

## ORIGINAL ARTICLE

# The Relationship Between Breastfeeding Motivation and Breastfeeding Myths of Primiparous Mothers with 0-6 Month-Old Babies

## 0-6 Aylık Bebeği Olan Primipar Annelerin Emzirme Motivasyonu ve Emzirme Mitleri Arasındaki İlişki

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### ABSTRACT

**Aim:** The aim of this study is to determine the relationship between breastfeeding motivation and breastfeeding myths, and the factors influencing breastfeeding motivation in primiparous mothers with infants aged 0-6 months

**Methods:** This is a descriptive and cross-sectional study. Data were collected in pediatric outpatient clinics in a private hospital in the south of Türkiye between August and December 2024. 252 mothers who volunteered for the study were included. The data of the study were collected with the Personal Information Form (PIF), Primiparous Breastfeeding Motivation Scale (PBMS), and Breastfeeding Myths Scale (BMS).

**Results:** There were differences between the total PBMS scores of the mothers and family type, education level, smoking status, number of pregnancies, delivery type, receiving breastfeeding education, receiving spousal support, receiving spousal support in breastfeeding and receiving social support in breastfeeding; and there were differences between the total BMS scores and age, education level, income status, number of pregnancies, receiving breastfeeding education and receiving social support in breastfeeding ( $p < .05$ ). In addition, a low-level, negatively significant correlation was found between the total PBMS and BMS scores ( $r = -0.127$ ,  $p < .05$ ). Moreover, it was found that family type ( $B = 15.663$ ,  $t = 6.676$ ,  $p < .05$ ), smoking ( $B = 7.296$ ,  $t = 4.202$ ,  $p < .05$ ), receiving breastfeeding education ( $B = -7.648$ ,  $t = -4.328$ ,  $p < .05$ ) and receiving social support for breastfeeding ( $B = -4.308$ ,  $t = 2.066$ ,  $p < .05$ ) significantly predicted the breastfeeding motivation levels of primiparous mothers.

**Conclusions:** The research results show that socio-demographic, obstetric, and some other factors affect breastfeeding motivation and the level of breastfeeding myths. Moreover, a negative, low-level relationship was found between breastfeeding myths and motivations. This situation reveals that individuals with higher breastfeeding myths have lower motivation levels.

**Keywords:** Breastfeeding, mother, motivation, myths, primiparous.

### ÖZ

**Amaç:** Bu çalışmanın amacı, 0-6 aylık bebeği olan primipar annelerin emzirme motivasyonu ve emzirme mitleri arasındaki ilişkiyi ve emzirme motivasyonunu etkileyen faktörleri belirlemektir.

**Gereç ve Yöntemler:** Tanımlayıcı ve kesitsel tipte bir çalışmadır. Veriler Türkiye'nin güneyinde bulunan özel bir hastanede pediatri polikliniklerinde, Ağustos-Aralık 2024 tarihleri arasında toplanmıştır. Çalışmaya gönüllü olan 252 anne dâhil edilmiştir. Araştırmanın verileri Kişisel Bilgi Formu, Primipar Emzirme Motivasyon Ölçeği (PEMÖ) ve Emzirme Mitleri Ölçeği (EMÖ) ile toplanmıştır.

**Bulgular:** Annelerin PEMÖ toplam puan ortalaması  $133,71 \pm 16,47$ , EMÖ toplam puan ortalaması  $102,19 \pm 21,28$ 'dir. Annelerin aile tipi, eğitim düzeyi, sigara kullanım durumuna, gebelik sayısı, doğum şekli, emzirme eğitimi alma, eş desteği alma, emzirmede eş desteği alma ve emzirmede sosyal destek alma durumuna göre PEMÖ toplam puanları; yaş, eğitim düzeyi, gelir durumu, gebelik sayısı, emzirme eğitimi alma ve emzirmede sosyal destek alma durumuna göre EMÖ toplam puanları arasında fark vardır ( $p < .05$ ). Ayrıca PEMÖ ve EMÖ genel puanları arasında düşük düzeyde, negatif yönde anlamlı ilişki saptanmıştır ( $r = -0.127$ ,  $p < .05$ ). Yanısıra aile tipi ( $B = 15.663$ ,  $t = 6.676$ ,  $p < .05$ ), sigara kullanımı ( $B = 7.296$ ,  $t = 4.202$ ,  $p < .05$ ), emzirme eğitimi alma ( $B = -7.648$ ,  $t = -4.328$ ,  $p < .05$ ) ve emzirmede sosyal destek alma ( $B = -4.308$ ,  $t = 2.066$ ,  $p < .05$ ) annelerin primipar emzirme motivasyon düzeyleri için anlamlı yordayıcılar olduğu belirlenmiştir.

**Sonuçlar:** Bu çalışmada, 0-6 aylık bebeği olan primipar annelerin sosyo-demografik, obstetrik ve bazı değişkenleri, emzirme motivasyonu ve emzirme mitleri düzeylerini etkilemektedir. İnteraktif ve bireyselleştirilmiş emzirme eğitimleri verilmesi, aile/sosyal destek mekanizmaları güçlendirilmesi, emzirme destekleyici politikalar geliştirilmesi ve emzirme motivasyonunun daha fazla etkilendiği diğer faktörleri keşfetmeye yönelik nitel çalışmalar yapılması önerilir.

**Anahtar Kelimeler:** Anne, emzirme, mitler, motivasyon, primipar.

## INTRODUCTION

Pregnancy is an important period in a woman's life with physiological, psychological, and sociological effects. The change in bio-psychosocial balance in primiparous pregnant women; changes in physical characteristics, changes in social relationships, differences in functions in the family and workplace, perception of pregnancy, presence of support factors, and ability to use them affect the postpartum period (1,2). Especially primiparous pregnant women may experience these changes more during pregnancy compared to multiparous pregnant women (3, 4). These changes affect not only the mother but also the family and the baby (5). Providing breast milk, which is the basic need of babies, directly affects not only the initiation and sustainability of breastfeeding, but also the timing of starting complementary foods. However, the main problem encountered with nutrition is that mothers tend not to breastfeed, to end breastfeeding early, or to start giving complementary products early (6, 7).

There are many underlying issues in breastfeeding problems, but the mother's desire to breastfeed, in other words, her motivation to breastfeed, is one of the main problems in breastfeeding. If a woman values breastfeeding less and/or believes that she will fail in breastfeeding, she will exhibit unmotivated behavior, and effective breastfeeding success will decrease (8). The mother's motivation to breastfeed, receiving antenatal breastfeeding education and counseling, kangaroo care, use of foreign substances, employment status, presence of chronic diseases and use of medication, uncomfortable living spaces, family support, anxiety about the mother's visual image being distorted,

not being able to breastfeed comfortably in every environment, breast problems, problems related to the newborn that make breastfeeding difficult, early transition to supplementary feeding, encouragement to use formula milk and use of pacifiers and baby bottles affect breastfeeding continuity (9,10).

In addition to motivation, the breastfeeding habits of primiparous mothers are also affected by breastfeeding beliefs and myths. Incorrect beliefs, taboos, and myths about breastfeeding in societies can harm the initiation and continuation of breastfeeding. The elimination of taboos and myths can be possible through a culture of negotiation and mutual therapeutic communication. Health professionals are responsible for providing support to pregnant women and mothers, preparing mothers for breastfeeding, and facilitating practices that encourage breastfeeding in society. In addition, creating an environment where taboos and myths about breastfeeding are corrected through education is an important part of this process. In order to prepare, educate, encourage, and support women for breastfeeding, it is necessary to identify the barriers to breastfeeding and create a roadmap to overcome these barriers (11-13).

In this context, it is extremely important for primiparous mothers to first equip themselves with the knowledge of breastfeeding and to develop a correct perspective on breastfeeding by clearing away cultural myths. Many studies conducted with primiparous mothers with no breastfeeding experience address the myths and motivation sources that are effective in the breastfeeding process (14-18), but there is a significant gap in

the literature regarding the relationship between breastfeeding myths and breastfeeding motivation. This study aims to determine the levels of breastfeeding motivation and breastfeeding myths of primiparous mothers with 0-6-month-old babies according to socio-demographic, obstetric, and some other variables, the relationship between breastfeeding motivation and breastfeeding myths, and the factors affecting breastfeeding motivation.

## **MATERIALS and METHODS**

### **Study Design**

It was designed as a descriptive and cross-sectional type. Data were collected in pediatric outpatient clinics in a private hospital in the south of Türkiye between August and December 2024.

### **Research Questions**

1. Does the breastfeeding motivation of primiparous mothers with babies aged 0-6 months differ according to socio-demographic, obstetric, and some variables?
2. Do the breastfeeding myths of primiparous mothers with babies aged 0-6 months differ according to socio-demographic, obstetric, and some variables?
3. Is there a relationship between the breastfeeding motivation of primiparous mothers with babies aged 0-6 months and breastfeeding myths?
4. What are the factors affecting the breastfeeding motivation of primiparous mothers with babies aged 0-6 months?

### **Sample and Setting**

The universe of the study consisted of mothers with babies aged 0-6 months who applied to the pediatric outpatient clinic of a private hospital between August and December 2024. The sample size of the study was calculated using the G\*Power 3.1.9.7 Program. The sample size to represent the universe was calculated based on the mean scores and standard deviations of the success expectation sub-dimension of the primiparous breastfeeding motivation scale used in Akçay and Bal's study, with a risk of  $\alpha = 0.05$ , an accuracy rate of  $1-\alpha = 0.95$ , and a power rate of  $B = 0.20$ ,  $1-B = 0.95$ , and the sample size was found to be 211 (10). Considering that there may be losses, 252 people were included in the study. Mothers who were of reproductive age (15-49), primiparous, had babies aged 0-6 months, could read and understand Turkish, did not have breastfeeding problems, and volunteered were included in the study.

### **Data Collection Tools**

The data of the study were collected with the Personal Information Form, Primiparous Breastfeeding Motivation Scale, and Breastfeeding Myths Scale.

#### **Personal Information Form (PIF)**

It was created as a result of a literature review and consists of a total of 13 questions about the socio-demographic characteristics of mothers, obstetric characteristics, and breastfeeding (13,19).

#### **Primiparous Breastfeeding Motivation Scale (PBMS)**

The scale, the validity and reliability of which was conducted in Turkish by Akçay and Demirgöz Bal in 2019, was developed by Stockdale et al. in 2013 to determine the

factors affecting breastfeeding motivation in primiparous women. It was determined that the scale, consisting of 29 items, is a seven-point Likert-type scale and has four sub-dimensions. These sub-dimensions are: the value given to breastfeeding, self-efficacy, midwife support, and expectation of success. As the score obtained from each sub-dimension increases, the breastfeeding motivation level for that sub-dimension increases (10,20).

### **Breastfeeding Myths Scale (BMS)**

The scale was developed by Yilmaz et al in 2024. It has been accepted as a valid and reliable tool in assessing the status of breastfeeding myths in Turkish society. The scale can be used by all women and men who are 18 years of age and older and who can read and understand Turkish. BMS consists of 30 items and a single dimension. All items are coded in reverse. The total score that can be obtained from the scale is calculated as the lowest 30 and the highest 150. As the total score obtained from the scale increases, the status of having breastfeeding myths increases, and as the total score obtained from the scale decreases, the status of having breastfeeding myths decreases. In addition, the cut-off score for the scale was determined as 119.50. Accordingly, individuals who score below 119.50 on the Breastfeeding Myths Scale show that their level of breastfeeding myths is low, and individuals who score above 119.50 show that their level of breastfeeding myths is high (21).

### **Data Collection**

The women in the study group were interviewed in the hospital's polyclinic waiting rooms. After the importance and purpose of the study were explained, their consent was obtained. Data were

collected from mothers who volunteered to participate in the study, signed the voluntary consent form, and met the inclusion criteria. Data were collected by the researcher in the polyclinic waiting room using a face-to-face interview method. It took approximately 10-15 minutes to complete the PIF, PBMS, and BMS. The survey questions were read by the researcher, and the participants were asked to answer.

### **Evaluation of Data**

The Statistical Package for Social Sciences, version 25.0 software (SPSS, IBM Corp., New York, USA) was used in data analysis. It gave distribution according to women's demographic characteristics and breastfeeding-related characteristics. The normal distribution status was examined with skewness and kurtosis values. When these values are between  $\pm 2$ , the scores are normally distributed. The Pearson correlation method, which is a parametric method, was used for the relationship between the PBMS and BMS scores. The independent groups t-test method was used to compare the PBMS and BMS scores according to the demographic characteristics of the women and their characteristics related to breastfeeding. For a parametric method, the score should be continuously distributed, and the number of data points in the groups should be sufficient ( $n > 30$ ). Finally, the Pearson correlation method was used for the effect of socio-demographic, obstetric, and some other characteristics on the PBMS scores.  $p < .05$  comparison was made for statistical analyses.

### **Ethical Statement**

Before the data collection process began, ethical approval from the Non-Interventional Clinical Research Ethics Committee of Istanbul Atlas University

(Decision date: 07/22/2024, Decision number: 06/38), institutional permission from the hospital where the data would be collected, and verbal and written consent of the participants were obtained.

## RESULTS

252 women participated in this study. The average age of the women was 28,016.81 (min: 19 and max: 45), 64.3% were 30 years old and under, 83.3% had a nuclear family, 52.8% had secondary education

or less, 59.1% were unemployed, 61.1% had less income than expenses, 62.3% did not smoke, 71% were primigravida, 51.2% had a girl baby, 55.6% had a cesarean section. It was determined that 54.4% of the women received breastfeeding education, 51.2% received spousal support, 60.3% received spousal support in breastfeeding, and 62.3% received social support in breastfeeding (Table 1).

There is a difference between the total PBMS scores of women according to their

**Table 1.** Distribution of socio-demographic, obstetric and some characteristics of women

Socio-demographic characteristics	Group	n (%)
Age	Under 30	162 (64.3)
	30 and above	90 (35.7)
Family type	Core	210 (83.3)
	Wide	42 (16.7)
Level of education	Secondary education and below	133 (52.8)
	Higher education	119 (47.2)
Working Status	Yes	103 (40.9)
	No	149 (59.1)
Income Status	Income is less than expenses	154 (61.1)
	Income is equal to/more than expenses	98 (38.9)
Smoking	Yes	95 (37.7)
	No	157 (62.3)
Number of pregnancies	Primigravida	179 (71.0)
	Multigravida	73 (29.0)
Baby's gender	Girl	129 (51.2)
	Boy	123 (48.8)
Type of birth	Vaginal birth	112 (44.4)
	Cesarean section	140 (55.6)
Receiving breastfeeding education	Yes	115 (45.6)
	No	137 (54.4)
Receiving spousal support	Yes	129 (51.2)
	No	123 (48.8)
Receiving peer support in breastfeeding	Yes	100 (39.7)
	No	152 (60.3)
Receiving social support in breastfeeding	Yes	95 (37.7)
	No	157 (62.3)

socio-demographic characteristics, family type ( $t=-8.654$ ,  $p<.05$ ), education level ( $t=-2.603$ ,  $p<.05$ ) and smoking status ( $t=-4.46$ ,  $p<.05$ ). The total PBMS score average of women from extended families is higher than that of women from nuclear families. The total PBMS score average of women with higher education is higher than that of women with secondary education or below. Finally, the total PBMS score average of non-smoking women is higher than

that of smoking women. However, there is no significant difference between the total PBMS scores of women according to their age, employment, and income status ( $p>.05$ ) (Table 2).

There is a difference between the total scores of the BMS according to the socio-demographic characteristics of women, age ( $t=-4.551$ ,  $p<.05$ ), education level ( $t=4.801$ ,  $p<.05$ ) and income status ( $t=-$

**Table 2.** Comparison of mean scores of the Primiparous Breastfeeding Motivation Scale and Breastfeeding Myths Scale according to socio-demographic characteristics of women

Socio-demographic characteristics	n	Primiparous Breastfeeding Motivation Scale	Breastfeeding Myths Scale
		Mean±SD	Mean±SD
<b>Age</b>			
Under 30	162	132.37±15.7	97.81±18.59
30 and above	90	136.11±17.62	110.07±23.54
t; p		-1.734; 0.084	-4.551; <b>0.000*</b>
<b>Family type</b>			
Nuclear	210	130.18±13.05	102.31±20.21
Extended	42	151.36±20.25	101.57±26.23
t; p		-8.654; <b>0.000*</b>	0.205; 0.838
<b>Level of education</b>			
Secondary education and below	133	131.18±16.63	108.02±18.55
Higher education	119	136.53±15.89	95.66±22.29
t; p		-2.603; <b>0.01*</b>	4.801; <b>0.000*</b>
<b>Working status</b>			
Yes	103	134.68±15.21	104.19±20.64
No	149	133.03±17.31	100.8±21.67
t; p		0.779; 0.437	1.247; 0.214
<b>Income status</b>			
Income less than expenses	154	134.71±16.58	98.29±22.15
Income equal to/more than expenses	98	132.13±16.26	108.32±18.31
t; p		1.211; 0.227	-3.742; <b>0.000*</b>
<b>Smoking</b>			
Yes	95	127.97±7.6	100.57±18.73
No	157	137.18±19.23	103.17±22.68
t; p		-4.46; <b>0.000*</b>	-0.939; 0.349

\* $p<.05$ ; t. Independent groups t-test statistics

3.742,  $p < .05$ ). The total average score of women aged 30 and over is higher than that of women under 30. The total average score of women with secondary education or below is higher than that of women with higher education. Finally, the total BMS score average of women whose income is equal to or more than their expenses is higher than women whose income is less than their expenses. However, there is no significant difference between the general BMS scores of women according to their family type, employment status, and smoking ( $p > .05$ ) (Table 2).

There is a difference between the total PBMS scores of the women according to the number of pregnancies ( $t = -2.753$ ,  $p < .05$ ), delivery method ( $t = 3.139$ ,  $p < .05$ ), receiving breastfeeding education ( $t = -5.561$ ,  $p < .05$ ), receiving spousal support ( $t = 3.168$ ,  $p < .05$ ), receiving spousal support in breastfeeding ( $t = 3.252$ ,  $p < .05$ ) and receiving social support in breastfeeding ( $t = 2.922$ ,  $p < .05$ ). The total PBMS score average of women with multigravida pregnancies is higher than women with primigravida pregnancies. The total PBMS mean score of women who gave birth vaginally is higher than that of women who had a cesarean section. The total PBMS mean score of women who received breastfeeding education is higher than that of women who did not receive breastfeeding education. The total PBMS mean score of women who received spousal support is higher than that of women who did not receive spousal support. The total PBMS mean score of women who received spousal support during breastfeeding is higher than that of women who did not receive spousal support during breastfeeding. Finally, the total PBMS score average of women with

social support during breastfeeding was higher than that of women without social support during breastfeeding. However, there was no significant difference between the total PBMS scores of women according to the gender of the baby ( $p > .05$ ) (Table 3).

There is a difference between the total scores of the BMS according to the number of pregnancies ( $t = -2.199$ ,  $p < .05$ ), receiving breastfeeding education ( $t = -2.544$ ,  $p < .05$ ) and receiving social support in breastfeeding ( $t = 3.584$ ,  $p < .05$ ). The total mean score of the women with multigravida pregnancies is higher than that of the women with primigravida pregnancies. The total mean score of the women who did not receive breastfeeding education is higher than that of the women who received breastfeeding education. The mean total score of women who received social support during breastfeeding was higher than that of women who did not receive social support during breastfeeding. There was no significant difference between the total scores of women in terms of breastfeeding characteristics, type of birth, gender of the baby, receiving spousal support, and receiving spousal support during breastfeeding ( $p > .05$ ) (Table 3).

Women's PBMS scores ranged from 96 to 203 with an average of  $133.71 \pm 16.47$ , and their BMS scores ranged from 47 to 186 with an average of  $102.19 \pm 21.28$ . A low-level, negatively significant correlation was found between PBMS and BMS general scores ( $r = -0.127$ ,  $p < .05$ ). As women's PBMS scores increase, their BMS general scores decrease and vice versa (Table 4).

A multiple regression model was used to determine the effect of variables that were found to be significant in terms of

**Table 3.** Comparison of mean scores of the Primiparous Breastfeeding Motivation Scale and Breastfeeding Myths Scale according to obstetric and some characteristics of women

Obstetrics and Some of Its Features	n	Primiparous Breastfeeding Motivation Scale	Breastfeeding Myths Scale
		Mean±SD	Mean±SD
<b>Number of pregnancies</b>			
Primigravida	179	131.91±15.48	100.32±19.26
Multigravida	73	138.12±18.05	106.77±25.12
t; p		-2.753; <b>0.006*</b>	-2.199; <b>0.029*</b>
<b>Baby gender</b>			
Girl	129	133.34±16.18	103.79±22.21
Boy	123	134.09±16.84	100.5±20.21
t, p		-0.36; 0.719	1.227; 0.221
<b>Delivery method</b>			
Vaginal delivery	112	137.29±18.79	104.97±22.27
Cesarean section	140	130.84±13.77	99.96±20.25
t, p		3.139; <b>0.002*</b>	1.869; 0.063
<b>Receiving breastfeeding education</b>			
Yes	115	139.66±17.85	98.5±21.97
No	137	128.71±13.37	105.28±20.24
t, p		5.561; <b>0.000*</b>	-2.544; <b>0.012*</b>
<b>Receiving spousal support</b>			
Yes	129	136.86±19.77	101.58±21.25
No	123	130.4±11.25	102.82±21.38
t, p		3.168; <b>0.002*</b>	-0.462; 0.645
<b>Receiving breastfeeding education</b>			
Yes	100	137.79±20.8	105.07±24.06
No	152	131.02±12.21	100.29±19.07
t, p		3.252; <b>0.001*</b>	1.752; 0.081
<b>Receiving social support in breast-feeding</b>			
Yes	95	137.55±20.99	108.22±21.94
No	157	131.38±12.52	98.54±20.07
t, p		2.922; <b>0.004*</b>	3.584; <b>0.000*</b>

\* $p < .05$ ; t: Independent groups t-test statistics**Table 4.** Correlation table between the scores of the Primiparous Breastfeeding Motivation Scale and the Breastfeeding Myths Scale

	Correlation coefficient	
	1	2
1. Primiparous Breastfeeding Motivation Scale	R	1
2. Breastfeeding Myths Scale	R	-.127*

\* $p < .05$ ; r: Pearson correlation coefficient

socio-demographic, obstetric, and some of their characteristics on primiparous breastfeeding motivation levels of women. The reference group, or the group that was compared, for each categorical variable, is shown in parentheses. The regression model established for the effect of socio-demographic, obstetric, and some of their characteristics on primiparous breastfeeding motivation levels of women is significant ( $F=18.02$ ,  $p<.001$ ). 37.9% of the variability in PBMS scores is explained by women's demographic and breastfeeding characteristics. Demographic variables such as family type ( $B=15.663$ ,  $t=6.676$ ,  $p<.05$ ) and smoking ( $B=7.296$ ,  $t=4.202$ ,  $p<.05$ ) were found to be significant predictors of women's primiparous breastfeeding motivation levels. PBMS scores of women with extended families were 15.663 units higher than those of women with nuclear families, and PBMS scores of non-smokers were 7.296 units higher than those of women who smoked. Among the characteristics related to breastfeeding, receiving breastfeeding education ( $B=-7.648$ ,  $t=-4.328$ ,  $p<.05$ ) and receiving social support for breastfeeding ( $B=-4.308$ ,  $t=2.066$ ,  $p<.05$ ) were found to be significant predictors of breastfeeding motivation levels. The PBMS scores of those who did not receive breastfeeding education were 7.648 units lower than those who received breastfeeding education, and the PBMS scores of those who did not receive social support for breastfeeding were 4.308 units lower than those who received breastfeeding education. A large value of the standard regression coefficient  $\beta$  indicates that the effect is large. Among the variables that were found to be significant, family type was the most effective variable

in affecting breastfeeding motivation levels, while the number of pregnancies was the least effective variable. Other demographic and breastfeeding-related characteristics did not affect women's breastfeeding motivation levels (Table 5).

## DISCUSSION

In this study, the levels of breastfeeding motivation and breastfeeding myths of primiparous mothers with 0-6-month-old babies according to socio-demographic, obstetric, and some other variables, the relationship between breastfeeding motivation and breastfeeding myths, and the factors affecting breastfeeding motivation were investigated. According to the findings, it was determined that women's age, education level, income status, number of pregnancies, receiving breastfeeding education and receiving social support in breastfeeding affected breastfeeding myths; family type, education level, smoking, number of pregnancies, delivery method, receiving breastfeeding education, receiving spousal support, receiving spousal support in breastfeeding and receiving social support affected breastfeeding motivation. In addition, a low-level, significantly negative relationship was found between the general scores of BMS and PBMS. In addition, it was determined that among the socio-demographic variables, family type and smoking, among the characteristics related to breastfeeding, receiving breastfeeding education and receiving social support in breastfeeding were significant predictors of breastfeeding motivation.

Breast milk is a basic and unique source of nutrition for babies, and continued nutrition

**Table 5.** Multiple regression model on the effect of breastfeeding motivation levels of primiparous mothers

Variable	B	S.H.	$\beta$	T	p
Family type (extended family)	15.653	2.345	0.355	6.676	.000
Income status (income equals or exceeds expenses)	-2.931	1.721	-0.087	-1.703	0.09
Smoking (no)	7.296	1.736	0.215	4.202	.000
Number of pregnancies (multigravida)	4.115	1.843	0.114	2.233	<b>0.026</b>
Type of birth (cesarean)	-3.371	1.727	-0.102	-1.951	0.052
Receiving breastfeeding education (no)	-7.648	1.767	-0.232	-4.328	.000
Receiving spousal support (no)	-1.546	1.802	-0.047	-0.858	0.392
Receiving spousal support in breastfeeding (no)	-2.903	1.996	-0.086	-1.454	0.147
Receiving social support in breastfeeding (no)	-4.308	2.066	-0.127	-2.086	<b>0.038</b>
<b>Model statistics</b>	F=18.02; p<.001 R2=0.379				

is considered the most fundamental right of every baby. Numerous initiatives have been implemented worldwide to support this right and increase breastfeeding rates (21-23). However, despite all these efforts, it is seen that breastfeeding rates do not reach the desired level or cannot be sustained (24). Literature reviews show that low breastfeeding rates are affected by many factors, such as women's socio-economic status, education level, working conditions, breastfeeding education, lack of access to health services, lack of support mechanisms, primiparous status, common misconceptions and myths about breastfeeding, and inadequate breastfeeding motivation (23, 25-27). These factors affecting breastfeeding can lead to serious consequences, including cessation of breastfeeding. In particular, breastfeeding myths and breastfeeding motivation are considered to be among the biggest obstacles to the sustainability of breastfeeding (28, 29). In this context, our study is the first to determine the relationship between breastfeeding motivation and breastfeeding myths among primiparous

mothers with babies aged 0-6 months, and it also reveals important findings.

In our study, it was observed that the total mean scores of women aged 30 and over were higher than those of women under 30. This suggests that individuals may tend to traditional beliefs more as they age. When the literature is examined, Balogun et al (2015) found that women aged 35 and over believed in breastfeeding myths more, and that this situation reduced their likelihood of exclusively breastfeeding their babies compared to other mothers (6). Similarly, Akram et al (2017) study also shows that the tendency to believe in breastfeeding myths increases with increasing maternal age (30). In contrast, in the study by Tomczewska et al (2015), it was determined that mothers aged 25 and under believed less in breastfeeding myths (31). This difference may be due to the ways of accessing information, learning habits, and social influence levels between age groups. Young mothers' greater access to digital information sources and up-to-date breastfeeding guidance services may play a role in reducing the impact of myths. On the other hand, it may be thought that

mothers at older ages may be more prone to myths, especially due to the influence of traditional beliefs and social environment. In addition, individual differences in accessing accurate information about breastfeeding and deficiencies in support mechanisms are among the important factors shaping this situation.

In our study, it was determined that the total BMS score average of women with secondary education or below was higher than that of women with higher education. This finding reveals that women with lower education levels believe in breastfeeding myths more. As the level of education increases, the opportunity for individuals to access information increases, critical thinking skills develop, and the rate of accessing accurate health-related information increases, which can be considered as critical factors that reduce the impact of myths. The literature also supports this situation. In the study by Gölbaşı et al (2018), it was determined that mothers with primary school education or below had a significantly higher rate of believing in breastfeeding myths compared to mothers with secondary school education or above (25). Similarly, the study by Tomczewska et al (2024) revealed that as women's level of education increases, their rate of believing in breastfeeding myths decreases (31). These results suggest that policies aimed at increasing the level of education may be an effective strategy in reducing breastfeeding myths.

In this study, it was observed that women's income status affected their breastfeeding myths. The fact that women whose income was equal to or more than their expenses had higher total BMS scores than women whose income was less than their expenses

suggests that economic status may increase belief in breastfeeding myths. This finding is significant when considering the impact of economic status on individuals' access to information and perceptions of health. Women with higher income levels can access information more easily and base their decisions about breastfeeding on scientific foundations rather than cultural myths or traditions. On the other hand, it is also possible that the opposite result occurs. Individuals who are more economically advantaged may be more exposed to social environments that may cause the spread of false information. In this context, some studies in the literature offer different perspectives. Nsiah-Asamoah et al (2020) study determined that breastfeeding myths were more common in low-income women (32). Similarly, Kavle et al (2017) study revealed that middle- and low-income women tend to believe in breastfeeding myths more (33). These findings show that beliefs about breastfeeding myths may differ depending on income level and reveal the need for more in-depth research on the subject.

In this study, it was determined that women's total PBMS scores showed significant differences according to family type, education level, and smoking status. The findings are consistent with similar studies in the literature and emphasize the importance of socio-demographic factors affecting breastfeeding motivation (16-18).

The fact that women from extended families have higher PBMS scores than those from nuclear families can be associated with the social support provided in extended families. The sharing of information and experience, especially between family members such as mothers and mothers-

in-law, can increase breastfeeding motivation. The positive effect of social support on breastfeeding motivation was clearly stated in the study by Gök et al (2023) (17).

The higher PBMS scores of women with higher levels of education can be explained by the positive effect of education on access to information and self-efficacy. The fact that women's awareness of the benefits of breastfeeding increases as the level of education increases supports this finding. Similarly, the studies by Mızrak (2017) and Lange et al. (2017) reported that increasing the level of education has positive effects on breastfeeding motivation and habits (14-15).

The fact that non-smoking women had higher PBMS scores than smokers indicates that smoking is a factor that reduces breastfeeding motivation. The result we obtained is parallel to the existing literature. In the study by Mennella et al (2007), it was determined that mothers who had a history of smoking but had a strong motivation to breastfeed their babies for a longer period quit smoking during the breastfeeding process (34). Similarly, in the study by Napierala et al (2016), it was determined that mothers who were motivated to breastfeed quit smoking during this process (35).

In this study, it was determined that the total scores of women on the BMS showed significant differences according to the number of pregnancies, the status of receiving breastfeeding education, and the status of receiving social support in breastfeeding. Higher BMS scores indicate the prevalence of breastfeeding myths, while lower scores indicate that these myths are less accepted. The findings show

that breastfeeding myths are affected by the demographic and sociocultural characteristics of women.

When evaluated in terms of the number of pregnancies, it was determined that the total BMS scores of multigravida women were higher than those of primigravida women. This situation shows that with the increase in the number of pregnancies, they may be more exposed to false beliefs and cultural myths. The fact that the pregnancy and birth experience does not always coincide with correct information and that the intergenerational transmission of myths continues is supported by these findings. There are studies in the existing literature that are parallel to our study (25, 26, 36).

It was observed that the total scores of women who did not receive breastfeeding education were higher than those who received education. This finding suggests that breastfeeding education plays an important role in reducing women's breastfeeding myths. However, it is also necessary to question the effectiveness of education programs. The fact that beliefs about myths do not completely decrease even in women who receive education may indicate that the content and implementation methods of education programs are not effective enough. As stated in the literature, it is emphasized that education programs should include interactive and individualized approaches that will change women's perceptions of myths, rather than focusing solely on transferring information (13,36).

In the evaluation made according to the status of receiving social support, it was determined that the total scores of

women who received social support for breastfeeding were higher than those of women who did not receive support. This finding reveals that social support may not always be based on accurate information and that environmental factors may contribute to the spread of breastfeeding myths. Therefore, it is of great importance to strengthen social support mechanisms with scientific and accurate information; otherwise, these mechanisms may cause false beliefs to be reinforced. This result is also consistent with similar studies in the literature (32,36).

In the evaluation made according to the number of pregnancies, it was determined that the total PBMS scores of multigravida women were higher than primigravida women. Kiragu et al (2014) reported that primigravida women had higher self-confidence and awareness than multigravida women (37). This finding in our study suggests that women who have had more than one pregnancy increase their self-confidence, awareness, and motivation for breastfeeding gained from their pregnancy experiences.

In the evaluation made according to the delivery method, it was determined that the total PBMS scores of women who gave birth vaginally were higher than those of women who gave birth by cesarean section. This result is supported by literature findings that the physical recovery process of women who gave birth vaginally is generally shorter and that they can start breastfeeding faster, which may increase their motivation (6,38,39).

In our study, it was observed that the total PBMS scores of women who received breastfeeding education were higher

than those of women who did not receive education. It is frequently emphasized in the literature that breastfeeding education has a positive effect on motivation by increasing women's knowledge and self-confidence regarding breastfeeding processes (27,40,41). Therefore, it is important to disseminate breastfeeding education and make it more accessible.

The findings in our study regarding spousal support and the status of receiving spousal support during breastfeeding revealed that the total PBMS scores of women who received spousal support were higher than those of women who did not receive spousal support. This shows that spousal support is an important factor in women's breastfeeding motivation. Developing and implementing programs that encourage more active participation of partners in breastfeeding processes can be an effective strategy to increase women's motivation to breastfeed. It is also stated in the literature that fathers' supportive attitudes positively affect the duration of breastfeeding and the mothers' motivation to breastfeed (42-44).

In our study, it was determined that the total PBMS scores of women who received social support during breastfeeding were higher than those of women who did not receive social support. Social support increases women's sense of confidence regarding the breastfeeding process and positively affects their motivation. However, it should not be forgotten that the quality of social support should be based on accurate information. Social support that contains incorrect or insufficient information may cause a decrease in motivation or the spread of breastfeeding myths. In this context, social support mechanisms

need to be strengthened with scientific knowledge. Our findings are in line with the existing literature (25,45).

In this study, a low-level and negatively significant relationship was found between the general scores of BMS and PBMS. The decrease in PBMS scores as the women's PBMS scores increased, or conversely, the decrease in PBMS scores as the women's PBMS scores increased, indicating that breastfeeding myths may harm breastfeeding motivation. This finding is consistent with studies in the literature indicating that breastfeeding myths negatively affect women's breastfeeding behaviors (32,33,36). In addition, the low level of relationship found in our study indicates that factors such as social support, level of education, and mode of delivery may indirectly affect this relationship. Therefore, it is important to expand programs aimed at reducing myths to include not only women but also family members and health professionals.

In our study, the effects of socio-demographic, obstetric, and some characteristics on the breastfeeding motivation of primiparous mothers were examined with a multiple regression model. The findings revealed that the demographic and breastfeeding-related characteristics of women explained 37.9% of the variability in PBMS scores. This situation shows that breastfeeding motivation does not depend solely on individual preferences; it is shaped under the influence of environmental and social factors, especially family type, which is determined as the variable that most strongly affects breastfeeding motivation, as well as smoking, breastfeeding education, and receiving social support. In addition, as the first study to examine the

effects of socio-demographic, obstetric, and breastfeeding-related characteristics on the breastfeeding motivation of primiparous mothers with a multiple regression model, we believe that this study will make an important contribution to the literature.

This study has some limitations. First, it was conducted in a single hospital. Second, primiparous mothers with 0-6-month-old babies were included, which may limit the generalization of the results. Another limitation is that the sample was women of general reproductive age (15-49). In addition, measurements based on mothers' self-reports may contain bias because they are based on subjective perceptions.

## CONCLUSION

The research results show that socio-demographic, obstetric, and some other factors affect breastfeeding motivation and the level of breastfeeding myths. Moreover, a negative low-level relationship was found between breastfeeding myths and motivations. This situation reveals that individuals with higher breastfeeding myths have lower motivation levels.

Based on these results, breastfeeding education should be made more effective, especially for women with low education levels and those who believe in breastfeeding myths. The inclusion of interactive and personalized approaches in these educations can reduce breastfeeding myths by providing women with access to accurate information. Social support mechanisms within the family should be strengthened. Breastfeeding support policies should be developed by considering socio-economic factors such as income

status and family type. For future research, it is recommended that qualitative studies be conducted to discover other factors that affect breastfeeding myths and motivation more.

### Conflict of interest

The authors report no actual or potential conflicts of interest.

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