COACTION PUBLISHING

EMPIRICAL STUDY

Breastfeeding: An existential challenge—women's lived experiences of initiating breastfeeding within the context of early home discharge in Sweden

LINA PALMÉR, PhD Student[1,2], GUNILLA CARLSSON, PhD[1], MARGARETA MOLLBERG, PhD[1], & MARIA NYSTRÖM, Professor[1]

[1]*School of Health Sciences, University of Borås, Borås, Sweden and* [2]*School of Health Sciences, Jönköping University, Jönköping, Sweden*

Abstract

For most Swedish women, breastfeeding is an essential part of the childbearing period. Yet, the meaning of breastfeeding from women's perspective is scantily explored. Therefore, the aim of this study is to describe women's lived experiences of initiating breastfeeding within the context of early home discharge. Eight women, two primiparous, and six multiparous were interviewed within 2 months after birth. A reflective lifeworld research design based on phenomenological philosophy was used during the data gathering and data analysis. The results show that the phenomenon, *initiating breastfeeding*, in spite of good conditions, i.e., early home discharge, is complex and entails an existential challenge. The essential meaning of the phenomenon is conceptualized as, "*A movement from a bodily performance to an embodied relation with the infant and oneself as a mother.*" This pattern is further described in its five constituents: "Fascination in the first encounter," "Balancing the unknown," "Devoting oneself and enduring the situation," "Seeking confirmation in the unique," and "Having the entire responsibility." Caring for women initiating breastfeeding entails, from a caring science perspective, to help the mother meet insecurity and strengthen confidence to trust her ability to breastfeed the newborn infant. According to these findings, it is suggested in the discussion that it is time for health care professionals to reject the idea of breastfeeding merely as meals or eating for the infant. Instead, they ought to embrace its origin, namely as a way to closeness between mother and infant.

Key words: *Breastfeeding, lived experience, caring science, phenomenology, reflective lifeworld research*

(Accepted: 14 September 2010; Published: 22 October 2010)

This study is part of a larger project that aims toward a deeper understanding of different aspects related to women who have recently become mothers (in this paper mentioned as woman/mother) and their lived experiences of breastfeeding. In this paper, the analysis of the phenomenon, *initiating breastfeeding*, is presented. The intention is to develop in-depth knowledge useful for developing evidence-based care for childbearing.

Background

It is well known that breastfeeding is associated with positive health benefits, both for mother and child (Hansson, 2004; Ip, et al., 2007; Kramer & Kakuma, 2002a), which is why it is important to promote breastfeeding (Gartner, et al., 2005; WHO, 2001). The World Health Organization (WHO) states that breastfeeding is the optimal way to feed an infant. Therefore, WHO recommends breastfeeding exclusively up to 6 months of age, followed by breastfeeding with supplementary food for 2 years or more (Kramer & Kakuma, 2002b; WHO & UNICEF, 2003). However, internationally there are large variations in breastfeeding initiation and duration, both partial and exclusive. In Sweden, most women initiate breastfeeding but, due to different reasons, almost one-fourth of the newborn infants receive supplementary food during their first weeks, so few women follow the recommendations on breastfeeding (SOS, 2010). Recent research has pointed out the first 5 weeks as critical for establishing

Correspondence: Lina Palmér, School of Health Sciences, University of Borås, SE-501 90 Borås, Sweden. Tel: +46 70 36 69 653. Fax: +46 33 43 54 010. E-mail: lina.palmer@hb.se

Citation: Int J Qualitative Stud Health Well-being 2010, **5**: 5397 - DOI: 10.3402/qhw.v5i3.5397

breastfeeding. Yet, many women stop or wean breastfeeding during this period, which mostly is earlier than they had expected (Kronborg & Vaeth, 2004).

One purpose of professional maternity and child health care is to protect, promote, and support breastfeeding (WHO & UNICEF, 1989). This is still valid, yet early home discharge from hospital after birth has increased. Previous research has found it difficult to reach consensus regarding correlations between breastfeeding duration and length of hospital stay after birth (Brown, Small, Argus, Davis, & Krastev, 2002; Ekström, Widström, & Nissen, 2003a; Waldenström & Aarts, 2004; Waldenström, Sundelin, & Lindmark, 1987). No obvious risk of early home discharge in relation to breastfeeding duration has been found, so as a consequence of this hospital stay after birth has been shortened. However, other researchers emphasize that support—professional, lay or social is crucial for successful breastfeeding (Britton, McCormick, Renfrew, Wade, & King, 2007; Ekström, Widström, & Nissen, 2003b; McInnes & Chambers, 2008). In addition to this, health care professionals' attitudes toward breastfeeding varies and this may have an impact on the support for breastfeeding mothers (Ekström, Widström, & Nissen, 2005). Caring in-hospital routines also influence breastfeeding (Bystrova, et al., 2007; Ekström, et al., 2003a; Moore, Anderson, & Bergman, 2007; WHO, 1998).

As mentioned above, there are several studies related to breastfeeding but most of them have a proliferation of epidemiological, medical, social or cultural aspects (Dennis, 2002; Dykes, 2005; Flacking, Nyqvist, & Ewald, 2007; Kramer & Kakuma, 2002a; Tarkka, Paunonen, & Laippala, 1998). Most common is research that assesses measurable factors related to breastfeeding initiation and duration, for example, by using questionnaires. In such research, breastfeeding is mostly regarded as a bodily function, and the breasts are merely seen as milk-producing organs with the sole purpose of a nutritious activity undertaken by the mother and her infant. Research with this perspective represents both possibilities and limitations but fails to explore the phenomenon *per se*, i.e., the lived experience of initiating breastfeeding from women's perspectives.

International research describes breastfeeding as a personal journey (Nelson, 2006), yet a challenging one (Dykes & Williams, 1999), which is also central for the experience of motherhood (Schmied & Barclay, 1999).

Despite the numerous amount of research on breastfeeding, there is a gap in current literature on breastfeeding, especially in a Swedish context. Until now, in-depth knowledge that aims to understand breastfeeding from the perspective of the women is limited; especially women's lived experience in the first weeks after birth. Thus, professional caregivers do not have access to adequate knowledge to individually care for a woman who has recently become a mother and wants to breastfeed. In order to develop care that enable mothers to breastfeed as recommended or as long as they want to, it is thus necessary to complement previous research and explore women's lived experiences of breastfeeding. Therefore, the aim of this study is to describe the phenomenon, *initiating breastfeeding*, from a caring science and lifeworld perspective as it is lived and experienced by women who initiate breastfeeding in the context of early home discharge in Sweden. Early home discharge (i.e., discharge within 48 h after birth) requires "well-functioning" breastfeeding.

Method and approach

In order to describe the chosen phenomenon, a reflective lifeworld approach was used based on phenomenological philosophy (Dahlberg, Dahlberg, & Nyström, 2008). The purpose of this approach is to describe phenomena as they are lived and experienced by individuals. A phenomenological approach can illuminate the essential meaning of the breastfeeding phenomenon and its variations, and thereby develop the understanding for women's experiences of initiating breastfeeding. The entire research process, this approach and the phenomenological attitude, is characterized by being open for the lifeworld phenomenon, employing critical reflection, bridling the understanding of the phenomenon as well as moving between closeness and distance (Dahlberg et al., 2008).

Informants and data collection

Women's lived experiences of initiating breastfeeding were explored in open and reflective interviews. Permission to conduct the study was granted by the head nurse and the director at the maternity ward. After permission was granted, midwives at the unit were informed and asked to initiate contact with the mothers. The following inclusion criteria guided the informant samples: early home discharge from hospital (within 48 h), i.e., normal birth, healthy mother with a healthy full-term infant (i.e., >37 gestational weeks), breastfeeding within 2 h of birth, breastfeeding regarded as well-functioning by the women as well as the caregivers during hospital stay and Swedish speaking. During their stay at the maternity ward, the women were asked to participate. The women who declared an interest to participate received verbal and written information

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5397 - DOI: 10.3402/qhw.v5i3.5397

both from the midwife and from the first author. Written consent was given from the informant before the interview. In total, eight women participated in this study: two primiparous and six multiparous between 24 and 35 years of age. They were living in rural as well as urban areas. Two of the women were born outside Sweden. All of them were living together with the father of the child, but the fathers did not always stay overnight at the maternity ward. At the time for the interview, they were all breastfeeding.

The setting for the interviews was chosen by the informants, and all of them did choose their own homes. Data was collected via tape-recorded interviews within 2 months after birth and lasted 30–60 min. Each woman was interviewed on one occasion by the first author (LP). The initial question was, "Would you like to tell me about your experiences of breastfeeding during these first few weeks?" In order to obtain detailed narratives of their experiences, questions such as, "Would you tell me more about that?" and, "What does that mean to you?" were asked during the interview. The women were thus encouraged to describe variations in their feelings and experiences.

Data analysis

The data analysis followed the descriptions used for reflective lifeworld research and phenomenology according to Dahlberg et al. (2008). The interviews were transcribed verbatim and analyzed by the interviewer. Each interview was read at least twice in order to gain a sense of the whole by trying to have an open mind. Then, with this sense of a whole in mind, meaning units described with a few words were marked in the text. In order to structure the meaning units, different clusters were formed. Each cluster consisted of meaning units that related to each other. Thus, a new whole was revealed that contained a description of the phenomenon, i.e., the essential meaning of *initiating breastfeeding*. The essential meaning was formulated and further described by its constituents, i.e., the variations of the essential meaning.

During the data analysis process, researchers strove to have a reflective phenomenological attitude toward the data and the phenomenon. One part of this reflecting attitude is described by Dahlberg et al. (2008) as bridling, which means, "to actively wait for the phenomenon and its meanings to show themselves." This was done by reflecting on the pre-understanding of the phenomenon before entering the texts together with the co-authors. An attempt was to remain in the first analysis phase, i.e., reading the texts over and over to gain a sense of the whole, to stay close to the data and then move back and forth a few times in order, "not to definite what is indefinite" (Dahlberg & Dahlberg, 2003).

Ethical considerations

Ethical approval and permission to undertake this study were obtained from Ethics Committee of the Medical Faculty at the University of Gothenburg, recorded (Dnr 283-04). The ethical standards of the Helsinki Declaration (2008) have been followed. All participants received written and verbal information about the purpose of the study, about their right to withdraw at any time and about the confidentiality of the information they give to the researcher. If needed, all women could have an extra appointment with a professional caregiver at the maternity clinic.

Findings

The essential meaning of the lived experience of initiating breastfeeding is conceptualized as, "A movement from a bodily performance to an embodied relation with the infant and oneself as a mother." This constitutes a balancing act experienced as an existential challenge, which is to understand and meet the needs from the infant as well as from oneself. Initially, the main focus is breastfeeding as a bodily performance and the body as a breast-milk producer. There are notions of whether or not to trust one's ability to produce milk and adequately nourish an infant. This signifies doubt and insecurity in one's body's efficacy. The movement, from breastfeeding as a bodily performance toward an embodied relation, entails a separate strive to manage breastfeeding, both from mother and from infant. Nevertheless, attaining confidence in one's ability to breastfeed, the infant and its responses to breastfeeding is essential for moving toward an embodied relation.

For the mother–infant dyad, breastfeeding is experienced as a tentative dance, which entails to respond to one another in a mutual way. In this intimate connection, both with the infant and with oneself, breastfeeding signifies being aware of, giving and sharing one's body with the infant in a different way than during pregnancy. However, the strive to do this in a new way requires support from partners as well as caregivers, although central in moving toward an embodied relation with the infant and oneself is the infant's reactions and responses to breastfeeding. The movement from a bodily performance to an embodied relation thus develops if mother and infant interpret each other's signals and respond to them in a mutual way. Over time, breastfeeding develops into a synchronic dialogue,

which includes gives and takes in order to satisfy both needs. Through breastfeeding, mother and infant become intertwined with each other in such a way that forms and functions as an entity. Thus, breastfeeding is an important way into motherhood and also a confirmation of it, which is why breastfeeding in the early weeks after birth is a challenge in trusting both infant and oneself.

The essential meaning is more thoroughly described below from its five constituents: "Fascination in the first encounter," "Balancing the unknown," "Devoting oneself and enduring the situation," "Seeking confirmation in the unique," and "Having the entire responsibility."

Fascination in the first encounter

The first encounter with the infant begins when the baby is placed naked on the mother's chest. This includes the time until the first breastfeed and is characterized by fascination with the infant's striving to reach the breast. In that very moment, the woman who has just become a mother follows the infant's own movements to the breast with fascination over its ability immediately after birth to show signs, seek for, root, find the breast, and latch on. Then successful, overwhelming feelings of happiness emerge. The first encounter and first breastfeed are difficult to imagine beforehand, hence the overwhelming feeling of fascination, joy, and astonishment.

> Yes, I had him on my chest. I saw his head moving like this (demonstrates), and he started doing like this with his hands (demonstrates). And then I took him to my breast and he found the nipple directly and latched on. This is happiness, I think. The whole situation just signifies happiness. (No. 8)

The fascination over the first encounter with the infant and its breastfeeding ability involves a feeling of confirmation the infant's capacity and ability to breastfeed as well as a confirmation of the ability of one's body to feed and satisfy the infant. The meaning of the first encounter thus implies that the infant is competent enough to breastfeed in spite of doubts during pregnancy. "Wonderful experience you couldn't imaging before or explain. Like, yes, incredible, like, I don't know …" (No. 5)

Having the privilege to be a part of such an important moment infuses feelings of harmony, which gives hope through the forthcoming breastfeeding moments. With the infant's ability in mind, the women can relax. The first breastfeed is visualized during later breastfeeding and the knowledge that the infant can breastfeed entails a profound and calming sense of confidence and security.

> The first breastfeed is a wonderful feeling. I felt that he's done it so well, now hopefully he can do it and know it later, too. This first hour was fantastic. (No. 3)

When the baby is breastfeeding for the very first time, it becomes a confirmation of motherhood: "It felt like it was when she was here with me (breastfeeding) than I became a mother. Somehow, it was in that moment I felt I became a mother." (No. 2)

Balancing the unknown

Initiating breastfeeding is experienced as "balancing the unknown." The unknown creates feelings of insecurity and gives rise to questions whether or not the body can produce and supply enough milk to satisfy the infant's needs. Actually, the milk can be experienced as something unknown, which means that it is out of control. Feelings of uncertainty about one's own ability to interpret and respond to the infant's signals also emerge. Such feelings are demanding and stem from calling the body's ability into question.

> I felt like I was a failure and damn, nothing (no milk) is coming. How should this be …? Do I need to give her formula for the rest of her life now or, you know, I had very gloomy thoughts about this. It felt really hard that she hadn't gained weight and that she didn't get enough milk. That situation was hard and strenuous. (No. 2)

Feelings of being an incompetent mother emerge if the infant appears to reject or seek the breast more often than expected or is fussy when it comes to breastfeeding. This brings about feelings of inability to breastfeed. Balancing in the unknown is also accompanied by insecurity and uncertainties of not doing it right. Women fumble for balance and harmony with the infant. Breastfeeding is of crucial importance when evaluating one's capability of motherhood, of which one central point is to trust oneself and the infant.

> At first, I felt like I was a bad mother. I haven't even thought about that he must breastfeed that often. Mostly because he didn't show any signs that he wanted to, but of course it's not always that which counts. (No. 6)

Balancing in the unknown is further described as a disappointment when the infant does not gain weight. If so, women tend to blame themselves and

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5397 - DOI: 10.3402/qhw.v5i3.5397

accuse their bodies for not being fit enough to produce milk, which entails feeling powerless. Hence, when breastfeeding do not work out as expected, it signifies a threat to one's ability of being a good mother. Feelings of being a worthless mother can emerge rather quickly, and how to continue motherhood is called into question.

> Very demanding, everything had been so good and worked out excellent until they discovered that she hadn't, she hadn't gotten anything. Then it was the contrary, you might say. It was the contrary and I felt worthless. I thought everything had worked out well and then she hadn't gotten anything. (No. 2)

Devoting oneself and enduring the situation

Initiating breastfeeding means devoting oneself and endure the situation. It involves a suffering when enduring the pain and the physical changes in one's body. In the first days after birth, it is common to have swollen breasts and sore nipples which can cause painful breastfeeding. Thus, women are dependent on the infant's ability to latch on and remove the swelling. The breast can feel bursting and the women want it desperately to go away, yet at the same time it hurts their sore nipples to breastfeed. Therefore, breastfeeding entails as an uncontrollable situation that can be controlled by devoting and enduring the situation.

> I felt it in my entire body, or what should I say . . . it's a discomforting feeling. But in spite of that, I must be strong. But I did not always look forward to it (breastfeeding), but the most important thing was that he did breastfeed and had food and that's the main thing. (No. 3)

Women devote themselves and endure the situation because of a strong and inner desire to breastfeed. Knowledge about the health benefits of breast milk is motivating when initiating breastfeeding, even if it is a bodily challenge at first. This knowledge gives breastfeeding other dimensions, and women experience a desire to fight the obstacles that occur. Initiating breastfeeding is experienced as doing something good for the infant's health.

> Breastfeeding, it is something positive, it is good for the infant and it protects against infections. That is what I had in mind all the time and it was that which motivated me to breastfeed. (No. 7)

Women want privacy (from close friends and relatives) and be together with the infant and partner (siblings if any) in order to devote themselves and endure the situation. Once the first challenging days or weeks are over, breastfeeding is experienced as less difficult. To devote oneself to the newborn and endure the situation thus means a temporary change in one's social life, which is seen as a limited wish to meet and relate to others outside the immediate family. Pain and feelings of discomfort cause this, and instead, a wish to escape and hide together with the infant appears.

> It was depressing or very sad when it was as bad with sore nipples, then I didn't want to meet anyone else outside my family. I was on the edge because it hurt that much. I felt the pain in my whole body, even down to my toes. I wasn't that social and not in the mood. I really strove with breastfeeding and the main thing was that he got what he should have. I felt that I must stand strong even if it was hard. (No. 3)

Seeking for confirmation in the unique

The meaning of being unique compared to others includes a desire to be seen as an individual with unique needs regarding breastfeeding. Initiating breastfeeding can entail loneliness if the caregivers are "invisible." This loneliness brings about vulnerability and results in an increased desire to be confirmed. Caregivers are "out there" and not present with the women. The women are longing for confirmation.

> When we came to the maternity ward and she was hungry, I offered her my breast and she latched on but it was never anyone there to care for me. Sometimes someone came in during breastfeeding and then they took the opportunity to watch and said "it looks good." Then they went out again and I know they wouldn't check anymore or show me anything. I felt abandoned. (No. 2)

There are ambiguous feelings concerning the care at the maternity ward. It is essential in women's longing for confirmation that they are paid attention to without having to ask for it. Instead, confirmation occurs when caregivers have the ability to see each woman as unique. Caregivers might be present but not all of them emotionally, so only a few have the ability to confirm. In turn, women might not want to interrupt caregivers because they seem occupied or stressed. Caregivers work in different ways, which entails confusion and alienation about breastfeeding. This results in mistrust both in the caregivers and in one's ability to handle breastfeeding alone. This is challenging in an already insecure situation. Despite the feelings of "invisible caregivers" at the maternity

ward, there is a contradictory feeling, namely being in safe hands if something actually happens.

> It was both good and bad at the maternity ward. They said different things and sometimes this was good but mostly it was confusing. Take breastfeeding technique for example. Some of them said "have him this way" and some said "have him that way" (demonstrates). It was a little bit confusing with these opposite views all the time, especially when it is a short hospital stay. Everyone has their own thoughts. (No. 3)

Seeking for confirmation is directed to the caregivers but also to the partners. If the partner is present at the maternity ward he has opportunity to discover his woman's requirements, and most of them have the ability to confirm her needs. Confirmation from a partner helps women to handle breastfeeding, which entails a feeling of shared responsibility. This relieves the pressure when initiating breastfeeding, as confirmation and presence of the partner strengthen one's self-confidence in breastfeeding.

> It was very good that my partner had the opportunity to stay with me (at the maternity ward). I felt that he helped me a lot because he's seen it from his point of view. It was a favor because then you're two, you're two who've seen and heard. I felt it was a big help for me. (No. 4)

Having the entire responsibility

Having the entire responsibility means feeling bound, which is ambiguous and involves an awareness of constantly being present, both spatial and temporal, without a chance to escape. This creates the sense of a burden. Sometimes, the women want to run away, which causes frustration over being constantly tied to the infant during the breastfeeding period.

> I knew that he must have food and I felt that I'm the food so, I must be around him all the time. I feel the same way now too, but then, initially, I felt that a lot. He was breastfed so often I couldn't do anything else than be very, very close to him. (No. 6)

However, these feelings mostly remain for a short time. Being tied up also includes the experience of being needed and loved by the infant. Therefore, the meaning of having the entire responsibility is equivocal: the bound and tied-up feelings equally signify a close relation between mother and infant. Women experience a privilege to breastfeed and having the entire responsibility:

> It's wonderful, I think, like we two are one, or so to speak (laughing). This is happiness, I think. The whole situation is happy. I felt that breastfeeding is cozy. This closeness and the little naked body against me ... (No. 8)

Initiating breastfeeding and having the entire responsibility is experienced as giving the infant first priority and let oneself come second. This could be an overwhelming and remarkable experience with total focus on the infant. During these first few days, everything circles around breastfeeding and efforts in handling this new situation.

> I know he's sleeping but it doesn't help me because I'm still that worried even though my husband is at home. It's to be the food that's demanding. I can't relax. (No. 6)

Having the entire responsibility also means that the infant is dependent on the mother. Also this issue has double meanings, both demanding and encouraging. The infant's vulnerability and needs entail feelings of importance as a mother. Then women are irreplaceable, which gives rise to feelings of being confirmed and appreciated. It involves developing essential and secret bonds, so as the relationship between mother and infant grows stronger if breastfeeding functions well. Having the entire responsibility thus means to endure the overwhelming feelings of being bound, and since the infant depends on the mother, mothers wants to manage breastfeeding so that the mother and infant relationship can develop.

> I have this strong, this ... I feel that he's depending on me and no one else. I feel ... because we haven't started bottle feeding yet. I've got these strong mother's feelings when breastfeeding. (No. 8)

Discussion

Variations concerning women's lived experiences of the phenomenon are described as different meanings interlaced into an entirety described as its essential meaning. The essential meaning, "A movement from a bodily performance to an embodied relation with the infant and oneself as a mother," indicates that initiating breastfeeding influence women at a deep existential level. The wholeness of such an experience contains fascination in the first encounter, balancing the unknown, devoting oneself and enduring the situation, seeking confirmation in the

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5397 - DOI: 10.3402/qhw.v5i3.5397

unique and having the entire responsibility. Thus, an existential issue as in this study is characterized by its focus on meaning.

In this study, initiating breastfeeding ought to be understood as a movement including the whole period from the first breastfeed until the mother experience breastfeeding as integrated into herself and the infant, i.e., an embodied relation. Therefore, initiating breastfeeding is interlaced with establishing it. Despite good conditions for breastfeeding (breastfeeding considered as "well-functioning" by the mother), this study indicates complexities when initiating breastfeeding. In the first few weeks, feelings can be ambiguous and the interviewed women, irrespective of whether they were primiparous or multiparous, questioned themselves and their ability to adequately breastfeed their infant. They doubted their bodies' efficacy, and it seems that there is a strive trusting both the infant and oneself. Therefore, from the mothers' perspective, initiating breastfeeding is an existential challenge; a balancing act between the infant's and the woman's needs. It entails a movement from a bodily performance to an embodied relation with the infant and oneself, which might be understood as developing a new aspect of *Being* (Heidegger, 1981/1927) for the new mother, i.e., attending to, giving and sharing one's body with the infant in a mutual way. The phenomenological analysis revealed that breastfeeding-as-lived is more than a biological adaption, it is an existential challenge, which according to Merleau-Ponty (1962) might be understood as an experience involving two subjective bodies. Initially, mothers experience breastfeeding as "to be the food" and the milk as something unknown, which is out of control, invisible. The milk and the breast, might as Merleau-Ponty's (1968) "the chiasm" be understood as a link between the mother and the infant. Embodied breastfeeding interlaces mother and infant into a communion and may be understood as a relation between two dyadic bodies which is an intercorporeal way of being. According to Merleau-Ponty (1962), the movement into an embodied relation can further be understood as two intentional subjects directed to each other and interlaced in a synchronic way. Breastfeeding as a chiasmic relation also means an intertwining of the two as well as the shared body experience affecting the being of each other. According to the present study, breastfeeding is experienced as an essential part of the childbearing period and central for entering motherhood.

Previous research has mainly focused on factors that contribute positively or negatively to the duration of breastfeeding (Dennis, 2002; Ekström, et al., 2003a,b; Kronborg & Vaeth, 2004; Kronborg & Vath, 2009; Tarkka et al., 1998). The results of our study complement previous research with the understanding of breastfeeding from an existential perspective. Also, previous research directs its interest to the fact that women start breastfeeding within different contexts (Bartlett, 2005). There is also a general perception of breastfeeding as something mother and infant can do without learning, if really want too. Such ideas are rooted in the western culture (Bartlett, 2005) where breastfeeding is the norm for infant feeding (WHO & UNICEF, 2003). Therefore, and as Waldenström (2007) points out, economic restrictions and parents' wishes have shortened the length of hospital stay after birth. One consequence of such assumptions is that some mothers are left alone with the responsibility for breastfeeding and this may undermine women's confidence (Dahl, 2004; Larsen, Hall, & Aagaard, 2008).

With this in mind, and also taking into account the existential dimension expressed in the present study, the main emphasis should be on individualized care and not standards, such as length of hospital stay. Waldenström and Aarts (2004) point out the fact that maternal characteristics are a more important predictor of breastfeeding duration than length of hospital stay. We agree with Waldenström and Aarts (2004) that initiating breastfeeding is more than a physiological process that depends on how much time a woman spends at a maternity ward. But the findings from our study make it fair to suggest the importance of a caring approach in order to overcome social and psychological obstacles for breastfeeding. Thus, initiating breastfeeding must be seen as a unique process taking time and differs from woman to woman, instead of merely the result of predetermined factors such as being healthy and a non-smoker, as described by Waldenström and Aarts (2004).

The findings of the present study confirm previous research on mothers' need of support as an important factor for breastfeeding (Bondas-Salonen, 1998; Britton et al., 2007; Dykes, 2005; Ekström et al., 2003b; Tarkka et al., 1998). Hence, this study emphasizes the importance of support at the same time as it identifies the central role of the infant when initiating breastfeeding. One previous study also emphasizes the important role of the infant for successful breastfeeding (Lothian, 1995). The women in our study seem rather unprepared for breastfeeding, especially for the demands of the infant. Since breastfeeding is experienced as a bodily performance, regarding for example the body's ability to produce milk, women ought to have the possibilities to reflect on this during pregnancy. According to our study, one way of caring for these women is to be aware of and meet their insecurity about their bodies' ability and strengthen their

confidence in trusting themselves and their infant. This can be achieved in a caring relationship during childbearing by reflecting on breastfeeding as an existential challenge and a new way of *Being* (Heidegger, 1981/1927). Initiating breastfeeding involves striving both for mother and for infant, and in order to facilitate this, it is important to gain an understanding of the infant's primal behavior. In terms of attachment, Bowlby (1970) explains an infant's behavior, for example, crying, as seeking care, security, and protection. From an evolutionary perspective, this primal behavior is a guarantee for survival, i.e., crying for help in order to be carried and protected. Thus, breastfeeding is one way for the infant to be close and protected by its mother (Ljungberg, 2001). But, also according to Bowlby (1970), one's next of kin have a responsibility to support mother and infant with security. An infant's primal behavior includes breastfeeding on demand, and this can be several times an hour (Ljungberg, 2001; Mead, 1965). In contrast to the medicalized breastfeeding manner of the early 1900s, when childbirth was moved from home to hospital, breastfeeding was recommended every fourth hour and regarded as "meals" for the infant. In between, the infant should be separated from close contact with its parents or others. Breastfeeding regulation was used as a way to foster the infant into obedience (Ekenstam, 1993; Ohrlander, 1992).

In the 2000s, mothers are, or at least should be, recommended to breastfeed on the infant's demand (WHO, 1998) but implicitly this can be restricted to six to eight "meals" during 24 h. But as mentioned above, an infant's primal breastfeeding behavior consists of far more than this (Ljungberg, 2001; Mead, 1965). This reveals that breastfeeding still is regarded as "meals" and "eating" for the infant (GrowingPeople, 2010). One consequence of such attitudes can be that women may experience perceived breast milk insufficiency (Dykes & Williams, 1999; Hillervik-Lindquist, 1991) as a result of the infant's request to breastfeed more often than their mothers expected. Dykes (2005) has similar results as ours in terms of expressed mistrust in the body's efficacy, but in contrast to ours the women in her study saw breast milk just as nutrition rather than relationally. Maybe mothers' doubts about their bodies' ability to produce milk and their initial experiences of breastfeeding as a bodily performance is rooted in the idea of breastfeeding as just "meals" or "eating" for the infant and an unawareness about the infants' primal breastfeeding behavior. As the results of our study indicate, it is time to draw attention to breastfeeding as an embodied and thus intertwining relation which affects the being both for the mother and for the infant. Also, attention must be paid to the infant's primal breastfeeding behavior to facilitate the movement into an embodied relation. We also recommend that health care workers in the field of childbearing and child health care to reject the idea of breastfeeding as merely "meals" or "eating" for the infant and focus on its origin, namely as a way to closeness between mother and infant. Then the main focus ought to be not only on the mother's ability to produce and deliver breast milk. Hopefully, this can prevent stress, demanding feelings and breastfeeding problems.

The findings of the present study make it fair to assume that a caring relationship entails an awareness of lifeworld descriptions (i.e., breastfeeding-as-lived), to have an existential gaze and confirm women in their uniqueness. When developing childbearing care, the value of such a caring relationship ought to be taken into consideration. Such assumptions are confirmed in several studies conducted during the childbearing period (Berg, Lundgren, Hermansson, & Wahlberg, 1996; Lundgren, 2005; Lundgren, Karlsdottir, & Bondas, 2009). It is also time to highlight the partner's presence as essential for breastfeeding. In fact, partners, mostly men, often experience themselves as unimportant with a secondary role during childbirth (Premberg, Hellstrom, & Berg, 2008). But on the contrary, the results of our study emphasize that partners has an important role in being with their women and supporting her uniqueness. This corresponds well to the aforementioned theory of attachment (Bowlby, 1970).

Methodological reflections

To describe and enter the phenomenon, *initiating breastfeeding*, a reflective lifeworld approach based on phenomenological philosophy was used for this study. The analysis followed the principles for descriptive phenomenology as suggested by Dahlberg et al. (2008). During the research process, it is important, "not to take the indefinite as definite" (Dahlberg & Dahlberg, 2003). This means being aware of one's pre-understanding of a phenomenon. For the first author, a midwife with special education in breastfeeding, this was quite a challenge. In order to decrease the influences of her pre-understanding, she tried to make explicit her inner thoughts and own experiences about the phenomenon during discussions with the co-authors. Another important principle for the analysis was to stay as long as possible in the first phase of the analysis, i.e., moving back and forth (between a specific meaning unit to

Citation: Int J Qualitative Stud Health Well-being 2010; 5: 5397 - DOI: 10.3402/qhw.v5i3.5397

the sense of the whole interview) several times in order to minimize the risk of misunderstandings to avoid explicit interpretations. By doing so, the phenomenon was understood as a figure against a background or the reverse. As the phenomenon is connected to its context as figure and background, the result is contextual.

Therefore, it is important to consider the context of this study. It was undertaken with a group of Swedish-speaking women who gave birth at a hospital in the southwest of Sweden. Also, one should bear in mind that our selection only concerned mothers, births, infants, and hospital stays without complications. All the women wanted to breastfeed and breastfeed at time for the interview. They considered breastfeeding as "well-functioning." The context can also be understood as early home discharge, i.e., within 48 h after birth. However, there are lessons to be learnt from these findings; by analyzing and considering the findings as they are related to childbearing context, they can help developing a more evidence-based professional approach when caring for women initiating breastfeeding. Hopefully, it also can contribute to professional knowledge when caring for women during the entire breastfeeding period.

Conclusions

Breastfeeding interlaces biological and existential issues that cannot be separated into different parts. Therefore, it must be regarded in its wholeness with the lived experience as essential. Breastfeeding is an essential part during childbearing and despite good conditions, initiating breastfeeding is a complex phenomenon and entails an existential challenge; a balancing act between mother and infant. This can be understood as a movement from a bodily performance to an embodied relation, which depends on trusting both oneself and the infant. When striving for well-functioning breastfeed, mother and infant are intertwined into each other. When breastfeeding is integrated into oneself, it is also embodied. From a caring perspective, it is important for professional caregivers to give attention to the lifeworld of breastfeeding mothers, i.e., breastfeeding-as-lived, and bear in mind that many women the first weeks after birth have concerns with their ability to produce enough milk and trust the signals of their bodies. Therefore, it is crucial to have a caring approach and meet women in their insecurity, even for early home discharges when the initial breastfeeding is considered "well-functioning."

Future research

If care during the breastfeeding period is to develop into evidence-based care, there is a need for more knowledge from women's perspectives with difficulties in breastfeeding. Consequently, this is the focus of the next study in this project.

Acknowledgements

The authors would like to thank the participants of this study. First author wants to thank Ingela Lundgren, Associate Professor, University of Gothenburg for support. The authors acknowledge the contribution of Ms Linda Lovecraft for revising the English text.

Conflict of interest and funding

The authors have not received any funding or benefits from industry to conduct this study.

References

Bartlett, A. (2005). *Breastwork: Rethinking breastfeeding*. Sydney, NSW: UNSW Press.

Berg, M., Lundgren, I., Hermansson, E., & Wahlberg, V. (1996). Women's experience of the encounter with the midwife during childbirth. *Midwifery*, *12*(1), 11–15.

Bondas-Salonen, T. (1998). New mothers' experiences of postpartum care – a phenomenological follow-up study. *Journal of Clinical Nursing*, *7*(2), 165–174.

Bowlby, J. (1970). *Attachment and loss. Vol. 1., attachment*. London: Hogarth.

Britton, C., McCormick, F., Renfrew, M., Wade, A., & King, S. (2007). Support for breastfeeding mothers. *Cochrane Database of Systematic Reviews*, (1). Retrieved September 28, 2010, from http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001141/frame.html. doi:10.1002/14651858.CD001141.pub3

Brown, S., Small, R., Argus, B., Davis Peter, G., & Krastev, A. (2002). Early postnatal discharge from hospital for healthy mothers and term infants. *Cochrane Database of Systematic Reviews*, (3). Retrieved September 28, 2010, from http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002958/frame.html. doi:10.1002/14651858.CD002958

Bystrova, K., Widstrom, A. M., Matthiesen, A. S., Ransjo-Arvidson, A. B., Welles-Nystrom, B., Vorontsov, I., et al. (2007). Early lactation performance in primiparous and multiparous women in relation to different maternity home practices. A randomised trial in St. Petersburg. *International Breastfeeding Journal*, *2*, 1–14.

Dahl, L. (2004). *Amningspraktikens villkor: en intervjustudie av en grupp kvinnors föreställningar om, förväntningar på och erfarenheter av amning*. [The conditions of breastfeeding: an interview study of a group of women´s perceptions of, expectations on and experiences of breastfeeding]. Unpublished Dissertation, Acta Universitatis Gothoburgensis, Göteborg.

Dahlberg, H., & Dahlberg, K. (2003). To not make definite what is indefinite. A phenomenological analysis of perception and

its epistemological consequences. *Journal of the Humanistic Psychologist*, *31*(4), 34–50.

Dahlberg, K., Dahlberg, H., & Nyström, M. (2008). *Reflective lifeworld research*. Lund: Studentlitteratur.

Dennis, C. L. (2002). Breastfeeding initiation and duration: A 1990–2000 literature review. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, *31*(1), 12–32.

Dykes, F. (2005). "Supply" and "demand": Breastfeeding as labour. *Social Science & Medicine*, *60*(10), 2283–2293.

Dykes, F., & Williams, C. (1999). Falling by the wayside: A phenomenological exploration of perceived breast-milk inadequacy in lactating women. *Midwifery*, *15*(4), 232–246.

Ekenstam, C. (1993). *Kroppens idéhistoria: disciplinering och karaktärsdaning i Sverige 1700–1950* [The history of ideas of the body: discipline and character-formation in Sweden 1700–1950]. Hedemora: Gidlund.

Ekström, A., Widström, A. M., & Nissen, E. (2003a). Duration of breastfeeding in Swedish primiparous and multiparous women. *Journal of Humam Lactation*, *19*(2), 172–178.

Ekström, A., Widström, A. M., & Nissen, E. (2003b). Breastfeeding support from partners and grandmothers: Perceptions of Swedish women. *Birth*, *30*(4), 261–266.

Ekström, A., Widström, A. M., & Nissen, E. (2005). Process-oriented training in breastfeeding alters attitudes to breastfeeding in health professionals. *Scandinavian Journal of Public Health*, *33*(6), 424–431.

Flacking, R., Nyqvist, K. H., & Ewald, U. (2007). Effects of socioeconomic status on breastfeeding duration in mothers of preterm and term infants. *European Journal of Public Health*, *17*(6), 579–584.

Gartner, L. M., Morton, J., Lawrence, R. A., Naylor, A. J., O'Hare, D., Schanler, R. J., et al. (2005). Breastfeeding and the use of human milk. *Pediatrics*, *115*(2), 496–506.

GrowingPeople. (2010). Amning första tiden hemma [Breastfeeding in early weeks]. Retrieved May 20, 2010, from http://www.growingpeople.se/templates/Page.aspx?id=2426&del=2

Hansson, L.-Å. (2004). *Immunobiology of human milk*. Amarillo: Pharmasoft Medical Pub.

Heidegger, M. (1981/1927). *Varat och tiden* [Being and time] (R. Matz, Trans.). Göteborg: Daidalos.

Hillervik-Lindquist, C. (1991). Studies on perceived breast milk insufficiency. A prospective study in a group of Swedish women. *Acta Paediatrica Scandinavica Supplement*, *376*, 1–27.

Ip, S., Chung, M., Raman, G., Chew, P., Magula, N., DeVine, D., et al. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. *Evidence Report Technology Assessment (Full Rep)*, (April no. 153), 1–186.

Kramer, M., & Kakuma, R. (2002a). Optimal duration of exclusive breastfeeding. *Cochrane Database of Systematic Reviews*, (1). Retrieved September 28, 2010, from http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003517/frame.html. doi:10.1002/14651858.CD003517

Kramer, M., & Kakuma, R. (2002b). *The optimal duration of exclusive breastfeeding [Elektronisk resurs] a systematic review.* Geneva: Department of Nutrition for Health and Development, Department of Child and Adolescent Health and Development, World Health Organization.

Kronborg, H., & Vaeth, M. (2004). The influence of psychosocial factors on the duration of breastfeeding. *Scandinavian Journal of Public Health*, *32*(3), 210–216.

Kronborg, H., & Vath, M. (2009). How are effective breastfeeding technique and pacifier use related to breastfeeding problems and breastfeeding duration? *Birth: Issues in Perinatal Care*, *36*(1), 34–42.

Larsen, J. S., Hall, E. O., & Aagaard, H. (2008). Shattered expectations: When mothers' confidence in breastfeeding is undermined – a metasynthesis. *Scandinavian Journal of Caring Sciences*, *22*(4), 653–661.

Ljungberg, T. (2001). *Vad är naturligt för mitt barn: en introduktion till hur man som förälder kan ta hand om sitt barn på ett mer naturligt och biologiskt ursprungligt sätt* [What is natural for my child? An introduction to how parents can take care of their children in a more natural and biological primal way]. Nyköping: Exiris.

Lothian, J. A. (1995). It takes two to breastfeed: The baby's role in successful breastfeeding. *Journal of Nurse-Midwifery*, *40*(4), 328–334.

Lundgren, I. (2005). Swedish women's experience of childbirth 2 years after birth. *Midwifery*, *21*(4), 346–354.

Lundgren, I., Karlsdottir, S. I., & Bondas, T. (2009). Long-term memories and experiences of childbirth in a Nordic context – a secondary analysis. *International Journal of Qualitative Studies on Health and Well-being*, *4*(2), 115–128.

McInnes, R. J., & Chambers, J. A. (2008). Supporting breastfeeding mothers: Qualitative synthesis. *Journal of Advanced Nursing*, *62*(4), 407–427.

Mead, M. (1965). *Kvinnligt Manligt Mänskligt* [Sex and temperament in three primtive societies]. Stockholm: Aldus/Bonniers.

Merleau-Ponty, M. (1962). *Phenomenology of preception*. London: Routledge & Kegan Paul Ltd.

Mearleu-Ponty, M. (1968). *The visible and invisible*. Evanston: Northwestern University Press.

Moore, E. R., Anderson, G. C., & Bergman, N. (2007). Early skin-to-skin contact for mothers and their healthy newborn infants. *Cochrane Database of Systematic Reviews*, (3). Retrieved September 28, 2010, from http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003519/frame.html. doi:10.1002/14651858.CD003519.pub2

Nelson, A. M. (2006). A metasynthesis of qualitative breastfeeding studies. *Journal of Midwifery & Womens Health*, *51*(2), e13–e20.

Ohrlander, K. (1992). *I barnens och nationens intresse: socialliberal reformpolitik 1903–1930.* [In the childen and the nations interest: Social liberal-policy reform 1903–1930]. Stockholm: Almqvist & Wiksell International [distributör].

Premberg, A., Hellstrom, A. L., & Berg, M. (2008). Experiences of the first year as father. *Scandinavian Journal of Caring Sciences*, *22*(1), 56–63.

Schmied, V., & Barclay, L. (1999). Connection and pleasure, disruption and distress: Women's experience of breastfeeding. *Journal of Human Lactation*, *15*(4), 325–334.

SOS (2010). *Amning och föräldrars rökvanor. Barn födda 2008* [Breastfeeding and smoking habits among parents of infants born in 2008]. Stockholm: Socialstyrelsen.

Tarkka, M. T., Paunonen, M., & Laippala, P. (1998). What contributes to breastfeeding success after childbirth in a maternity ward in Finland? *Birth*, *25*(3), 175–181.

Waldenström, U. (2007). *Föda barn: från naturligt till högteknologiskt* [Childbirth: From natural to high-tech]. Stockholm: Karolinska Institutet University Press.

Waldenstrom, U., & Aarts, C. (2004). Duration of breastfeeding and breastfeeding problems in relation to length of postpartum stay: A longitudinal cohort study of a national Swedish sample. *Acta Paediatrica*, *93*(5), 669–676.

Waldenström, U., Sundelin, C., & Lindmark, G. (1987). Early and late discharge after hospital birth: Breastfeeding. *Acta Paediatrica Scandinavica*, *76*(5), 727–732.

WHO. (1998). *Evidence for the ten steps to successful breastfeeding*. Geneva: World Health Organisation.

Citation: Int J Qualitative Stud Health Well-being 2010; **5:** 5397 - DOI: 10.3402/qhw.v5i3.5397

WHO. (2001). *The optimal duration of exclusive breastfeeding. A systematic review* (No. 92-4-156221-8). Geneva: World Health Organisation.

WHO & UNICEF. (1989). *Protecting, promoting and supporting breastfeeding: The special role of maternity services – a joint WHO/ UNICEF statement*. Geneva: World Health Organisation.

WHO & UNICEF. (2003). *Global strategy for infant and young child feeding*. Geneva: World Health Organisation.

World Medical Association Declaration of Helsinki. (2008). *Ethical principle for medical research involving human subjects*. Retrieved September 28, 2010, from http://www.wma.net/en/30publications/10policies/b3/17c.pdf