hospital: Midwives, Mothers and the Production Line*. London: Routledge, 2006.
15. Beake S, McCourt C, Rowan C, Taylor J. Evaluation of the use of health care assistants to support disadvantaged women breastfeeding in the community. *Matern Child Nutr* 2005;1(1):32–43.
16. Dykes F. Government funded breastfeeding peer support projects: Implications for practice. *Matern Child Nutr* 2005;1(1):21–31.
17. Kirkham M, Sherridan A. 'Breastfriends' Doncaster: The story of our peer support project. In: Hall Moran V, Dykes F, eds. *Maternal and Infant Nutrition & Nurture: Controversies and Challenges*. London: Quay Books, 2006;250–274.
18. Fairbank L, O'Meara S, Renfrew M, et al. *A Systematic Review to Evaluate the Effectiveness of Interventions to Promote the Initiation of Breastfeeding 2000*. Accessed September 6, 2010. Available at: http://www.hta.ac.uk/execsumm/summ425.shtml.
19. Dennis CL. Peer support within a health care context: A concept analysis. *Int J Nurs Stud* 2003;40:321–332.
20. Thorne S, Jensen L, Kearney MH, et al. Qualitative metasynthesis: Reflections on methodological orientation and ideological agenda. *Qual Health Res* 2004;14(10):1342–1365.
21. WHO and UNICEF. *Innocenti Declaration. On the Protection, Promotion and Support of Breastfeeding*. Geneva: UNICEF, 1991. Accessed September 6, 2010. Available at: http://www.unicef.org/programme/breastfeeding/innocenti.htm.
22. Joanna Briggs Institute. *JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research*. Accessed September 6, 2010. Available at: http://www.jbiconnect.org/connect/downloads/QARI_crit_apprais.pdf.
23. Noblit GW, Hare RD. *Meta-Ethnography: Synthesizing Qualitative Studies*. Newbury Park: Sage Publications, 1988.
24. Campbell R, Pound P, Pope C, et al. Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Soc Sci Med* 2003;56(4):671–684.
25. Raisler J. Against the odds: Breastfeeding experiences of low income mothers. *J Midwifery Womens Health* 2000;45(3):253–263.
26. Davis H, Day C, Bidmead C. *Working in Partnership with Parents*. London: Harcourt Assessment, 2002.
27. Freire P. *Pedagogy of the Oppressed*. Harmondsworth: Penguin, 1972.
28. Hall WA, Hauck Y. Getting it right: Australian primiparas' views about breastfeeding: A quasi-experimental study. *Int J Nurs Stud* 2007;44(5):786–795.
29. Hong TM, Callister LC, Schwartz R. First time mothers' views of breastfeeding support from nurses. *MCN Am J Matern Child Nurs* 2003;28(1):10–15.
30. Dykes F, Moran VH, Burt S, Edwards J. Adolescent mothers and breastfeeding: Experiences and support needs—An exploratory study. *J Hum Lact* 2003;19(4):391–401.
31. Gill SL. The little things: Perceptions of breastfeeding support [see comment]. *J Obstet Gynecol Neonatal Nurs* 2001;30(4):401–409.
32. Moore ER, Coty MB. Prenatal and postpartum focus groups with primiparas: Breastfeeding attitudes, support, barriers, self-efficacy, and intention. *J Pediatr Health Care* 2006;20(1):35–46.
33. Engel G. The need for a new medical model: A challenge for biomedicine. *Science* 1977;196:129–136.
34. Bowes A, Domokos T. *Negotiating Breast-Feeding: Pakistani Women, White Women and Their Experiences in Hospital and at Home*, 1998. Accessed September 6, 2010. Available at: http://www.socresonline.org.uk/3/3/5.html.
35. McCourt C. Social support and childbirth. In: Squire C, ed. *The Social Context of Birth*. Oxford: Radcliffe Medical Press; 2003:187–210.
36. Omer-Salim A, Persson LA, Olsson P. Whom can I rely on? Mothers' approaches to support for feeding: An interview study in suburban Dar es Salaam, Tanzania. *Midwifery* 2007;23(2):172–183.
37. McInnes RJ, Chambers JA. Supporting breastfeeding mothers: Qualitative synthesis. *J Adv Nurs* 2008;62(4):407–427.
38. Larsen JS, Hall EOC, Aagaard H. Shattered expectations: When mothers' confidence in breastfeeding is undermined—A metasynthesis. *Scand J Caring Sci* 2008;22(4):653–661.
39. Dennis C, Hodnett E, Kenton L, et al. Effect of peer support on prevention of postnatal depression among high risk women: Multisite randomised controlled trial. *BMJ* 2009;338(7689):280–283.
40. Fenwick J, Barclay L, Schmied V. Craving closeness: A grounded theory analysis of women's experiences of mothering in the Special Care Nursery. *Women Birth* 2008;21(2):71–85.
41. Blyth R, Creedy DK, Dennis CL, et al. Effect of maternal confidence on breastfeeding duration: An application of breastfeeding self-efficacy theory. *Birth* 2002;29(4):278–284.
42. Dennis CL, Faux S. Development and psychometric testing of the breastfeeding self-efficacy scale. *Res Nurs Health* 1999;22(5):399–409.
43. Williams P, Barclay L, Schmied V. Defining social support in context: A necessary step in improving research, intervention, and practice. *Qual Health Res* 2004;14(7):942–960.
44. Bailey C, Pain RH, Aarvold JE. A "give it a go" breast-feeding culture and early cessation among low-income mothers. *Midwifery* 2004;20(3):240–250.

45. Baker SR, Choi PY, Henshaw CA, Tree J. "I Felt as though I'd been in Jail": Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Fem Psychol* 2005;15(3):315–342.
46. Cricco-Lizza R. The milk of human kindness: Environmental and human interactions in a WIC clinic that influence infant-feeding decisions of black women. *Qual Health Res* 2005;15(4):525–538.
47. Dillaway HE, Douma ME. Are pediatric offices "supportive" of breastfeeding? Discrepancies between mothers' and healthcare professionals' reports. *Clin Pediatr* 2004;43(5):417–430.
48. Graffy J, Taylor J. What information, advice, and support do women want with breastfeeding? *Birth* 2005;32(3):179–186.
49. Hauck Y, Langton D, Coyle K. The path of determination: Exploring the lived experience of breastfeeding difficulties. *Breastfeed Rev* 2002;10(2):5–12.
50. Ingram J, Rosser J, Jackson D. Breastfeeding peer supporters and a community support group: Evaluating their effectiveness. *Matern Child Nutr* 2005;1(2):111–118.
51. Kelleher CM. The physical challenges of early breastfeeding. *Soc Sci Med* 2006;63(10):2727–2738.
52. Manhire KM, Hagan AE, Floyd SA. A descriptive account of New Zealand mothers' responses to open-ended questions on their breast feeding experiences. *Midwifery* 2007;23(4):372–381.
53. Marshall JL, Godfrey M, Renfrew MJ. Being a "good mother": Managing breastfeeding and merging identities. *Soc Sci Med* 2007;65(10):2147–2159.
54. McFadden A, Toole G. Exploring women's views of breastfeeding: A focus group study within an area with high levels of socio-economic deprivation. *Matern Child Nutr* 2006;2(3):156–168.
55. Meier ER, Olson BH, Benton P, et al. A qualitative evaluation of a breastfeeding peer counselor program. *J Hum Lact* 2007;23(3): 262–268.
56. Memmott MM, Bonuck KA. Mother's reactions to a skills-based breastfeeding promotion intervention. *Matern Child Nutr* 2006;2(1):40–50.
57. Raine P, Woodward P. Promoting breastfeeding: A peer support initiative. *Community Pract* 2003;76(6):211–214.
58. Scott JA, Mostyn T. Greater Glasgow Breastfeeding Initiative Management T. Women's experiences of breastfeeding in a bottle-feeding culture. *J Hum Lact* 2003;19(3):270–277.
59. Spear HJ. Breastfeeding behaviors and experiences of adolescent mothers. *MCN Am J Matern Child Nurs* 2006;31(2):106–113.