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Breastfeeding-Related Breast Problems And Infant Care Experiences Among Primiparous Mothers: A Qualitative Phenomenological Study

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Abstract

Background

Breast problems are a leading cause of early breastfeeding cessation, particularly in primiparous women, yet their subjective experience remains poorly understood. This study therefore aims to explore the experiences of primiparous women with breastfeeding-related breast problems in breastfeeding and infant care.

Methods

The study was designed in a qualitative and phenomenological design and in-depth individual interviews were conducted with 17 primiparous women. Data were collected using a semi-structured interview form and analyzed according to Colaizzi's phenomenological analysis steps.

Results

The themes of “feeling of motherhood”, “breastfeeding experience”, “challenges experienced during the breastfeeding period and their ımpact on daily life” “coping with breast problems and “the effect of breast problems on baby care” emerged in the study. Participants defined motherhood as a sacred identity and stated that problems such as nipple sores, mastitis and breast rejection were physically and psychologically devastating. This situation decreased mothers' motivation to breastfeed and negatively affected the ability to hold the baby, breastfeeding positioning and continuity of care. In addition to physical difficulties, guilt, feelings of inadequacy and social pressures were also prominent. The empowering effect of professional counseling, spouse support and peer sharing was emphasized.

Conclusion

Breastfeeding-related breast problems affect not only mothers' breastfeeding behavior but also their overall quality of care and mother-infant bonding. Therefore, providing individualized, empathic and holistic support to mothers is important for maintaining breastfeeding and improving the quality of infant care.

Background

Breastfeeding is an important process with both physiological and psychosocial aspects that supports the healthy growth and development of the newborn and strengthens the mother-infant bond. It also has long-term positive effects on both maternal and neonatal health [1]. The World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) recommend that all infants be breastfed within the first hour after birth and be exclusively breastfed for the first six months of life. Exclusive breastfeeding during the first six months provides protection against diarrhea and infections, thereby reducing neonatal mortality rates. In addition, while breast milk serves as the primary source of energy and nutrients for the infant, it also reduces the risk of breast and ovarian cancer in mothers, thus positively contributing to maternal health [2].

Especially primiparous women experience serious difficulties in initiating and maintaining breastfeeding [3, 4]. A review of the literature shows that primiparous mothers commonly experience issues such as cracked nipples, pain, blocked milk ducts, mastitis, and nipple sores during breastfeeding [4, 5]. Negative breastfeeding experiences physically and psychologically exhaust mothers, reduce their motivation to breastfeed, and may lead some mothers to discontinue breastfeeding earlier than intended [6].

Persistent pain and a sense of failure during breastfeeding can lead to feelings of inadequacy, anxiety, and symptoms of depression in mothers [4]. These negative emotions can affect not only breastfeeding behaviors but also the overall parenting experience and the mother's motivation to provide care for her baby. This situation may result in disruptions in the mother-infant bond and a decline in the quality of care [3]. Understanding the experiences of primiparous women who experience breastfeeding-related breast problems is highly valuable for determining the quality of professional support to be provided during the postpartum period. Qualitative exploration of these experiences can help healthcare professionals deliver empathetic, individualized, and evidence-based care to mothers [7, 8]. Furthermore, this knowledge can contribute to improving breastfeeding counseling services and developing postpartum support programs.

Methods

Type of study

A qualitative, interpretive, phenomenological design was used. The study was conducted in accordance with the COREQ checklist [9].

Study population

Data were collected between September 2, 2024, and March 11, 2025. The study population consisted of primiparous women who applied to the breastfeeding counseling unit of a Training and Research Hospital in Türkiye. Participants were selected using purposive sampling. The sample included 17 women who met the following criteria: being primiparous, having no history of multiple pregnancies, currently breastfeeding, experiencing breastfeeding-related breast problems, and voluntarily agreeing to participate. Women who did not consent to audio recording or who had a psychiatric or neurological condition were excluded from the study. The sample size was determined according to the principle of data saturation, which is common in qualitative research. Data saturation was considered to have been reached when the themes and sub-themes derived from participants began to repeat.

Data collection

In the data collection process, in-depth individual interviews were conducted [10]. This technique allows for an in-depth understanding of the structures and underlying reasons related to individuals' feelings, thoughts, beliefs, experiences, and observations. Within the scope of the study, women who applied to the Breastfeeding Counseling Unit of a Training and Research Hospital in Türkiye and were experiencing breastfeeding-related breast problems were first informed about the study. After the information was provided, verbal and written consent was obtained from the participants. Audio recordings were made during the interviews.

Before starting the main interviews, pilot interviews were conducted with two women who were not included in the sample. Based on these pilot interviews, the semi-structured interview form and the interview procedure were reviewed and revised as needed.

Individual interviews with women who agreed to participate were conducted in the breastfeeding counselor's office in a quiet setting free from distractions. Only the researcher and the participant were present during the interviews to ensure that the interview process was not interrupted and to establish a sense of trust between the participant and the researcher. All interviews were conducted by by Fatma Aslan Demirtaş (FAD), one of the authors of this study.

Each interview lasted an average of 45 minutes (min = 30 min, max = 60 min). During this process, the Descriptive Information Form and the Semi-Structured Interview Form prepared by the researchers were used. In qualitative data collection, interviews were concluded when data saturation was reached, which was determined when repetition of

information began, no new insights were gained, and all research questions had been answered. For confidentiality, participants were coded as P-1, P-2, ..., P-17 in the interview records.

Measures

The data of the study were collected using a Descriptive Information Form and a Semi-Structured Interview Form.

Descriptive Information Form

Data were collected using a researcher-developed Descriptive Information Form and a researcher-developed Semi-Structured Interview Form. Both forms were developed specifically for the present study based on a review of the relevant literature [3–5]. Neither form was adopted from or previously published as a standardized questionnaire or interview instrument.

Semi-Structured Interview Form

The Semi-Structured Interview Form was developed specifically for this study by the researchers based on the relevant literature [3, 11, 12]. It consists of open-ended questions designed to explore mothers' experiences of breastfeeding and infant care in relation to breast problems experienced during the breastfeeding period. The interview guide included an engagement question, subsequent questions, an exit question, and a probe intended to minimize misunderstanding. The open-ended questions used in the semi-structured interview form are presented in Table 1.

Table 1
Interview guide

Engagement question
Can you describe what being a mother and breastfeeding mean to you?
Subsequent questions
How do you feel when you are breastfeeding?
What breastfeeding-related breast problems have you experienced during this period and how have they affected your life?
How did you cope with the breast problems related to breastfeeding?
Did your breast problem affect your infant care?
Exit question
Is there anything else you would like to add about the impact of your breast problem on your infant care?
Probes in order to minimize misunderstanding
Could you please give an example related to this?

Human Ethics and Consent to Participate declarations

This study was approved by the Non-Interventional Research Ethics Committee of the Faculty of Health Sciences at a university in Türkiye (Date: 17.05.2025 / No: 2024–99). Subsequently, institutional permission was obtained from a Training and Research Hospital in Türkiye (Date: 16.07.2025 / No: 44767171-000-248667397). The research was conducted in accordance with the principles of the Declaration of Helsinki. Before the study commenced, all participants were informed about the aim, scope, procedures, voluntary nature of participation, confidentiality of their personal

information, and their right to withdraw from the study at any time without any negative consequences. Written informed consent was obtained from all participants before data collection. Participants were given sufficient time to ask questions and receive clarification regarding the study procedures. Ethical principles were strictly observed throughout data collection and data storage. All data were anonymized using pseudonyms to ensure confidentiality. Digital data were password-protected and are planned to be destroyed three years after completion of the research and publication processes.

Data analysis

The audio recordings were transcribed by the researchers who conducted the interviews, and the consistency and accuracy of the transcriptions were carefully checked. The transcribed texts were read multiple times by the researchers, short notes were taken, and the participants' non-verbal responses were also documented by hand. The interview data were analyzed in accordance with Colaizzi's (1978) phenomenological analysis steps. During this process, significant statements were selected, common meanings were identified, similar contents were grouped, and meaningful structures were developed [13]. These meanings were then classified as codes, sub-themes, and themes.

MAXQDA 20.0 software was used for the data analysis. The researchers independently coded the data and then came together to reach a consensus on the codes, categories, and themes. The findings were linked to the participants' life experiences to increase the contextual depth of the study. The fundamental conceptual structure of the phenomenon under investigation was thus revealed.

To ensure trustworthiness, the criteria of credibility, transferability, dependability, and confirmability, which are valid for qualitative research, were applied. Credibility was ensured through participant confirmation, and transferability was supported by presenting the analysis process in a transparent manner. The findings were reviewed by an external expert to strengthen dependability, and confirmability was ensured by having different researchers independently analyze the data. Finally, each interview transcript was shared with the relevant participant, and content approval was obtained to enhance the trustworthiness of the data.

Results

The participants' ages ranged from 19 to 35 years, and the majority (n = 6) were Undergraduate. Most of the women (n = 12) stated that their pregnancies were planned. It was determined that only eight of the participants had a vaginal birth. The gestational age of the infants ranged between 36 and 42 weeks, and their birth weights ranged from 2,700 to 4,200 grams. Most of the women sought breastfeeding counseling due to mastitis and breast refusal problems. Detailed findings regarding the participants' descriptive characteristics are presented in Table 2.

Table 2
Profile of the women (n = 17)

Participant	Age	Education Level	Planned Pregnancy	Mode of Delivery	Birth Weight (g)	Gestational Age (weeks)	Infant's Sex	Breastfeeding-Related Breast Problem
1	24	High School	Planned	Cesarean	3200	38 + 4	Female	Nipple Soreness
2	31	Undergraduate	Planned	Cesarean	3400	40 + 3	Female	Breast Refusal
3	32	Postgraduate	Planned	Cesarean	3500	41	Male	Nipple Soreness
4	23	High School	Planned	Vaginal	3800	40	Male	Mastitis
5	27	Undergraduate	Unplanned	Vaginal	2900	37	Male	Mastitis
6	33	Primary School	Planned	Cesarean	3650	38 + 2	Male	*Inverted Nipple* + Breast Refusal
7	31	Postgraduate	Planned	Vaginal	3290	39 + 3	Male	Mastitis + Hyperlactation
8	35	Undergraduate	Planned	Vaginal	3420	40 + 6	Male	Nipple Soreness + Mastitis
9	30	Primary School	Unplanned	Cesarean	4040	38	Female	Breast Refusal
10	29	Primary School	Unplanned	Cesarean	3250	38 + 2	Female	Nipple Soreness
11	24	Undergraduate	Planned	Vaginal	3500	39	Female	Nipple Soreness
12	25	Undergraduate	Planned	Vaginal	2800	37 + 4	Male	Mastitis
13	22	Primary School	Unplanned	Vaginal	3850	42	Female	Breast Refusal
14	30	High School	Planned	Cesarean	3420	37 + 3	Female	Breast Refusal+mastit
15	33	Primary School	Planned	Cesarean	2900	36	Male	Breast Refusal
16	30	Undergraduate	Planned	Cesarean	4200	39 + 4	Female	Inverted Nipple
17	19	High School	Unplanned	Vaginal	2700	38	Male	Mastitis

Table 3
Themes, sub-themes, and codes derived from the participants' experience

Theme	Sub-theme	Codes
Feeling of motherhood	**Positive expressions**	• Formation of Motherhood Identity
		• A gift from God
		• A sacred feeling
		• Unconditional attachment
		• A feeling that only women can experience
		• Compassion
		• Intense love
		• Affection
		• Madness
		• Being courageous
	Negative expressions	• Exhausting
		• Fatigue
		• Sleeplessness
		• Lack of time for oneself
		• Difficulty in meeting basic needs
Breastfeeding experience	**Positive expressions**	• Establishing physical contact with the baby
		• Feeling happy
		• Feeling peaceful
		• Fulfilling the responsibility
	Physical challenges	• Experiencing pain
		• Development of pain
		• Nipple soreness
		• Fatigue
	Psychological challenges	• Feeling guilty
		• Feeling under pressure
		• Irritability
		• Anger
Challenges experienced during the breastfeeding period and their ımpact on daily life	**Physical Challenges**	• Breast pain
		• Breast soreness
		• Breast warmth/fever
		• Breast swelling
		• Breast tenderness

Theme	Sub-theme	Codes
		• Nipple/breast wounds and redness • Fatigue • Weakness • Tiredness • Cessation of breastfeeding • Baby's refusal to breastfeed
	Psychological and emotional distress	• Difficulty adapting to motherhood • Disappointment • Anxiety • Stress • Anger • Tension • Feeling inadequate and unsuccessful • Sense of guilt • Helplessness
	Social and familial pressures	• Interventions and pressures from close circle • Inability to carry out daily activities • Social isolation
Coping with breast problems	**Coping Strategies with Professional Support**	• Teaching correct breastfeeding positions • Use of protective nipple shields • Providing information about the healing properties of breast milk • Techniques to enhance nipple prominence (pump, manual methods) • Recommendation of lanolin-based creams • Use of antibiotics and painkillers • Hot-cold applications for mastitis • Breast care with natural oils (olive oil, vitamin E, aloe vera, St. John's wort, etc.) • Breast milk expression and massage practices • Herbal support (e.g., consumption of pineapple, lemon)
	empowering effect of social support and sharing	• Psychological support from family • Expressions of empathy

Theme	Sub-theme	Codes
		• Partner's contribution to household chores • Solidarity with mothers experiencing breastfeeding problems
	Individual coping methods and self-control	• Seeking information and developing solutions • Watching YouTube videos • Reviewing suggestions from women's communities • Being gentle with oneself • Being aware of the process • Peace of mind and moral relief from feeding the baby • Determination to continue breastfeeding • Satisfaction derived from fulfilling the motherhood role
Impact of Breast Problems on Infant Care	**Care limitations due to physical challenges**	• Difficulty in carrying and positioning the baby • Inability to breastfeed directly and reliance on bottle-feeding • Feeding with only one breast • Disruption of the baby's feeding plan
	Emotional burden and disruption of self-care	• Mother feeling distracted and tired • Disruption in the baby's self-care routines • Mother's difficulty focusing on her own basic needs • Reluctance to provide care due to low energy and emotional exhaustion
	Recovery with support and adaptation to the motherhood role	• Sharing household tasks with the partner • Development of positive emotions during the baby's care process • Acceptance of the motherhood role and experiencing it as a joyful process

Table 3 summarizes five main themes identified in the qualitative analysis: feeling of motherhood, breastfeeding experience, challenges experienced during breastfeeding and their impact on daily life, coping with breast problems, and the impact of breast problems on infant care. The themes comprised positive and negative expressions of motherhood, positive breastfeeding experiences, physical and psychological challenges, social and familial pressures, coping strategies, social support, and difficulties in infant care.

Feeling of Motherhood

Participants described experiencing both positive and negative emotions regarding motherhood after giving birth. On the positive side, they expressed motherhood as acquiring a new identity, a gift from God, a sacred feeling, and a form of unconditional attachment. In contrast, they described negative feelings with expressions such as exhausting, tiring, and sleeplessness.

Positive expressions;

"For me, becoming a mother was like being born again, both spiritually and physically. I didn't just have a new baby; I gained a new identity. 'I became a mother.' (laughs) (P-1)*"Being a mother is an indescribably beautiful feeling. I see it as a gift from God given to women. It is an experience that only women can have. I am very happy because I had been planning and longing to have a baby for a long time. That's why I thank God.* (P-3)

"It is a feeling so magnificent that it cannot be described. I can never get enough of loving my baby. After becoming a mother, I realized that I have become more compassionate and affectionate. (P-16)

"Motherhood is very exhausting but also very beautiful. Motherhood is, in a way, a kind of madness. One can endure so much pain only for such a sacred duty. (P-4)

"Being a mother means being enchanted, frightened, exhausted, sleepless, happy — and at the same time, being strong and courageous. It allows me to experience many emotions all at once. (P-7)

Negative expressions;

"*I haven't been able to get used to being a mother. My baby wakes up frequently. It tires me out. I have pains. This makes me very upset and worn out". (P-8)*

"It was an unplanned pregnancy. I am not yet ready to be a mother. But for now, I am trying to meet my baby's needs and we are trying to get used to each other. My baby is my everything. I cannot find time for myself. (P-15)

Breastfeeding Experience

Breastfeeding was found to evoke positive feelings in mothers, such as bonding with the baby, skin-to-skin contact, and a sense of peace; however, it also caused physical challenges such as pain, soreness, nipple wounds, and fatigue, as well as psychological difficulties including feelings of guilt, irritability, and anger.

" *Breastfeeding is a noble and sacred feeling. I can say it is both challenging and beautiful. I love making eye contact with my baby. The touch of my baby's skin and warmth warms my heart. I feel as if I am fulfilling all the responsibilities of motherhood." (P-4)*

"I don't perceive breastfeeding as an obligation. We build our bond through this experience." (P-13)

" *Due to the pain I experienced in the first months, breastfeeding initially felt like a burden to me. As we started to understand each other, breastfeeding became more enjoyable." (P-7)*

"I believe breastfeeding is the strongest tool for understanding my baby, meeting their needs, and building our bond. The more I breastfeed, the stronger our bond becomes. When I am unable to breastfeed because of my breast problems, I feel guilty." (P-2)

" *When I first started breastfeeding my baby, I felt peaceful, happy, and close. Seeing my milk flow and my baby relax after feeding gave me strength. However, developing mastitis turned my breastfeeding times into a nightmare. I experienced*

unbearable pain in my breast. I breastfeed by clenching my teeth. But an inner voice tells me I must not stop breastfeeding, that my baby's need is more important than my pain." (P-12)

" *Breastfeeding is wonderful and gives me peace of mind, but my pain is unbearable. As feeding times approach, I become irritated. I want to avoid this act. I feel torn: 'Should I continue breastfeeding despite the pain?' or 'Should I give my body some time to recover?'"* (P-1)

Challenges Experienced During the Breastfeeding Period and Their Impact on Daily Life

Participants reported experiencing various difficulties related to breastfeeding, including physical challenges such as breast pain, soreness, warmth, and swelling; psychological and emotional distress such as difficulties adapting to motherhood, disappointment, anxiety, stress, and anger; as well as social and familial pressures such as interference and pressure from close relatives, inability to carry out daily activities, and social isolation (Table 3).

Physical challenges;

"The first four months were very challenging. I experienced hyperlactation and mastitis. At first, I did not understand the hyperlactation situation. My milk was coming out with strong pressure, and my baby was biting my nipple with her palate. I was in extreme pain, my clothes were constantly soaked, and I had to change them frequently. The pain was unbearable. Adapting to motherhood, the hormonal changes in my body, and the breast pain were all very difficult, both psychologically and physically. In short, it was the hardest period of my life." (P-7)

"The pain I experienced due to mastitis was worse than the pain I felt after my C-section." (P-4)

"Because of the wounds on my breast, I used to tense up and close my eyes and mouth when my baby latched on, silently crying. I couldn't scream because if I did, my baby would get scared and refuse to feed." (P-1)

"I had inverted nipples and my baby rejected the breast. I kept trying to breastfeed, but my baby kept pushing her head back. I spent days and hours trying to breastfeed. While I thought breastfeeding would bring peace and closeness, going through this painful process was exhausting." (P-6)

Psychological and emotional distress;

"I had really wanted my baby, even going through IVF treatment. But the nipple wounds turned breastfeeding into agony. I was breastfeeding while clenching my teeth. My baby's crying increased my anxiety and stress. I was constantly worried about my baby waking up. Because of my breastfeeding problems, motherhood was not how I had imagined it." (P-3)

"My baby's refusal to breastfeed made me question whether I was doing something wrong. I tried so hard, I made so much effort. Every time my baby refused to latch and turned away crying, I felt helpless. I forced myself to stay patient and strong, but deep down I was wearing myself out." (P-9)

"The clothes I wore, the way I sat or lay down, how I held my baby — everything was shaped by my nipple wounds. I felt inadequate and like a failure. There were times when I thought about quitting breastfeeding, but the guilt I felt inside and my baby's need for me outweighed everything. Every night I felt at peace knowing I had fed my baby with breast milk that day." (P-8)

Social and familial pressures;

"I had pain, redness, warmth, and swelling in my breast. I felt so weak that I couldn't even lift my arm. I experienced physical, psychological, and social collapse for a short time. I couldn't manage my daily tasks (like cooking, cleaning the house). My

body was giving me warning signals. There were moments when I didn't even have the strength to breastfeed my baby. I also withdrew from social activities like going out or making time for myself." (P-12)

"My mother-in-law's comments like 'Feed the baby, she's hungry,' 'Your milk is not enough,' 'You're holding the baby wrong,' 'You're not eating enough foods to increase your milk,' and her interference in my breastfeeding process exhausted me." (P-17)

"I experienced social isolation because I was under intense stress about my body and self-care. At times I wondered, 'Are there other mothers who feel like me?' This increased my sense of loneliness. Seeing mothers on social media who breastfed 'effortlessly' made me feel even worse." (P-6)

Coping with Breast Problems

It was found that participants developed coping strategies for dealing with breast problems by seeking professional support, benefiting from the empowering effect of social support and sharing, and developing individual coping methods and self-control.

Coping strategies with professional support;

"I continued while crying. My breastfeeding consultant helped me. They suggested manual methods to draw out my nipple, a silicone nipple shield, and a breast pump. The pump was especially helpful in making the nipple more prominent. I expressed milk and felt relieved." (P-11)

"First, I went to a breastfeeding consultant. They recommended correct breastfeeding positions and a protective nipple shield. They informed me about the healing properties of my own breast milk. I used lanolin-based creams." (P-3)

"The clear information given by the breastfeeding consultant about how I would recover and what I could and couldn't do helped me get better. They corrected the mistakes I thought were right." (P-4)

"I visited a specialist doctor. They prescribed antibiotics and painkillers for me. Regular massage and expressing milk made me feel more comfortable." (P-17)

"Following my breastfeeding consultant's advice, I applied warm compresses before breastfeeding and cold compresses afterward for mastitis. They also recommended eating pineapple and lemon to prevent milk duct blockage." (P-7)

"Together with the breastfeeding consultant, I used various oils on my nipple (olive oil, oils containing vitamin E, aloe vera extract, St. John's wort oil, quince seed extract, etc.)." (P-10 and P-1)

"To reduce the pain in my breast and prevent contact with clothing, I wore nursing pads and loose clothes, and kept my breast uncovered." (P-11)

Empowering effect of social support and sharing;

"My husband's and mother's support gave me great psychological relief during this process. Even hearing them say 'You're right, this is a difficult process' made me feel better." (P-2)

"I talked with other mothers around me. Hearing about their experiences and knowing that others had similar problems — hearing 'You're not the only one going through this' — comforted me a lot." (P-5)

"My husband's help with housework and his encouragement made me feel more at ease." (P-4)

Individual coping methods and self-control;

"I watched YouTube videos, did research on Google, and checked the suggestions of women with similar problems on websites created by women's communities. I read both Turkish and international articles." (P-15)

*"I knew this was part of the process. Being patient and knowing that my baby needed me made me feel that I had to be strong." (*P-9)

"I insist on trying to breastfeed. It is exhausting, but I keep going." (P-13)

"I love my baby so much. His existence is worth everything. I know this is just a phase and it will pass. This knowledge brings me psychological comfort. Even though it is painful, feeding my baby gives me peace of mind. My soul feels fulfilled." (P-3)

"Skin-to-skin contact and trying in a calm environment helped me a lot. Being patient and gentle with myself were part of the process." (P-16)

Impact of Breast Problems on Infant Care

Participants reported that breast problems led to limitations in caregiving due to physical challenges, caused emotional burden and disruptions in the baby's self-care, and that they adapted to the motherhood role through support and recovery.

Care limitations due to physical challenges;

"Sometimes I had to leave my baby with my husband or my mother. Lack of sleep and pain made me act impatiently toward my baby." (P-1)

"Most of the time, it was not possible to breastfeed my baby directly. Because my nipple did not protrude enough, my baby could not latch on properly, which negatively affected both his feeding and my milk production. Every breastfeeding attempt took a long time, my baby would cry, and I would get stressed. This made him more restless, disrupted his sleep routine, and caused him to wake up more frequently." (P-6)

"During the mastitis period, my body was almost unusable. Breastfeeding became difficult because any contact caused burning and pain. Even carrying my baby, holding him in my arms, or getting into a breastfeeding position became challenging. I constantly worried about whether my baby was getting enough milk. I felt the need to use a bottle for feeding." (P-17)

"Due to my nipple wounds, I had to shorten breastfeeding sessions at first. This made it necessary to express milk, but pumping could further irritate the wounded nipple. This disrupted the baby's feeding routine because sometimes I had to rely on feeding from only one breast." (P-10)

"My baby's constant crying and colic, combined with my breast problem, made me feel absent-minded. I didn't know what I was eating, nor could I provide proper care for my baby. I would bathe my baby once every five days and change his clothes every two to three days. Before my baby was born, I had prepared so much — clothes, grooming sets for hair, nails, and baths." (P-14)

Emotional burden and disruption of self-care;

"I didn't want to breastfeed. At first, it negatively affected my bond with my baby. Whenever he woke up, I felt unhappy and wished he would sleep longer. Both my energy and my mental state were exhausted. But no matter what, I didn't give up." (P-8)

"The severity of the pain also reduced my emotional tolerance; I became more easily irritated and prone to crying. Sometimes I was angry at my body, sometimes I questioned my motherhood. This emotional state made it difficult to show compassion to myself and created short-term emotional distance between me and my baby." (P-5)

"When my baby cried and I couldn't breastfeed him or felt discomfort because of the pain, I felt like a 'bad mother.' It made me ask myself: 'What if I reach the point where I can't breastfeed?' 'What if my baby rejects me?' 'Will I be able to get through this

process in a healthy way?"' (P-14)

Recovery with support and adaptation to the motherhood role;

"I had to ask for help. I received support from my husband or a close relative with carrying the baby, expressing milk, or putting the baby to sleep. I had to delegate household chores and other responsibilities." (P-12)

"It did not negatively affect my bond with my baby; his need for me and my unconditional love for him were like medicine for me, and we got through the process more easily." (P-2)

"As my pain decreased, I began to enjoy being a mother and taking care of my baby." (P-3)

Discussion

This study, conducted to understand the experiences of primiparous mothers who face breastfeeding-related breast problems, identified five main themes: *"feeling of motherhood," "experience of breastfeeding," "challenges associated with breastfeeding," "coping with breast problems,"* and *"impact of breast problems on infant care."* These themes were interpreted collectively as *"an inner journey in which caregiving, empowerment, and bonding are shaped simultaneously within the first experience of motherhood, influenced by breastfeeding and breast problems."* The findings also provide insights into the impact of breastfeeding problems on both the mother and infant care.

Motherhood is one of the most significant turning points in a woman's life and represents a dynamic and active process that continues throughout her lifetime. The more successfully a mother adapts to her maternal role, the stronger her efforts will be to embrace her baby and provide care [14]. In this study, while some mothers described motherhood as sacred and wonderful, a gift from God, and a new identity, others complained about it being exhausting and painful, and expressed their struggles with not being able to make time for themselves, indicating that some mothers were not yet ready for the role. Mahon and Dreyer (2024) reported that primiparous women who experienced early breastfeeding interruption faced emotional challenges and adaptation difficulties in their maternal roles [3]. Similarly, another study by Hamnøy et al. (2024) revealed that mothers' experiences during breastfeeding counseling reflected that motherhood can be both empowering and draining at the same time. The results of the present study are consistent with the literatüre [7]. These findings demonstrate that the sense of motherhood can be defined by women as a sacred, meaningful, and identity-giving experience, but at the same time, it can also be experienced as a challenging, exhausting process that requires significant adaptation.

Mothers who discovered that they did not enjoy breastfeeding reported that they experienced a difficult process they had to cope with. Mothers who stated that they did not want to breastfeed their babies due to pain began to question their motherhood, experienced decreased emotional tolerance, and became psychologically exhausted. Consistent with the literature, breast problems such as engorgement, pain, inverted nipples, and mastitis negatively affect breastfeeding [15, 16]. Increased blood flow and milk production in the breast can cause fullness and pain in the breasts. During these periods, mothers may feel tenderness and pain in their breasts [17]. The sensitivity and pain experienced by mothers during breastfeeding actually show how vulnerable they are and how much they need support during this period. In such challenging situations, mothers sometimes do not know how to find a solution and may feel that they cannot break out of this vicious cycle. These difficulties experienced during breastfeeding can lead some mothers to feel lost in their motherhood and to struggle in building a bond with their baby [18].

The findings revealed that some mothers, who were ready to learn how to breastfeed correctly and to develop coping strategies for the process, expressed trust in healthcare professionals and became more open to receiving breastfeeding counseling. A previous study indicated that mothers returning home from the hospital often lack sufficient information about what to expect regarding breastfeeding, which leads to feelings of unpreparedness and an inability to manage

challenges such as blocked milk ducts, breast engorgement, pain, and mastitis. In contrast, mothers who received breastfeeding support felt more relieved and confident [7]. Breastfeeding is described as a personal choice that requires adaptation and support and is often more challenging than expected [19]. Mastering the breastfeeding process can be closely linked to a woman's identity; women who wish to breastfeed but are unable to do so may experience significant distress [20, 21]. In this challenging process, it is crucial for healthcare professionals to adopt a compassionate attitude towards mothers experiencing breastfeeding problems and to create an environment where mothers feel genuinely heard, valued, and respected. Such an approach will empower mothers who are facing difficulties during the breastfeeding period.

Families have been found to play a facilitating role in the breastfeeding process in general. We found that mothers who received psychological support from their partners while carrying, putting their babies to sleep, expressing milk, or soothing their crying babies felt more at ease during this period. A qualitative study conducted in Canada also highlighted the importance of support from partners and grandmothers in the breastfeeding process [22]. In our study, however, one mother reported that her mother-in-law made the breastfeeding process more challenging. Similarly, a study conducted in Indonesia indicated that grandmothers may negatively influence breastfeeding practices by providing incorrect information about feeding [17]. Drawing on their previous experiences, grandmothers can sometimes act as a complicating factor during the mother's breastfeeding journey. Therefore, ensuring the involvement of family members along with mothers in counseling sessions or group-based training organized during pregnancy or the postpartum period is important for supporting breastfeeding.

Breast problems are not only a physical discomfort for mothers but also a source of psychological stress that directly affects infant care. Common breast issues such as nipple wounds, mastitis, and blocked milk ducts can cause mothers to experience pain during breastfeeding and perceive breastfeeding as a burden. This situation reduces mothers' motivation to hold their babies, ensure proper positioning, and breastfeed for an adequate duration, thereby complicating the caregiving process [23, 24]. Research has shown that mothers who experience pain while breastfeeding tend to be more impatient and restless towards their babies, which in turn negatively affects infants' sucking behaviors [23, 25]. Such impatience and restlessness weaken mother-infant interaction, leading to increased infant discomfort during feeding, more frequent crying, and disruptions in sleep patterns. Moreover, breast problems often result in shortened breastfeeding durations, frequent interruptions, or complete cessation of breastfeeding, preventing the achievement of the WHO (2023) recommendation of exclusive breastfeeding for the first six months. Mothers who struggle with breastfeeding difficulties frequently experience a sense of moral responsibility and may feel inadequate and guilty if they are unable to breastfeed [12]. This emotional burden raises mothers' stress levels and can negatively affect their patience and expressions of compassion towards their babies. During this period, some mothers may avoid certain physical caregiving tasks such as frequently holding the baby or adjusting breastfeeding positions, which can reduce physical contact and weaken the mother-infant bond [26]. Therefore, learning appropriate breastfeeding techniques, receiving professional counseling support, and benefiting from social support such as peer support play a critical role in sustaining breastfeeding and strengthening patience, compassion, and physical closeness in infant care, thus contributing significantly to the protection of maternal and infant health.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the study was conducted with a small sample of primiparous mothers from a single cultural and geographical context, which may limit the transferability of the results to other populations. Second, as the data were based on self-reported experiences, participants' responses may have been influenced by recall bias or social desirability. Finally, qualitative findings are context-specific and subjective in nature; therefore, the results should be interpreted with caution and should not be generalized beyond similar settings. Future studies could include more diverse samples and longitudinal designs to deepen the understanding of breastfeeding challenges and coping strategies.

Conclusion

In conclusion, the experiences of primiparous mothers facing breastfeeding-related breast problems indicate a complex and multi-layered process that encompasses physical, emotional, and social dimensions. The challenges encountered during breastfeeding can affect not only maternal health but also the quality of care provided to the infant and the strength of the mother-infant bond. Appropriate and compassionate support from healthcare professionals during this period contributes to mothers' empowerment and facilitates a positive transformation in their breastfeeding experience. Addressing breastfeeding difficulties through combined interventions at the individual, family, and system levels may enable mothers to maintain their breastfeeding practices more successfully. Furthermore, involving family members in the breastfeeding process and providing a supportive environment can help ease the mother's emotional burden and enhance the sustainability of breastfeeding.

Strengths and Limitations

This study has several strengths. The phenomenological design and use of Colaizzi's analysis steps allowed for a deep exploration of primiparous mothers' experiences, while strategies such as member checking, independent coding, and external expert review enhanced the trustworthiness of the data. The study also highlighted not only the physical and emotional challenges of breastfeeding but also its impact on infant care, thereby providing a holistic perspective. In addition, various coping strategies, including professional support, family support, and individual methods, were identified, offering practical implications for nursing care. Nevertheless, some limitations should be acknowledged. The study was conducted with a small sample of 17 primiparous mothers from a single cultural and institutional context, which restricts the generalizability of the findings.

Abbreviations

WHO
World Health Organization
UNICEF
United Nations Children's Fund

Declarations

Clinical trial number

Not applicable.

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Data availability

Data sharing can be done upon request from the authors.

Human Ethics and Consent to Participate declarations

This study was approved by the Non-Interventional Research Ethics Committee of the Faculty of Health Sciences at a university in Türkiye (Date: 17.05.2025 / No: 2024–99). Subsequently, institutional permission was obtained from a Training and Research Hospital in Türkiye (Date: 16.07.2025 / No: 44767171-000-248667397). The research was conducted in accordance with the principles of the Declaration of Helsinki. Before the study commenced, all participants were informed about the aim, scope, procedures, voluntary nature of participation, confidentiality of their personal

information, and their right to withdraw from the study at any time without any negative consequences. Written informed consent was obtained from all participants before data collection. Participants were given sufficient time to ask questions and receive clarification regarding the study procedures. Ethical principles were strictly observed throughout data collection and data storage. All data were anonymized using pseudonyms to ensure confidentiality. Digital data were password-protected and are planned to be destroyed three years after completion of the research and publication processes.

Consent for publication

Consent for publication was not applicable, as no personally identifiable information or identifying images of individual participants are presented in this study.

Authorship contributions

Fatma ASLAN DEMİRTAŞ: Resources, Investigation, Data curation, Software, Methodology, Formal analysis, Conceptualization. Supervision, Writing – review & editing, Writing- original draf. Zübeyde Ezgi ERÇELİK: Resources, Investigation, Methodology, Conceptualization, Writing – review & editing, Writing- original draf.

Consent to publish

Not applicable

Competing interests

The authors declare no competing interests.

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