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Difficulty with breastfeeding in the newborn and new mother population is all too common, and too little is known about the type of healthcare assistance most relevant to these families. Therefore, 18 mothers were interviewed for their experiences with suboptimal breastfeeding and their perceptions of the healthcare they had received for the problem. These mothers attended an interdisciplinary breastfeeding clinic (midwifery and chiropractic) on the south coast of England. The goal of this study was to better understand mothers' preferences in healthcare resources to facilitate the most efficient and effective assistance to improve breastfeeding for mothers and infants. The main themes were that mothers desired ongoing reassurance and contextualized, nonconflicting advice that was specific to their baby.

Keywords: breastfeeding, qualitative, maternal perceptions

Inability to breastfeed a newborn is a common and frustrating problem for families and their assisting healthcare professionals. The risks of not breastfeeding are legion and include the following:

- Asthma
- Atopic dermatitis
- Celiac disease
- Diabetes
- Gastroenteritis
- Inflammatory bowel disease
- Lower respiratory tract infection
- Necrotizing enterocolitis
- Obesity
- Otitis media
- Respiratory syncytial virus–bronchiolitis

- Sudden infant death syndrome (SIDS)
- Upper respiratory tract infection (American Academy of Pediatrics, 2012).

The World Health Organization (WHO) guidelines recommend exclusive breastfeeding until 6 months of age (with breast milk continued alongside solid foods from that age onward) for the optimal lifelong health of both the child and mother (World Health Organization [WHO], 2013). Maternal benefits of breastfeeding include the following:

- Decreased postpartum blood loss
- Decreased postpartum depression
- Decreased rate of child abuse
- Decreased rate of breast cancer
- Decreased rate of ovarian cancer
- Decreased rate of uterine cancer
- Increased child spacing with lactation amenorrhea
- Rapid contraction of uterus after delivery (American Academy of Pediatrics, 2012).

In the United Kingdom, 84% of mothers initiate breastfeeding as soon after birth as possible (McAndrew et al., 2012). However, the rate of decline is precipitous

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to 69% at 1 week, 55% at 6 weeks, and 34% at 6 months of age for any breastfeeding. In terms of exclusive breastfeeding, the rates are even lower with 17% at 12 weeks and 12% continuing to 4 months of age (McAndrew et al., 2012).

One of the key reasons that mothers give for stopping is that they did not have sufficient help and support from the healthcare community to facilitate successful breastfeeding. National statistics shows that 80% of mothers who stop breastfeeding would have preferred to continue (McAndrew et al., 2012).

Costs of stopping breastfeeding are high in terms of the health of mother and baby as well as actual healthcare costs (Pokhrel et al., 2014). Their UK study estimated £11 million (US\$16 million) annual savings in just four childhood infections (lower respiratory and gastrointestinal infections, otitis media, and necrotizing enterocolitis) if mothers were supported to breastfeed for 4 months. An estimated £31 million (US\$46 million) could be saved in costs of maternal breast cancer by doubling the proportion of mothers breastfeeding for 7–18 months (Pokhrel et al., 2014). Studies from the United States have likewise determined that suboptimal breastfeeding may increase U.S. maternal morbidity and pediatric healthcare costs significantly (Bartick & Reinhold, 2010; Bartick et al., 2013). An estimated minimum of US\$3.6 billion (in 1999 US\$) would be saved if breastfeeding were increased to 50% at 6 months, by reducing the healthcare cost of treating only three conditions: otitis media, gastroenteritis, and necrotizing enterocolitis in the United States. This figure could be considerably higher if other conditions or maternal health issues related to breastfeeding were accounted for (Weimer, 2001). For a myriad of reasons, breastfeeding is best feeding, and all healthcare professionals must be vigilant to provide assistance.

The purpose of this study was to investigate what mothers say about care received and care needed for feeding difficulties, including their general perceptions about their experiences with healthcare professionals.

Method

This study evolved out of a larger study designed to create and validate an outcomes survey for parents accessing healthcare for their infants. Because a significant proportion of mothers interviewed had attended a breastfeeding clinic, it was important to document their specific needs and desires relative to the care accessed for the particular problem of breastfeeding. The purposes of this research were to identify the goals of the mother,

the ways that healthcare professionals responded or did not respond to their needs, and to discover any themes that may lead to improved care for such mothers in the future.

This was designed as a qualitative study. Ethical approval was granted from an independent college ethics committee prior to the commencement of interviews. During August and September of 2014, mothers of infants attending an interdisciplinary breastfeeding clinic were interviewed. There was no specific recruitment other than to ask mothers at the end of their session if they would be willing to participate. Mothers could decline to participate. Informed consent was gained prior to interviews, which were semistructured, recorded anonymously, and completely confidential. Mothers were allowed to speak freely, and interviews lasted 10–30 minutes. Interview topics were the following:

- Impact of problem on mother and family
- Outcomes that the mother would like from care
- Time with healthcare professionals: What is her experience?
- Perceptions of the infant's problems
- Review of advice given: Is it useful?
- Experience of this exposure to the current feeding clinic

Interviews were transcribed verbatim and then analyzed by a team of six researchers, with a minimum of three members at a time. Content analysis was used for both quantitative and qualitative data collection (Wilkinson, 2011). Quantitative analysis was achieved by coding answers to each question and inputting the data from all participants to a spreadsheet. The qualitative analysis involved each team member individually deciding on the main themes of each transcript. The team then met, discussed, and agreed on final themes for each transcript. Categories were created (Ritchie, Spencer, & O'Connor, 2003) based on areas of healthcare that were apparent in the identified themes. Quotes that best represented each category were identified.

The setting was an outpatient, interdisciplinary midwifery and chiropractic breastfeeding clinic affiliated with a chiropractic teaching clinic and a British university on the south coast of England. Midwives and chiropractors are just two of many professions providing assistance with breastfeeding, each with their own areas of expertise. This clinic combines these two

complementary approaches, aiming to provide their best possible assistance for the problem of suboptimal breastfeeding.

Results

Eighteen mothers agreed to participate. No mother refused to answer any of the questions. All mothers had presented for the problem of suboptimal breastfeeding for their baby. The characteristics of the mothers and babies were the following:

- Reason for presentation: suboptimal feeding
- Number previous professionals seen for the problem: mean: 7.7 (range: 2–17)
- Age of infants: 7–91 days; 14, younger than one month; 4, older than one month
- 16/18 mothers were primiparous
- 5/18 reported multiple interventions during birth
- 5/18 babies had tongue ties
- 12 female babies, 6 males
- 13 exclusively breastfed, 3 combination breast and formula milk, 2 exclusively formula fed

Mothers commented about the importance of breastfeeding and the difficulties of bottle feeding:

Yeah I know the benefits of breastfeeding . . . not to mention it's easier to breastfeed, so that's why you know [I want] to breastfeed him.

I think it's the inability to provide and then the kind of for me it was having to formula feed, which was something I never wanted to do because I'm such a fan of breastfeeding, so it kind of had the guilt association with that and then it's the physical strain of feeding bottles, washing bottles, sterilizing bottles, expressing milk every 3 hours it's just a nightmare, exhausting . . .

I can try and sleep when he sleeps during the day but yeah I don't know I think if I could feed him from the breast rather than expressing and doing bottles which is a nightmare then it'll be easier.

Yeah it's the fact that I can't (breastfeed), I'm spending every 3 hours, I'm spending 45 minutes pumping which I can't do whilst he's having a bottle on me so I have to give him food and then get him to go to sleep which will take about an hour and then pump for 40 minutes and then he'll be awake like in an hour and then that's it like constantly and that's a lot of stress.

Over the weekend we stopped breastfeeding and went to bottles, it was just horrendous. We had lots of tears from everybody, big disruption . . . we couldn't leave the house.

The issue that I've got at the moment is . . . the time it takes me to get the bottle ready for her. Because very often I'm leaving her in the cot crying while I'm getting her feed ready which is one of the reasons why I sort of, you know, ideally would like to breastfeed.

The mothers' comments about their experiences in this feeding clinic were generally positive, with emphasis on individualized help in a teamwork setting:

It was really reassuring and that is a vital thing.

I found here it's probably the most unhurried . . . and also a place where you get the advice just to you, not sat among a big group of people . . . so it did really help.

I'm quite a practical person so I want to know kind of like specifics so it's like right I've got a problem what's the kind of resolution, what do I actually just need to do to make it work. And I think that that's been really helpful today.

I liked everyone was very friendly, welcoming, they explained what they were doing, why they were doing it, there's no pressure . . . and really helpful advice and supportive but not patronizing which is a balance to get right.

In relation to this clinic . . . it's great, I think the two professions there to look at things from each individual point of view but work together.

It was very honest, it was really friendly. The professionals that I met were absolutely lovely, very honest, and very kind of open with everything and you could tell that they really wanted to be there.

It's just nice to be surrounded by people who know what they're doing.

I learned a lot from her (chiropractor) the first time we came last week about her feeding, you know just things that we wouldn't have known about if we'd not come here . . . No one would tell us that anywhere else so it's quite nice to understand why she's doing the things she's doing now.

Everyone was listening and when I asked the questions I got answers and everything was explained.

Themes were broadly categorized under the mothers' report of likes and dislikes in healthcare and whether these were experienced or not. There were two main themes under their likes: reassurance and specific advice; there were two main themes classified as dislikes: stressors (with two categories: personal stressors and family stressors) and unsatisfactory healthcare resources (with three

categories: poor continuity of care, insufficient time, and rules and pressures). Main themes are identified in bold, categories in italics, and quotes are indented. A subtheme of conflicting advice emerged in many interviews and was widely discussed as a stressful and difficult to manage entity. Conflicting advice was reported within and between professions, as well as from family and friends.

What Were Their Likes?

Reassurance

It's really important to be encouraged . . . to keep you going when you are having a bad day and you are thinking, Oh God, I cannot do this anymore.

Reassurance is good because I think when you have kind of got worked up about it, or sort of worried that he wasn't eating . . . the reassurance is helpful that you are getting it and getting somewhere.

Specific Advice

I can look up generic advice on Google . . . I want somebody to actually look at her (the baby) and look at what we're doing and see if there's anything specific to us that can help.

Actually, what we need is somebody to sit down and watch us and correct us.

I want to know kind of like specifics, so it's like right I've got this problem, what's the kind of resolution, what can I actually do? I actually just need to make it work.

What Were Their Dislikes?

Stressors

The key elements of their personal stress were self-esteem issues around not being able to feed their baby, not knowing what to do with the baby around feeding, sleeping, and crying. Family stressors included isolation and trying to protect the rest of the family.

Personal Stress

They don't come with a manual!

I think it's (the great stress) the inability to provide.

The reality is so much less sleep. I thought if a baby feeds every 3 hours then that meant that when you finished feeding, you had 3 hours, but I didn't realize that it took an hour to feed her, and then she doesn't sleep for more than an hour at a time.

I think it is the fact that he is completely inconsolable, so it doesn't actually matter what you do and again . . . it's not knowing and then having to accept that.

Family Stress

During the day when I am dealing with it myself, I can kind of just get through it, but it's at night time that is the hardest because it is disturbing the sleep of my husband and that's not so great. So it's trying to make sure that he is happy . . . and that my husband is able to sleep . . . if it becomes frustrating, that's when we feel the most kind of change in our tension levels.

My husband had to go back to work, so I sent him off to the spare room because he has to get up at 5.

It's difficult because the time she cries is the time my husband is at home.

Unsatisfactory Healthcare Resources

Poor Continuity of Care or Poor Care

I couldn't even say who my midwife is, I had so many. I haven't seen anyone twice, so I have never really established a relationship.

Tongue-tie: I've asked 3 people to look for it and all of them missed it, so it was only really my perseverance that meant that anyone saw it.

Insufficient Time

When they are half way through a feed, you don't want somebody saying, "right, we need to let somebody else in now."

I was more conscious that I was taking up their time.

You go to a normal GP and you are rushed in 10 minutes, which obviously is never long enough, especially when you are new parents. We went in yesterday and we had about six or seven questions but . . . we felt we weren't getting much out of it.

Rules and Pressures

It's the very strict rules [for healthcare] . . . as a first time mom, I think too much of that, not letting you enjoy your baby.

I would like to enjoy it rather than feeling the pressure of weight gain.

The subtheme of conflicting advice was discussed in most interviews in response to various questions about multiple aspects of healthcare. Mothers generally found conflicting advice stressful and difficult to manage and viewed it as a negative outcome when seeking care.

In hospital, I had a lot of conflicting advice, which was quite frustrating . . . There would be a different midwife on duty who would come up with a completely different way of doing it.

I have been given different advice which is has been quite confusing . . . and I think . . . hindered at times, her feeding.

One of the most frustrating things is that everyone tells you something different, so that you don't know who's the one to believe.

Discussion

This study explores current perceptions and preferences of mothers of infants suffering from suboptimal breastfeeding. Most mothers wanted contextualized, specific advice, support, and help for their child. Mothers found general advice and competing advice stressful and at times felt it even hindered their progress. It is likely that this group of mothers is a special population, where general advice was insufficient to solve their feeding problems. This was demonstrated in the high average number (eight) of professionals consulted prior to entering this specialty clinic, which is most often accessed by direct referrals from other healthcare professionals (midwives, health visitors, tongue-tie clinic), who have presumably already given their assistance.

The mothers' main goals varied depending on their babies' age and the severity and chronicity of their problem. Mothers of babies with small problems usually wanted to fully resolve those issues. However, mothers of babies who had more severe or long-lasting feeding problems tended to be looking for an explanation as much as a resolution and had perhaps accepted that they may not be able to continue breastfeeding exclusively. All planned to include breast milk in the baby's diet as long as physically and emotionally possible.

No matter what the problem, mothers wanted advice that was specific to their baby and found generic advice to be pedantic and self-serving, even "talking down" to the mother as though she hadn't tried to find her own answers. Their main desires were specific, individual advice for themselves and their babies and reassurance; they also wanted homework to help themselves and a brief, written record of the explanations received to remember and pass on information to family members.

One of the main complaints mothers have about healthcare was the perceived lack of time, which restricted time to ask questions and to obtain full explanations. The mothers also disliked the lack of consistency in their care. They wished to see the same healthcare professional over time to allow an ongoing and trusting relationship to develop and to avoid conflicting advice, which was an ever-present irritation.

Mother's frustrations included general expectations that they could handle all aspects of caring for a new baby, even the second time around, although they did

not feel fully equipped to do so ("they don't come with a manual"). They were protective of the rest of the family, particularly the father; the mothers bore the brunt of not only the feeding, which is logical, but also the excessive crying and sleep deprivation. When help arrived, reassurance was valued, except when it was not contextualized or sufficiently specific to answer their needs. Over and over, mothers did not value generic advice for feeding but wanted individual analysis of their problem. It seems that professionals, such as lactation consultants, with their high-level training might be in the best position to offer this specificity. Yet most mothers in this cohort had not been able to access that level of help.

Conclusion

Mothers value support during breastfeeding in the forms of reassurance, specific individualized advice, and adequate time with a healthcare professional. Implementation of these areas of support may aid continuation of breastfeeding, benefiting the long-term health of both mother and infant.

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Anna Telford, BSc, is a 4th year master's student at the Anglo-European College of Chiropractic. She is passionate about providing chiropractic care to patients of all ages and backgrounds. She believes awareness should be raised among the public about the benefits of chiropractic care, from the pediatric patient through to the geriatric population.



Brechtje Huizinga, BSc, is a 4th year master's student at the Anglo-European College of Chiropractic. She became interested in pediatrics after she saw what a difference it can make in someone's life. She believes breastfeeding is a key element for a healthy life and wants to promote this where she can. She is planning to set up breastfeeding sessions once she is out in practice.



Manu Pinkster, BSc, originally from Holland, is currently a 4th year student at the Anglo-European College of Chiropractic. Her degree is in Human Sciences, and she is currently completing her Master's in Chiropractic.



Jorieke ten Heggeler, BSc, is a 4th year master's student at the Anglo-European College of Chiropractic. She is passionate about providing care to patients who are in need, with a focus on pediatric patients and pregnant women. She believes that awareness should be raised among mothers about the huge benefits of breastfeeding. For the foreseeable future, she wants to promote greater education for mothers to empower them to make the best choices for their children's health.



Joyce Miller, BSc, DC, PhD, is a pediatrics lecturer with more than 25 years practice experience. Currently an associate professor at Anglo-European College of Chiropractic in England, she oversees the busy feeding clinic in the teaching clinic and leads the University of Bournemouth's Master's Degree in Musculoskeletal Health-Pediatrics. Her PhD is in musculoskeletal health of the excessively crying baby. She is a certified Brazelton neonate examiner, and a diplomat of the RCPCH Nutrition Program.