

Breastfeeding and the adjustment process in the family context: a qualitative approach

Aleitamento materno e o processo de adaptação no contexto familiar: abordagem qualitativa

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ABSTRACT

Objective: To understand women's adaptation to the breastfeeding process and the support provided by family and health services. **Method:** A qualitative study based on the methodological framework of Ethnonursing, following Leininger's Transcultural Nursing Theory. A semi-structured interview guide was used. **Results:** Three thematic categories were identified: "Facing something unexpected, changing, and challenging"; "Dealing with doubts, uncertainties, and disorientation"; and "Identifying sources of support for breastfeeding maintenance". **Conclusion:** The breastfeeding adjustment process has doubts, uncertainties, and challenges. Women rely on and are directly influenced by their past experiences and family culture. The role of primary health care is crucial in this context.

Descriptors: Breast Feeding; Anthropology, Cultural; Nursing.

RESUMO

Objetivo: Compreender a adaptação das mulheres ao processo de amamentação e o apoio familiar e dos serviços de saúde. **Método:** Estudo qualitativo fundamentado no referencial metodológico da Etnoenfermagem, conforme a Teoria de Enfermagem Transcultural de Leininger. Foi utilizado um roteiro de entrevista semiestruturada.

Resultados: Evidenciaram-se três categorias temáticas: "Enfrentando algo inesperado, mutável e desafiador"; "Convivendo com dúvidas, incertezas e desorientação" e "Identificando fontes de apoio para a manutenção da amamentação".

Conclusão: O processo de adaptação do aleitamento materno é permeado por dúvidas, incertezas e desafios. As mulheres apoiam-se em suas experiências prévias e na cultura familiar e sofrem influência direta destas. O papel da atenção básica é essencial nesse contexto.

Descritores: Aleitamento Materno; Antropologia Cultural; Enfermagem.

INTRODUCTION

Low adherence to exclusive breastfeeding (EBF) is a global phenomenon, as reported by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), which have shown that only 23 out of 194 countries achieve exclusive breastfeeding rates above 60%. Exclusive breastfeeding rates in Brazil have improved in recent decades; however, the prevalence of 45.8% is still below the WHO recommendations for 2030⁽¹⁻³⁾.

Often, women remain silent about their difficulties because they bear the burden of early weaning and its consequences for their child's health alone. For this reason, women rely on deeply ingrained cultural knowledge, often associated with myths or beliefs such as "small breasts do not produce enough milk", "consumption of sugar cane juice, alcoholic drinks, and porridge will increase milk production", "babies get thirsty so they should be given water/tea", and "using a bottle/pacifier does not interfere with breastfeeding"⁽⁴⁻⁷⁾. Other reasons for breastfeeding failure recognized by women in recent decades include breast problems, infant refusal, misinterpretation of infant crying, and the need to work outside the home. These factors contribute to early weaning⁽⁴⁻⁸⁾.

Continued support for breastfeeding after hospital discharge has been advocated as an important resource for maintaining breastfeeding as the predominant feeding practice. The importance of the family and those closest to the breastfeeding mother, providing primarily emotional and informational support, and the socio-cultural environment in which she lives, cannot be overemphasized. In addition, primary care is a source of educational support⁽⁸⁻¹⁰⁾.

Understanding the family resources used to cope with breastfeeding challenges, the knowledge transmitted, the individuals involved in these experiences, and the integration of beliefs, myths, and culture is essential. Professional understanding of these aspects can guide health care practices to provide better guidance in promoting, supporting, and protecting breastfeeding⁽¹¹⁾. Therefore, this study aims to understand how women adapt to breastfeeding and how much family and health care support they receive.

METHOD

This is a qualitative study based on ethn nursing, as proposed by Madeleine Leininger. This theory is relevant to the research topic because it reveals an individual's behavior, considering their cultural context. Leininger mentions that a nurse can understand a phenomenon based on a few informants in focused ethnography. The term "informant" refers to individuals who provide information about the beliefs and customs of a group, thereby representing their cultural identity⁽¹²⁾.

The study setting included four family health strategies in a municipality in northern Minas Gerais, Brazil, in 2019. There was no prior contact with the participants before the interviews; contact with them occurred through home visits, during which the researcher explained the objectives of the study and the reasons for its development. Women in the postpartum period who were breastfeeding children aged zero to two years and who freely consented to participate in the study while respecting ethical principles and showing potential to provide substantial information about the phenomenon under study were considered eligible for inclusion. One of the nurse authors of this study was in the field for one academic semester through curricular internships. Mothers with contraindications to breastfeeding were considered as exclusion criteria.

The participants consisted of nine postpartum women, considered "key informants" because

they experience and understand the phenomenon, identified by codes KI-1 [...] KI-9; and seven individuals close to the postpartum women, as indicated by them as family supporters in the breastfeeding process, defined in this study as "general informants", coded as GI1, GI2 [...] GI7. The general informants were instructed to share their opinions and views, even if they differed from those of the key informants. There was no refusal or withdrawal from any participant.

Two facilitation models were used during data collection and organization: the Observation-Participation-Reflection (OPR) model was used as a facilitator during data collection through observation and active listening, and the Stranger-Friend model was used, in which the researcher is considered a stranger when entering the research field. After initial contact with the research subject, the researcher moves from the role of a stranger to that of a friend in order to understand the individual's phenomena^(12, 13).

A pilot test was conducted with three women in another family health strategy. A semi-structured script consisting of two parts was used for data collection, and the questions were asked orally to the participants during a single home visit. The first part included socioeconomic profile questions and data on breastfeeding and the child. General informant data included age and relationship or association with the general informant. The second part was dedicated to the interview and consisted of two guiding questions: 1) How did you adapt to breastfeeding? Tell me about the doubts/problems you faced and the solutions you found. 2) Who do you see as a supporter or helper in this adaptation process and why?

Participants volunteered after being informed about the aims and purposes of the research and after signing the informed consent form and the voice recording authorization form in duplicate. The interviews were recorded using a smartphone in offline mode with a digital recorder application and lasted an average of 10 minutes. The transcripts were then listened to and transcribed in full using Microsoft Office Word 2007 software; no corrections were required from the participants, as instructions were provided after the interviews.

Data analysis followed the four stages proposed by Leininger: Collecting and documenting raw data from observations and notes of everything that happened during the research presence in the field, recorded in a field diary; Identi-

fyng descriptors and components based on the previous stage by checking for similarities and differences between the behaviors of the informants; Contextual and pattern analysis, in which the information obtained was transcribed and organized according to the categories found, and carefully examined using Microsoft Office Excel® 2007 software; and Identification of themes, relevant findings and theoretical formulations, which allowed the synthesis of thoughts and a creative analysis of the information worked on in the previous stages, facilitating the development of thematic categories.

The number of participants was determined based on data saturation, considering the population's heterogeneity⁽¹⁴⁾. The research complied with the guidelines of Resolution 466/2012, which regulates research on human subjects, and was approved by the Human Research Ethics Committee (HREC) of the State University of Montes Claros (UNIMONTES), with Opinion No. 2,896,717. The Consolidated Criteria for Reporting Qualitative Research (COREQ) requirements were followed to guide the writing of qualitative studies.

RESULTS

The sample was heterogeneous, as intended, among the nine key informants and the seven general informants, as described in Figures 1 and 2. Differences in obstetric and sociodemographic variables were observed among the participants. The first group agreed on where they received their first breastfeeding advice, which was the hospital.

The classification of breastfeeding types, according to the Ministry of Health, was as follows Exclusive Breastfeeding (EBF), when the child receives only breast milk directly from the breast or expressed, or human milk from another source, without any other liquids or solids; Predominant Breastfeeding (PBF), when the child receives breast milk along with water or water-based drinks (sweetened water, teas, infusions), fruit juices, and ritual liquids; Mixed Feeding (MF), when the child receives both breast milk and other types of milk; and Complementary Feeding (CF), when the child receives any solid or semi-solid food in addition to breast milk to supplement, not replace, not replacing, breast milk⁽¹⁵⁾.

The analysis enabled the identification of three thematic categories presented below.

Facing something unexpected, changing, and challenging

In this category, it was noted that breastfeeding in the home context is something unpredictable, a phenomenon full of expectations and discoveries. Difficulties and doubts were mentioned by the participants in the process of adapting to breastfeeding, and these experiences can influence the maintenance of breastfeeding. Doubts and difficulties related to issues of breastfeeding management, such as positioning, handling, latching, and let-down, and are present among both mothers and caregivers, as reported in the following statements:

At the beginning of her breastfeeding journey (the nursing mother), her breast became sensitive. What also made it difficult was that she didn't let the baby latch onto the entire areola. So, I started guiding her to latch on and lift the breast the right way, and the baby started latching on correctly, and everything worked out. (GI4)

In the beginning, I felt a bit unsure, for example, about how often I should put the baby to breastfeed and whether the milk was satisfying the child. But later on, I started learning more about breastfeeding, and I didn't have many doubts anymore. However, during the first few weeks, we feel quite apprehensive, with that fear, and there's already the difficulty of getting the latch right. We have to teach the baby how to latch first before we get the hang of it ourselves. (KI7)

Other problems in breastfeeding management include nipple trauma and other breast changes that lead women to associate breastfeeding with pain and suffering, while their loved ones feel helpless in the face of the challenges of lactation:

Oh, it was really tough because she (the nursing mother) cried due to the inflammation in her breast, and it hurt so much, you know? My daughter (the nursing mother) suffered a lot. We didn't know what to do because it's something like, what can I do? (GI9)

When I started breastfeeding, my breast cracked, and I had to bite a towel or a diaper because of the intense pain I felt. I think that's why some mothers give up, right? Because of these things. (KI7)

Key informants	Marital status	Education	BF guidelines	NB's current age	BF Standard	BF at 1 am	Need for complementary feeding at the hospital
KI 1	Single	Incomplete high school	Hospital	4 months	PBF	Yes	No
KI 2	In a civil union	Complete elementary school	Hospital	3 months	EBF	No	Yes
KI 3	Married	Complete high school	Hospital	6 months	MF	No	Yes
KI 4	Single	Incomplete high school	Hospital	5 months	EBF	Yes	No
KI 5	Married	Complete high school	Hospital	3 days	EBF	No	Yes
KI 6	Married	Complete high school	Hospital	2 months	MF	Yes	Yes
KI 7	Married	University education	Hospital	3 months	EBF	Yes	No
KI 8	Married	Complete elementary school	Hospital	9 months	CF	Yes	No
KI 9	Single	Incomplete university education	Hospital	44 days	MF	Yes	Yes

Abbreviations: **EBF**: Exclusive Breastfeeding; **PBF**: Predominant Breastfeeding; **MF**: Mixed Feeding; **CF**: Complementary Feeding.

Figure 1 - Socioeconomic characteristics of the key informants. Montes Claros, MG, Brazil, 2019

General informants	Marital status	Education	Degree of kinship with the key informant
GI 2	Married	Incomplete elementary school	Mother-in-law
GI 3	Married	Complete high school	Mother
GI 4	Married	Complete high school	Husband
GI 6	Married	Complete high school	Mother
GI 7	Married	University education	Husband
GI 8	Married	Complete high school	Husband
GI 9	Married	Complete elementary school	Mother

Figure 2 - Socioeconomic characteristics of the general informants. Montes Claros, MG, Brazil, 2019

Concerns about the quantity of milk produced, "low milk supply", or its quality, "weak milk", continue to be a challenge in the daily lives of many families and are culturally rooted beliefs in our society that can have a significant impact on breastfeeding practices. On the other hand, the lack of continuous support from health services

or the lack of preparedness of some professionals to deal adequately with these situations only reinforces these myths and beliefs, as can be observed in the following statements:

He used to nurse all day long, and when I took my breast out of his mouth, he would

cry out of hunger. I felt like my breast was empty because he cried even when he had been on the breast for a while. My sister had already given (formula) to my niece, so I bought it and gave it to him to try, and it worked. I went to the health center two days later, and the nurse said it was okay to give it. I think it's good to give it because what if he's feeling hungry and thirsty? For example, he really wants to drink water! (KI1)

At the beginning of her breastfeeding journey, the baby nursed a lot, and at night, he cried a lot because there was hardly any milk coming out, so the doctor prescribed formula to give during the times when the breast wasn't producing enough milk. (KI6)

I didn't let him feed on demand... I would take him off when he was asleep because he can get used to being on the breast, and that's not good, right? Because he'll become demanding. (KI1)

Living with doubts, uncertainties, and (mis) guidance

In this category, it is evident that the practice of breastfeeding, although highly desired by the mother/family, is influenced by different social actors and sometimes the guidance provided by services/professionals is not perceived as something that brings clarity to the decision.

The baby sucked strongly and ended up injuring my breast... I only used the "meme" ointment to help with healing. They also told me to take Plasil, which would help with milk production. (KI6)

Regarding my daughter, everyone who comes to my house gives different advice, for example: some say to give her tea, others say not to. Everyone says something different. But the advice that caught my attention the most was when some doctors told me not to breastfeed the baby lying down because they could choke, but there are others who told me it's okay to breastfeed lying down. Some doctors say, "You can give water!" while others say, "You shouldn't give water; breast milk is enough." Everyone says something different, and it can be confusing. (KI6)

He already drinks boxed milk... I offered water after he started drinking this milk because it's practically just sugar, right? The nurse said it was okay because he didn't have any adverse reactions (baby's age: four months). (KI1)

Over time, new challenges arise, such as working outside the home and introducing other foods to the baby, and these events affect the entire family dynamic. As a result, mothers and caregivers seek solutions that they believe are appropriate to maintain breastfeeding, even if they are not always scientifically supported:

Today, we're concerned because she (the nursing mother) will have to learn how to give the bottle to the baby because she's going back to work next month, and after he started breastfeeding, he doesn't want anything to do with the bottle anymore... We're not thinking about expressing her milk; we plan to use regular milk in the bottle. We've already bought four bottles to see if any nipple resembles her breast, but they're all too thick, and we can't find one that's similar. He just wants the breast, nothing else! (GI2)

I believe that giving foods like canjica, cuscuз (...) these foods have the proteins that mothers really need during breastfeeding... It's the substances and vitamins in these foods that help... So, we're making cuscuз, canjica, and I'm not letting her go without these foods, and I always tell her to drink plenty of water and juice because it strengthens and helps improve. Before, I just used to hear people say this, and now I see that it really helps. (GI6)

On the other hand, previous personal experiences with breastfeeding, or observations of family or friends' experiences, serve as a foundation for the choices made in this new experience. If these experiences are positive, they increase confidence and security about breastfeeding and make it easier to cope with its challenges:

I didn't have many doubts because this is my second child... (KI2)

I didn't have any doubts at any moment about breastfeeding. Because before I got married, I worked as a nanny for a long time, so when

my child arrived, I knew how to handle a child. (K14)

Identifying sources of support for breastfeeding maintenance

The support received to maintain breastfeeding is perceived as positive by the respondents. However, the women mentioned hospital services at the time of their child's birth, family support, especially the experience of grandparents, and the support of their partners, as reflected in the following statements:

In the first moment, I acknowledge the nurses who guided me in the hospital as my supporters, as well as my husband who is always by my side. He supports me and reminds me all the time: "Put him to breastfeed! Look at this little boy!" (K15)

In the beginning, it was smooth, and I had support from the hospital... The constant support I had was from my husband, who stayed with me. (K13)

We used to ask our mothers (paternal grandmother) and such what would be good to do, and she guided us during breastfeeding. (K18)

These statements illustrate the specific support provided by hospitals and the ongoing support provided primarily by family members.

DISCUSSION

Some women have difficulty adjusting to breastfeeding because they are not adequately prepared and/or encounter a different routine than expected. However, problems with breastfeeding management, especially incorrect latching of the newborn (the way the baby grasps the breast) or incorrect positioning of either the baby or the mother during breastfeeding, continue to cause problems with the breast and negative experiences with breastfeeding. The persistence of these inadequacies may lead to early weaning. Therefore, mothers should be instructed in proper breastfeeding management during antenatal care and receive timely support at home. Prenatal care should be reconsidered as an opportune time for perinatal education, and home visits should be proposed as a primary care intervention, not just as a one-time intervention, but as a diagnostic approach that may require individualized, ongoing care⁽²⁰⁾.

Breastfeeding pain and problems are reported by postpartum women, often as an inherent breastfeeding experience. However, it is known that appropriate support and assistance can change this reality. Associating a baby's crying exclusively with hunger, without considering other factors involved in the newborn's communication, promotes the construction of the idea of "weak milk" or "low milk supply" in the breastfeeding mother and family, which then becomes a socially accepted value, a culture. Mothers also become tense, anxious, and frustrated by the baby's crying, and these feelings can be transferred to the baby, leading to more crying.

When endorsed by others, such as family members, friends, and even professionals, this discourse undermines the specific support received in the hospital setting, leading women to conclude that they cannot meet their children's nutritional needs. Hence, the importance of professional training and the adoption of supportive policies, such as the Baby-Friendly Hospital Initiative (BFHI).

It is worth noting that exposure to other types of milk and fluids reduces the benefits of exclusive breastfeeding, and this practice is strongly associated with early weaning^(17,20,22). The strength of this collective ideology was revealed by this study, which also showed that the early introduction of formula milk provided relief and/or a solution to the problems experienced. This was the solution for mothers who had to return to work early. This reason was also cited as a barrier to breastfeeding maintenance, with studies confirming that the main difficulty often lies in continuing breastfeeding when mothers have to work outside the home and end up introducing formula or other foods and using bottles/pacifiers⁽²³⁾.

Women who have had a positive breastfeeding experience are willing to breastfeed for longer. Their prior knowledge is critical and leads to higher breastfeeding prevalence and self-efficacy, a factor that educational programs can also influence. However, a different approach is needed for primiparous and multiparous women, considering their acquired knowledge and lived experiences and seeking teaching-learning processes tailored to these different needs^(19,23,24). This study identified the direct influence of culture and breastfeeding practice as aspects capable of modifying the course of breastfeeding.

The importance of effective training of health professionals in breastfeeding management was

observed regarding the teaching process, given its complexity and the professional impact on maternal/family decision-making. To implement such policies, professionals need to have theoretical and clinical knowledge, communication skills, listening and learning skills, and the ability to build trust and provide support, as suggested in breastfeeding counseling courses^(15,19).

In addition, although women are the protagonists of breastfeeding, their partners and family members strongly influence their decisions. This influence can hinder or support breastfeeding, as supporters, by sharing their experiences, may spread myths, traditions, and beliefs rooted in the family without any scientific basis, as observed in this study. This highlights the need for strategies to include these individuals in perinatal education efforts^(17,22,25). It is important to note that discrepancies in the advice given by health professionals to breastfeeding mothers, as well as advice that is not scientifically based, highlight the need for improved professional training processes related to breastfeeding. Some health professionals have demonstrated inappropriate breastfeeding support behaviors, such as a lack of skills in assisting breastfeeding mothers and providing contradictory/misleading information, which act as barriers to breastfeeding^(2,26).

Finally, there is a need for continuous support services for breastfeeding mothers, especially during the postpartum period, when the greatest demands are made. Notably, in this study, women unanimously indicated that the hospital was their main source of information on breastfeeding. Therefore, the creation of initiatives focused on the success of breastfeeding in primary health care has been a common concern in several countries⁽²⁰⁾.

In primary care, pregnant women and mothers should be educated about the rights and be-

nefits of breastfeeding, encouraged to practice exclusive and complementary breastfeeding, informed about how to maintain lactation and breastfeeding even when they are separated from their children, and breastfeeding support groups should be conducted/implemented, accessible to all pregnant women and breastfeeding mothers, with efforts to involve family members as well⁽²⁰⁾. It is important to note that a limitation of the study is the small sample size, and the results should not be generalized a priori. The results of this investigation can only be generalized a posteriori, depending on the similarities of the cases presented here with other situations involving women in the breastfeeding process.

The data presented contribute to the practice of professionals involved in the perinatal cycle, as they facilitate the development of strategies to strengthen culture as a facilitating tool for breastfeeding to minimize misconceptions about breastfeeding for all involved in this process.

CONCLUSION

Adapting to breastfeeding at home is fraught with doubts, uncertainties, and challenges that manifest differently depending on the duration of lactation and previous experiences. Breast problems and myths related to breastfeeding practices were highlighted and interrelated in this study, confirming the strong cultural influence on breastfeeding practices. The roles of health professionals and services, especially primary care, need to be reconsidered to provide individualized and continuous care that considers the importance of breastfeeding as a health-promoting activity.

CONFLICT OF INTERESTS

The authors have declared that there is no conflict of interests.

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