Promoting INDIVIDUALIZED Breastfeeding Experiences

Abstract
Breastfeeding is beneficial for the baby and the mother, but is yet to be successfully practiced by newly delivered women as proposed in the Healthy People 2020 goal. Most breastfeeding education during the prenatal or postpartum period provides adequate information for interested women. However, mothers need individualized client–professional interactions and follow-up after hospital discharge. This article describes the breastfeeding experiences of two women and the implications for nurses and other healthcare professionals in relation to efforts to promote breastfeeding. Two anecdotal case studies are presented illustrating that even when mothers have resources and education, the breastfeeding education can be frustrating and misunderstood. Nurses can master the skill of closing the feedback loop in breastfeeding education by assessing and clarifying women’s interpretation of breastfeeding information they received. This nursing skill can empower mothers to make informed decisions for effective and sustained breastfeeding.

Keywords: Breastfeeding; Health communication; Maternal behavior; Psychosocial; Support

Some challenges contributing to early cessation of breastfeeding can be altered by individualized nursing interventions that offer support and education to new mothers.
The health benefits of breastfeeding during the first year of life cannot be overemphasized. Breastfeeding is one of the practices that have been associated with tremendous positive health outcomes for the baby, the mother, and the society (American Academy of Pediatrics [AAP], 2005; American College of Nurses and Midwives [ACNM], 2004; Hoddinott, Tappin, & Wright, 2008). Breastfeeding, including exclusive feeding during the first year of life, has been associated with decreased infant mortality, better future physiological, mental, and social development, and reduced risk of obesity (AAP, 2005; Center for Disease Control and Prevention [CDC], 2007; National Institute of Health [NIH], 2004; World Health Organization [WHO], 2007). As part of the efforts to promote breastfeeding in the United States, the Healthy People 2020 goal is to increase the breastfeeding rates to 81.9% at birth, 60.6% continuation at 6 months, and 34.1% at 12 months (United States Department of Health and Human Services [USDHHS], 2010).

Major health organizations in United States and worldwide describe breastfeeding as the ideal form of nutrition for infants and very important for promoting infant health (AAP, 2005; ACNM, 2004; American College of Obstetricians and Gynecologists [ACOG], 2003; USDHHS, 2010). The WHO recommends exclusive breastfeeding for the first 6 months (WHO, 2002). Despite the increasing percentage of women who initiate breastfeeding, the recent national statistics show that the United States is yet to achieve some of the proposed goals on breastfeeding (CDC, 2009). Healthy People 2020 reports 74.0% of infants born in the United States in 2006 were breastfed at some point, but still fall short of the target of 81.9% (USDHHS, 2010). Although longer breastfeeding duration has been associated with improved infant development and health (Ferguson & Molfese, 2007; Harder, Bergmann, Kallischnig, & Plagemann, 2005; Vennemann et al., 2009), only 43.1% of women continue breastfeeding up to 6 months, which is less than the targeted 60.6%, and only 14.1% of infants are exclusively breastfed through 6 months of age, short of the target of 25.5% (USDHHS, 2010). Health-care professionals still need to increase efforts to promote breastfeeding to reach the Healthy People 2020 goals.

Many new mothers receive superior education and support from nurses during their time in the hospital and afterward through lactation consultants and hospital nurse-outreach programs. Still, some of these mothers continue to experience frustration and feelings of failure with the breastfeeding experience (Beck, 2009; Campbell & Gutman, 2007). There are various reasons mothers may continue to struggle to establish successful breastfeeding routines or continue breastfeeding beyond 6 months, even though their motivation is high (Racine et al., 2009; Thulier & Mercer, 2009). Multiple factors have been associated with breastfeeding initiation, continuation or discontinuation, and breastfeeding duration. The risk factors include maternal race and ethnicity, especially African American descent, teen births, and low educational and socioeconomic levels (Forste & Hoffman, 2008; Li, Ogden, Ballew, Gillespie, & Grummer-Strawn, 2002; Singh, Kogan, & Dec, 2007). Perceptions of social approval, community-level factors, along with the resources and support to which women have access, may influence women’s choice to breastfeed (Forste & Hoffman, 2008; Li, Rock, & Grummer-Strawn, 2007). Higher likelihoods of breastfeeding are also associated with increased levels of social support (Singh et al., 2007; Taveras et al., 2003). These factors are important and should be considered in an effort to increase breastfeeding practices, but are outside the scope of this article. The modifiable risk factors addressed here include attitudes, beliefs, perceived barriers of mother related to the breastfeeding experience and maternal confidence (Dunn, Davies, McCleary, Edwards, & Galboury, 2006; Nommsen-Rivers, Chantry, Cowen, & Dewey, 2010; Thulier & Mercer, 2009).

Both mother and infant contribute to the success or failure of the breastfeeding relationship (Johnson, Mulder, & Strube, 2007). The process of establishing confident breastfeeding can be foiled due to the unique characteristics of the mother–infant pair in both physiological and psychosocial/emotional areas (Johnson et al., 2007; McCartner-Spaulding & Dennis, 2010; Thulier & Mercer, 2009). Some of the concerns contributing to early cessation of breastfeeding can be altered by nursing interventions (Lewallen et al., 2006; Nommsen-Rivers et al., 2010). Nurses and other healthcare professionals can intervene by assessing the individual mother’s needs and offering support and education in not only physical, but also in cognitive and affective domains to help meet those needs. Professional support and individualized intervention become even more significant when the mother has inverted nipples or is ill, and if the infant has special situations such as poor latching, short frenulum, preterm birth, congenital anomalies, or hospitalization for a long period.

Successful client–professional interactions may provide opportunities to reduce maternal frustration and ensure adequate infant nutrition during the first few...
years of life. Breastfeeding practices, maternal coping strategies in relation to breastfeeding, benefits of breastfeeding, breastfeeding intervention birthing methods, client–professional communication and support have been studied extensively in the literature (AAP, 2005; Campbell & Gutman, 2007; CDC, 2007, 2009; O’Brien, Buikstra, Fallon, & Hegney, 2009; Pate, 2009; Tavers et al., 2004). Most of the studies on client–professional interactions focused on identifying communication gaps and dealing with special situations such as preterm births (Campbell & Gutman, 2007; Tavers et al., 2004). There are few studies that examined mothers’ unique characteristics including cognitive level, affective state, and communication/learning style and how this influences breastfeeding success.

This article describes the anecdotal real-life experiences of two mothers who successfully breastfed after a period of adjustment, but initially experienced frustration and lack of confidence with breastfeeding. The article also discusses how nurses and other healthcare professionals can provide education, support, and clarification to identify the cause of these breastfeeding problems and frustrations mothers experience and increase maternal confidence in the breastfeeding experience.

Case 1
Amanda is a 22-year-old White female who has had her first child in a Midwestern medical center. Her infant, weighing 7 lb 0 oz, is delivered vaginally at 39 weeks without complications. Amanda believes breastfeeding provides the best nutrition for her baby and is highly motivated to succeed at breastfeeding at the time of the baby’s birth. She has done extensive research on infant growth and development and understands breastfeeding is superior to formula feeding in development of an infant’s healthy immune system. Amanda has a college degree with a major in finance. She is intelligent, self-motivated, and goal-oriented. She describes her thinking as concrete and linear and influenced by her love of the order and logic of mathematics. She admits she interprets things literally most of the time.

Breastfeeding instruction and support for Amanda and her infant begin in the hospital. They are discharged approximately 30 hours after the baby’s birth, giving Amanda 2 days in which to absorb all the instruction and demonstration on infant care. The breastfeeding support team includes postpartum nurses and a lactation consultant. Amanda has inverted nipples, which makes breastfeeding more difficult. She is taught how to help the baby latch on, use a nipple shield, break the baby’s suction safely, and use different methods for holding the infant while breastfeeding. The lactation consultant helps Amanda secure an electric breast pump for home use and instructs her on its use. The nurses explain that infants need to breastfeed frequently and rather than putting the infant on a schedule, she should feed the baby whenever the baby is hungry. Amanda also understands infants may “cluster-feed” many times in a short time frame. Amanda and her baby are discharged home with information that the lactation consultant is on-call as needed and a nurse will be visiting the home within a few days for follow-up. The baby’s discharge weight is 6 lb 5 oz.

At home, Amanda has the support of the infant’s two grandmothers for the first 2 days and her husband the first week. The baby is sleepy and difficult to arouse to eat well during the first 3 days, but Amanda attempts to breastfeed the baby about every 1 1/2 to 2 hours. The baby begins to be more wakeful and wants to eat more often. She latches on with difficulty due to the inverted nipples, but Amanda feels the baby is eating relatively well. Amanda keeps meticulous records on the chart provided by the hospital as to when the baby feeds, urinates, and stools. As promised, the hospital nurses call to follow-up on the well-being of mother and baby, visit the home, and obtain additional bilirubin levels until they begin to decline to a normal range by the end of the first week of life. They weigh the baby at the home visit at 6 lb 8 oz.

Over the next 2 weeks, Amanda continues to breastfeed the baby frequently as she has been taught. The baby begins to awaken and be fussy more frequently so Amanda breastfeeds her. Amanda feels her milk has come in well and feels the letdown reflex as the baby suckles. Because the infant is not consoled for long periods after feeding, Amanda feeds her again and again. Amanda is soon breastfeeding about every 30 minutes much of the day and night. She states that her understanding of the breastfeeding instructions are to feed the baby “frequently whenever she is hungry” and to expect the baby to “cluster feed” at times where the baby eats many times in a short amount of time. She admits she is confused as to when is “cluster feeding” occurring and why is it all the time? She calls the lactation consultant for help by the end of week 2 because she is getting no rest, and the baby is not satisfied most of the time. Amanda is discouraged and feels like she is failing at breastfeeding her baby. The lactation consultant suggests she take the baby into the hospital for a weight check. After 2 weeks, the baby weighs 6 lb 7 oz. The nurses and lactation consultant are supportive and encourage Amanda to continue breastfeeding frequently and expect the baby to feed more frequently at times. After two and a half weeks, the baby weighs 6 lb 5 oz, and the nurses request Amanda bring the baby in daily for weight checks over the next week and begin formula feeding supplements after each breastfeeding attempt.

At 3 weeks of age, the baby weighs 6 lb 7 oz. Amanda begins attending a breastfeeding support group the hospital offers and keeps in regular contact with the lactation consultant. As the baby’s weight normalizes, Amanda returns to breastfeeding exclusively over the next 3 weeks. The baby’s weight increases to 50% for age by the 2-month check-up, and she is breastfed successfully until 10 months of age.
Case 2
Connie is a 24-year-old White mom who has given birth to twins. Connie is a registered nurse who works in a neurotrauma unit and is highly motivated to breastfeed. The first of the twins is born vaginally and the second is born by Caesarian section due to fetal distress 90 minutes after the first. The twins are 5 weeks early and weigh 5 lb 11 oz and 5 lb 4 oz. The babies are placed in a Neonatal Intensive Care Unit (NICU), and their weight is below 5 lb by the end of the first week. Both babies have minor health issues that include difficulty maintaining body temperature, hyperbilirubinemia, problems with feeding and swallowing, and fragile skin.

Connie is not allowed to breastfeed them for the first few weeks. She pumps breast milk for the babies during this time. She describes the exhausting task of setting up the breast pump, pumping, storing the milk, then “force feeding” the babies that takes 1 hour each, and feeding them every 3 hours. Connie has one half hour free every 3 hours keeping this schedule, and it is a difficult time.

Due to the prematurity issues of these twins, Connie and her husband are taught how to position the babies for optimal swallowing and massaging their cheeks and jaws to encourage sucking. Their feet are to be uncovered and rubbed and flicked to keep the babies awake to eat. This is not the cuddling and bonding experience Connie expects with her son and daughter as she describes holding the babies at a 90 degree angle away from her own body and spending an hour to get them to take 1 oz of milk. She shares how disappointing it is when one of them spits up all the milk, and the process must begin all over again.

When the babies are given permission to breastfeed, they are not interested. They prefer the ease of the artificial nipples to which they have become accustomed. They pull away from the breast and cry. This frustrates Connie desperately, and she also worries about not being able to measure the exact amount of milk taken in as she has been careful to do in the NICU.

Eventually, the larger of the babies begins to nurse well, but the smaller of the two continues to resist breastfeeding. Connie is supported by a lactation consultant who suggests she use an artificial nipple over the breast. Connie describes the tricky balance of attempting to hold an unhappy squirming infant, a little piece of fake rubber breast, and her own engorged bosom. After much effort and frustration, this baby too is able to breastfeed but always prefers a bottle nipple over the breast when she can get one.

This mother describes the support of the neonatal nurses and lactation consultant who provides home visits, but still she is frustrated during the breastfeeding process. The babies have other challenges related to prematurity that complicate the breastfeeding process. Connie feels much of the problem is because the babies were fed with bottles and nipples the first few weeks of life and had much difficulty in breastfeeding once that was the main source offered. She also admits the babies continue to be fed with both bottles and breast over the first few months as she solicits help with the babies from family members.

Connie is determined to breastfeed her babies and has to overcome many obstacles to do so. She has support of the nurses and received much teaching. She attempts to follow the instructions she was given, yet she continues to experience frustration for some time with the breastfeeding process and instructions she is to follow. Her determination and the feeling that breastfeeding is best for her babies keep her working at the process. The babies are eventually successful with the breastfeeding process and breastfed until 8 months of age.

Clinical Implications
Individualized education and support for mothers during their first postpartum weeks are essential to establish successful breastfeeding practices. The case studies presented describe clients who have high motivation to succeed in breastfeeding, are well-educated, and bring prior knowledge and beliefs about breastfeeding and its benefits to the birth of their child. Each of the cases presents interactions with nurses and lactation consultants who have knowledge and expertise in their field and provide information on breastfeeding in a timely and appropriate manner. Yet, even when the “statistics” are in the mother’s favor, there is still frustration and unmet needs experienced by these mothers. These needs could be alleviated by healthcare professionals who are skilled at closing the feedback loop on how clients interpret and internalize the breastfeeding education they were given and provide affective support for the mothers.

Reviews of the nursing assessment of these clients reveal that they are concrete, logical thinkers that are likely to interpret information literally. In the first case, Amanda takes the instruction to breastfeed “frequently” literally and is confused about the “cluster feeding” concept, which leads her to breastfeed too often to foster adequate milk production for her baby. Amanda did what she thought she had been taught, but no one asked her to describe her interpretation of the instructions in her own words. There is no healthcare provider available to assess her affective state or tell her that she does not need to feed her baby every 30 minutes around the clock, provide alternatives for a fussy infant, inform her about ways to increase milk production, and decrease her stress of breastfeeding. It is not known if the healthcare professionals have awareness of Amanda’s true feelings and how she interprets instructions more literally than they were intended.

In the second case, Connie has to deal with challenges related to prematurity and feeding the babies as instructed with bottles and nipples the first few weeks of life. This leads to much difficulty in establishing breastfeeding once it was initiated. To Connie’s recollection, no healthcare professional assessed Connie’s affective state, her frustration with breastfeeding, and her unmet expecta-
tions of the breastfeeding experience that led to a lack of confidence in her ability to breastfeed.

Both of these mothers bring their background, personal characteristics, and affective states into the relationship with their nurses, and these nurses are providing proper education. These mothers are well-educated, and it is important to them to project an image of knowledge and understanding. They admit they may be less than forthcoming to the nurses about their feelings of inadequacy as they do not want to be perceived as incompetent or failing in infant care.

The major gap in the client–professional interactions in these case presentations is the feedback loop in the relationship; individualized care that assesses the affective domain of the mothers and verifies how the mothers interpret the education they are given. Nurses are skilled in assessment. The nursing process taught in schools of nursing includes assessment, diagnosis, outcome identification, planning, implementation, and evaluation (Muller-Staub, Needham, Odenbreit, Lavin, & van Achterberg, 2007). The nurses and other healthcare professionals in these case studies gave breastfeeding instruction to their client. Yet, for improved individualized breastfeeding experiences, healthcare professionals need to continually reassess their clients’ perception and interpretation of the information they receive.

**Practice Implications**

It is unclear if the nurses were aware of the frustration and sense of failure the mothers felt. This could be corrected by use of simple therapeutic communication techniques of listening for affective cues, restating what the nurse is hearing the client express for validation by the client, and having the client state to the nurse how they are interpreting the information and education given. Nurses should initiate conversations probing how the breastfeeding experience is going for the mother and encourage moms to share their feelings in a nonthreatening and supportive manner. In this way, the healthcare provider is responding to the affective and cognitive needs of the client and can better tailor the education to the individual’s needs. Nurses can increase confidence in mothers by reassessing how the moms interpret the information given, what this means to them, and how they feel about the breastfeeding experience.

**Research Implications**

Many nurses do not feel confident and knowledgeable in breastfeeding education (Watkins & Dodgson, 2010), yet providing accurate information and support to the breastfeeding mother are important influencing factors (Bernaix, Beaman, Schmidt, Harris, & Miller, 2010). Providing individualized affective support and empowering clients with the confidence to make good health choices is done through the client–professional interactions; these are influenced by both the client and professional and their relationship to one another. These interactions can be studied for better understanding related to breastfeeding practice.

New mothers may struggle to establish successful breastfeeding routines even when they receive excellent education and support for breastfeeding and their motivation is high. Limitations of this article include the use of only two cases and potential lack of accuracy of maternal recall of breastfeeding practice in case 2 (Connie) more than 3 years after cessation of breastfeeding. The two cases were chosen to represent how maternal frustration and lack of confidence exist even when many other factors to breastfeed successfully are in the mother’s favor. These cases do not address some populations, including those at risk and most likely not to breastfeed such as teenagers, single mothers, women with low educational level, and African American women. The frustration experienced by the individuals in these two cases suggests that nurses and other healthcare professionals may need to provide additional client–professional interactions, clarifications of information, and reassessment for the women with higher risk of not breastfeeding.

**Implications for Education**

The cases presented included interactions with nurses and other healthcare professionals that reached across the initial postpartum hospitalization as well as weeks after discharge. Watkins and Dodgson (2010) highlight the need for a broader approach to breastfeeding education for nurses beyond the perinatal/postnatal specialties. The Baby Friendly Hospital Initiative (BFHI) (WHO & United Nations Children’s Fund, 2009) has been identified as a “gold standard” for best practice when coupled with support and encouragement from healthcare professionals (Watkins & Dodgson, 2010). The BFHI states all healthcare providers working with lactating women should receive at least 20 hours of didactic breastfeeding education. New employee orientations and yearly competency renewals should include breastfeeding education as well as inclusion in nursing programs (Bernaix et al., 2010). Emphasis on the importance of nursing reassessment and clarification to explore mothers’ interpretation and accuracy of what they have learned along with their affective state strengthens confidence in new mothers’ breastfeeding experiences.
Suggested Clinical Implications

• Breastfeeding instruction should be individualized and consider mothers’ affective and cognitive state.

• Nurses and other health professionals need to continuously reassess and clarify from new mothers their interpretation of the breastfeeding information they received.

• Client-professional interactions need to include therapeutic communication that can confirm maternal breastfeeding knowledge as well as increase maternal confidence.

Conclusion

Nursing care involves a complex and dynamic interaction between the nurse and client in providing for the individual’s physical, mental, emotional, and spiritual concerns. Physical assessment of clients is a developed skill that may be almost automatic for most nurses. With time constraints and workload pressures, whether working in hospitals, home-care, specialties, or primary care sites, it is important for nurses to take time to assess the affective and cognitive needs as much as their clients’ physical needs. Amanda and Connie needed someone to ask what they had heard, clarify the instructions, and empower and encourage them to use their own knowledge and decisions in the care of their infants.

Nursing interventions should be tailored to consider the individual client’s background that includes demographic characteristics, social influences, and previous healthcare experiences. Clients’ motivation and cognitive appraisal of their healthcare concerns, affective responses to those concerns, and expressed healthcare needs should also be considered in relation to establishing a breastfeeding routine. By completing the feedback loop, putting into action nursing’s expert therapeutic communication skills, and helping to empower clients and individualize care, nurses can make a significant impact on the breastfeeding experience of new mothers.

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Implementing a Perinatal Mood and Anxiety Disorders Program: Erratum

In the article that appeared on page 80 in the March/April 2012 issue of MCN: The American Journal of Maternal/Child Nursing, a picture of a bumper pad in a crib was included. This photo was also included on the cover. The American Academy of Pediatrics’ recommendations from October 2011 state that the use of bumper pads or similar products is not recommended because of the potential for suffocation, entrapment, and strangulation. (http://pediatrics.aappublications.org/cgi/content/113/5/e405)

We regret any confusion the inclusion of this photo may have caused.

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