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Maintenance of the lactation of preterm newborns: health care routine, mother-child relationship and support

Manutenção da lactação de recém-nascido pré-termo: rotina assistencial, relação mãe-filho e apoio

Manutención de la lactancia del recién nacido prematuro: la atención de rutina, la relación madre-hijo y el apoyo

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Abstract

Objective: To comprehend the experiences of mothers of preterm newborns admitted to the Neonatal Intensive Care Unit regarding the maintenance of the lactation. **Methods:** This is a phenomenological approach study, of qualitative nature, grounded on the theoretical-philosophical-methodological benchmark of Martin Heidegger. It was developed with seven mothers, through phenomenological interviews, in the period from December 2010 to May 2011. **Results:** Mothers deal with the maintenance of lactation and fear for the health of their babies and for the end of milk reserves. They present themselves as 'the being of the relationship' when she places the child on the breast. She gets involved with the dual routine that includes hospital and home duties. **Conclusion:** Breastfeeding the infant on the chest in the neonatal unit enhances the bond and enables the mother to exit the mode of occupation with the maintenance of the lactation to establish her relationship with the child.

Keywords: Mothers; Infant, Premature; Neonatal Intensive Care Units; Hospitalization; Nursing.

Resumo

Objetivo: Compreender a vivência da mãe de recém-nascido pré-termo internado na Unidade de Terapia Intensiva Neonatal diante da manutenção da lactação. **Métodos:** Estudo de abordagem fenomenológica, de natureza qualitativa, pautado no referencial teórico-filosófico-metodológico de Martin Heidegger. Desenvolvido com sete mães, mediante entrevista fenomenológica, no período de dezembro de 2010 a maio de 2011. **Resultados:** A mãe se ocupa com a manutenção da lactação, teme pela saúde do filho e pelo leite secar. Mostra-se como ser de relação quando coloca o filho no peito. Ocupa-se com a dupla rotina do lar e da hospitalização. **Conclusão:** Amamentar o filho no peito, na unidade neonatal, potencializa o vínculo e possibilita que a mãe saia do modo da ocupação mantendo a lactação para estabelecer sua relação com o filho.

Palavras-chave: Mães; Prematuro; Unidades de Terapia Intensiva Neonatal; Hospitalização; Enfermagem.

Resumen

Objetivo: Conocer la experiencia de la madre de recién nacidos prematuro ingresados en la Unidad de Cuidados Intensivos Neonatal delante de la manutención de la lactancia. **Métodos:** Estudio cualitativo fenomenológico de naturaleza cualitativa, con base en el marco teórico-filosófico y metodológico de Martin Heidegger. Desarrollado con siete madres, a través de encuestas fenomenológicas, de diciembre 2010 a mayo 2011. **Resultados:** La madre se preocupa con la manutención de la lactancia, teme por la salud del niño y por la falta de la leche. Evidencia la relación del niño con su pecho. Tiene una doble rutina el hogar y en el hospital. **Conclusión:** Amamantar el niño en el pecho en la unidad neonatal fortalece el vínculo y permite que la madre salga del modo de ocupación con la manutención de la lactación para establecer una relación con su hijo.

Palabras clave: Madres; Prematuro; Unidades de Terapia Intensiva Neonatal; Hospitalización; Enfermería.

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INTRODUCTION

Premature birth is considered a risk factor for neonatal mortality, since the pre-term newborns (PTNB) present a risk of death approximately 50 times higher than that of those born at term[1]. The prediction of preterm delivery is associated with some demographic and obstetric risk factors such as maternal age, socioeconomic status, prematurity history, maternal height, twin pregnancy, vaginal bleeding in the second quarter, cervical ripening and increased uterine activity before the 29th gestational week[2].

PTNB are those born with less than 37 completed weeks of gestation. Prematurity is classified into two categories: spontaneous (result of spontaneous labor or premature rupture of membranes) and elective (medically indicated), the latter of which represents 20 to 30% of premature births[2].

The hospitalization of PTNB arises from the difficulty in adapting to the extra-uterine life, due to the anatomical and physiological immaturity and the diagnostic and therapeutic process. This inevitably occurs in Neonatal Intensive Care Units (NICU) to meet clinical demands and should focus attention to the triad mother/child/family[3]. The family, especially the mother, will have to follow the child in the NICU environment, which is an environment of advanced technology that typically cause impact and fear[4].

For mothers, the birth of a premature child represents the breaking of the social symbolism of maternity as a sovereign act. Thus, the hospitalization of their child in the NICU requires of women the detachment from the family life and submission to a stressful hospital routinization, with daily observation of painful and invasive procedures that make up the neonatal care and, throughout this process, they have feelings of fear, insecurity, and uncertainty in terms of the child's survival[5].

In the accompanying condition, the mother is subjected to the hospital routine, which includes, very often, the circumstances of clinical indication for the non-breastfeeding of the baby. This implies the need for lactation maintenance[6], which requires from health professionals to welcome the family, encourage the mother-baby bond, develop educational activities for the early start of breastmilk in addition to the attention to the negative feelings that the mother can present[6].

In the NICU, mothers become the food providers for their child, since the concern in terms of the nutrition of these babies can be a priority for the Health Team[7]. On the other hand, the desire for the recovery of the child and the desire to be with him makes them seek strategies to cope with prematurity and hospitalization[8], in an attempt to reestablish the bond and develop skills in specific care given to the preterm infants, as they are required at home[3,9,10].

The resumption of the mother-child relationship that often becomes impaired due to hospitalization, which compromises the bond and affection between them[11], can be restored through the maintenance of lactation. Thus, in addition to ensuring adequate nutrition to PTNB, the mother starts to be included in the care of the child[6].

Thus, support for the mothers, for their participation in the direct care given the preterm infants, including their food, should be a priority in neonatology services. The team takes on roles and responsibilities in order to evaluate, understand, and provide support to newborns, mothers and family during this period[12].

Therefore, there is the need to provide care for mothers who have their children admitted to the NICU. The objective was to understand mothers' experience in terms of the PTNB hospitalized in the NICU regarding the care aimed at lactation.

LITERATURE REVIEW

The birth of a PTNB is surrounded by uncertainty because of the need for hospitalization in the NICU and the unexpected separation between parents and child. This separation may cause as much damage to newborns as for parents, modifying the relationship started during pregnancy. The mother-infant initial contact, hampered by hospitalization in the NICU, may negatively influence the construction of the relationship between them and the family atmosphere, causing increased stress in the family and loss for the establishment of bond between mother/family and the child[12].

In the daily care in the NICU, it can be perceived that the professional relationship with the other is sometimes permeated by a careful objective, since it is a therapeutic environment of high complexity. In addition to the latest technology and diversified equipment, this unit has highly qualified professionals and specific protocols for the care aimed at newborns[13].

Thus, the relationship of professionals with mothers becomes more distant and, often, these professionals are led by the situation, exempting themselves from the responsibility of mediating the mother-infant relationship, prioritizing the development of medical technology and the bureaucratic and administrative issues of the institutions. This action ends up leaving aside the focus of assistance, which is human care.

Therefore, there is a need for a humanistic care that meets the needs of the baby and its family, which is based on the relationship established between the nurses and the family of PTNB, mediated by a living dialogue in which each one perceives the availability, proximity and understanding of one another. Therefore, it is important to understand the meaning of the experiences of each other, and the professional should be willing to go beyond the technical competence and the biological domain[14].

In this sense, professionals establish a relationship with the intention of reducing the fear of the unknown environment, providing support and encouraging early contact of parents with their child. The clarification of what can be accomplished with and for the baby can enable better recovery, and especially favor the interaction between the PTNB and its family.

In this context, one sees the need to expand studies to devise how to be mothers of these infants, considering their experiences, completeness and uniqueness, with their existential entanglements, incorporating their history of life so that care at the NICU may focus on newborns and their families in full, aligning the technique to the humanized care.

The inclusion of the family in care during hospitalization facilitates communication and strengthens the relationship established between them. Similarly, it encourages family members to look after their children after hospital discharge[10].

METHODS

This is a qualitative study, which used a phenomenological approach and the theoretical framework of Martin Heidegger[15]. This approach seeks to unveil in the subject matter the way it is in itself, that is, the experience of mothers regarding lactation maintenance through its meaning.

Data collection took place from December 2010 to May 2011 at a university hospital located in the central-western region of Rio Grande do Sul. The setting of the research was the NICU, which offers high and medium risk beds and isolation. It is a hospital of excellence for risk newborns in that region.

The study subjects were mothers of PTNB admitted to the NICU that were in lactation and breastfeeding. Mothers who did ablactation or discontinuation of milk secretion were excluded. The initial selection was made by professional service based on inclusion criteria, and the mothers were subsequently invited to participate in the study.

The number of subjects was not predetermined, since the field stage developed concomitantly with the analysis showed the quantitative interviews necessary to meet the objective of the research, pointing to the sufficiency of meanings expressed in the speech of mothers[16]. Thus, the total was seven mothers of PTNB who were in lactation and breastfeeding.

For the production of data a phenomenological interview was conducted through a meeting singularly established between the researcher and each subject. The meeting was mediated by empathy and intersubjectivity from the reduction of assumptions[17].

Thus, during the meeting, the professional had to be alert to the behavior of the interviewed mothers, capture what was said and not said, and watch the other forms of speech: the moments of silence, gestures, pauses and ellipses; and she should also respect the space and time of each interviewee. This opening position of the researcher enabled the progressive improvement of the conduction of the interview, allowing the phenomenon to emerge in each interview[17].

The interview began with the question "How is the experience of taking the milk to feed your child?" During the interview, empathic questions were formulated to avoid inducing answers, highlighting questions expressed by the mothers that needed to be enhanced in order to better understand the possible meanings indicated. To end the interview, a feedback, in which we asked if the mothers would like to add something, was developed and we thanked them for their willingness for this meeting[17].

The interviews were recorded upon agreement and the transcription of the interviews, where the silences and body language were pointed out during the meeting, respected the original speech. The interviews were coded with the letter M for mother, followed by the numbers 1 to 7.

The analysis made by means of the Heidegger's method, was developed in two methodical moments: comprehensive analysis and interpretive analysis[15]. At first the researcher dismissed assumptions in order to develop a careful listening and reading of the interviews with a view to understand the meaning of the experience of mothers of PTNBs without imposing predetermined categories of theoretical/practical knowledge.

The essential structures were underlined in the transcripts, forming a framework of analysis that formed the basis for the meaning units and the phenomenological discourse. The interpretative analysis (according to a methodical moment) includes the understanding of senses from the meanings expressed by mothers[15].

The research project, approved by the Ethics Committee of the Federal University of Santa Maria (RS) under CAAE 0294.0.243.000-10, ensured compliance with the principles of voluntariness, anonymity, confidentiality of research information, justice, equity, reducing risks and leveraging the benefits, protecting their physical, mental and social integrity in terms of temporary and permanent damage. Mothers who agreed to participate signed the Term of Free and Clear Consent.

RESULTS

Mothers say they have not rested since giving birth to the baby. They have a routine of going from home to the hospital and vice versa. It is a busy, tiring and complicated daily routine. Coming to the NICU every day is difficult, but it is part of life.

> *I come every day [to the ICU] at noon, because in the morning I have to take care of the other [...] We feel tired of the routine of coming and going. (M1)*
>
> *I come back here in the morning and come back home at night. [...] everything is (sigh) really fast [...]. (M2)*
>
> *[...] It is tiring, but now it's easier because I get a ride, so I come every day. (M3)*
>
> *[...] I have to take care of others [other children] as well. I'm too tired of going back and forth [...] I arrive there, I and stay with him for as long as possible. (M4)*
>
> *When I can, I come here in the morning, then I go to work and come back here again. When I'm running out of bus ticket, I come every other, but I call to know about her. [...] It's kind of hard, but that's how things are. (M5)*
>
> *[...] Before we used to come twice a day, now we're coming just once, because it is a rush. (M6)*
>
> *[...] it's hard [...] I get up without the [child's name] and I come here, I collect his milk and go downstairs to take some coffee, then I come to get him more milk again. I stay here until the evening, have some dinner and go up a little more and then I sleep. (M7)*

Mothers report that they would like to be breastfeeding; that allowing the milk to end is not good, because their breasts hurt so

much and it is uncomfortable. They believe that it is complicated, difficult, and they express it as a sacrifice that is made for the baby. The sight out of the milk coming out because they have to take it out makes no sense; sometimes they do not take away the whole milk, because they thought it would be stored in the breast. If they could donate it, it would be better. At the beginning they have plenty of milk, and sometimes it gets thicker. Over the days, and the difficulty of exhausting it, they feel that it is drying or has dried.

> *It [milking] was awful because it was hardened [...] I was studying at home and threw it out because I could not bring it to her. (M1)*
>
> *I'm afraid my milk might get dried [...] I can't take it from home to the hospital. [...] It distresses me. I'm throwing it away while he's there, without being able to use it [...] I feel okay my milk is diminishing. (M2)*
>
> *It´s really bad [milk] there is almost nothing [milk] [...] one thing is to put the baby on your breast, another is to get it out to put in it a bottle or throw it away, because he was not really for baby suckling. [...] I did not take it out; I thought it was going to be saved. (M4)*
>
> *For me it's easy to draw it because I have plenty, it gets hardened. But I throw it away because she I'm not nursing her. (M5)*
>
> *It's a bit uncomfortable; it is for the babies, then we do it from the heart. [...] If I could donate the milk... I throw it away, because it gets hardened. (M6)*
>
> *[...] I'm taking out the milk [...] the desire to give it to him is stronger [...] I wish he were on my breast nursing, but we do the sacrifice [...] It's difficult to see all that milk leaving. [...] The first time it was hard, it hurt a lot. (M7)*

Mother say that staying with the baby is pleasant and wonderful; staying all day long sitting next to him is good. It helps to know that you can come anytime to see your baby.

> *It is wonderful to be near her. [...] In the afternoon I come to be with her. (M1)*
>
> *[...] If I'm here, I'm sitting the whole day here with him; I go downstairs to have lunch and come back. (M2)*
>
> *[...] It's better for him. (M3)*
>
> *[...] I come and spend the whole afternoons with him [...] it is nice, it is good to be close to him, it help us to be stronger [...] To know that we can stay the whole day there with him, makes us feel a little more comfortable. I take care of him, change his diaper and clothes, I breastfeed him. (M4)*
>
> *[...] Here we can come to see him at any time. (M7)*

Mother describe the moment when they put their child on the breast; they state that the baby suckles well; sometimes he gets tired, just sleeps and gets lazy. While breastfeeding they felt more like a mother, which was tranquil sensation; it was great, the best feeling. They believe that breast milk could help in the child's recovery.

> *After she began to suckle [...] I don't even feel pain [...] Breastfeeding her makes me feel like a mother [...] It seems that we are more attached to the child and they feel more protected [...] I prefer her suckle on my breast, so that we can avoid worse things like diseases. (M1)*
>
> *[...] He even suckles on my breast, but little; he comes to my lap and just sleeps; he doesn't want to suckle. [...] I will try to give him the breast more calmly, to see if it picks up. (M2)*
>
> *[...] Yesterday I've tried to put him to breastfeed [...] It is great, exciting, but he didn't take it very well; he doesn't feel comfortable, but it's the best feeling; I hope he gets it soon so he can get used to it. (M3)*
>
> *Yesterday he got my breast, then I think he got tired, because there is little [milk]. (M4)*
>
> *At the same time I get happy 'cause when leaves the hospital, she will have my milk [...] I think she should be breastfed; it'd help on her recovery. (M5)*
>
> *[...] Today it was the first day I breastfed [name of the child], but he was a little lazy and slept most of the time. (M6)*
>
> *[...] On these days I could breastfeed and I thought he would take a while for him to get used to it because of the mamadeira, but it was easy. [...] If he stayed with me [at the hospital unit] I would breastfeed him all the time. (M7)*

Mother state they are hopeful and pray that the child gets better, gains weight, recovers and stays well. They hope they can go home and take the baby together. While they wait for discharge, they adjust everything in the house to receive it. Only when they are together at home they will be able to relax and feel at ease.

> *I'll just relax when she goes home. [...] You think [the child] will be discharged, but he won't. [...] When he is at home we can relax. (M1)*
>
> *[...] I try to think he'll be better soon and I'll be able to take him home. [...] If he has the right weight and if he is suckling well, they will release him. [...] This is what I want [...] to take him home. (M2)*
>
> *[...] I wish I could take him home now, but it's alright; it's not the end of the world. (M3)*
>
> *[...] Now I know he goes home. He just needs to gain a little weight. [...] In little time he will be home. [...] (M4)*
>
> *[...] I can hardly wait to take her out of there. I really hope so. [...] I have much faith, I pray a lot. She needs to*

gain weight, to recover. [...] I iron her clothes, wash it; I'm organizing everything for when she goes home. [...] I hope I can take her home. (M5)

[...] Fortunately she is fine. She goes home if that's God's will. (M7)

Mothers report that they could not go through this alone. They received support from the family, from nursing professionals and from others. The nurses were attentive, they talked, they calmed us and it helped us to relax and take away some of the burden of the concern. They helped with bus tickets to go to the hospital, as well as others who gave us rides.

The nurses give me bus tickes to come to the hospital. (M1)

[...] It is painful to be away from my husband, from my family, especially my son; to have their support. [...] The family I have here are the nurses, because they talk to us. [...] It is an agony that makes you want to cry all day. They [the nurses] talk to me, explain things, cheer me up. [...] It's relaxing. [...] It made me take some of the weight off my head. (M2)

I got a ride, so I'll be here whenever it's possible. (M3)

The girls are very considerate. My family gave me great support. [...] We get up for the [other] kids we already have. [...] I think that, if I didn't have the support of the staff here and my family I wouldn't have gone through it. When I'm just willing to fall, the girls come and soothe me, then I cheer up. (M4)

Nurses are patient. They talk to us [...] and we become friends. [...] I thought I would feel more uncomfortable, that I wouldn't have that interaction with the nurses; that we wouldn't chat. (M6)

DISCUSSION

The mothers who have the child admitted to the NICU experience a double factuality that is seen under different conditions: on a permanent basis of having a child born prematurely and in the transitory fact that he is hospitalized in an NICU. The mother cannot escape from them; these situations are brought into their daily lives.

Therefore, mothers talk about themselves and facts: they feel tired; they are not used to the routine of coming and going from hospital to home and vice versa. When they are home they have to look after the other children and household chores, and when they are at the hospital they stay next to the baby all the time, and that becomes a routine. Thus, mothers show they are in the occupation mode[15].

They are busy with the routine of coming and going to the hospital and the routine of the house. When they develop what is expected of them, they show themselves as women. They describe that they have to assist the children, tidy things up and provide attention to the other children. They get busy with their studies and work within and outside the house.

For being this way, she announces a worldview of the social role of women. This understanding of herself, inherited from tradition, opens and regulates the possibilities of their being and it anticipates their steps[15]. Thus they say that the maintenance of these activities is tiring, however they state that mothers do not get tired. They strive to establish a routine of coming and going from home to the hospital.

This involvement with what has to be done keeps women-mothers focused on a way of dealing with what comes their way, such as the hospitalization of the baby. Therefore, "the being in the world" is taken by the world in which he/she lives"[15].

When they get involved in this routine, mothers report that they become used to it; it is a situation that is part of that time of life. Every day is different, but they prefer to think ahead. They realize that, despite being a bad routine, they strive to maintain it. So they show that they are engaged in living together, in which being remains as everyone is and wants him to be, and does not reveal himself as he is in his uniqueness.

When speaking of the maintenance of lactation, mothers report that they have to carry out the milking, and for this they received information on the subject. They know the importance of breast milk for the experience of living with other women in the pregnancy and childbirth or breast-feeding experiences of other children, and have heard about milking and the need to maintain milk production. This prior interpretation of the facts opens up and regulates the chances of their being.

They repeat what they were told about the importance of breast milk for the baby to gain weight. Therefore, mothers are shown in the chatter mode of being[18]. Due to the need to remain in the world, they repeat what they heard and pass the information on, without really understanding what happened; what exactly remains to be understood, deep down, unlimited and unquestioned.

The chatter is the language in which it seems that the being understood everything without having to previously take ownership of the thing[18]. Things are as they are because that's what is (impersonally) said to reveal the authoritarian character of speech[18].

By repeating the importance of breast milk and milking for the maintenance of lactation, they also state that they wait for the opportunity to put the baby to breastfeed. They describe the number of times they must perform milking; they report that, due to the fact that they have to throw the milk away, they sometimes do not milk their breasts, as they thought they could save the milk.

From the moment they put the baby to the breast, they report that they no longer feel pain, they cling to the child, have the feeling that the child feels more protected and it could help in his recovery; therefore, they wish to breastfeed at all times. Thus, they show the way to be-with, pointing the relational dimension of the human, fundamental and genuine characteristic of being a mother of a PTNB.

At this time they recognize/know the baby as a son or daughter. "The ontological relationship with others becomes therefore a projection of one's being for himself in another. The other is his double."[18]. Thus, the mother relates as a be-with the child, as he himself is present, and this feature of relating and living gives meaning to human life.

Thereafter, they show that they not only deal with the milking, but they do it because they believe that breast milk helps in the recovery of their child. At this point, we can see the movement of the decision with the maintenance of lactation for the relationship with the child[18]. This mode-of-being enables mothers to have an existential movement of realization that they have to take the breast milk off so they can understand the importance of breast milk for the child.

The mothers say that they await discharge praying to God for the child's healing and weight gain, and they prepare the home for the arrival of the child. They say that they can go to the hospital to see the newborn at any time and they know that it is good. When they are next to the child, even if just looking, they feel better. Accompanying the baby during hospitalization helps them to face the difficulties, brings comfort and tranquility. Thus, they manage to control themselves during the phase of decadence, without expressing any negative assessment, but indicate how the presence most often is in everyday life.

They also receive support from family, other children, mother and nursing professionals. The professionals help on the purchase of bus tickets and the acquaintanceship and conversations help during the child's hospitalization period. Therefore, mothers are related in the way of being-with people who help, demonstrating the need for help.

CONCLUSION

Breastfeeding the PTNB in the NICU enhances the baby's bond with their mothers and allows these mothers to leave the occupation mode with the maintenance of lactation to establish a relationship with the child. In care practice, this means providing support for the maintenance of lactation and breastfeeding initiation still in the hospital environment, through educational practices; moments of dialogue between staff, mothers and family; and hospital routines that allow mothers' involvement in the care for the child.

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