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Western Australian women's perceptions of conflicting advice around breast feeding

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ABSTRACT

Objective: to explore women's perceptions of conflicting advice around breast feeding from formal support networks, specifically health professionals involved in postnatal support.

Design, setting and participants: a qualitative exploratory design was employed using the critical incident technique. Data were obtained from 62 Western Australian women who responded to an invitation to share incidents of receiving conflicting advice. Women who had breast fed a child within the past 12 months shared their experience through a telephone interview ($n=50$) or completing a brief questionnaire ($n=12$) addressing the following questions: Describe a situation in detail where you felt you received conflicting advice about breast feeding from a health professional. How did this situation affect you and/or your breast feeding?

Findings: a modified constant comparison method was used to analyse the critical incidents revealing commonalities under who offered conflicting advice; what contributed to advice being perceived as conflicting; topic areas more inclined to being regarded as conflicting; what protected against advice being perceived as conflicting; the consequences of receiving conflicting advice; and strategies that women used to manage these incidents.

Key conclusions and implications for practice: advice that was viewed as conflicting extended beyond the provision of information that was inconsistent or directly contradictory, and included issues around information overload and disparities between the mother's and health professional's expectations. The manner of presenting information or advice, the skills of using effective communication, demonstration of a caring attitude with an empathic approach and focusing upon the woman as an individual were seen to be important to minimise these incidents. Attention to women's perceptions and the consequences of conflicting advice must be addressed, otherwise the credibility and confidence in health professionals' knowledge and ability to support breast feeding is questioned, resulting in a valuable support network being selectively ignored.

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Introduction

Women seek information from numerous sources to support their breast feeding efforts. These sources include their partner; health professionals; written information from books, magazines and online sources; and informal networks such as mothers,

sisters or friends who have breast fed (Hauck and Irurita, 2003; Smith, 2003). Maternal expectations around the accuracy and relevance of information provided by health professionals is higher than that for advice provided from informal networks such as family and friends (Hall and Hauck, 2007). A British study identified that women want specific information about breast feeding, such as what to expect, practical help with positioning, effective advice and suggestions, acknowledgment of their experiences and feelings, plus reassurance and encouragement (Graffy and Taylor, 2005). Health professionals' advice can have a positive or negative impact on breast feeding. For example, British

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women's success with breast feeding has been associated with the help provided by hospital staff (Rajan, 1993). Conversely, American first-time mothers were more likely to decrease their breast feeding if encouraged by a health professional to supplement with foods and/or other fluids or to wean (Humenick et al., 1998).

The provision of consistent, realistic and evidence-based information regarding breast feeding is strongly advocated (Moore and Coty, 2006). In fact, the 10 steps to successful breast feeding were developed to reinforce the importance of having a breast feeding policy, and to ensure that clinicians have the knowledge and skills to implement the policy (World Health Organization, 1989). The Baby Friendly Hospital Initiative is an international project that promotes breast feeding as the norm by advocating these 10 steps. The Australian Government funded their Baby Friendly Health Initiative in 2002–2004 and, to date, Australia has 67 accredited Baby Friendly Health Services, with the leaders being Victoria with 21 agencies and South Australia with 11 (Baby Friendly Health Initiative, 2009). Western Australia currently has three accredited Baby Friendly Health Services.

The reality of breast feeding women experiencing conflicting advice is international and has been noted in Ireland (Cronin, 2003), the USA (Moore and Coty, 2006), Britain (Simmons, 2002) and Australia (Stamp and Crowther, 1994; Cox and Turnbull, 2000). A British study revealed that inconsistent advice had a detrimental effect on mothers; inconsistency is mostly evident as inaccurate information, although the authoritarian way in which the information is communicated worsens the inconsistencies (Simmons, 2002). One Australian study indicated that women perceived midwives as unable to provide adequate breast feeding support due to time limitations and rosters not allowing for continuity of caregiver. When conflicting advice was noted, mothers reported feelings of confusion (Hailes and Wellard, 2000). In fact, one-third (33.5%) of Australian women surveyed have reported receiving conflicting advice, with 18.6% indicating that this advice negatively affected their breast feeding (Cox and Turnbull, 2000). A British qualitative study noted that breast feeding was challenging, and 'falling by the wayside' was partly the consequence of receiving inadequate or conflicting advice from health professionals (Dykes and Williams, 1999).

Although conflicting advice presents a dilemma for women, an Australian study found that conflicting advice was not associated with mothers' confidence and did not influence breast feeding prevalence at 12 weeks post partum (Hauck et al., 2007). Women's perception of their ability to manage and be actively involved in decisions was more predictive of breast feeding prevalence at 12 weeks. Nonetheless, women who do not receive the support they need from formal support networks express anger and frustration. In addition, the credibility of health professionals can be damaged, resulting in women being reluctant to accept further advice (Hall and Hauck, 2007).

Although women are clearly indicating dissatisfaction with the reality of receiving conflicting advice around breast feeding issues, midwives do not always see this as a concern. In particular, an Australian study revealed that a majority of midwives (90%) held positive perceptions of their supportive role, whilst feeling confident and effective in being able to meet the breast feeding needs of women in the early postnatal period (Cantrill et al., 2003).

Current evidence on conflicting advice has focused more upon confirming its existence, rather than clearly describing aspects of this event. Evidence indicates that one-third (33.5%) of Australian women surveyed reported receiving conflicting advice (Cox and Turnbull, 2000). To begin to address the concern with conflicting advice, more insight is needed into this phenomenon from the

perspective of the recipients. Therefore, the purpose of this study was to explore women's perceptions of conflicting advice around breast feeding from formal support networks, specifically maternity health professionals, to deepen our understanding of this concerning issue.

Methods

A qualitative exploratory design was employed using the critical incident technique. Three assumptions are associated with the critical incident technique: it refers to a clearly demarcated incident, a detailed account of what happened must be obtainable and the incident is the basic unit of analysis (Byrne, 2001). The critical incident technique focuses upon a factual incident, an important event in a person's life that they feel had a discernible impact on their experience; in this instance, breast feeding a recent child (Polit and Beck, 2010). Given the prevalence of receiving conflicting advice and the potentially negative effect on their breast feeding (Cox and Turnbull, 2000; Simmons, 2002), it is reasonable to assume that women who experienced conflicting advice could clearly articulate the circumstances around this incident.

The critical incident technique offers the advantage of identifying patient experiences in health care, exploring the dimensions of interactions between those involved and identifying patient responses to care (Kemppainen, 2000). This technique has been used extensively in service industries to evaluate consumer expectations and perceptions, but has great potential for application into evaluating health-care delivery. This flexible qualitative method can be used to improve existing practices, is collected from the patient's perspective in their own words, does not force the participants into any given framework, can be applied using questionnaires, email or interviews, and, importantly, provides rich information. Nevertheless, the technique has the potential of recall bias unless the incident happened recently, and therefore recent incidents should be examined.

Generally, data on approximately 100 critical incidents are recommended (Polit and Beck, 2008), but final sample size is determined by data saturation and recruitment is continued until data analysis indicates information redundancy. Two recruitment strategies were used in this study. Information letters and a brief questionnaire were posted to 186 breast feeding women three weeks after discharge from a metropolitan public maternity hospital in Western Australia over a three-month period (January–March 2008). No record was kept of the respondents and no reminders were sent out. Women were given an option of how to submit their breast feeding critical incident: post the questionnaire back to the research team in the stamped self-addressed envelope provided, respond in an email to the chief investigator or tele if they preferred to chat about their experience. Four questions were asked: What is your postcode? How many children have you breast fed (including your most recent infant)? Describe a situation in detail where you felt you received conflicting advice about breast feeding from a health professional? How did this situation affect you and/or your breast feeding? Twelve women responded with written accounts of their recent breast feeding experience that involved conflicting advice. It is unknown how many of these women chose to telephone and participate in a brief interview as the name of their maternity hospital was not sought to ensure anonymity.

The second recruitment strategy involved placement of an advertisement in local community newspapers in February and March 2008. The advertisement heading read 'We need your feedback on breast feeding' with a subheading of 'Are you currently breast feeding or stopped breast feeding within the

past 12 months' to target women who had recent experiences around breast feeding issues and avoid recall bias. Ideally, periods of less than three years for recall are recommended for valid and reliable maternal recall of breast feeding practice (Li et al., 2005). The advertisement noted that a study was being undertaken by researchers to explore mothers' perceptions of receiving conflicting advice about breast feeding issues from health professionals, and how this affected them and/or their breast feeding experience. The first author's contact details were provided, inviting participants to respond and share their stories. Fifty-two women responded to the advertisement and left their name and contact number; 50 were able to be contacted and interviewed over the telephone using a digital recorder. The same four questions were asked during the telephone interview. The interviews ranged from 15 to 45 minutes, with an average of 30 minutes. After an explanation of the purpose of the interviews was offered and demographic information (i.e. post code and parity) were obtained, permission was sought to begin recording the interview. All participants agreed to being recorded. The interviews were transcribed and the transcriber signed a confidentiality agreement confirming that they would not disclose any information contained in the audio recordings.

A modified constant comparison method was used to analyse the transcribed critical incidents (Polit and Beck, 2008, 2010). Questions considered in the analysis included: Who offered conflicting advice? What contributes to advice being perceived as conflicting? Are particular topic areas more susceptible to being regarded as conflicting? What protects against advice being perceived as conflicting? What are the consequences for women? What strategies do women use to manage conflicting advice? Examples from the transcribed data were compared to identify commonalities and variations in the perception and descriptions of conflicting advice under these questions. The first author, who conducted the interviews, analysed all the transcript data. The co-researchers each analysed a cross-section of transcripts ensuring that each data source was reviewed by three team members. Team members analysed their data sets and then came together for discussions to clarify, negotiate and refine the findings. Disagreements on interpretation were negotiated by referring back to the interview transcripts. Final sample size was determined by data saturation when ongoing analysis revealed redundancy of information (Macnee and McCabe, 2008). An audit trail was kept to provide transparency of the decisions and allow evaluation of how data were categorised. To ensure trustworthiness and confirm validity of the findings, a summary of the tentative findings was posted to five participants who indicated an interest in providing this feedback.

Ethical approval was obtained from the hospital and university ethics review committees. Given that women were being asked to comment on a potentially negative situation where they experienced conflicting advice from a health professional, it was essential that they were able to feel safe and anonymous. The research team did not keep a record of names or addresses. Transcript documents and demographic data (post codes and number of children breast fed) were securely stored at the university.

Findings

Sixty-two women shared their experiences and opinion of conflicting advice around breast feeding. Thirty-eight women (61.3%) had breast fed one child and 24 (38.7%) had breast fed two or more children. The majority of participants were able to discuss two or more incidents where they felt they had received conflicting advice. Women were asked to focus upon their most recent birth experience, which in 31 cases involved the private

health sector, and for 29 women involved a public maternity setting. One participant had a home birth and another woman, although living in Western Australia, had her recent birth overseas. Postcodes were categorised in the five quintiles of relative social disadvantage based on Australian census data in 2001, confirming that 63.3% of participants lived in areas labelled 4 or 5, with 5 considered 'extreme advantage' and 1 regarded as 'extreme disadvantage': only 16.6% lived in postcode areas labelled 1 or 2 (Australian Bureau of Statistics, 2001). Direct quotes from the women's transcripts to support and illustrate the findings are presented in *italics*.

Who offered conflicting advice?

No maternity health professional was protected from accusations of delivering conflicting advice around breast feeding. Within the immediate postnatal period in hospital, women cited examples relating to midwives, lactation consultants and medical staff, although incidents predominately focused upon midwives as being the primary source of breast feeding advice. One woman stated that: *Midwife after midwife at the hospital told me and showed me 100 different ways every time they clocked on to their shift*. Another participant indicated: *I had a lot of different midwives come in and contradict all the advice that I'd been given by the previous midwife*. Incidents drawing from the community included the child health nurse, practice nurse at a clinic, general practitioner, Australian Breast feeding Association (ABA) counsellors and community lactation consultants. Although asked to relate one critical incident, most of the participants offered more than one example where they felt they received conflicting advice:

Because literally one person can walk in and say 'so why don't you put the baby under your arm' and then the next person will walk in 'oh no put them that way', and you like 'ok I'll put it that way this time'.

What contributes to advice being perceived as conflicting?

Mismatch between expectations and reality

A mismatch between maternal expectations and reality around breast feeding was found to contribute to perceptions of conflicting advice. To illustrate, participants discussed their beliefs that breast feeding is natural, which was equated with ease and that difficulties were not anticipated. Therefore, when difficulties did occur, women were surprised, shocked and disappointed: *I never thought that it would be so difficult but really it's not as easy as what you would expect it to be*. In addition, women mentioned how they did not appreciate complexities of breast feeding problems or that problems could not be simply fixed. If a problem occurred and was addressed, they were astonished when a solution worked temporarily. Women shared how they did not anticipate that subsequent problems would occur as breast feeding progressed or their infant's behaviour changed. Women commented how they did not realise or, more importantly, were not told that although certain advice may work initially, it may not be the answer for subsequent problems.

Mother's circumstances

The mother's circumstances when advice was offered also impacted upon advice being perceived as conflicting. For example, women who were more vulnerable, such as a first-time mother, a mother with an unsettled infant or a infant who was not responding to strategies could challenge a woman's confidence and ability to interpret information. These features could make it difficult for an anxious mother to remain calm and relaxed when

trying to interpret advice. A further aspect contributing to vulnerability was timing, and the early weeks of breast feeding initiation were particularly trying as mothers were still developing confidence in their abilities.

Approach of the health professional

The approach or manner of the health professional when assisting the mother with her breast feeding could influence perceptions around this advice. A *taking over* or *hands-on approach* to breast feeding problems, which did not allow the mother to be actively involved in management, was seen to contribute to advice being perceived as conflicting. One woman commented how she imagined *some midwives just felt it was just easier to do it yourself*. This approach was regarded as *the easy option*, which could undermine a mother's confidence. Health professionals who did not have the time or skills to offer practical breast feeding advice were also a concern. Moreover, a number of interpersonal aspects were cited as being problematic to women, such as perceptions that the health professionals' agenda was taking precedence over the mother's needs. Feeling *caught up in hospital politics* when there were personality differences between staff members, or being offered advice in a manner perceived as critical, judgmental or blaming by using terms such as *you should* or *you shouldn't be doing that*. Additionally, the use of *throw-away statements* or *blanket statements* did not acknowledge individual situations. Women commented upon not being able to *connect* with certain health professionals due to personality issues, communication styles, loss of their credibility, uncaring attitudes and minimal demonstration of empathy.

Information and advice

Information or advice presented *here and now* as *the only right solution* without suggesting that the advice might not hold true as the situation or infant changed was problematic. Mothers commented how they accepted information presented as *the one right way* but became discouraged when it either did not work or did not resolve a problem over time. In addition, some midwives directly contradicted and discredited the advice from other midwives, and were told *don't listen to her*. For some women, the concern was receiving too many options to address a problem, continuously changing strategies, not taking time to see what was working and not *sticking with a strategy for more than one feed*. The following quote highlights an example of information overload:

Every different nurse on every different shift would kind of say 'well how about you try this then or you know sit up or slouch or put a pillow here or put a pillow there'. It was just quite overwhelming and as I say not necessarily conflicting, cause it was a lot of similar sort of things were being said but just really too much.

Are particular topic areas more susceptible to being regarded as conflicting?

Examples of recurring topic areas where conflicting advice was noted included information around positioning, use of nipple shields, the practicalities of demand feeding and the interpretation of infant sleeping and settling issues upon breast feeding advice. A final point to note is that women were generally well informed on breast feeding topics due to their access to resources, and were aware when advice was contrary to the evidence recommended in their reading.

What protects against advice being perceived as conflicting?

Rationale behind advice

When women were offered a rationale behind the advice offered, they felt better informed to accept the information and make judgements about its relevance in their current situation: *It definitely helps if you know they say we advise you to sit like this and this is the reason why, it makes a lot more sense*. Women want a supportive environment that offers consistent evidence-based information: *They tried to get the lactation consultant to come in every time I was feeding and all the midwives seemed to have the same, had exactly the same advice*. Being a coach with an encouraging approach was valued rather than taking over. This also provided an atmosphere where mothers felt informed and supported to make their own choice: *She did give me options in that she was just saying 'you know do what you feel feels comfortable for you', and she was encouraging*.

Presentation manner, communication, empathy and individual focus

The manner of presenting information or advice, the skills of using effective communication, demonstration of a caring attitude with an empathic approach and focusing upon the woman as an individual were seen to be important by women struggling with breast feeding issues. The importance of doing a thorough assessment and then offering advice with supporting rationale could not be stressed enough by the women: *She listened, she saw and she showed me properly, whereas the other ones were sort of like seemed to always be busy in and out like a quick thing*. Taking the time necessary to *watch you rather than actually doing it for you* was desired. Women wanted one-on-one support and advice that was also supportive of their personal goals: *They [lactation consultants] seem to be a bit more sympathetic you know towards your goals of continuing breast feeding than maybe a GP [general practitioner] would*. Finally, not presenting advice as the only answer to a particular problem was suggested: *To have someone say to you, you know there isn't one right way to do it, it is very good, it's very helpful*.

Connection with the health professional

Women spoke about the importance of their *connection* with the health professional, and how it was based upon personality, perceived credibility and the development of trust. One woman shared how her connection *built up the relationship that helped me to trust her* and another stated how her midwife *was calm*. *She didn't treat me like I was silly*. *She explained herself better*. The credibility of the support person in relation to their knowledge level and expertise with breast feeding issues was valued. The opportunity to have continuity of midwifery care enabled development of trust and facilitated follow-up regarding breast feeding issues:

There were a few other midwives that we had consistently on shift with us while we were in hospital and that's just so reassuring because they know what happened the day before and if you had a problem they can come and follow up with you.

Some women were still able to achieve a connection with certain midwives without continuity: *Some of them were so fantastic that I would almost cry when they walked in the door because you did just think 'oh thank God she's here'*. Another mother stated how *one midwife seemed to care about me as a person rather than me as a patient and I cannot tell you how much that meant at the time*. *In contrast, the ones that I did not connect with seemed a lot more uncaring – business to them*.

Mother's confidence

Although many multiparous women ($n=24$, 38.7%) chose to participate in this study, mothers with more confidence were less vulnerable to conflicting advice. Women with past breast feeding experience and confidence in their own abilities were better able to ignore or select information that suited their situation: *With my second child, I had confidence to persist because I just sort of realised by then that my body took a while to sort of up the supply.* Another woman cited how maturity afforded her the confidence to persist:

I'm a bit older so maybe I thought well if this is working for me you know I don't really have to answer to anyone else so in the end I just decided it's working.

What are the consequences for women?

Women expressed their feelings of being confused, unsure and disappointed when receiving what they perceived to be conflicting advice: *You start feeling quite incompetent because everyone has a different idea.* The emotional impact of dealing with conflicting advice during a trying breast feeding experience cannot be underestimated: *I cried a lot. I was really upset and I remember holding him [baby] and lots of crying.* In addition to this emotional cost, women talked about questioning their desire to continue breast feeding, feelings of guilt and diminishing confidence. A loss of trust and credibility in a particular health professional also occurred as a result of receiving conflicting advice: *I think I would go straight to the ABA resources and listen to them first rather than going along and seeing all these GPs.* Unfortunately, these actions mean that health professionals may not receive feedback regarding the impact of their actions: *I thought I'm going to change doctors but I didn't tell him that, but I never went back to him again.* The final consequence of women receiving conflicting advice from health professionals was that they could choose not to use them as a resource: *well after I think I just stopped asking.*

What strategies do women use to manage conflicting advice?

Women used a number of strategies to manage the conflicting advice they received. They could avoid health professionals and focus upon advice from informal networks such as their other mothers and family members whilst learning to trust their own judgement: *I was working it out on my own or using mothers' group, talking to other mums.* Alternatively, they could still use advice from health professionals but, depending upon their perceived credibility, either ignore the advice completely or selectively accept advice:

I thought bugger you, I'm going to keep using them [nipple shield] because I thought I would rather feed, be able to breast feed him and use a nipple shield than not be able to breast feed at all.

Most women indicated they would not overtly share this strategy and, if necessary, would withhold information: *You need to get off them [nipple shields], you need to get off them and I went 'ok fine'. I just did not tell her [child health nurse] I was still using them.* Women noted the importance of developing their own knowledge without relying on a health professional, or having the knowledge to question and determine if a health professional had credibility:

I feel very confident that if any sort of health professional queried anything, I'd just be able to say well accept it you know like 'I'm sorry I'm not listening to this bullocks anymore'.

Mothers also suggested that they would specifically seek advice from 'an expert' perceived as being trustworthy such as a

lactation consultant as opposed to a midwife, child health nurse or general practitioner who may not have adequate knowledge. One woman noted the defensive reaction she received from a midwife when she asked for a lactation consultant in hospital: *Isn't my advice good enough for you I know about breast feeding too.* As well as seeking out credible support, learning to trust their own judgement was also a strategy that women employed in managing their breast feeding challenges: *Regardless of what the experts think, what I think is important too and as another women stated Learning to trust self, but what I think about things, my personal gut reaction has a lot of merit too.*

Discussion

The findings from this study represent a sample of self-selected Western Australian women who responded to an invitation to share breast feeding experiences of conflicting advice. Although recruitment methods aimed to access a diverse sample of women within a Western Australian context, the majority of respondents resided in socially advantaged areas. Nonetheless, based upon qualitative research standards, rich description of the data has been presented to allow the reader to determine relevant transferability of findings across other settings and groups (Polit and Beck, 2008). Given the vulnerability of first-time mothers to breast feeding concerns, it is not surprising that the majority of participants in this study (61.3%) had breast fed one child. It is also noteworthy that 38.7% of experienced breast feeding mothers chose to share their experience with conflicting advice.

Women in this study confirmed the belief that breast feeding is natural, and as many women equate natural with easy, they did not anticipate experiencing problems. Western Australian mothers in another study also indicated that they were not prepared to experience breast feeding difficulties (Binns and Scott, 2002). Nonetheless, 83% of these hospitalised women went on to experience one or more breast feeding problems, reinforcing how common this phenomenon is. Being unprepared for the possibility of breast feeding difficulties reinforces the importance of effective advice from health professionals to ensure that unresolved problems do not result in women giving up breast feeding earlier than intended. Evidence suggests that having an unmet need for support has been associated with breast feeding cessation (Sheehan et al., 2001). Women must be informed about breast feeding to promote realistic expectations around the effort involved to breast feed successfully. One strategy could be assisting women to understand how common it can be to have initial difficulties, thereby focusing upon ensuring that women know where to find support to overcome difficulties. In fact, evidence from long-term breast feeding women has revealed the need to persist (Bottorff, 1990), overcome many challenges (Gribble, 2008), the need for ongoing breast feeding guidance and support (Rempel, 2004), and specifically mother-to-mother support, spousal support plus personal attributes of confidence and strength in the face of challenge (Hills-Bonczyk et al., 1994; Kendall-Tackett and Sugarman, 1995).

From the perspective of women, conflicting advice goes beyond just the provision of information that is inconsistent or directly contradictory, but includes issues around information overload, the manner in which the information is presented and a perceived disparity between the mother's and health professional's expectations. Other studies have found that inconsistent advice was associated with inaccurate information, and propose that an authoritarian manner of communication can worsen the effect of inconsistencies in approach and information provided (Simmons, 2002; Tarrant et al., 2002). Resolving inconsistent

professional breast feeding support requires understanding the multiple institutional and personal factors that could influence this phenomenon. Fostering strong collaborative relationships with a multidisciplinary support team is essential and must include midwives, general practitioners and child health nurses. Regular opportunities for all team members to dialogue and actively participate in the updating of breast feeding policies may increase 'buy in', promote greater collaboration and decrease both conflict and inconsistencies (Nelson, 2007). The promotion of partnerships and opportunities for interagency educational seminars for health professionals working with postpartum women could not only foster communication links but ensure that consistent evidence-based information is being disseminated.

Addressing perceptions of conflicting advice goes beyond just the provision of consistent advice around a breast feeding problem, but includes attention to interpersonal communication skills such as listening so the woman feels she is being heard; conducting a thorough assessment to understand the woman's situation; providing advice that is tailored to her individual situation; and providing the rationale behind advice so the woman can determine when it is not suitable any longer and seek additional support. Advice provided during the early stages of breast feeding may not be relevant or helpful for subsequent issues, and could be considered conflicting when alternatives were presented that differ from original advice. In other words, advice related to breast feeding issues for a newborn may not be appropriate for a two-month-old infant, and women must be encouraged to understand that breast feeding advice must be taken in the context of the current situation, which can change.

In fact, all forms of extra support have an impact on increasing breast feeding duration (Britton et al., 2007; Chung et al., 2008), and specifically needs-based, one-to-one, informal education or support sessions have been advocated as effective in promoting breast feeding initiation (Dyson et al., 2005). First-time breast feeding mothers have confirmed the value of being shown practical skills rather than just being provided with information (Hoddinott and Pill, 2001). Time spent watching their feeding methods, continuity of care and having a reassuring relationship with a health professional were associated with satisfaction with communication around infant feeding. Excellence in breast feeding counselling and continuity of care has been found to strengthen the maternal–infant relationship, specifically maternal feelings for the infant (Ekstrom and Nissen, 2006).

Finally, the risk of not addressing the issue of conflicting advice goes beyond the impact of creating additional challenges to women's breast feeding success. The credibility of health professionals is being jeopardised as women can lose confidence in their support, question their knowledge, become discriminating in accepting advice or even ignore advice. Unfortunately, this can decrease the effectiveness of those health professionals with the knowledge and skills to truly assist breast feeding women. An important role of the midwife can potentially be undermined due to perceptions of conflicting advice as mothers will seek out 'experts' such as lactation consultants for basic breast feeding problems that are definitely within the scope of midwives.

Conclusion

Conflicting advice from a woman's perspective is not only the provision of inconsistent or contradictory information by health professionals. Aspects such as information overload, differences in expectations around breast feeding, an uncaring judgemental approach in presenting advice, poor communication skills around demonstrating empathy and listening, and not acknowledging the

individuality of each woman's situation were found to contribute to perceptions of conflicting advice. The emotional impact of dealing with conflicting advice cannot be underestimated as women can choose to dismiss the advice from health professionals when the effectiveness of appropriate formal support around breast feeding success has been well established.

Conflict of Interest

None to declare

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