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ORIGINAL ARTICLE

I want to breastfeed my baby: Unvealing the experiences of women who lived difficulties in their breastfeeding process

"Yo quiero amamantar a mi hijo": Develando la experiencia de mujeres que enfrentaron dificultades en su proceso de lactancia

Camila Lucchini Raies[a], Francisca Márquez Doren[a], María Soledad Rivera Martínez[a]

[a]School of Nursing, Catholic University of Chile, Santiago, Chile

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Abstract

Introduction: Breastfeeding is the most beneficial feeding practice for infants. However, it is not always the first choice for mothers and their encouragement and support from health professionals is variable. **Objective:** To understand the experience of mothers who had difficulties with their breastfeeding process. **Patients and Method:** A phenomenological study was conducted in a University Health center. Twelve breastfeeding women were included. Data collection technique was in depth interviews, taped recorded with participants' consent. Phenomenological analysis of data followed Streubert´s method. The rigor of the study was guarded by criteria for qualitative research and the research process. Ethical aspects were sheltered through the informed consent process, confidentiality and methodological rigor. **Results:** The experience of living difficulties in the breastfeeding process is revealed in five comprehensive categories: recognizing the difficulties with breastfeeding; emotional impact when unable to breastfeed; motivation to overcome the difficulty and ask for help; support for breastfeeding recovery; and transition process from stress and anxiety to peace, gratification and empowerment. **Conclusion:** The understanding of this experience is qualitative evidence that contributes to a comprehensive understanding of the situation of each mother and child, allowing to improve support care interventions in health.

Keywords:
Maternal-Child Nursing;
Nursing Care;
Breast Feeding;
Qualitative Research

Correspondence:
Francisca Márquez Doren
fmarquez@uc.cl

Introduction

Breastfeeding is essentially the best way to feed a child. The advantages of breastfeeding are widely recognized and there is a general agreement in its election as first eating practice in childhood[1].

In the last National Health Survey in Chile, 2013, exclusive breastfeeding at 6 months of age represents a 56%, a figure that has increased compared to the previous national survey (43%), performed in 2011. This increase is due to the efforts and the implementation of strategies for its promotion[2]. Although the current number is closer to the expected rate (60%), the percentage of children with exclusive breastfeeding at one month of age is 74%, which is the lowest rate since 1993[3].

Breastfeeding is an essential period both for the mother and for the child when a number of difficulties can arise and lead to an early interruption. Most studies on breastfeeding are carried out with quantitative designs, addressing its physiological aspects[1], benefits[4], length[5] and what are the problems that lead to the interruption[5-7]. However, there are less studies that reveal the experience of mothers going through difficulties during this process[8-10], and there are no publications of national qualitative studies on this subject. The aim of this study was to recognize mothers experiences during their breastfeeding process, and the way that they live and face the difficulties that arise. This will enable comprehensive knowledge to give better support to them.

Patients and Method

A phenomenological design was conducted to reveal the experiences of mothers undergoing breastfeeding problems. This method is the most suitable because it studies any kind of phenomenon necessary for understanding the perception of some experience, allowing us to reveal any experience that their conscious mind is trying to hide[11].

This qualitative method of research is a strict, critical and systematic way to address a phenomenon. In accordance with Husserl, its purpose is to explain the structures of lived experiences, while searching units of meaning, which are the identification of the essence of the experience and an accurate description according to the witnessed experience[11].

The participants of this study were mothers with breastfeeding problems who were part of a child growth and development monitoring support program from an ambulatory health care center that belongs to a university health network. At the time of the research, two of the authors of this article were nurses at the Breastfeeding Clinic in this health network.

The selection of participants was made through purposive sampling, based on the specific knowledge that they had about the phenomenon[11]. The criterion for determining the number of participants was by saturation, which means, when no new units of meaning came up and the data began to repeat, which happened in the tenth interview. However, data gathering continued until researchers ensured that the saturation had been reached[11], conducting two more interviews (12 participants). It should be noted that the concept of saturation in the qualitative paradigm of research seeks to ensure the in-depth understanding of a phenomenon, which can be transferred to a similar reality and not the generalization of results[11].

The information gathering technique was through in-depth interviews with each participant, at a time and place agreed before. The principal investigator (PI) conducted the interviews, after signing informed consent. All participants contacted by the PI agreed to participate, however it was not possible to coordinate the interview with one of them. It is important to note that the researchers made a permanent record of their own feelings and emotions, as a way to separate the experience told by the mothers from their own experience (Process of phenomenological reduction called bracketing)[11].

The in-depth interview was chosen because the purpose of the research was to understand a particular experience, where the researcher focuses his or her attention on everything that the person communicates in relation to that experience[12]. The interviews were recorded (average duration of 40 minutes) and transcribed verbatim. Digital files with interviews were password protected and deleted after the analysis.

The question that guided the interview was: *What has it meant for you to have experienced difficulties during the breastfeeding of your child?*

A content analysis of the first interview was conducted to identify units of meaning. Then, the remaining interviews were performed until reach the saturation, constituting comprehensive categories of the phenomenon. In a first instance, each author carried out this process independently and then together to agree on the units of meaning and comprehensive categories. The phenomenological analysis of the research was done manually and then the process that Streubert postulates followed it[11].

The strictness of the research ensured that the revealed phenomenon represented the experiences of the study participants, following the strategies suggested by Guba & Lincoln[11], which support the rigor of a qualitative research: credibility, fidelity, confirmability, and transferability. The structure of the revealed phenomenon was shared with two of the participants

so that they could confirm that the emerging results were a reflection of their experiences (member check) and each comprehensive category was supported with textual quotations mentioned by the participants. Furthermore, authors kept their own written record of each step of the research and of the analysis process, so that other researchers interested in the topic (audit trail) could follow the record.

The ethical aspects of the research were addressed through the informed consent process[13], the study was approved by the Ethics Committee of the Nursing School UC.

Results

The mothers included in this study were mostly married[9], first-time mothers[10], with university or higher technical studies and ranging in age from 18 to 41 years (31 years on average).

Regarding boys and girls, they were four months and a half old in average (range: 2.5-4 months) at the time of the interview. The gestational age at delivery was 38.5 weeks in average (range: 34-40.5), eight of them were delivered vaginally and four were delivered via cesarean. They were all in skin-to-skin contact with their mothers, except for one case where the delivery was multiple and preterm. Eight of the children were born in maternity wards of university hospitals and four of them in public hospitals.

Women sought for health advice in the Breastfeeding Clinic for multiple problems, some focused on the mother and other on the child and, in some cases, on both. The problems of the mothers were cracked nipples, mycosis of the nipple, breast engorgement, and breastfeeding twins. In the case of children's problems, the difficulties were suck dysfunction, loss of weight, low weight gain, and latch-on difficulties.

For the participants, the experience of living difficulties in breastfeeding meant experiencing a frustration and suffering process along with high levels of distress that encourage them to take action to recover breastfeeding. The mentioned process was unveiled in five comprehensive categories: realizing the breastfeeding difficulties; the emotional impact to be unable to breastfeed; motivation for overcoming the difficulty and ask for help; support in breastfeeding recovery; and transition process from stress and distress to peace of mind, gratification and empowerment in decision-making.

Realizing difficulties in breastfeeding recovery

Mothers reported that one of the first meanings attributed to having breastfeeding problems, was the recognition of difficulties that they faced. These difficulties focused on the mother and/or the child, and the women themselves identified the moment when the problem occurred.

"*Sin-ce the ba-by born* (she says it lengthening the sentence) *Yes,* (sighs*) I mean, from the minute that I gave birth to my baby. They brought him to me after two hours to give him the colostrum* (sighs), *and there was no way that he held on. Then, I squeezed my breast so that droplets would fall on him, but he didn't suck*" (E1).

Emotional impact to be unable to breastfeed her child

Once the mothers were capable to recognize and identify the difficulties that they went through and the moment these difficulties appeared, they experienced a period full of emotions related to the inability to breastfeeding their children. The meaning of the emotional impact was unveiled as a process that passes through the feelings generated by the difficulty of overcoming problems. They were negative emotions in relation to the experience, such as distress; despair at the lack of knowledge and lack of information; insecurity and confusion over the situation they are living; frustration as a mother facing the inability to breastfeed their child, among others.

"*At first, it was a terrible despair, because as a first-time mom, I had no idea where I was going to. I felt very helpless not being able to give him a the breast, that he wouldn't drink, that he wouldn't grab the breast... At the end, that is what it was, because I had no idea where I was going to either*" (E3).

Motivation for overcoming the difficulty and asking for help

Despite the feelings, these women felt when they could not breastfeed; the great motivation for overcoming the difficulties was the well-being and integral development of their child because they knew that it was the best thing they could give to their children, due to the benefits of breastfeeding. They also valued the attachment bond that develops through breastfeeding.

"*Because I know what is best for him. If it is totally up to me, I'm going to do it, because the breast is much healthier, much more than giving him powdered milk and if I can do it for him, I mean, I'm going to do it anyway. If I've got to get on my belly, upside down, the way I have to, but I'm going to do it*" (E6).

Support in breastfeeding recovery

The support in this recovery process was crucial since it was the main reason for the mothers to feel able to overcome difficulties. They said that those who sup-

ported them in this process were the health team and someone meaningful to them. In some cases, this process also occurred with situations where they felt pressured by others. Facing the first difficulties in breastfeeding, these mothers experienced a lack of support or inefficiency of part of the health team and mentioned the characteristics that they expected to have the professionals who took care of them.

"I would say that more than support, it is coherence or consistency in the same discourse. I mean, what happened to me was that shift change came and we had a different vision. Another midwife would come and say to me "no, it does not matter, relax, and do not feed anything (breast)"... Then another person would come and say to me "no, let us try"... I lacked coherence..., a consistency with something, especially in this matter... Try to support the mother that if she needs psychological support give it to her, talk more with her, about what happens to the baby, about breastfeeding. They lost the kind of integrity that considers the whole mother-child relationship which is established through breastfeeding" (E6).

As part of the support received from the health team, it is worth highlighting the importance that the mothers gave to the nursing staff of the breastfeeding clinic. It was a source of energy and positive support to cope with the difficulties they were experiencing.

"The fact that, for example, when they saw me, they told me: How is it going? I felt like they remembered my case that I was not a regular patient, no. I mean, that they had individualized me. That was super important to me, that they remembered what my problem was... That was super important to me, I felt they were worried" (E5).

Along with the importance of support from the health team, the mothers highlighted that the support provided by a relative or significant person for them was fundamental, as they relied on them in the day to day to overcome the difficulties, being their partner the main source of support. They formed the main cornerstone for overcoming the problem.

Transition process from stress and distress to peace of mind, gratification, and empowerment

When mothers received adequate support to face their difficulties with breastfeeding, they realized that they developed the skills and abilities to overcome problems. During this stage, they went through a transition process from the stress and anguish of the beginning to empowerment in decision-making, tranquility, and gratification, as they gained more confidence and acquired more tools during the sessions in the breastfeeding clinic, which favored the relationship with their children.

"I was stressed at first... I mean, to be breastfeeding every three hours, I did not have time for anything... But as I was learning, as I was instructed on the subject, finally now it's nice, it's rewarding. Now I do feel the closeness, the attachment, I got the taste for the sensation of feeling him that he is like a part of me. It is nice, he has a good time and I have a good time too. It is no longer a stressful matter for me" (E3).

Thus, the mothers understood that they could conquer the possibility of breastfeeding, beginning to see certain results that allowed them to visualize the solution of the problems. Once they experienced this transition process, feelings of satisfaction arose and they said that all the effort and wear that meant the path to recovery from breastfeeding had been worth, feeling satisfied with their achievements.

"I love breastfeeding, I mean, no matter how stressful it is, or the sacrifices for meals or for smoking less, or for all those things, I love to breastfeed. In essence, that is why I do it because I know what is best for my daughter..." (E4).

Discussion

The initiation and implementation of breastfeeding are characterized by a period of high vulnerability and transition, producing in the mother a series of hormonal adjustments and the adaptation of the child to the extra uterine environment[8]. Therefore, this is a challenging period for any mother, which can intensify when the process does not develop physiologically or when certain health team practices interfere with it[8,14,15].

From the maternal perspective breastfeeding a child is an experience full of mixed emotions since, on one side, the mother expects to be happy with the arrival of the baby but, on the other side, she begins to feel negative emotions towards herself. Those around her and, sometimes, her own child, in situations where things are not how she and her environment expected, which occurs, for instance, when the mother has difficulties with breastfeeding[9,16].

In this study, at the beginning of breastfeeding difficulties, the feelings of distress, emotional stress, physical and mental fatigue have a key role which coincides with other publications[17-19].

Consistent with the investigation, studies suggest that the decision of breastfeeding and the desire to keep doing it despite the difficulties, are based on the belief that breastfeeding is best for the child. Some research even shows that the decision to breastfeed is made during pregnancy and that the duration of breastfeeding becomes a personal goal for women[9,19,20].

Mothers identify nurses and other health profes-

sionals as a significant source of support, allowing them to feel secure, confident and encouraged to explore their maternal skills, as referred in this study, where mothers identified the nurse at the breastfeeding clinic as a source of motivation and support to overcome their difficulties[19,21,22]. Participants also noticed that the support in the recovery process of breastfeeding is crucial since it is the main reason for mothers to feel able to overcome difficulties. They referred that this support should be provided by the health team and by someone significant to them (partner, family and friends), which is consistent with what was reported by other authors[21,23].

In addition, in relation to the perceived support received by significant people for the mother, evidence indicates that the support given by men during this period is crucial, becoming an ally of their partner during breastfeeding, which is consistent with the results of this study. It has been suggested that the partner should participate in the whole reproductive process so that they can be a real support for the mother during pregnancy and even more so, once the child is born, it is necessary to consider strategies to incorporate them into this process[9,17,19].

Some of the breastfeeding difficulties reported by the mothers in this study were related to the lack of confidence in their ability to breastfeed, adolescent motherhood, decreased milk production, nipple soreness and cracking, sucking problems of the baby, prematurity, and lack of support from the health care team, which is consistent with what was found in other studies[7,9,15].

Additionally, the existence of contradictory professional speeches expressed by the mothers regarding breastfeeding technique, and how to deal with difficulties coincides with other authors results. They point out that the contradictory and inconsistent speech by members of the health team, negatively influences the efforts made by mothers to breastfeed, generating frustration, confusion, and insecurity in themselves[8,9,14,18,24,25].

There is evidence that suggests interventions that empower mothers in breastfeeding decision-making, enable them to identify their problems for themselves, which allows them to put into practice strategies to solve these problems. In addition and while establishing the professional-patient relationship, it is emphasized the importance of considering the respect for their gender status and new mother, establishing a horizontal relationship, prejudices free, respecting individual times and based on trust[26-28].

According to the results of this and other studies, they concluded that the period of greatest vulnerability for women and their child, in relation to the implementation of breastfeeding, corresponds to the first weeks postpartum. Thus, in order to prevent difficulties that could lead to breastfeeding failure, the suggestion is to provide early support. Ideally prior to maternity discharge, considering key aspects identified by the mothers in this study such as having support that responds to their needs, providing personalized and welcoming care, assign time to actively listening to them, developing consistent messages from the health team.

Likewise, there should be an ambulatory network of care, which mothers could go during the first weeks postpartum, with the objective of diagnose and treat in a pertinent and timely manner any problem that arises, in order to support the process of implementation and maintenance of breastfeeding. Another complementary source of support is peer groups, made up of mothers who accompany other mothers in the breastfeeding process, which is an information that health professionals should acknowledge and give to mothers. On the other hand, an important aspect for further nationally study is the effect of the contradictory speech of health professionals on mothers regarding breastfeeding support needs in order to provide professional support with greater relevance and congruence to those needs.

The reality revealed in this study corresponds to a group of mothers with homogeneous characteristics. So further investigation should study the experience lived by breastfeeding women with different characteristics. Such as those who were unsuccessful and who weaned their children prematurely, those who work and have to be separated early from their children, those who experience a postpartum depression during their period of breastfeeding, or those who belong to other socioeconomic levels, with the aim of building a more comprehensive view of the phenomenon. The contribution of this study is the in depth point of view of the mothers regarding the breastfeeding process and the support received from the health team.

Ethical Responsibilities

Human Beings and animals protection: Disclosure the authors state that the procedures were followed according to the Declaration of Helsinki and the World Medical Association regarding human experimentation developed for the medical community.

Data confidentiality: The authors state that they have followed the protocols of their Center and Local regulations on the publication of patient data.

Rights to privacy and informed consent: The authors

have obtained the informed consent of the patients and/or subjects referred to in the article. This document is in the possession of the correspondence author.

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Conflicts of Interest

Authors declare no conflict of interest regarding the present study.

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References

1. World Health Organisation. Infant and young child feeding [Internet]. Geneva; 2009. Available from: http://www.who.int/mediacentre/factsheets/fs342/en/
2. MINSAL. Encuesta Nacional de Lactancia Materna en la Atención Primaria. 2013.
3. DEIS MINSAL. Prevalencia de lactancia materna exclusiva: 1, 3, 6, y 12 meses de vida. [Internet]. 2015. Available from: www.deis.cl
4. Schellhorn C, Valdés V, Juez G, et al. Manual de lactancia Materna [Internet]. 2010. 238 p. Available from: http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:Lactancia+Materna#0\nhttp://books.google.com/books?hl=en&lr=&id=Ulxyj72VZD0C&oi=fnd&pg=PR9&dq=Manual+de+Lactancia+Materna&ots=jpkU9wqOvV&sig=gwfmLOpWDozw0dCfQK9SE4Qu2_E.
5. Balogun OO, Dagvadorj A, Anigo KM, Ota E, Sasaki S. Factors influencing breastfeeding exclusivity during the first 6 months of life in developing countries: a quantitative and qualitative systematic review. Matern Child Nutr [Internet]. 2015;11(4):433-51. Available from: http://doi.wiley.com/10.1111/mcn.12180.
6. Ahluwalia IB, Morrow B, Hsia J. Why do women stop breastfeeding? Findings from the Pregnancy Risk Assessment and Monitoring System. Pediatrics. 2005;116(6):1408-12.
7. Emmanuel A. A Literature Review of the Factors that Influence Breastfeeding: An Application of the Health Belief Model. Int J Nurs Heal Sci [Internet]. 2015;2(3):28-36. Available from: http://cactus.unijos.edu.ng/jspui/handle/123456789/1010.
8. Belintxon-Martín M, Zaragüeta MC, Adrián MC, López-Dicastillo O. El comienzo de la lactancia: experiencias de madres primerizas. An Sist Sanit Navar. 2011;34(3):409-18.
9. Palmér L, Carlsson G, Mollberg M, Nyström M. Severe breastfeeding difficulties: Existential lostness as a mother-Women's lived experiences of initiating breastfeeding under severe difficulties. Int J Qual Stud Health Well-being. 2012;7:1-10.
10. Zahra S, Monreh A, Easa M, Susan P. Successful breastfeeding mothers' experiences of the difficulties of exclusive breastfeeding. Acta Médica Mediterr. 2015;2010(11):1479-87.
11. Streubert H, Carpenter D. Qualitative Research in Nursing: Advancing the Humanistic Imperative. 5ª ed. Lippincott Williams & Wilkins; 2010. 1-496 p.
12. Marshall C, Rossman G. Designing Qualitative Research. Sixth. Marshall C, Rossman G, editors. London, England: Sage Publications; 2010. 344 p.
13. Emanuel EJ, Wendler D, Killen J, Grady C. What makes clinical research in developing countries ethical? The benchmarks of ethical research. J Infect Dis [Internet]. 2004;189(5):930-7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/14976611
14. Chaplin J, Kelly J, Kildea S. Maternal perceptions of breastfeeding difficulty after caesarean section with regional anaesthesia: A qualitative study. Women and Birth [Internet]. Australian College of Midwives; 2016;29(2):144-52. Available from: http://dx.doi.org/10.1016/j.wombi.2015.09.005
15. Couto de Oliveira MI, de Oliveira Souza IE, Moreira dos Santos E, Bastos Camacho, Antonio L. Avaliação do apoio recebido para amamentar: significados de mulheres usuárias de unidades básicas de saúde do Estado do Rio de Janeiro Evaluation of breastfeeding support: meanings from mothers receiving care at primary health care units in the State of.: 599-608.
16. Williamson I, Leeming D, Lyttle S, Johnson S. "It should be the most natural thing in the world": Exploring first-time mothers' breastfeeding difficulties in the UK using audio-diaries and interviews. Matern Child Nutr. 2012;8(4):434-47.
17. Cinar ND, Alvur TM, Kose D, Nemut T. Breastfeeding twins: A qualitative study. J Heal Popul Nutr. 2013;31(4):504-9.
18. Jagiello KP, Azulay Chertok IR. Women's Experiences With Early Breastfeeding After Gestational Diabetes. J Obstet Gynecol Neonatal Nurs. 2015;44(4):500-9.
19. Lommen A, Brown B, Hollist D. Experiential Perceptions of Relactation: A Phenomenological Study. J Hum Lact [Internet]. 2015;31(3):498-503. Available from: http://jhl.sagepub.com/cgi/doi/10.1177/0890334415581646.
20. Palmér L, Carlsson G, Mollberg M, Nyström M. Breastfeeding: An existential challenge-Women's lived experiences of initiating breastfeeding within the context of early home discharge in Sweden. Int J Qual Stud Health Well-being. 2010;5(3):1-12.
21. Meedya S, Fahy K, Kable A. Factors that positively influence breastfeeding duration to 6 months: A literature review. Women and Birth [Internet]. Australian College of Midwives; 2010;23(4):135-45. Available from: http://dx.doi.org/10.1016/j.wombi.2010.02.002.
22. Hannula L, Kaunonen M, Tarkka MT. A systematic review of professional support interventions for breastfeeding. J Clin Nurs. 2008;17(9):1132-43.
23. Bolton TA, Chow T, Benton PA, Olson BH. Characteristics associated with longer breastfeeding duration: an analysis of a peer counseling support program. J Hum Lact. 2009;25:18-27.
24. Obeng CS, Reed D. Healthcare workers' breastfeeding practices and beliefs in Ghana. Int Public Heal J [Internet]. 2015;7(3):289-93. Available from: http://search.proquest.com/docview/1706514258?accountid=11752
25. Nelson AM. Maternal-newborn nurses' experiences of inconsistent professional breastfeeding support. J Adv Nurs. 2007;60(1):29-38.
26. Lucchini Raies C, Uribe T. C,

Villarroel Del P. L, Rojas R. A. Determinantes para una lactancia materna exitosa: Intervención integral *vs* cuidado estándar. Ensayo clínico aleatorio controlado. Rev Chil Pediatr. 2013;84(2):138-44.

27. Meedya S, Fahy K, Parratt J, Yoxall J. Supporting women to achieve breastfeeding to six months postpartum - The theoretical foundations of a successful program. Women and Birth [Internet]. Australian College of Midwives; 2015;28(4):265-71. Available from: http://dx.doi.org/10.1016/j.wombi.2015.06.006
28. Cricco-Lizza R. Ethnography and the generation of trust in breastfeeding disparities research. Appl Nurs Res. 2007;20(4):200-4.