

EMPIRICAL STUDIES

Severe breastfeeding difficulties: Existential lostness as a mother—Women’s lived experiences of initiating breastfeeding under severe difficulties

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Abstract

A majority of women in Sweden initiate breastfeeding but almost a quarter stop or wean the infant in the first few weeks after birth because of difficulties. In order to develop care that facilitates initiation of breastfeeding and enables mothers to realize their expectations concerning breastfeeding, it is necessary to understand what having severe breastfeeding difficulties means for women who experience them. The aim of this study is to describe the lived experiences of initiating breastfeeding under severe difficulties. A reflective lifeworld research design was used. Eight women, seven primiparous and one multipara, were interviewed within 2 months of giving birth. The essential meaning of the phenomenon is described as “*Existential lostness as a mother forcing oneself into a constant fight*”. This pattern is further explicated through its constituents; shattered expectations, a lost time for closeness, being of no use to the infant, being forced to expose oneself, and gaining strength through sharing. The results show that mothers with severe breastfeeding difficulties feel alone and exposed because of their suffering and are lost in motherhood. Thus, adequate care for mothers should enhance the forming of a caring relationship through sharing rather than exposing.

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

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This is the second study in a larger project aimed at deepening understanding of various aspects related to mothers’ (referred to in this paper as women/mothers) lived experiences of initiating breastfeeding. A previous study describes women’s experiences of initiating breastfeeding in the context of early home discharge i.e., when breastfeeding is experienced as functioning well. Despite favorable conditions breastfeeding entails complexities which are described as posing an existential challenge. Mothers experience breastfeeding as a way into and a confirmation of motherhood (Palmér, Carlsson, Mollberg & Nyström, 2010). This raises questions about the situation for mothers who have severe breastfeeding difficulties and what this means for them. This paper concerns the phenomenon *initiating breastfeeding under severe difficulties*.

Background

Based on the health benefits for both mother and infant, the World Health Organization promotes breastfeeding exclusively up to 6 months of age and thereafter partially for the infants’ first 2 years or longer (Kramer & Kakuma, 2002; WHO & UNICEF, 2003). Nearly all women in Sweden initiate breastfeeding but, for various reasons including difficulties, almost a quarter of them stop or wean the infant in the first few months after birth and 10% breastfeed exclusively up to 6 months of age, meaning few women follow the recommendations (Socialstyrelsen, 2010) and often give up earlier than they themselves expected to (Kronborg & Vaeth, 2004; Zwedberg, 2010). Painful nipples/breasts, low milk supply and suckling difficulties are identified as the most frequent problems that

lead to early weaning (Lamontagne, Hamelin & St-Pierre, 2008).

Healthcare professionals have the responsibility to protect, promote and support breastfeeding and thus to provide mothers wanting to breastfeed with information to facilitate it (Socialstyrelsen, 2003, 2008; WHO & UNICEF, 1989, 2003). There are factors which influence breastfeeding negatively, such as regulating and disempowering attitudes among healthcare professionals (Ekström, Matthiesen, Widström & Nissen, 2005), routines that separate mother and infant before the first breastfeed or supplementary feeding (Bystrova et al., 2007), lack of support (Britton, McCormick, Renfrew, Wade & King, 2007; Ekström, Widström & Nissen, 2003a, 2003b; McInnes & Chambers, 2008) and limited knowledge about breastfeeding among professional carers (Laanterä, Pölkki & Pietilä, 2011). Birth by cesarean section is also more negatively associated with duration of and/or more problems with breastfeeding than vaginal delivery (Häggkvist et al., 2010; Nissen et al., 1996). Postpartum pain is another hindrance to breastfeeding (Karlström, Engström-Olofsson, Norbergh, Sjöling & Hildingsson, 2007). It is also well known that socioeconomic factors and maternal characteristics, such as being a first-time mother or a smoker, contribute negatively to breastfeeding initiation and duration (Flacking, Nyqvist & Ewald, 2007; Waldenstrom & Aarts, 2004), as does the mother's intention regarding and knowledge about breastfeeding (Kronborg & Vaeth, 2004).

However, these studies do not provide an understanding of the lived experiences of initiating breastfeeding. To contribute to understanding and care development for new mothers wanting to breastfeed it is thus necessary to supplement existing knowledge with knowledge about the meaning of breastfeeding and the difficulties involved from the mother's perspective. The aim of this study is, therefore, to describe the lived experience of initiating breastfeeding under severe difficulties.

Method and approach

A reflective lifeworld research approach (Dahlberg, Dahlberg & Nyström, 2008) was used in order to describe the phenomenon as it is lived and experienced by new mothers with severe breastfeeding difficulties. A phenomenological approach illuminates the essential meaning of the phenomenon under research and its variations. The entire study has been approached with a phenomenological attitude i.e., openness to the lifeworld phenomenon, reflection during the research process, bridling the understanding, as well as moving between

closeness and distance in order to illuminate what Gadamer (1960/2004) calls "the otherness" of the phenomenon. By "seeing the otherness" he means being aware of one's own pre-understanding of the phenomenon, in order to allow the text to present itself in all its otherness, thus asserting its meaning in the face of one's preconceptions.

Informants and data collection

Women's lived experiences of initiating breastfeeding under severe difficulties were explored in open and reflective interviews. Once permission to conduct the study was granted by the head nurse and the director of the maternity ward, midwives at the unit were informed and asked to initiate contact with the mothers. The following inclusion criteria guided the informant samples: Swedish-speaking, full-term infant (i.e., >37 gestational weeks), single pregnancy, breastfeeding experienced by the mother as very difficult and need for a prolonged maternity stay because of this, care provided in a breastfeeding clinic or other care setting. To find a range of difficulties i.e., variations on the phenomenon, mothers with breast complications, infections and abscesses, infants with problems suckling and/or other difficulties were included.

Women who met these criteria were asked during their stay on the maternity ward or when visiting the breastfeeding clinic to participate in the study. None of those asked refused. Eight mothers agreed to participate and received verbal and written information from both the midwife and the first author. Informed written consent was obtained from each participant before their interview. Of the eight women who participated in this study seven were primiparous and one multipara and ages ranged from 20 to 37 years. Their delivery mode varied e.g., vaginal and cesarean section/instrumental birth. They came from both rural and urban areas and all were living with the father of the child. At the time of the interview, which was within 2 months of the birth, four women breastfed, one used a pump and three had stopped breastfeeding (earlier than they had planned to).

The setting for the interviews was chosen by the informants and all chose their own homes. Data were collected by tape-recording the interviews. Each woman was interviewed on one occasion by the first author (LP). The initial question was asked to stimulate reflections about the phenomenon, "Would you like to tell me about your experiences of initiating breastfeeding?" In order to obtain in-depth reflection and encourage the women to describe variations in their experiences, probing

individual questions were asked during the interview. The interviews were transcribed verbatim.

Data analysis

The data analysis followed the descriptions used for reflective lifeworld research and phenomenology, according to Dahlberg et al. (2008). The analysis was characterized by a movement between the whole—the parts—and the whole. During this movement the goal was to remain as open and reflective as possible, an approach characterized by closeness to the text. After familiarization with the text as a whole the data were divided into parts, meaning units in the text were marked forming different clusters, each consisting of meaning units that related to each other. When all meanings had been identified a new whole was revealed that contained a description of the phenomenon i.e., the essential meaning of *initiating breastfeeding under severe difficulties*. The essential meaning was formulated and further described by its constituents i.e., the variations on the essence.

The analysis was done together with co-authors and the analytical process was characterized by a striving to achieve a reflective and bridling attitude (Dahlberg et al., 2008) towards the phenomenological meaning of the data. This was done with the co-authors and in seminars, by reflecting on the first author's pre-understanding of the phenomenon before examining the texts, and during the analysis. An attempt was made to remain in the familiarization phase, by reading the text many times in order to gain a sense of the whole, staying close to the data and then constantly moving back and forth, "not to make definite what is indefinite" (Dahlberg & Dahlberg, 2003). Thus, in the movement between whole-parts-whole the otherness is revealed i.e., what is new in data could be seen, not simply the researcher's preconceptions (Gadamer, 1960/2004) and the phenomenon could be described and understood.

Ethical considerations

Ethical approval and permission to undertake this study were obtained from the Regional Ethics Review Board at the University of Gothenburg (Dnr 244-10). The ethical standards of the Helsinki Declaration (2008) were respected. All participants received written and verbal information about the purpose of the study, their right to withdraw at any time without prejudice and the confidentiality of the information they gave to the researcher. All the women were offered an extra appointment

with a professional carer at the maternity clinic, if needed.

Findings

The essential meaning of initiating breastfeeding under severe difficulties is described as "*Existential lostness as a mother forcing oneself into a constant fight*". The philosophical term "lostness" means feeling lost as a mother and not finding one's way into motherhood. This is further experienced as a threat to one's further existence as a mother. This constitutes having the connectedness established with the infant during pregnancy adversely affected and feeling disconnected from the infant, oneself and the world.

Breastfeeding difficulties entail alienation and ambivalence. Alienation is understood as losing oneself as a mother when unable to fulfil the expectations from pregnancy. Breastfeeding difficulties weaken the image of oneself as a mother and lead to feelings of failure. There is an ambivalence regarding meeting one's own needs, the infant's needs or the request to breastfeed from others, such as healthcare professionals, partners, parents and friends.

Breastfeeding difficulties make it hard to give and attend to, and share with the infant in the expected mutual way, thus setting boundaries for togetherness and closeness with the infant. Life as a mother turns into chaos, enforcing a constant fight, which is described as an attempt to eliminate existential lostness, alienation and ambivalence. The fight begins as soon as the mother herself experiences problems during the initial attempts to breastfeed. It is a desperate fight to escape from difficulties, to find stillness and harmony in life. There is also a desire to re-establish closeness with the infant and one's dignity as a mother but it entails a burdensome and lonely fight involving exposure of oneself and managing difficulties alone. The fight is also characterized by attempts to find someone to share one's feelings with in order to gain strength. The act of fighting is positioned between oneself, the infant and other people in order to achieve connectedness and closeness between oneself and the infant and to find one's way into motherhood.

The meaning of the phenomenon of initial breastfeeding difficulties is explicated through the following constituents, which should be seen as variations of the phenomenon: shattered expectations, a lost time for closeness, being of no use to the infant, being forced to expose oneself, and gaining strength through sharing.

Shattered expectations

When expectations do not correspond with experience there is a clash in which expectations of breastfeeding are shattered. Education in parenting and information from maternity care are experienced as generating a view of breastfeeding as natural and therefore easy and something every woman can manage, according to the women. Caring routines, such as early home-discharge and a self-care approach, reinforce this view. The ability to breastfeed is experienced as taken for granted during pregnancy, seducing the mothers into false hope, which is then crushed when difficulties occur. Consequently feelings emerge of being misled and alone as the only mother with difficulties, which in turn brings about a sense of worthlessness and failure compared to other mothers.

Everything turns into darkness or And it is also like I think it should just work out well ... it is a natural thing and a lot of people manage it but not me ... I compare myself to others ... (8).

Breastfeeding difficulties are experienced as a defeat and, therefore, proof of failure as a mother. Not living up to one's image of a breastfeeding mother is hard and the shattered expectations undermine self-confidence entailing lostness and devaluation of oneself as a mother.

I may not be a good mother and ... (crying)
I know that I could not be a worse mother to him because I do not breastfeed but I feel that these are linked to each other (4).

The women themselves expected to breastfeed but they also felt that others, such as professional carers, partners, friends and parents, expected them to do so. When difficulties occur these expectations are hard to satisfy, and this in turn entails a lack of pride in oneself. There is also a sense of having to defend oneself against others and therefore wanting to hide and not reveal the failure.

When I could not manage what was expected of me I felt a failure and bad and ... other people added to this feeling by implying that I would be a bad mother. I almost have ... to defend myself because I have stopped breastfeeding (4).

Shattered expectations give rise to feelings of anger and sadness, stimulating an inner driving force to manage to breastfeed the next child but they also cause concerns and fears about failing again. Anger and sadness are finely balanced against each other.

When I think back, the difficulties were both good and bad. The bad thing is that it was very strenuous, but it made me stronger because now I know what to do with the next child (7).

Shattered expectations due to difficulties are the start of a competition against oneself, the infant and others. The feeling is that one should be able to breastfeed and show others one's ability and also be proud of oneself. This creates the opportunity to win but also the risk of further losing oneself.

A lost time for closeness

Breastfeeding difficulties severely affect being a mother and the time for closeness with the infant is impeded.

In the beginning it was really cozy ... But when the sores occurred it destroyed everything ... Then the only way to be close to and cuddle him ... was by looking at him (7).

The first few weeks with the infant become chaotic, entailing suffering for the mother. Relations among all family members are experienced as troubled and in this trying situation mothers react with distress and resignation. Under such circumstances it is hard to feel joy about becoming a mother and about the infant. The first few weeks are experienced as lost, never to be recovered.

In the beginning when it was at its worst then it felt like we had lost his first period in life ... and it is a terrible feeling losing the whole of the his first period in life (8).

Time for closeness is lost due to a feeling of being trapped in breastfeeding and fears emerge concerning the next breastfeeding occasion. These fears grow stronger each time the infant wants to suckle and as the mother does not know how to manage it, instead of being present she just wants to escape from this stressful situation.

It really built up ... I sat just like this [showing how she tenses her body] it was really strange. ... I was sort of sitting and preparing ... you know like I was about to jump into cold water, bathing in cold water. Then I start to sweat very much ... it was some distress and anxiety (6).

The meaning of time lost for closeness also emerges when the mothers' fight to solve the situation forces them to set the infant aside; yet this fight is for the infant's health and well-being.

I did not spend time being with the infant. Instead I spent time with the pump ... Breastfeeding would have taken the same time but then I would have been with the infant ... I spent time on the wrong things (4).

There is a desire to regain closeness to the infant and bring an end to the difficulty of breastfeeding because the fight is strenuous. This generates a desperate fight where the risk of further loss of closeness is balanced against a desire to breastfeed successfully.

“It is not nice either ... because it takes time from her (the infant) when I must sit and pump that often and every time ... it is killing us ...” (1).

The sense emerges of being a machine whose sole purpose is to produce and deliver milk to the infant. This means forcing oneself to endure emotions of pain, sadness and anger and to just perform without joy. The difficulties act as a barrier, complicating closeness.

I feel like a breastfeeding machine because I have been so ill and tired. I have not managed to be with the infant and therefore my husband has been with him instead. It is only now that I can manage to be with the infant more (6).

Being of no use to the infant

When the infant is offered the breast but is fuzzy and cries instead of suckling or when breastfeeding is painful the mother feels rejected by the infant. The functions of the body are called into question, which in turn generates feelings that the mother and infant do not belong together; the mother feels that she is of no use to the infant. Mothers blame themselves for the emerging difficulties and feel guilty and worthless because of them.

I really feel worthless, totally worthless and I am questioning myself all the time to ... thinking about if I could have done something else or maybe I could have breastfed after all (8).

Feelings of uselessness entail feelings of having failed as a mother and engender doubts about being able to care adequately for the infant. If they cannot even manage to breastfeed, which is experienced as a basic human ability, then their ability to care for the infant is experienced as inadequate. A desire to let someone else more suitable take over emerges. “I wanted to give him back ... to someone who

can manage breastfeeding better” (2). Occasionally difficulties result in feelings of irritation and frustration with the infant and oneself which are reinforced when the difficulties persist and the infant then becomes part of the difficulties. “But ... I can feel a sort of frustration towards him too ... damn kid take the breast now, breastfeed ... but mostly I feel useless [tears coming]” (4).

One’s ability to mother the infant is evaluated through the infant’s reactions and responses to breastfeeding. Not being able to give the infant what it wants and not being able to understand how to satisfy it or how to improve the situation is frustrating and entails experiencing powerlessness.

He does not want to breastfeed or he wants to but cannot manage it and I can’t manage it either ... then I feel alone ... and powerless as well (3).

Managing breastfeeding becomes a heavy burden of responsibility, depending on the ability of the mother. In these situations the uselessness is obvious; no one can take over the mother’s responsibility for breastfeeding, she bears it alone.

So, it still depends on my ability. I didn’t know if there was something wrong with me. If I could produce sufficient milk, or if I was doing the right thing (2).

Being forced to expose oneself

There is a feeling that one is forced to expose oneself and give professional carers access to oneself and one’s body in order to overcome breastfeeding difficulties. Mothers feel like objects in such situations, care mostly focuses on the infant’s milk intake, breasts and milk production.

I feel like a big experimental animal, in came trainees and doctors just to look at me almost like a monkey in a cage. It was like here we have someone with strange problems, take the opportunity to watch her while you can (8).

Being forced to expose oneself is degrading and increases the feeling that one’s body is malfunctioning. When care mostly focuses on the mother’s body a feeling of being a machine and distrust of the one’s ability emerges, giving rise to insecurity.

There was one carer on the maternity ward she said that my nipple was pointing in the wrong

direction ... how could I change that? I can't change it and I felt I could not breastfeed on that nipple because of that ... there were a lot of questions going around in my head (2).

Many professional carers are involved in the care and sometimes give contradictory advice, which leaves mothers alone, confused, not knowing what to do and losing control over the situation. This is experienced as an uncaring approach which intensifies exposure. "I was sure I would die ... because I did not know what to do and they, the carers, did not know what to do. It is the worst thing I have experienced" (8).

Different advice, sometimes advocating fixed feeding intervals and fixed positions, reinforces exposure and complicates an understanding of the infant's breastfeeding signals making it difficult for the mother to interpret and respond to them. Being unable to perform in the manner determined by carers, the mother evaluates herself as a less worthy human with a less worthy infant. Such an approach forces the mother to assess each carer in order to decide who to trust. In the fight women try out different pieces of advice, even if they are totally contradictory. Being forced to be flexible in response to individual carers entails a feeling of doing everything wrong, not being good enough and losing even more control. "I had no control ... of all the different advice and changes in caring approaches. I did not know what was happening, I was exposed to someone else" (4).

Being forced to give access to one's body entails enduring hands-on breast touch i.e., professional carers take the breast and force it into the infant's mouth. That causes difficulties in understanding the infant and it demolishes interaction. When the infant is forced to the breast, despite crying and refusal signals, it gives rise to anger and loss of confidence in the carer's ability.

She just took him, shook him and held him and said "now you be quiet" and then she pushed him into my breast. I didn't know what was right or wrong. It was hard; everything I thought I had done right just disappeared when she did that to me (2).

Hands-on breast touch is experienced as often being used without permission being asked, and even if it is asked it is hard to refuse. Exposure to hands-on breast touch means subordinating oneself in the hope of overcoming difficulties but it is felt to be an abuse of oneself and the infant. One's integrity is threatened, entailing to dislike of oneself and making breastfeeding even more difficult.

It is too much, sitting naked, asking for help, being totally new, it is too much ... When you have done it ten times that day and ten different people have held and lifted my breasts ... and I did not protest or think it is hard when they did it but afterwards I feel myself disgusting and unattractive and ... (3).

Gaining strength through sharing

Sharing with others is strengthening. Those others can be, for example, carers, friends, partners or women in the same situation. Sharing means being met as a unique mother, as a subject and not just a milk producer for the infant, not judged for having difficulties, and this is strengthening. Caring focused on such sharing is described as an act of respect. The carer is present, sees the mother and has the ability to understand and help her in an individual and unique way. This relieves pressure and stress and creates a peaceful atmosphere which strengthens women's trust in themselves and the infant. In such sharing the burden of difficulties is eased.

She was listening. She asked how I felt. Before, on the maternity ward, everything was focused on the baby. How I felt in my body, she listened closely. ... She was good because she was calm (1).

Sharing brings with it a sense of being a capable mother. Carers who believe in the ability of women provide care that enables the mother to handle the situation of having breastfeeding difficulties. Sharing also means sharing responsibility with someone and this facilitates an understanding of the infant's behavior and responses to it.

It is a relief sharing responsibility ... with someone ... who had done it a thousand times before and seen hundreds of infants doing it, then I felt calmer and me and the infant got into a better rhythm (5).

Another dimension of sharing that is strengthening is meeting women in the same situation, through reading or talking. Such sharing ends the feeling of being alone with the difficulties. It is a relief to know that other women are in the same situation and having a difficult time.

It is a relief to meet and talk to someone in the same situation, then I can feel that I am not alone in having difficulties. Many women have exactly the same experience and that is a relief (4).

Partners or other trustworthy people such as friends and their own mothers can also contribute to strength from sharing when they are present and confirm the mother in her experiences. It is also strengthening if one is not judged. "I talk about it a lot with my friends and my family. I have been open about thinking it is hard ... and then I have been confirmed ... by others" (3).

Discussion

Reflections on the findings

This study focuses on the lived experience of having severe difficulties when initiating breastfeeding, a phenomenon rarely described in other studies, which are usually concerned with measurable factors regarding breastfeeding issues.

In this study, initiating breastfeeding under severe difficulties is understood as experiencing an existential lostness as a mother being forced to constantly fight. It is also understood as not finding one's way into motherhood and into *Being* (Heidegger, 1962/2008) a mother which means feeling a failure as a mother and fighting for one's existence.

One important and relevant finding for professional healthcare is that experiencing breastfeeding difficulties makes life as a mother a burden, and entails the loss of oneself as a mother and feelings of guilt and self-blame for having difficulties. Breastfeeding difficulties limit togetherness and closeness to the infant and it becomes essential to find a solution to the situation. The dilemma is to balance the needs of the infant and the mother against the request to breastfeed that comes from others such as mothers themselves, caregivers, parents, friends etc. This in turn raises the question of whether breastfeeding difficulties have the potential to cause trauma that will impact negatively on the health and well-being of both mother and infant. Such consequences are also suggested by Zwedberg (2010) when she describes shattered expectations due to breastfeeding experiences as triggering crisis reactions in mothers. Shakespeare, Blake and Garcia (2004) and Henderson, Evans, Straton, Priest and Hagan (2003) also found that breastfeeding difficulties are common in postpartum depressive mothers. On the other hand Watkins, Meltzer-Brody, Zolnoun and Stuebe (2011) show that women with early negative breastfeeding experiences were more likely to have depressive symptoms 2 months after the birth. A Swedish study shows that as many as 12% of mothers were depressed postpartum (Rubertsson, Wickberg, Gustavsson & Radestad, 2005). This gives rise to questions about what causes what, but regardless

of the answer it is time, according to the results from our study, to consider seriously the situation for mothers with breastfeeding difficulties.

One key finding from the present study, which tentatively explains discomfort and unease in the breastfeeding situation, is the mothers' ambivalence towards their own needs while satisfying the infants' needs. The feeling of being rejected by the infant and not being good enough as a mother is an obstacle in this situation. Some parts of the findings also indicate that this can create ambivalence towards the infant. Such serious consequences are hinted at when women describe breastfeeding difficulties (as their relationship with the infant) in terms of a fight and a competition with the infant, and express the desire to temporarily set the infant aside and the wish to give it away. According to the psychoanalytical object-relation theory, the experience of early mother and child interactions is of crucial importance as it explains a lot about the ability to establish interpersonal relations in adult life. Melanie Klein (2002) describes the early mother and child interaction symbolically as a relation to the mother's breasts, suggesting the existence of 'a good and a bad breast'. According to Klein's theory there may be consequences for future interpersonal relations in infants who have had breastfeeding difficulties, such as suckling problems, and as a consequence of this been forced to the breast by professional carers. It is, therefore important to facilitate as harmonious breastfeeding experience as possible for mother and infant, not forcing them together with an intrusive hands-on breast approach. The potential risk of harm to the mother-infant relation with negative impacts on the health and well-being of both highlights the immense importance of adequate care for breastfeeding women and their infants.

The results of the present study confirm those of previous studies which emphasize that support—both professional and lay—is crucial to the experience of satisfactory breastfeeding for both mother and infant (Britton et al., 2007; Bäckström, Hertfelt Wahn & Ekström, 2010; Ekström et al., 2003a; Ekström, Widström & Nissen, 2006; Ekström, Guttke, Lenz & Hertfelt Wahn, 2011; McInnes & Chambers, 2008; Zwedberg, 2010). Our study adds to an understanding of the meaning of such support, and the meaning of being exposed to uncaring interventions. The results from our study show that mothers with difficulties experience exposure and loneliness when fighting and struggling with breastfeeding. Even if professional carers are well-intentioned some of them seem to get it wrong; for example an uncaring intervention such as an intrusive hands-on approach can obviously

be experienced as an abuse and as a necessity to be endured. An intrusive hands-on breast approach increases the mother's sense of being a machine that can be turned off and on by others. One's is transformed from private to public and is available to others, which seems to complicate mother-infant interactions during breastfeeding. A hands-on-breast approach has also been described in previous studies, one in the context of neonatal care (Weimers, Svensson, Dumas, Navér & Wahlberg, 2007) and one concerning full-term infants (Mozingo, Davis, Droppleman & Merideth, 2000) in terms similar to those we use. On the other hand, Dewey, Nommse-Rivers, Heinig and Cohen (2003) show that professional carers are stressed when helping mothers with breastfeeding difficulties and this may be the reason they sometimes use the hands-on approach. An alternative explanation is the limited knowledge about breastfeeding described by Laanterä et al. (2011). Is it possible that such uncaring behaviors might contribute to further destruction by harming the well-being of both mother and infant and hindering them from forming an attachment and bonding to each other?

As Bowlby (1997) suggests in his theories about attachment and a secure base, close and continuous physical contact and sensory interactions between mother and infant are necessary for the child to thrive emotionally. Severe breastfeeding difficulties seem to complicate this contact and for some women in this study ending breastfeeding was the only way for them to come close to the infant. Klaus and Kennel (1982), however, were able to show that, because of the adaptability of humans, attachment can occur later after birth. According to the results of our study, it is important to respect the wishes of women who want to end breastfeeding and not force them to continue, and of course vice versa. It is most important to listen to the woman herself and let her wishes guide the care provided. Helping a woman with severe difficulties to stop breastfeeding can be as caring as helping a woman to continue breastfeeding, depending on what they themselves want to do. In the light of the present findings mothers experience that they gain strength through sharing and this can be seen as a way to cope with the burdensome and lonely situation they have. It is therefore fair to assume the importance of an adequate caring relationship, helping the mother to find her place as a mother, regardless of whether or not she is breastfeeding. In this study a caring relationship is exemplified by sharing relations that focus on wholeness and uniqueness in a mutual and respectful manner, and are seen as improving interactions between mother and infant thus easing the burden of difficulties. The provision of care

focused on sharing seems to make it easier to endure difficulties and find one's way in lostness. Zwedberg (2010) describes support as the provision of consultative meetings in an atmosphere of reciprocity and meaningfulness. According to Ekström, Widström and Nissen (2005) this can be understood as being more of a facilitator and less of a regulator as a professional career. Our results show that breastfeeding is not the only activity that should be the focus of care. Enabling mothers to come close to the infant and to feel connected regardless of whether they are breastfeeding or not is also important. Ekström and Nissen (2006) describe a process-oriented breastfeeding training program for midwives and nurses, that includes continuity of care, as strengthening the maternal relationship with the infant and the feelings for the infant. It thus appears necessary for professional carers to reflect more on the way they provide care for mothers with breastfeeding difficulties.

This phenomenological analysis further revealed that "breastfeeding difficulties-as-lived" is more than a problem of biological adaption, it is an existential issue. Initially, mothers experience breastfeeding difficulties as a fight to breastfeed. As suggested in a previous study (Palmér et al., 2010) the milk and the breast might, like Merleau-Ponty's (1968) "chiasm", be understood as a link intertwining mother and the infant into one entity. Thus, when breastfeeding is associated with difficulties that entail disconnectedness between the mother and her infant "the intentional threads slacken" i.e., mother and infant drift apart, rather than come together, preventing a close relation. Breastfeeding then entails a fight between two subjective bodies, a way of *Being* (Heidegger, 1962/2008) that is unfavorable. This can further be understood as two intentional subjects directed towards each other, fighting to interlace in a synchronic way. Breastfeeding as a chiasmic relation when difficulties are experienced entails an untying of the two as well as a disruption of the shared body experience affecting the *Being* (Heidegger, 1962/2008) as a mother.

Conclusions and clinical implications

Mothers with severe initial breastfeeding difficulties are alone and exposed as a result of their suffering, related both to the situation with the infant and to uncaring behavior. From a caring science perspective there is a need to highlight the existential issues around initiating breastfeeding and to give priority to establishing a caring relationship which is characterized by sharing in order to support the mother's well-being and help her to find her way

out of lostness and into motherhood, regardless of whether or not she is breastfeeding.

From a caring science perspective the results of this study should prove useful to all professional carers who meet breastfeeding mothers. The result, described as the meaning of severe initial breastfeeding difficulties, may contribute to the development of a professional caring approach. Hopefully, this knowledge will enable professionals to provide care that allows mothers to breastfeed as they expect and wish to do.

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