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The effect of breastfeeding counselling provided to primiparous mothers on postpartum breastfeeding outcomes and dyadic adjustment

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ABSTRACT

Aims: The aim of this study is to determine the effects of breastfeeding counselling provided to primiparous mothers on postnatal breastfeeding outcomes and dyadic adjustment.

Methods: This study was a randomised controlled trial. The study was conducted at a public hospital in Bursa between November 2023 and November 2024 with primiparous pregnant women. Mothers in the follow-up group received the hospital's routine breastfeeding education. Women in the experimental group received individual breastfeeding counselling eight times at specific intervals from the 28th to 35th week of pregnancy to the sixth month postpartum. Data were collected using an Information Form, the Adverse Childhood Experiences Scale, the Breastfeeding Support Scale, the Revised Dyadic Adjustment Scale, the LATCH Breastfeeding Assessment Scale, and the Girl and Boy Infant Percentile Curves. Data were assessed electronically.

Results: There was no difference between the couples' compatibility and partner support scores of mothers receiving individual breastfeeding counselling, and those in the follow-up group ($p>0.05$). Mothers who received individual breastfeeding counselling had higher LATCH score averages and a higher frequency of feeding their babies exclusively with breast milk at 6 months compared to women in the follow-up group ($p<0.05$).

Conclusion: Individual breastfeeding counselling has been found to be more effective than breastfeeding counselling provided as part of routine hospital care, positively affecting breastfeeding outcomes.

Keywords: Breastfeeding counselling, primiparous, adverse childhood experiences, dyadic adjustment

INTRODUCTION

Breastfeeding is one of the foundations of child health development and survival. Particularly in the absence of breastfeeding, malnutrition, diarrhoea and pneumonia are common causes of death in children under five years of age. Furthermore, breastfeeding helps reduce overweight and obesity worldwide and protects maternal health. Therefore, in line with the recommendations of the World Health Organisation (WHO), the Turkish Ministry of Health recommends starting breastfeeding immediately after childbirth, exclusively breastfeeding for the first 6 months, and continuing breastfeeding until 2 years of age and beyond, within the framework of the 'Breastfeeding Promotion and Baby-Friendly Health Facilities Programme'. (Turkish Ministry of Health, 2018; WHO, 2018).

Despite the many benefits of breastfeeding, the rate of exclusive breastfeeding in the initial six months is 41% in Turkiye (Soyhan, 2020; TNSA, 2018; Zengin, 2023). Globally, the region with the highest prevalence of exclusive breastfeeding is South Asia (60%), while the lowest is North America (26%). Worldwide, this rate is 48% (UNICEF, 2022). Although breastfeeding is common worldwide, the rates have declined compared to previous years. The main reasons for the decline in breastfeeding rates are problems during the breastfeeding process and the mother's inability to access the social and professional support she needs following this period (Demirbağ, 2023; Onat, 2018).

Breastfeeding counselling should begin during the antenatal period with a holistic approach (Onat, 2018). The breastfeeding counsellor plays a vital role in assessing breastfeeding, correcting mistakes made during breastfeeding, and providing support to the mother. The breastfeeding counsellor's fundamental duties are not only to provide information to the

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mother but also to help her overcome the difficulties she faces, to empathise with her, and to be supportive. These duties continue throughout the breastfeeding period. In our country, breastfeeding counselling training is mostly provided by nurses and midwives (Turkish Ministry of Health, 2018).

When mothers do not receive breastfeeding support, the breastfeeding process may be negatively affected (Aksoy et al., 2016). Mothers' emotional state also plays a role in this process. A study found that depressed mothers were less likely to breastfeed than non-depressed mothers and were more likely to discontinue breastfeeding earlier (Jiang et al., 2022). Mothers experiencing depression may have difficulty initiating and continuing breastfeeding due to common fatigue, low mood, and difficulties forming an emotional bond with their babies (Beyene et al., 2025).

Even in the absence of a mental disorder diagnosis, one factor affecting mothers' mental well-being is reported to be their negative experiences during childhood (Shaikh et al., 2020; Watson et al., 2021). Adverse childhood experiences (ACE) encompass the effects of all types of neglect and abuse experienced by individuals in their family environments up to the age of 18 and cause individuals to encounter many psychological and physical problems in the future (Canbolat, 2023; Gündüz et al., 2018; Işık, 2023). Adverse childhood experiences also increase the risk of physical and mental health problems during pregnancy and after childbirth. Adverse childhood experiences may reduce mothers' likelihood of initiating and continuing breastfeeding. Furthermore, breastfeeding may trigger memories of childhood sexual abuse and symptoms of post-traumatic stress disorder, which may lead to the discontinuation of breastfeeding (Umar et al., 2025).

The support of partners, who are closest to mothers during breastfeeding, is also important. It has been reported that whether a woman has spousal support during breastfeeding is important for her adaptation to her maternal role (Isıguzo et al., 2022; Tucker, 2022; Uğurlu et al., 2023). It has been found that spousal support significantly affects maternal mental health; women with problematic relationships with their spouses experience these negative effects (Wall and Dempsey, 2023). Dyadic adjustment becomes more apparent during pregnancy and the postpartum period. Dyadic adjustment constitutes the emotional dimension of the importance couples attach to family concepts, their feelings of love, respect, and trust for each other, and their sense of belonging (Türkseven, 2020; Çolak, 2017; Yurtsal and Uslu, 2023). On the other hand, changes observed in dyadic adjustment that are parallel to the changes experienced during pregnancy and the postpartum period affect breastfeeding (Yurtsal and Uslu, 2023). It has been found that psychological problems increase due to disagreements and incompatibilities experienced by couples (Rodoplu, 2019). Furthermore, it has been reported that negative experiences in childhood may cause individuals to experience conflict with their spouses in adulthood and a decrease in marital satisfaction (Pehlivanlı and İkizer, 2020; Altıparmak, 2021).

Although there are publications suggesting that fathers may also play a role in the breastfeeding process (Kale, 2024), it has been reported that breastfeeding counselling improves breastfeeding outcomes in mothers, while the lack of breastfeeding counselling and social support reduces breastfeeding rates in women. Therefore, it is recommended that mothers receive individual breastfeeding education (Gerhardsson et al., 2023).

A review of the literature revealed no studies examining the effect of breastfeeding counselling provided to primiparous mothers with adverse childhood experiences on postnatal breastfeeding outcomes and dyadic adjustment. Therefore, this study was designed to examine the effect of breastfeeding counselling provided to pregnant women with adverse childhood experiences on postnatal breastfeeding outcomes and dyadic adjustment.

Research Hypotheses

H1: The frequency of exclusive breastfeeding among pregnant women receiving individual breastfeeding counselling is higher than among pregnant women receiving routine care.

H2: The perceived dyadic adjustment among pregnant women receiving individual breastfeeding counselling is higher than among pregnant women receiving routine care.

METHODS

Ethics

For this study, permission was obtained from the Non-interventional Clinical Researches Ethics Committee of the Institute of Health Sciences at Marmara University (Date: 19.12.2023, Decision No: 117). Primiparous pregnant women who volunteered to participate in the study completed the relevant forms and scales face-to-face during data collection. Permission was obtained via email from the individuals who conducted the Turkish validity and reliability studies of the scales. Throughout the study, the ethical requirements outlined in the Declaration of Helsinki were adhered to. After the study was completed, the mothers in the follow-up group were provided with counselling on breastfeeding and infant nutrition for 0-2-year-olds, in line with their requests.

Setting and Procedure

The study was conducted at the Bursa Specialized Training and Research Hospital. The study population consisted of 207 primiparous women who attended the antenatal clinic between November 2023 and November 2024. The study was completed with 60 women, including 30 women who completed the individual breastfeeding counselling training, and 30 women in the follow-up group who completed the measurements.

Study Design

This study is a randomised controlled trial. Each pregnant woman attending the antenatal clinic was assigned a number from the start of the study in order of application, and randomised using the randomizer.org website.

Inclusion Criteria

Women with at least one adverse childhood experience, primiparous, with a singleton pregnancy, married and living with their spouse, aged 18-35 were included. They had not previously received psychiatric treatment, had not previously received breastfeeding and antenatal education, could speak and understand Turkish, and had at least a primary school education.

Exclusion Criteria

Women who gave childbirth prematurely (before 37 weeks), did not complete the programme, developed postpartum maternal complications, had a baby requiring neonatal intensive care after childbirth, did not complete the questionnaire forms, or wished to withdraw from the study.

In the follow-up group, participants attended routine antenatal classes and received breastfeeding counselling once in the maternity ward before being discharged from the hospital after childbirth.

Experimental group: In addition to routine antenatal classes, they received individual breastfeeding counselling based on the same curriculum used in the Ministry of Health's mother and baby-friendly hospitals program. Individual counselling sessions were conducted by the first author, Sedanur Balım. Within this scope, individual breastfeeding counselling consisting of a total of eight sessions, starting between 28 and 35 weeks of pregnancy, and continuing until the sixth month after delivery, was provided via WhatsApp/online video calls.

Preparation of Sessions

Breastfeeding counselling was conducted at the hospital's antenatal school. The antenatal school was equipped with soft cushions, pillows, comfortable chairs, and well-lit surroundings to ensure the comfort of the expectant mothers. Presentations were enriched with models of the uterus, breast, and toy babies. Visual materials, including slide shows, and video presentations from the Turkish Ministry of Health, were used.

Session Content

1st session: Conducted in person between the 28th and 35th weeks of pregnancy. Detailed information about the research was provided to the expectant mothers, and questionnaire forms were administered.

2nd session: Conducted face-to-face between the 35th and 36th weeks of pregnancy. Topics covered included 'the anatomy of the breast, breast milk composition, oxytocin hormone, breastfeeding positions, the importance of breastfeeding and skin-to-skin contact, and kangaroo care.' The session lasted 45-60 minutes.

3rd session: Conducted face-to-face between the 37th and 38th weeks of pregnancy. Topics such as breast milk expression methods, milk storage methods, breast-related problems, back massage, and relactation were discussed, with the discussion lasting 45-60 minutes.

4th session: A WhatsApp/online video consultation was held between the 1st and 2nd days after childbirth. Information and assessment were provided on the breastfeeding process, follow-up breastfeeding, the baby's urine and stool output, and signs of jaundice. It lasted 30-45 minutes.

5th session: A WhatsApp/online video consultation was held between 7-14 days postpartum. The breastfeeding process was evaluated, counselling was provided on topics where mothers needed support, and effective recommendations were made to increase milk supply.

6th session: 28-35 days postpartum, conducted via WhatsApp/online video call. The breastfeeding process was evaluated counselling was provided on topics where mothers needed support, and effective advice was given to increase milk supply.

7th session: Between 90-97 days postpartum, a WhatsApp/online video consultation was conducted. The mother's management of the breastfeeding process was evaluated, breastfeeding counselling was provided on topics they needed, and support was given to the mother to continue breastfeeding. The aim was to support the mother's breastfeeding process, continueing it for at least 6 months.

8th session: Conducted face-to-face when the baby was 6 months old (±7 days). Information was provided about complementary feeding and the importance of continuing breastfeeding until the age of two. Questionnaires were given for final measurements; and the babies' height and weight were measured.

Synchronised measurements were taken for the experimental and follow-up groups, and the results were compared.

Data Collection

Within the scope of the study, the initial and final measurements were collected face-to-face by the first author (SB) at the antenatal education class of the public hospital where the study was conducted. The scale forms were completed by the researcher. The anthropometric measurements of the infants were taken by the researcher.

Data Collection Tools

The Personal Information Form, Adverse Childhood Experiences Scale, Breastfeeding Support Scale, Revised Dyadic Adjustment Scale, LATCH Breastfeeding Assessment Scale, and Girl and Boy Infant Percentile Curves, prepared by the researchers in line with the literature, were used to collect research data.

Personal Information Form: The personal information form prepared by the researchers consisted of questions covering the socio-demographic characteristics (age, educational status, income level, etc.) and obstetric characteristics (mode of childbirth, first antenatal care week, etc.) of the individuals.

Adverse Childhood Experiences Scale (ACE): Developed in 1997 by the Centers for Disease Control (CDC) and Kaiser Permanente, its validity and reliability in Turkish were studied by Gündüz et al. (2018). This scale consists of 10 items that inquire about childhood traumas. The questions only include a "yes" option, otherwise, they are left blank. The CSEI-P total score ranges from 0 to 10. An increase in the score indicates an increase in adverse childhood experiences. In the validity and reliability study of the scale, Cronbach's alpha (α) reliability coefficient was found to be 0.74, whereas, in this study, it was found to be 0.77.

Dyadic Adjustment Scale (RDAS): Developed by Busby et al. (1995), its validity and reliability were studied in Turkish (Bayraktaroğlu and Çakıcı, 2017). It is a 14-item measure. They adapted it to their culture. The scale was developed to assess the quality of relationships in marriages or similar dyadic relationships. Items 7, 8, 9, and 10 of the scale are reverse-scored. The maximum score that can be obtained from the scale is 70 points, and the score obtained indicates the quality of the relationship. In the validity and reliability study of the scale, Cronbach's alpha (α) reliability coefficient was found to be 0.88, and in this study, the Cronbach's alpha reliability coefficient was found to be 0.81.

Breastfeeding Assessment Scale: Developed by Moriwaki and Haku (2016) to assess the current status of breastfeeding support from the spouse. Its validity and reliability were studied in Turkish (Akgün, 2019). The scale consists of 14 questions and 3 factors. Each item that the woman describes as "present" is given a score of "1". The maximum score that can be obtained from the scale is 14, and the minimum score is 0. As the score increases, the breastfeeding support felt by women also increases. In the validity study of the scale, Cronbach's alpha (α) reliability coefficient was 0.68, and in this study, it was 0.79.

LATCH Breastfeeding Assessment Scale: LATCH was developed by Jensen and colleagues (1994) and has been validated and tested for reliability in Turkish (Yenal and Okumuş, 2003). LATCH is an assessment tool created based on the Apgar scoring system in terms of its scoring method. The maximum score that can be obtained from the scale is 10, and the minimum score is 0. Higher scores on the scale indicate successful breastfeeding. In the validity and reliability study of the LATCH Breastfeeding Assessment Tool, Cronbach's alpha (α) reliability coefficient was 0.95 (Yenal and Okumuş, 2003), whereas in this study it was found to be 0.65.

Statistical Analysis

The research data were analysed using SPSS (Statistical Package for the Social Sciences). Frequency and percentage distributions, and mean±standard deviation (min-max) values were used in data evaluation. The Chi-square and Mann-Whitney U tests were used to evaluate the difference between the intervention group and the follow-up group before and after the intervention. A p-value less than 0.05 was considered statistically significant.

RESULTS

A total of 60 women participated in the study, comprising study and follow-up groups. The mean age of the participants was 28.50±3.15. It was determined that 88.3% of the women lived in a small family, 63.3% had a monthly income equal to their expenses, 88.3% were university or college graduates, and 41.7% were not working. When comparing the individual characteristics of the women in the follow-up and study groups, no statistically significant difference was found between them (p>0.05). The characteristics of the participants are presented in Table 1.

When examining the couple's compatibility at the beginning and end of the study, no significant difference was found between the study and follow-up groups (p>0.05). When comparing the breastfeeding support levels of fathers after childbirth to a control group or mean score level, no significant difference was found (p>0.05). It was determined that the mean LATCH breastfeeding assessment score of women in the experimental group was higher than that of women in the follow-up group, and when the mean of scores was compared, this difference was found to be significant (p<0.005). The participants' scale scores are presented in Table 2. When the weight, height, head circumference, and percentile curves of the infants of the women included in the study were compared at the 6-month follow-up, no difference was found between the study and follow-up groups (p>0.05). When the feeding patterns of the infants of women in the study group at 6 months were examined, it was determined that there were more infants exclusively breastfed compared to the infants of women in the follow-up group. This difference was statistically significant (p<0.001) (Table 3).

Table 1. Demographic characteristics of participants

Demografic characteristic		Experimental group (n=30) Number (n) mean±SD	Experimental group (n=30) Percentage %	Follow-up group (n=30) Number (n) mean±SD	Follow-up group (n=30) Percentage	Analysis
Age		28.67±3.17		28.33±3.17		t=-0.406 p=0.686
Family type	Small	26	86.7	27	90.0	χ^2=0.162 p=0.688
	Extended	4	13.3	3	10	
Educational status	Primary school	-	-	-	-	χ^2=0.352 p=0.839
	Secondary school	1	3.3	2	6.7	
	High school	2	6.7	2	6.7	
	University	27	90.0	26	86.7	
Spouse's educational status	Primary school	-	-	-	-	χ^2=2.274 p=0.321
	Secondary school	3	10.0	1	3.3	
	High school	8	26.7	5	16.7	
	University	19	63.3	24	80	
Employmnet status	Working	16	53.3	19	54.3	χ^2=0.0686 p=0.7935
	Not working	14	46.7	11	36.7	
Economic situation	Income is less than expenditure	1	3.3	-	-	χ^2=1.534 p= 0.464
	Income equals expenditure	20	66.7	18	60.0	
	Revenue exceeds expenditure	9	30.0	12	40.0	
ACE score	0-3 points	-	-	30	100	χ^2= 60.000 p<0.001
	4-10 points	30	100	-	-	

SD: Standard deviation, ACE: Adverse Childhood Experiences Scale, *χ2: Chi-square tests, **t: Independent samples test

Table 2. Participants's total scale scores after the session

		Experimental group (n=30) mean±SD	Follow-up group (n=30) mean±SD	
Dyadic adjustment score	Pre-childbirth	52.56±6.95	55.40±7.42	p=0.133 t=1.525
	6 months postpartum	50.60±6.87	53.4 ±7.4	p= 0.135 t= 1.515
Fathers' level of breastfeeding support		9.53± 3.5	9.06±2.85	p= 0.574 t= -0.566
Midwives's Latch breastfeeding assessment		7.96±1.58	6.66±1.84	p<0.005 t = -2.927

SD: Standard deviation, *χ2: Chi-square tests, **t: Independent samples test

Table 3. 6 month follow-up findings for infants

		Experimental group (n=30) mean±SD	Percentage	Follow-up group (n=30) mean±SD	Percentage	Total	Analysis
Baby's weight		8.23± 0.56		8.15± 0.404			p=0.120 t = -0.709
Baby's height		66.90±1.95		65.93±2.89			p=0.135 t= -1.514
Baby's head circumference		44.40±0.58		44.37±0.74			p=0.135 t=-1.514
Height percentil	15-50 per	4	13.3	3	10	11.7	p= 0.838 t= -0.205
	50-85 per	16	53.3	19	63.3	58.3	
	85-97 per	10	33.3	8	26.7	30	
Weight percntil	0-3 per	-	-	1	3.3	1.7	p=0.292 t=-1.063
	3-15 per	5	16.7	9	30	23.3	
	15-50 per	7	23.3	8	26.7	25	
	50-85 per	14	46.7	5	16.7	31.7	
	85-97 per	4	13.3	7	23.3	18.3	
Baby's feeding method	Exclusively breast milk	16	53.3	4	13.3	33.3	χ^2=14.958 p<0.001

SD: Standard deviation, *χ2: Chi-square tests, **t: Independent samples test

DISCUSSION

Breastfeeding is not only an essential source of nutrition for the baby's development, growth, protection from various bacteria, and survival, but it also has a physical and psychological healing effect on the mother. For this reason, it is important to feed the baby only breast milk for the first 6 months. According to World Health Organization data, the rate of infants exclusively breastfed for 6 months is 48% (WHO, 2023). According to the Turkish Population Health Survey (2018), this rate is 14% in Turkiye. In this study, by providing individual breastfeeding support, the rate of exclusive breastfeeding was found to be 53.3% in the study group and 33.3% in the total study and follow-up group. Breastfeeding is noted to have an important restorative function, particularly for mothers with a history of trauma, as it alleviates symptoms associated with traumatic experiences, supports mental health, and reduces the risk of mothers exhibiting negative parenting behaviours towards their children (Kendall-Tackett, 2022; Watson, 2021). Indeed, studies show that women with a history of ACE have higher rates of breastfeeding than women who have not experienced ACE (Watson, 2021). The study commenced with 207 women. The study group comprised 30 women and the follow-up group comprised 30 women, totalling 60 women who completed all stages of the study and for whom data was collected in full. At the end of the study, it was observed that the ACE scores of the women included in the analysis differed. Although this study was planned and conducted as a randomised controlled trial, it was terminated due to participant dropouts and time constraints arising from it being athesis study. Despite this, the study found that women who had higher childhood adverse life experience scores and received one-to-one breastfeeding counselling were more likely to exclusively breastfeed their babies at the six-month postnatal follow-up.

It has been reported that ACE has long-term and multifaceted effects on both romantic relationships and motherhood. Therefore, comprehensive approaches that include not only individual psychological support but also breastfeeding counselling, couple counselling, and social support mechanisms should be developed for these individuals. In particular, it is argued that the widespread implementation of counselling practices during the breastfeeding process could play an important role in extending these individuals' breastfeeding periods and supporting bonding processes (Lorenc et al., 2020). Childbirth can affect mothers' breastfeeding experiences in complex ways, both psychologically and physiologically; for example, mental health issues such as post-traumatic stress disorder (PTSD) can negatively affect the sustainability of breastfeeding, and the dysregulation of stress hormones can affect milk production (Eagen-Torkko et al., 2017; Kendall-Tackett, 2022; Matyas et al., 2024). Therefore, breastfeeding counselling is critical to support mothers with a history of ACE in achieving their breastfeeding goals and helping them cope with potential difficulties (Walker-Mao et al., 2024; Johnson et al., 2023). This counselling should include understand how mothers' past traumas affect their breastfeeding experiences, providing a safe and supportive environment, enhancing self-efficacy, and supporting mental health. Such counselling can help mothers understand how their past traumas impact breastfeeding.

The mantra 'what doesn't kill you makes you stronger' resonates with many people and can be associated with a compelling general belief that hardship can be a source of strength and opportunity for post-traumatic growth. Nietzsche's renowned writings on this subject, as well as songs by contemporary popular musicians such as Kelly Clarkson and Taylor Swift, are widely known in society (Jayawickreme et al., 2021). Tedeschi and Calhoun (2004), who first used the term post-traumatic growth, defined positive post-traumatic changes as psychological changes experienced after coping with traumatic events or situations. Adapting to the postpartum period and the relationship established with the baby are thought to be important in the regression of PTSD symptoms. Indeed, in a study examining 685 women, it was found that the mother-baby relationship in the postpartum period showed a positive correlation with the child's mental health and a negative correlation with the mother's mental symptoms (Dekel, 2019). The mother's recovery from childhood abuse may increase her motivation to breastfeed and lead to higher breastfeeding outcomes due to lower anxiety and depression (Watson et al., 2021).

A study (Kale, 2024) found that primiparous women, or women giving birth for the first time, had lower breastfeeding self-efficacy and needed more support and breastfeeding counselling throughout the process. In addition, it was found that primiparous mothers experienced more breastfeeding problems, and researchers concluded that they needed breastfeeding education. This situation demonstrates how much more individualised breastfeeding counselling is needed. The importance of breastfeeding education provided in hospitals cannot be denied, but a review of the literature suggests that one-to-one breastfeeding counselling can positively affect breastfeeding outcomes (Kale, 2024). Indeed, it was found that in this study, individual breastfeeding counselling provided in addition to routine antenatal classes and routine care offered at the hospital had a more positive effect on the rate of exclusive breastfeeding at 6 months.

Fathers were not included in the breastfeeding counselling training within the scope of this study. Considering that data loss might occur, and as fathers rarely participated in the antenatal classes at the hospital where the research was conducted, it was decided to follow-up only the results of breastfeeding counselling provided to mothers. At the end of the research, it was found that breastfeeding counselling provided only to mothers did not affect fathers' support during the breastfeeding process. However, the literature reports that fathers' attitudes towards breastfeeding, their knowledge, and the practical and emotional support they provide have a direct impact on both the initiation and continuation of breastfeeding. Academic studies show that fathers' education and positive attitudes towards breastfeeding increase the likelihood of mothers initiating and continuing breastfeeding (Agrawal et al., 2022). For example, fathers' participation in night-time baby care can positively affect breastfeeding outcomes by allowing mothers to rest, while their emotional support during pregnancy strengthens the mother's breastfeeding self-efficacy. However, deficiencies in fathers' participation in the breastfeeding process may be observed due to sociocultural factors and lack of knowledge. Therefore, including fathers in breastfeeding education and developing support programmes for them, is of great importance in increasing breastfeeding rates and duration (Zhou et al., 2024).

Mothers with a history of Adverse Childhood Experiences (ACE) tend to experience mental health problems such as stress, anxiety, depression, and PTSD (Kendall-Tackett, 2022). These conditions can negatively affect mothers' emotional regulation skills, increasing parenting stress and limiting their ability to provide sensitive and responsive care to their children (Hanetz-Gamliel & Sagi-Schwartz, 2022). The triggering of past traumas may cause mothers to relive their own childhood experiences, which can lead to difficulties in parent-child interactions. Research indicates that mothers who experienced adversity in childhood are more likely to adopt problematic parenting styles with their children. These styles, on the part of parents, may include low parental responsiveness, difficulty setting boundaries, high aggression, and a tendency to reject others (Herbell, 2020; Lotto & Altafim, 2023). A study by Luo et al. (2023) revealed an intergenerational relationship between maternal ACE and behavioural problems in preschool children, mediated by maternal rejection styles (Luo et al., 2023). Such parenting behaviours may increase children's risk of developing behavioural problems. To prevent such situations, supporting mother-infant bonding from the beginning of life and strengthening infants' mental health through breastfeeding is crucial.

Such parenting behaviours may increase the risk of children developing behavioural problems. Supporting the mother-infant bond from the very beginning of life and promoting breastfeeding can be important protective factors in preventing such situations and strengthening the infant's mental health. Breastfeeding counselling is an individualised and equitable approach, particularly aimed at breastfeeding mothers and their families. This process includes clinical management, guidance and health education. This method aims to increase the individual's knowledge and confidence regarding breastfeeding. Previous studies have also shown that when breastfeeding women receive appropriate support, both they and their environment are positively affected. However, despite the strong recommendation of the World Health Organization, the number of mothers benefiting from breastfeeding counselling remains low, at approximately 33 percent (Ruiz et al., 2025; Tucker et al., 2022). As recommended by the World Health Organization and UNICEF, investment should be made in breastfeeding counselling to initiate and sustain breastfeeding early and thereby improve maternal and infant health (Yurtsal and Uslu, 2023).

Limitations

The scale assessments presented in this study are based on women's self-assessments. Furthermore, the study is limited to primiparous pregnant women attending a maternity school at a public hospital.

CONCLUSION

This study found that the rates of exclusive breastfeeding among mothers who received individual breastfeeding counselling were significantly higher than the rates in the follow-up group. In this study, the LATCH Breastfeeding

Assessment Scale scores of mothers who received individual breastfeeding counselling, were found to be significantly higher than those of mothers in the follow-up group.

No difference was found when the couple's compatibility scores were compared between the experimental and follow-up groups. As fathers were not included in the education programme in this study, it is recommended that fathers be included in breastfeeding education programmes in future studies.

In line with the findings, as individual breastfeeding counselling may be effective in increasing breastfeeding success, the widespread implementation of individual breastfeeding counselling practices may contribute significantly to increasing breastfeeding rates.

ETHICAL DECLARATIONS

Ethics Committee Approval

For this study, permission was obtained from the Non-interventional Clinical Researches Ethics Committee of the Institute of Health Sciences at Marmara University (Date: 19.12.2023, Decision No: 117).

Informed Consent

Written informed consent was obtained from all individual participants prior to their inclusion in the study. Participants were fully informed about the study's aims, procedures, potential risks and benefits, and their rights—including the right to withdraw at any time without consequence. All participants voluntarily signed a written informed consent form.

Peer Review Process

This manuscript was subject to external peer review.

Conflict of Interest

The authors declare no conflicts of interest related to this study.

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Author Contributions

All authors contributed significantly to the study's conception, design, data acquisition, analysis, and interpretation. All authors reviewed and approved the final version of the manuscript.

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