The Experience of Formula Feeding Infants
Among Women with Mental Health Challenges

BY

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University of Victoria, 2002

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ABSTRACT

Women in the perinatal period who suffer from mental health challenge (and specifically mood disorders) have a number of special considerations to which they must attend. Issues around psychotropic medication, hormonal fluctuations and/or sleep hygiene, for example, may lead women to a decision to feed their infants with formula. In this hermeneutic study, the experiences of six women are studied. The women are registered with Perinatal Mental Health Program at Vancouver Island Health Authority, and are feeding their infants with formula. Evidence-based-practice guidelines are explored in the context of mental health challenge. A dilemma has been exposed around the perceived need expressed by participants for ‘permission’ to discontinue or not initiate breastfeeding. The potential for further understanding looms with regard to the relationship between breastfeeding challenge and the onset of a mood disorder, including the speculation that breastfeeding difficulties may belong on the list of risk factors for postpartum depression.
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Dedication

This work is dedicated to all mothers everywhere.
Chapter One; the Birth of Inquiry

The Experience of Formula Feeding Infants among Women with Mental Health Challenges

When examining the current culture of maternity care, there appear to be many taken-for-granted practices that bear exploration. Over the last two decades of my maternity nursing practice, I have worked with marginalized and vulnerable populations such as those with mental health challenges. This experience has created personal interest as to whether gaps in understanding have evolved among health care providers as a result of the movement to support exclusive breastfeeding practice.

The value of breastfeeding practice is not at the center of my query. I do wonder, however, about how the fervour with which breastfeeding practice has been embraced among health care providers is experienced by women, and whether the commitment to breastfeeding may contribute to marginalization of those who are feeding their infants with formula. Questions have arisen for me about how breastfeeding is presented to be the feeding method of choice for virtually every woman. Therefore, I believe there is reason to explore the experiences of women in current culture of maternity care.

The nursing care in maternity settings has evolved a great deal as result of celebrating the superiority of breastfeeding practice as outlined in guiding literature. However, for some time I have been unsure if guidelines for care may be at odds with holistic notions that have historically shaped nursing practice. In preparation for undertaking research to further explore these preliminary wonderings, it has been
necessary to explore some aspects of the complexity that underpins infant feeding
decisions among women who are experiencing mental health challenges. I share some
of the exploration that served as a foundational perspective to approaching women
with mental health challenge who are feeding their infants with formula.

*Exploring Holism and Nursing Theory*

The discussion of ‘holism’ as it pertains to the discipline of nursing may be
understood in reference to the human sciences, and the contributions of the
philosopher Wilhelm Dilthey (Mitchell and Cody, 1999). Dilthey proposed that
understanding life “as it is humanly lived” (p. 203) holds ultimate meaning, in contrast
with the natural and social sciences (and particularly psychology) which adhere to
“conventional empirical methods” (p. 203) in their approach. Instead, Dilthey stresses
the ‘lived experience’ as the foundational datum, and suggests that the researcher is
inextricably linked with the investigation. According to Mitchell and Cody, Dilthey
conceived the human experience as “a coherent whole to which subjectivity is
fundamental; objectivity is a human creation” (p. 203).

Where nursing theory is concerned, understanding around the human being’s
‘wholeness’ have spawned considerable discourse over the past several decades
among academics. Discussion around the ‘unitary nature’ of humans, as opposed to
the human as a ‘system’ (that is made up of individual and reducible physiological
structures) has made its way into nursing literature by theorists such as Newman,
Rogers, Watson, Paterson and Zderad, and Parse. For example, Cowling (2007)
interprets Newman’s emphasis for nursing knowledge to be grounded in wholeness. He states:

Newman supports the ideal of a nursing mandate to address the wholeness of the human being, encompassing all its dimensions. Likewise, she acknowledges that recognition of and appreciation for inherent wholeness are critical aspects of the experience of healing. (p. 710)

While the articulation of understandings around wholeness has evolved, and continues to evolve, the tenets of humanistic nursing practice and holism in nursing literature appear constant (Mitchell & Cody, 1999). These authors cite Paterson and Zderad, who envision the nurse to “see(s) the patient as a whole, a gestalt” (p. 206).

Advanced Nursing Practice (ANP) “develops and uses multiple assessment strategies within a holistic (client-centered) nursing framework for individual clients and the client population” (Canadian Nurses Association, 2002, p. 6). Bright (2002) explains holism in the context of health:

Holism encompasses a process of understanding the meaning and the purpose of life. The holistic model asserts that health cannot be understood if the health of the earth, or the integrity of human relationships, or spiritual meaning is not also taken into consideration. (p. 32)

By honouring the possibilities for holistic perspectives that could be important to infant feeding choices, I believe there is an opportunity to further understand women who experience mental health challenges. For example, there are many unique needs associated with women living with depression. A woman’s requirements during the perinatal stage are distinct, and perhaps best informed by understandings of the woman as a whole; taking into account her situation as it is lived. Decisions around
infant feeding for these women are made in a milieu of complexity; and often result in
the choice to feed an infant with formula.

Coming to the Question

Reflections on Mothering

The hope of explaining ‘motherhood’, or defining the ‘state of motherhood’ as a
means of providing a foundational ideology for my research question, is a daunting
prospect indeed. As Leier (2007) suggests: “The idea of motherhood is so conceptually
rich that it is difficult to suggest any specific emotion or even combinations that will
provide a sufficient description of all that the mother-child relationship entails” (p. 32).
Yet, as I reflect on how it is that I have come to care about this topic of infant feeding
among a marginalized population, I am called to explore a broader and deeper
understanding of what it is to ‘mother’. I am also invited to reflect on how these
understandings have underpinned my nursing practice, and primarily practice that
intersects with women who experience mental health challenges.

My personal engagement with the experience of motherhood has shaped my
adult life, both personally and professionally. I have raised my three children to young
adult status, and devoted over two decades of my nursing practice to maternal/child
care; including labour-delivery, ante-partum, post-partum, pediatrics, and community
settings. A significant amount of my professional career has been spent in the
employment of the Vancouver Island Health Authority (VIHA), enabling a perspective
on local mores and practices. The wealth of these experiences weaves a fabric of
personal perceptions around mothering that is rife with contrasts and complexities. My
prevailing outlook, however, is a deeply situated ‘knowing’ regarding the profound importance of the mothering experience during the perinatal phase. Bergum (2007) suggests global implications of understanding the maternal/child relationship, by describing the ‘way of the mother’. She states: “The relational ground that is developed between mother and child [a relationship necessary for the health and growth of children and mothers] is the natural ground of the impulse toward a morality of responsibility in which one thinks of the other person as well as oneself- the move from me, me, me to us” (Author’s emphasis, p. 3). The implications of her words incite optimism for a societal shift which finds its roots in mutuality and selflessness (as found in the mother-baby relationship), as opposed to self-interest and exploitation. The words also suggest a certain intimacy between mother and baby, and my thoughts extend from there around the significance of supporting that relationship in whatever way is possible. The substance of the act of mothering, according to Bergum, is therefore at the very center of hopefulness for humanity. Her stance, without question, represents a powerful recognition of the important relationship between mother and baby, and it is tempting to further explore meanings embedded in that bond, such as the place that infant feeding plays in relationship building between mother and babe. When searching for academic sources that addressed formula feeding in the context of the mothering relationship, it was very difficult to find literature that addressed that query. One classic article (Murphy 1999), “‘Breast is Best’: Infant Feeding Decisions and Maternal Deviance” offers a depth of exploration that has articulated many of my own speculations. The results of my literature search have led me to question why her work
has not garnered more responsiveness among nurse academics and practitioners. In turn, personal assurance around the significance of my own explorations has been fueled. In her article, Murphy muses: “The intention to formula feed threatens women’s claims to qualities such a selflessness, wisdom, responsibility and far-sightedness all of which are widely seen as evidence of being a ‘good mother’” (p. 188). Is it possible that the potential for building the sacred connection between mother and baby can be disrupted by the judgments of others? Given that possibility how is it possible to reconcile opposing perceptions of motherhood, based on infant feeding decisions?

In my nursing practice, knowledge regarding the importance of maternal/child connection translates into a value for enabling the most positive mothering experience that is possible. The magnitude of honoring the unique needs of women with mental health challenges as they enter into the experience of mothering seems critical, especially when considering the pivotal nature of the transition to motherhood. I am therefore propelled to advocate for deeper understanding around taken-for-granted practice surrounding the prevalent breastfeeding rhetoric, which touts ‘breast is best’. As Nelson (2006) observes, “The slogan ‘breast is best’ is the oft-heard battle cry of those promoting breastfeeding in clinical settings” (p. 13). I ruminate about how the statement is interpreted by women who are already at risk for experiencing a lowered self-esteem by reason of their mental health challenges (Rusch, Lieb, Bohus, & Corrigan, 2006). I wonder how mothering feels for certain women, who may be feeding an infant in a way that may be viewed as ‘second best’. In the process of
articulating my sense of disequilibrium around breastfeeding fervor, I am invited to consider the possible relationship between infant feeding and positive mothering experiences during the perinatal period. I am also called to understand the experience of women who choose formula amidst a prevailing dominant discourse that challenges their decisions in an attempt to better understand how nurses can offer support and encouragement that is meaningful.

Narratives for Contemplation

In my practicum experience with the Perinatal Mental Health program, there were two occasions that stimulated my thinking about messages that may be given or received involving current breastfeeding rhetoric. The experiences of these women, who were struggling with mental health challenges, drew attention to the impact of discourse surrounding infant feeding. I was compelled to contemplate the potential for additional anguish among a vulnerable population, given the burdens that the women and their families already faced because of the illness. The possibility for further exploration into women’s experience therefore surfaced as an important prospect. In fact, the impossibility of discounting my personal uneasiness was confirmed as a result of these two situations. In the following paragraphs, I describe the two scenarios. In both cases, I use pseudonyms to protect the identities of the individuals involved.

Julie. A profoundly depressed woman, “Julie” was a patient I met on the Ante-Partum unit. Julie (Gravida Two, Para One) was 36 weeks in gestation, and had been hospitalized for several weeks when I met her. At the time of our meeting, Julie’s psychiatric condition was improved, compared to when she had initially been
hospitalized and plagued with frightening psychotic images. A series of Electroconvulsive Therapy (ECT) treatments had been initiated, and Julie was scheduled to receive her sixth and last treatment, in which I had been invited to participate. My presence was deemed potentially important to Julie, given my background with supporting women through anesthesia. In Julie’s case, the prospect of anesthesia was creating anxiety for her. On the morning of our meeting, Julie remained emotionally labile and fragile, and was tearful frequently throughout the course of our conversation.

As I recall the details of our interaction, the primary fascination relates to a part of the conversation having to do with infant feeding. Once trust was established between us, she shared her anxiety around the post-partum experience, because of her previous experience with breastfeeding challenges. In Julie’s case, anxiety steeped with the sleep deprivation associated with infant feeding, frustration over milk supply issues, as well as concerns around psychotropic medication, led her to a decision that favoured formula over breast milk. According to Julie, once she made her decision, she felt unsupported and judged by the nursing staff. The perceived response of the nurses created a stance of defensiveness from Julie, and even as I spoke with her a full two years after the birth of her first child, she still felt the need to justify her choice to formula feed. I was struck with the unease and apprehension she expressed regarding the upcoming post-partum phase in the midst of the many challenges she currently faced; including a scheduled caesarean section, difficulties with anesthesia, ECT, and acute depression. I was concerned that Julie was tormented with what she
remembered as disapproval from nurses. I wondered about the nature of the interactions that had occurred two years ago. I speculated about the added burden of guilt that Julie bore over the issue of infant feeding in the midst of a time of extreme distress. The weight of the issue seemed ‘out of place’ with the other serious challenges that Julie was currently facing. All of these personal responses gave birth to my evolving sense of curiosity; and I found myself considering the nuances of a topic that has become laden with emotion and opinion.

Peggy. Peggy was five weeks post-partum. She had been admitted with a diagnosis of post-partum depression to our local psychiatric facility several days prior to our meeting. Her infant had been with her at all times during her hospitalization, during which time Peggy had maintained exclusive breastfeeding. However, her condition was becoming more reclusive and hostile, and Dr. D. invited me to attend an interview to assess the most recent behaviours. Soon, Dr. D. ascertained that Peggy was paranoid and psychotic. Peggy was unwilling to make eye contact with either of us or anyone else, including her husband, because of the ‘evil’ penetrating from our eyes. Even more worrisome, as we learned later from another nurse, she had, over the past couple of hours, been observed covering the baby’s face with a blanket on several occasions. Once these insights had been gleaned, Dr. D. acted swiftly. The baby required immediate removal, because Peggy’s behaviour suggested she was at risk for committing for infanticide. Dr. D. also recommended transfer to the psychiatric intensive care unit (PIC) where Peggy could be medicated with large doses of psychotropic medications, and observed closely in a locked unit.
I could hardly believe I was witness to such a scene; the drama of post-partum psychosis revealed to me so suddenly and unexpectedly. The plans were made. I was to arrange for the baby’s father to come and take his baby home with him. However, I was not prepared for the reaction of the staff nurses at the nursing station when the plans were shared with them. An immediate manifestation of a ‘staff divided’ surfaced, as a heated discussion among them ensued regarding the treatment plan. “Why does Peggy have to go to Psychiatric Intensive Care (PIC)? Why can’t we just check on her frequently to make sure the baby is OK?” A further protest followed: “It would be terrible to interrupt the breastfeeding just because she has to go to PIC!” And, conversely, “How can we possibly keep that close of an eye on her? It only takes moments to suffocate a baby!” The most responsible nurse (MRN) was clearly upset about the breastfeeding cessation, in spite of the danger of leaving the baby unattended with Peggy, and the new information about the psychotropic medications that would be required to treat Peggy’s psychotic state. Meanwhile, the task of contacting the father (Rob) continued. Understandably, when Rob arrived to collect the baby, he appeared dazed, as though he could hardly ‘take in’ what was happening. I worried that he had not understood what he had been told about his wife’s condition. Instead he seemed fixated on the negative aspects of formula feeding that he was about to commence. “Would the baby be all right if I give him formula?” he asked, “Isn’t formula bad for babies? That’s what I have read! That’s what they told us in prenatal classes! I hope to hell you guys know what you’re doing!” My parting image was of Rob sobbing, as he drove from the hospital parking lot with his tiny infant safely
secured in the car seat. Again, I speculated about the meaning that infant feeding held in the midst of a family crisis. I wondered what it would be like to feed a beloved infant with a substance which, in Rob’s case, had obviously been equated with negative outcomes.

In both of the cases I have described, I wonder about the power of the message that reaches parents regarding breastfeeding superiority, and what cost to emotional well-being may ensue, when the efficacy of breastfeeding practice is challenged by circumstance.
Chapter Two

A Backdrop of Historical, Theoretical and Ethical Queries

*Meanings of Successful Motherhood*

What then, constitutes meaning for successful motherhood? Lemermeyer (2007) states: “Of course I want to survive labour and delivery with a healthy baby, but where have we arrived when survival alone is the measure of our success?” (p. 111). Lemermeyer’s words bear witness to the quagmire of issues surrounding the medicalization of birthing settings, as well as the need for women to experience a sense of ‘success’ around their birth experience. The meaning of success in the perinatal period appears far-reaching, and perhaps individual in its connotation. Nelson (2007) discusses the “cultural practices that mark women’s journey into motherhood” (p. 87), and describes the discursive space that is occupied by the larger culture of motherhood. She cautions: “Although it might be the only place to articulate a wide range of mothering experiences, it is also a place where one might be negatively judged, even rejected” (p. 99). Even at the outset of the motherhood experience, then, and even while among peers, it seems there are possibilities for stigmatization. What kinds of pressures exist for new mothers as a result of these possibilities? Does infant feeding choice constitute a position that is at odds with perceived ‘successes’ amidst a dominant culture?

The profile of infant feeding is extensive during the perinatal period, where successful breastfeeding is frequently presented as a measure of accomplishment, and
equated with attachment and bonding to the infant. However, Murphy (1999) postulates: “By deciding to formula feed, the woman exposes herself to the charge that she is a ‘poor mother’ who places her own needs, preferences, or convenience above her baby’s welfare” (p. 187). Is it true that women consider themselves to be ‘poor mothers’, or are there other ideas that take precedence in the face of mental health challenge? Interestingly, according to the research of Wilkinson and Sherl (2006) there is reason to challenge the widely held assumption that breast-feeding is pivotal for maternal attachment with infants and overall well-being. Instead, the authors suggest that security with experiencing a variety of individually constructed ‘attachment styles’ plays a greater role in the adjustment to new motherhood. Wilkinson and Sherl’s research therefore has meaning for a population of women with mental health challenges, who are known to struggle with issues of self-esteem, and may experience feelings of shame as a result of the ‘charges’ Murphy describes. Beck (2002) identifies the concept of ‘conflict’ among women with postpartum depression that includes notions of what makes a ‘good mother’. Breastfeeding practice is among the conflicts identified, highlighting the potential for stress that accompanies the topic of infant feeding for women who are confronted with mental health issues. Beck’s identification of conflict and the subsequent associations serve as a beacon for me to further clarify the tension that may be exacerbated by the topic of infant feeding during the post-natal period. I ponder the extent to which new insights around women’s experience could assist the navigation to successful perceptions of mothering.
Situating Mental Health Challenges in the Current Culture of Maternity Care

The culture of maternity care that exists today represents an evolution of sensibilities around breastfeeding that are significantly different from what they were decades ago.

*Historical and Contextual Backdrop*

*Reflections on the evolution of current best practice guidelines.* The history of infant feeding practice over the past century has been tumultuous in nature and mired in ethical complexity for women globally. Sociological, economic, anthropological, political and feminist influences have explored and tracked the shift that occurred from widespread breastfeeding practice at the beginning of the 20th century, to a point between 1950 and 1975, where formula feeding had gained statistical prevalence for infant feeding (Baumslag, Michels & Baumslag, 1995; Sol, Aguago, & Clarke, 2007).

In the Western world, including Canada, factors such as the increasing presence of women in the workplace, and the view that formula feeding was connected with women’s emancipation contributed to the movement away from breastfeeding among mothers, particularly during the 1950’s and the 1960’s (Nathoo & Ostry, 2009). Explanations for the diversion away from breastfeeding have also included analysis of the marketing strategies of formula companies, wherein it has been suggested that women’s confidence in their own abilities to breastfeed was undermined over the past half century, and extends into the consciousness of today (Palmer, 2009).

A highly profiled expose surrounding the decline of breastfeeding surfaced regarding the situation in underdeveloped countries, wherein there was an infiltration
of ‘for profit’ formula companies during the 1960’s and 1970’s. Retrospectively, the introduction of formula to these impoverished areas is seen to have been exploitative to populations of financially and educationally challenged peoples. Most troubling, infants in many areas of the world were exposed to sickness and death resulting from improper formula preparation due to contaminated water supplies (Goshcett, 1986; Baumslag et al, 1995; Lieberman, 1996). As a result of public awareness surrounding the presence of formula companies (such as Nestle) in developing countries, a well-known boycott of Nestle products surfaced in the mid 1970’s and shaped much of the rhetoric around infant feeding that followed (Lieberman, 1996). It could be argued, therefore, that the current impetus for exclusive breastfeeding practice has arisen as a backlash of sorts, and finds its roots both nationally and internationally. The movement thus attracted the attention of international guiding bodies such as the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF). The culmination of the movement towards reinstating breastfeeding as the prevalent method for infant feeding was the 1990 WHO Innocenti Declaration. The declaration is a lengthy and comprehensive plan for global breastfeeding support, but is summarized as follows:

The Innocenti Declaration reflected both the spirit of the support that was being mobilized for breastfeeding, and the recognition of the right of the infant to nutritious food enshrined in the Convention on the Rights of the Child.

(UNICEF Innocenti Research Center, 2005, p.vii)

*Canadian perspectives.* According to Grassley and Nelms (2009), 85% of Canadian women initiate breastfeeding. The numbers of continued breastfeeding
practice decrease over the ensuing months of the post partum period, and are variable throughout Canada. British Columbia boasts the highest duration rate; with 55% of women breastfeeding at six months.

There are multiple interpretations of how these statistics can provide meaning about the ‘success’ of breastfeeding promotional efforts. Since the Innocenti Declaration of 1990, there has been a 15% worldwide increase in breastfeeding initiation (UNICEF Innocenti Research Center, 2005), pointing to some measure of success around implementation of breastfeeding initiatives. However, Kellehen (2006) offers an important perspective, by drawing attention to an important historic understanding of the breastfeeding movement, wherein “feminist scholarship on breastfeeding has addressed a variety of issues related to women’s breastfeeding experiences, but has tended to ignore or downplay the potentially physically challenging aspects of early breastfeeding” (p.28). Kellehen’s study revealed that women were often unprepared for the challenges, and concludes: “Feminist scholars addressing the topic of breastfeeding, women's postpartum health, and embodiment must more directly and comprehensively account for the potentially negative physical implications and demands associated with early breastfeeding.” (p.28). Her findings point to the possibilities around breastfeeding cessation statistics, and illuminate understanding around the perspectives that shape women’s infant feeding choices.

Reductionism and the Baby Friendly Hospital Initiative (BFHI). It is salient to explain some of the foundational approaches that have fashioned the present culture of maternity care in Canada. Guiding literature such as the BFHI is authored by the
Breastfeeding Committee for Canada (2004) and serves as the national authority for WHO and UNICEF. Given the profile of those international organizations that have provided impetus to encourage exclusive breastfeeding practice worldwide, the document represents a significant influence in the health of women and their infants. With international breastfeeding advocacy perspectives at the forefront, the BFHI represents a series of guidelines to promote breastfeeding in hospitals. The document is extensive, offering steps to guide practice, and evaluative goals to be met in order to gain the official status of a ‘baby-friendly’ facility. Guidelines include policy, education (including written materials), and practice recommendations associated with the successful implementation of breastfeeding. All of these recommendations are aimed at protecting breastfeeding practice as an attainable method for infant feeding. (Breastfeeding Committee of Canada, 2004a, 2004b, 2004c, & 2004d). I identify some aspects of the document that have stimulated my thinking around current practice.

Included in the BFHI literature is a list of “Acceptable Medical Reasons for Supplementation” which include a short list of examples of medications that are contraindicated in breastfeeding (Breastfeeding Committee for Canada, 2004c, p.19). There are several psychotropic medications that can be recommended during pregnancy and lactation periods. However, because of the unknown risks to the infant associated with clinical trials in the context of pregnancy and lactation there are many medications for treating mood disorders that may not well-studied (Usher, 2007). Beck and Watson Driscoll (2006) quote “expert consensus guidelines” which “recommend for women with a milder major depression that the treatment with
medications and psychosocial support is supported only if the mother is not breastfeeding” (p. 103). In the context of breastfeeding, mood stabilizers and antidepressant medications may be prescribed with caution or discouraged (VIHA, 2007; VIHA, 2008). The consequence of this dilemma is that women may choose to avoid breastfeeding out of concerns for known or unknown potential difficulties with infant development. Interestingly, psychotropic medications are not among those listed in the BFHI literature. This oversight, I believe, validates overall concerns regarding the stigmatization of mental illness that exists (Corrigan, Watson et al., 2004), and exposes the disconnection between disciplines that results in a reductionist model of care delivery. When discussing the ‘perils of reductionism’, Doyle (1995) warns that the biomedical approach “is often of little use in understanding psychological distress and disability” (p. 16). It is possible that the omission of any reference to mood disorders in the document represents an example of detachment between the disciplinary interests of mental health and the breastfeeding movement. Indeed, empiricism around statistical correlations of improved health as a result of breastfeeding provides the underpinning to assert superiority in the BFHI document. As a result of exposure to the empiricism, I began to wonder what possibilities loomed for reinforcing the ‘psychological distress and disability’ to which Doyle alludes. I was eager to uncover more about what it is to experience mental health challenge in the midst of a culture that equates the birth of a child so strongly with behaviours such as breastfeeding; behaviours which may or may not be realized as part of an individual’s plan for parenthood. I continue to wonder if assumptions about ‘best practice’ may obscure a
divide that has been created by overlooking special needs of those who are vulnerable by nature of their mental health challenge.

When considering the specific nature of mental health challenge that I was interesting in exploring, I decided to narrow my focus to women suffering from mood disorders (either depression or bi-polar illness). This decision included the assumption that I would be making meaning of experiences among individuals who were emotionally stable enough to participate. The choice also allowed a focus for my study that appeared reasonable in its breadth, considering my inexperience as a researcher. I reasoned that my interest in women with perinatal mood disorders could contribute to my understanding with substantial clarity. The language that I use in this work, then, includes the assumption that the experience of mood disorder is the nature of the mental health challenge that is being investigated.

*Medication, hormones and sleep.* There are many aspects to consider with women who suffer from unipolar or bipolar illness, and especially where infant feeding choices are concerned. An important deliberation, for example, concerns psychotropic medications that are generally recommended to treat and prevent acute episodes of depression and/or mania. For severe depression and/or psychosis, Haloperidol has been relatively well-studied, and is considered safe while breastfeeding (VIHA, 2008). For women with unipolar depression some anti-depressant medication is considered safe in the context of lactation (such as Sertraline or Paroxetine). Others such as Buproprion or Clonazepam, are not recommended (Usher & Foster, 2006; VIHA, 2007). For women with a history of depression, or who are actively suffering with clinical
depression, there are other considerations that may affect these women’s decision to
breastfeed, including past history of sexual abuse and/or acute anxiety around
breastfeeding practice (Beck, 2009; Klingelhafer, 2007; Prentice, Lu, Lange & Halfor,
2002). Where psychosis is concerned, although a medication such as Haloperidol may
be deemed clinically safe in breast milk, the nature and severity of the psychosis may
guide recommendations in the direction of formula while the mother recovers
sufficiently to maintain safe contact with her infant. In the case of bipolar disorder,
one commonly used mood stabilizer (lithium carbonate) is not recommended during
breastfeeding for at least the first three months of the infant’s life (Gentile, 2004;
Yatham, Kennedy et al., 2005). In all cases, the amount of medication that is
transferred through the breast milk and the potential effect to the infant, guides
recommendations around safety with breastfeeding (VIHA, 2007) As Ross, Gunasekera,
Rowland, and Steiner (2005) state:

Nearly all drugs, including psychotropic medications, pass through the
placenta into the fetal circulation. Therefore, there is concern that in utero
exposure could result in complications to the fetal development and neonatal
adaptation or in long-term neurobehavioural sequelae. (p.112)

Further complicating treatment assessment is the “unique hormonal milieu that
women do not experience outside of lactation” (Stowe, Ragan, & Newport, 2005,
p.138). During the first few days following birth, the hormonal shifts that occur in post-
partum women are significant, defined by fluctuating levels of serum prolactin,
oxytocin, and decreased estrogen, among other complex hormonal interactions. It is
believed that these hormonal alterations may have “a direct impact on mental
functioning” (p. 138). However, the authors state: “The hormonal levels in women with postpartum depression have not been investigated systematically and extensively” (p. 102), alluding to preliminary findings that suggest no differences have been found in hormonal levels between depressed and non-depressed women. It seems, then, that empiric scientific evidence continues to evolve regarding the specifics of the etiology that may be involved with hormonal shifts post-partum. Beck and Watson Driscoll (2006) recount: “Clinically (however), women have shared with me that they are exquisitely sensitive to exogenous hormones and have often felt devalued by health care providers when they were told that their experiences where not supported by research. Sadly, their experiences are not considered valid” (p. 126). It is important to note that in the presence of depression or bi-polar disorder, the effects of “exogenous hormones” have the potential to be magnified (Beck & Watson Driscoll, 2006) in the form of extreme mood alterations. Those effects, in turn, may constitute considerable importance when decisions around infant feeding and medications are considered. Because there is “an understandable reluctance on the part of many new mothers and their clinicians to use antidepressant medication during lactation” (Stowe, Ragan, & Newport, 2005, p.142), women may choose not to breastfeed.

An important aspect of care for women with mental health challenge involves the concept of “sleep hygiene”. Recommendations for mothers with a history of unipolar or bipolar disorders encourage six to eight hours of uninterrupted sleep for several nights in succession during the early days and weeks following delivery (Beck & Watson Driscoll, 2006). While it may be possible for a woman to pump breast milk and
have a partner feed the infant at night, individual circumstances such as anxiety or concerns with medication may play a role in the decision not to breastfeed. The counsel for extended sleep is often a rationale for choosing formula, and any plans for care should be “customized” according to infant feeding choice (Beck & Watson Driscoll, 2006, p. 20). In the case of women with bipolar disorder, a significant determinant involves the risk for an acute manic or depressive episode. The euphoria of labour-delivery experience, combined with the sleep deprivation associated with the early post-partum period exacerbates the risk for a manic episode and possible post-partum psychosis during the post-partum period (Callahan, Sejourne, & Denis, 2006; Beck & Watson Driscoll, 2006). As Beck and Watson Driscoll state: “Often sleep loss precedes mania; thus, early identification and treatment of sleep disturbances need to be important parts of managing at risk women such as those with a bipolar disorder or history of post partum psychosis” (p. 49). The exacerbation of a manic episode further complicates the experience of women, the baby, and the family, who are already well acquainted with the challenges associated with mental illness. Beck and Watson Driscoll (2006) conclude that women who have suffered a manic episode “have to come to grips with the shame and stigma of the illness and negotiate repair work on relationships with themselves, family, and friends” (p. 128). The authors also point to the concerns around maternal-infant interaction in women with acute mental health challenges, illustrating yet again the importance of establishing as much stability as possible in the perinatal period; stability that may require a comprehensive perspective of care, and the possible employment of psychotropic medications. Beck and Watson
Driscoll reiterate: “Breastfeeding with psychopharmacologic agents is a large concern in the care of women with bipolar II disorders because limited data exist about the safety of the mood-stabilizing agents and the neuroleptics on the infant.” (p.131)

To describe the many complexities associated with infant feeding decisions is beyond the scope of this work. What became clear to me in the review of the literature is that there are layers of contingencies that comprise the reality for women who are faced with mental health challenge. In spite of the inevitable challenge for any women with a new infant, I wondered to what extent women struggling with mental health issues are able to successfully navigate the territory of best practice in the post-partum period. I wondered if that landscape is potentially laden with misunderstanding, recriminations, and stigmatization. I also wondered how easy or difficult it may be to establish the all-important connection with the infant considering the scope of complexity that accompanies mental health challenge. These questions surfaced in the context of a clear personal understanding that there are women for whom breastfeeding may not be the best option.

*Corporate ideology and cost-saving potentials.* Another observation with the BFHI (Breastfeeding Committee of Canada, 2004d) takes its roots in well-meaning public responsibility. In this case, information is provided about the potential for cost saving to the individual and the system that has occurred as a result of the breastfeeding movement. Motives aimed at fiscal responsibility have resulted in significant organizational changes. However, I suspect the ‘ideology of scarcity’ may also be at work here, wherein “quick problem solving and efficient processing”
(Rodney, Pauly et al., 2004, p. 82) is honoured. For example, ‘well-baby’ nurseries have been dissembled, in accordance with interpretations of the BFHI, which recommend physicians and other independent practitioners must “practice in a manner that ensures mothers and babies remain together throughout the hospital stay, unless separation is medically indicated.” (Author’s emphasis; Breastfeeding Committee for Canada, 2004c, p.6). In theory, twenty-four hour access to the newborn enables optimal breastfeeding initiation, wherein mothers are better able to respond to their infant’s cues, and milk supply is subsequently enhanced (Breastfeeding Committee for Canada, 2004c). It is possible health authorities support BFHI recommendations that allow for cost saving, including reductions in the amount of formula that hospitals purchase, lower staffing levels because of rooming in practices, and early discharge, which is aimed at normalizing the birthing experience. All of these initiatives support breastfeeding practice, and, may at the same time, reduce hospital costs. However any possible reduction to hospital expenditures does not acknowledge the special considerations around sleep (sleep hygiene) for women with histories of mental health challenge such as unipolar or bi-polar disorders. The practice of exclusive infant ‘rooming in’ may have implications for women who require uninterrupted sleep and opportunities for rest, given the possibility of a long labour from which they must recover. With nowhere else for the baby to go while in hospital, infants are relegated to the mother’s room, creating a situation that may undermine the goal of uninterrupted sleep. I have speculated about the meaning of these messages among a vulnerable population, who may be struggling with their infant feeding decision, based
on rationale that may or may not be articulated as a legitimately ‘medical’, but important nonetheless. I have also wondered if women feel comfortable sharing any anxieties, given the forcefulness of evidence around breast milk superiority. As previously described in the narratives, I consider the potential for anxiety to exacerbate feelings of guilt among women with mental health challenges and their families. When considering the possibilities for research, I wondered about the implications of anxiety and guilt during such an essential time; the beginnings of relationship with one’s child.

The Stigma of Mental Health Challenge

Much has been written about the stigmatization and marginalization of people with mental illness. Finfgeld (2004) states: “Stigmatization results in stereotyping and failure to relate to patients as individuals rather than as diagnoses. Consequences include societal devaluation, discrimination, social isolation, decreased self-esteem, and hopelessness” (p. 46). Where the onset of mental health challenge is concerned, I have been led to speculate as to what may happen if individual needs are not accommodated in the current maternal/child settings. Further conjecture occurs about the potential for crises among women and their families, once they are dealing with the inevitable dilemmas of the early post-partum phase, and especially the many breastfeeding challenges that may be associated with that time frame (Kellehen, 2006). Beck and Watson Driscoll (2006) state: “It is difficult enough to be the woman living with the mood disorder, but to have a critical aspect of your biology ignored by the psychiatric health care team and the primary health care team is unconscionable” (p. 126). While the thrust of breastfeeding advocacy and policy changes to support the
normalization of the birth experience may be altruistic, I wondered if unique needs for women with mental health challenge, or the potential for mental health challenge, are met using the current model of care. I became interested in exploring how women perceive their experiences of the early post-partum days, and what effect those early days may have on their overall experience of the perinatal period.

I have described many examples of recommendations that have been embraced by the maternal/child world. To some extent, it seems that these recommendations resonate as a “one size fits all” approach to maternity care. I have wondered whose voices may be silenced beneath the cacophony of breastfeeding fervor. It is possible, for example, that women with mental health challenge are reluctant to assert their needs for support during the post-natal period because of their vulnerability. Nurses’ voices may also be silenced in the cascade of support for exclusive breastfeeding practice, for fear of being branded as ‘politically incorrect’ or not ‘baby-friendly’.

Interestingly, an ethical movement in health care during the 1960’s involved criticisms that patients were treated “in an impersonal manner and given ‘assembly-line’ treatment” (Lamb, 2004, p. 28). I was curious as to whether participants in my study would perceive similarities today.

The Lens of Ethics

The ongoing debate of philosophers throughout the ages, as described by Rodney, Burgess, McPherson, and Brown (2004), is to ascertain “how best to live” (p. 58). The relevance that this statement holds for ethical practice and for the issues that I have identified is profound; the statement embraces a scope of understanding that is
far reaching. I suspect that women with mood disorders, for example, are attempting to live in the best way that is possible for them, given the nature of their challenges.

*Disrupting the Dominant Discourse of Breastfeeding Superiority*

As the momentum builds in maternity settings for the promotion of breastfeeding practice, I reflect on taken-for-granted practice, and how it may affect women who are vulnerable.

*Informed choice and the BFHI.* Rodney, Burgess et al. (2004) encapsulate the relational aspect of informed consent. They say: “Rather than being a one-time evaluation of information and a decision about how to proceed, the emphasis is on a relationship in which the health professional provides new information about effectiveness and risks and encourages patients to reflect on and express their interests” (Author’s emphasis, p. 63). The reference to a relational interaction offers hope for an authentic interaction with patients, wherein dialogue is encouraged, and reflection is valued. However, I wonder if a worrisome breach of informed consent is found in the text of the BFHI, where counsel is given for nurses to avoid teaching formula feeding techniques during pre-natal instruction: “For example, the policy prohibits prenatal or postnatal group instruction on breast milk substitute use, stating instead that information on formula should only be given after a woman has made an informed choice about her decision ‘not to breastfeed’” (Breastfeeding Committee for Canada, 2004c, p. 9). It is difficult to fathom how an “informed choice” can be made amidst a prejudiced approach in the pre-natal setting. In fact, it is possible to question the impetus behind that recommendation; by withholding the information about
formula, will the “correct” decision prevail? I speculate that the irony of patriarchal practice is uncovered. Nelson (2006), citing Cody, discusses paternalism as it relates to evidence based practice (EBP). She explains that “paternalism is widespread in the current health care system, often under the guise of a genuine beneficent belief of practitioners that people ought to do what is recommended for them. Practitioners frequently justify this belief by referring to positive outcomes or health benefits” (p. 11). Most importantly, I contemplate the meaning that transpires around information that is privileged, and information that is withheld.

_Research and the BFHI; privileging empiricism._ Johnson (2004) proposes that nurses are becoming “enamored of science” (p. 47). She goes on to expose the issue of evidence-based practice in nursing, warning:

> Evidence-based practice is a technique for governing nursing practice that ultimately might undermine the agency of the nurse. As we consider the frontiers of nursing ethics, it is clear that the borders between science and good practice will continue to be a topic that requires our attention” (p. 48).

Certainly, there is a plethora of accessible information around the topic of ‘evidence’ and breastfeeding promotion. The widespread availability and visibility of data regarding the empirical benefits to breastfeeding is displayed in maternity settings and embedded in ‘breastfeeding support’ education for nurses (Murphy, 1999; Breastfeeding Committee for Canada, 2004d). Documented benefits to the infant include protection against the development of childhood asthma, allergies, type 1 diabetes, celiac disease, intelligence, childhood cancer, inflammatory bowel disease, and prevention of malnutrition and death, among others (Nelson, 2006; Breastfeeding Committee for Canada, 2004d). However, as Nelson cautions, many of the evidence-
based benefits of breastfeeding remain “uncertain, due to multiple mixed research findings” (p. 14). Nelson’s words raise questions about the responsibility of promoting some of the evidence that has been embraced by the breastfeeding movement; evidence which has the potential to create strong responses among those making choices. In particular, the examples of increased intelligence and decreased mortality rates among breastfed infants raise questions for me, when considering the emotional situatedness of women who may choose formula. The choice for formula feeding may come about, for example, as a result of issues that extend beyond what are ‘medically acceptable’, such as heightened anxiety associated with breastfeeding and/or a history of sexual abuse (Prentice, Lu, Lange, & Halfon, 2002). Other kinds of evidence, some of which is empiric itself, may also merit consideration. For example, there may be knowledge that breast milk will carry inappropriately high levels of lithium for an infant less than three months of age (Gentile, 2004). Evidence that is more subjective in nature may include understandings that the emotional challenges of establishing breastfeeding may be too daunting for a fragile emotional state. Therefore, the dissemination of evidence that implies a child fed with a breastfeeding substitute (Breastfeeding Committee for Canada, 2004d) will suffer from a lowered intelligence, or an increased risk of death seems problematic. Firstly, the evidence in these cases is inconclusive. Der, Batty, and Deary (2006), in a landmark quantitative study, find that the mother’s Intelligence Quotient (I.Q.) is highly predicative of breastfeeding status (meaning that women of intelligence tend to choose breastfeeding), but that maternal intelligence is more predictive of the child’s I.Q. than the breast milk. These findings
dispute earlier claims that link the quality of the breast milk with brain development and therefore, ‘intelligence’ in the infant (White, 2000). The Breastfeeding Committee for Canada (2004d) posits that ‘manufactured products’ fail to prevent malnutrition, and states the consequence can “affect the IQ potential and learning readiness of children and can even cause death” (p. 2). Often, the ‘evidence’ about intelligence, risk of death (and its alleged relationship to breastfeeding superiority) is posted on maternity units for all to see. For women in a delicate emotional state, I have wondered about the consequences of assuming responsibility for those outcomes, and whether responses to information that is disseminated could be clinically significant. I deliberate on how it may feel to make a choice which has the potential to deprive an infant of intelligence, and possibly even life itself. What strategies are employed by women who feed with formula in the early days of mothering, in the face of the widespread ‘evidence’ that places them in a position of being ‘other’? These and other questions about the current culture of maternity care proved to be the defining underpinnings of my inquiry prior to undertaking the research process.

Discussions of attitudes toward mental health challenge may include references to Descartes, and the Enlightenment period, when reason and emotion were viewed as separate attributes (Doane, 2004). There is relevance around the issue of how women with mental health challenges are perceived in the maternity setting, wherein the focus is healthy mothers and healthy babies. It is possible that challenges have the potential to be overlooked if staff’s attitudes reflect the stigmatization associated with the mind/body separation of mental illness (Corrigan, Watson, Warpinski & Gracia, 2004).
Prior to my research, I was interested in learning about women’s experience where this potential is concerned.

Johnson (2004) asks: “Do we believe that there can be a code of ethics that can be applied to all nurses in all situations, or do we acknowledge that there are always contingencies that must be taken into consideration?” (p. 49). Her statement has relevance for valuing holistic nursing perspectives in the face of scientific evidence which has the potential to restrict our vision. Simington (2004) explores the concept of ‘wholeness’ in nursing practice as it relates to spirituality. She describes the teachings of Plato, Jesus Christ, and Einstein, each of whom (in specific ways) recognize emotions, the soul, and the interrelatedness of environmental factors. Simington links this knowledge with a sense of balance, and being ‘whole’. Simington goes on to say: “While considerable rhetoric is devoted to promoting holistic care, there is evidence that many who provide health care services are unable to apply the knowledge of holism, thus demonstrating a lack of true understanding of the concept” (p. 471). Her statement raises questions for me about how holistic practice may be lived and understood in maternity settings, and especially in the context of what may transpire among vulnerable individuals such as women with mental health challenges. Johnson’s question also underpins the need for nurses to consider the specific experience that exists for women who suffer from depression or bi-polar disorder, and value the concept of emotional well being for women who have given birth. Nurses have a unique opportunity to integrate the contextual knowledge that shapes our practice (such as the emotional condition of a woman). Going into my research, I was curious
about what understanding could be gained by further exploration of women’s experience of prevalent practice recommendations for infant feeding.

Relational and Caring Ethics

Indeed, attention to the nature of our relational practice offers promise. Brown, Rodney et al. (2004) explore the importance of the ‘relational’ and ‘caring’ aspects of nursing when considering the unique nature of nursing ethics. They connect the moral underpinnings of nursing practice with the relationship that is built between the nurse and the patient. The concept of advocacy (including the importance of reconciling paternalistic approaches to best practice) is cited. Here, I believe that the inequality of power relations has the potential to be exposed, wherein ‘silencing’ among women struggling with mental health challenge could be fostered. Simington (2004) equates spirituality with advocacy. She states: “Advocacy is about love, compassion, and caring” (p. 480), and encourages ethical actions that will reduce any barriers for people to live their lives fully, being cognizant of the role that power plays for patients as well as nurses. Her words promote advocacy, by empowering patients whenever possible, and empowering nurses in ways that reflect ethical solutions. I have wondered if women with mental health concerns, and who use formula to feed their infants, have experienced barriers that have impacted a satisfying experience of motherhood.

Brown, Rodney et al. (2004) discuss care-based discourses that promote adherence to protocols and non-individualistic approaches. The authors express disdain “for abstract principles supposedly applied with impartiality, finding them irrelevant, ineffectual, and constricting” (p. 134). These words reinforce previous
references in this work around ‘holism’; references suggesting that naturalistic impressions of knowledge are limiting, and may be manifested in rigid interpretations of empiricism (such as evidence around breastfeeding superiority) and lead to rigidity in practice. Implications around the relational ethic of caring abound; and invite fresh perspectives around the need to involve philosophical analysis that “reflects the enormous diversity and complexity of moral experience” (p. 135). The result of such insight leads me to explore the diversity and uniqueness that constitutes the experience of women in the perinatal setting who are challenged with mental health concerns, and who may benefit from relational and individualistic approaches for care.

It follows that understandings around ethical notions which can be discussed in the context of relational and caring ethics (such as empowerment, paternalism and inequality of power relations) can be also be equated with the foundations of feminist ethics, wherein these concepts also occupy a significant profile.

**Feminist Ethics**

Much of the momentum for the inquiry that has unfolded for me finds resonance within the terrain of feminist ethics. Within this view, there is opportunity for examining both contemporary and traditional theories relating to the practice of ethical health care (Rodney, Pauly & Burgess, 2004). As the authors state: “A primary contribution of feminist ethics is the examination of a wider variety of ethical issues than in traditional bioethics, especially those issues related to sexism in health care delivery” (p. 84). Feminists have critiqued the traditional principles of bioethics (autonomy, justice, beneficence/non-malificence, and informed consent) warning that
the “rational, non-contextual application of ethical principles misses the subtle and pervasive power dynamics that infuse patient/family/provider relationships within hierarchical institutions” (Rodney, Burgess et al., 2004, p. 68). Their words nudged me towards examining exclusive needs in the context of the institutional ‘baby-friendly’ culture of maternity care. Briefly stated, a feminist ethics approach incorporates principles of caring, but has the potential for illustrating aspects of social injustice that may inform a given situation (Brown, Rodney et al, 2004). Therefore it seems that feminist perspectives, which approach oppression and power inequities, have particular relevance to my question. Firstly, as discussed, women with mental health challenges are well acquainted with marginalization. Feminist ethics require attention to the nature of the power relations that could be at play (Rodney, Burgess, & Pauly, 2004). Knowledge of the patient, her family, the care providers (and their biases), and institutional policy are therefore key components when analyzing power relations. Feminist ethics also addresses the principle of justice from an expanded perspective; not only using a framework of distributive justice, but also using a deeper insight that identifies ‘domination and oppression’ as instrumental barriers to access. It follows that issues such as the ‘silencing’ of women with mental health challenge align with the feminist ethic of justice. There are many multi-faceted possibilities for analyzing domination and oppression in institutional settings, and especially when considering the experience of marginalized populations such as women with mental health challenges. Rodney, Burgess, and Pauly (2004) cite Wolf, stating: “Feminist theory draws attention to the quality of relationships-particularly the power in those
relationships-at individual, organizational, and societal levels” (p.84). Where infant feeding is concerned, as is consistent with a feminist ethical stance, I am led to explore how organizational and political trends have informed women’s experience.

Relevant Perspectives

Coercion. The BFHI (Breastfeeding Committee for Canada, 2004c) recommends that nothing containing references to breastfeeding substitutes should be available pre-natally. The document reads “This information should be provided in a separate document only to those specific women who have made an informed decision not to breastfeed” (p. 9). Under “policy”, BFHI prohibits prenatal and postnatal group instruction on breast milk substitute use. “The visual representation of breast milk substitutes, bottles, artificial nipples and pacifiers are not promoted, displayed or distributed to mothers or staff in the facility” (p. 18). I have considered the possibility that withholding key aspects of infant feeding options constitute coercion, because only selected information is disseminated, and therefore privileged. Women know that formula feeding is available as a possible option, but I wonder what implications emanate from the biased approach of information dissemination that is encouraged by the BFHI literature. In my own experience, while teaching pre-natal classes, I recall many occasions where I felt uncomfortable about upholding the expectations of the ‘baby-friendly’ approach; expectant parents were asking relevant questions about formula, and I felt awkward about deferring their legitimate queries. Not only did I experience a sense of frustration about the partiality that was presented, I also felt that
I was betraying the trust that I had established with couples, by failing to present the forthright response they had come to expect from me.

The language throughout the BFHI document is also of interest. Most references to formula are called “breast milk substitutes”, and descriptions of decisions around infant feeding are framed as being alternative to the ‘protected’ practice of breastfeeding. I question the subliminal effect that is created as a result of the language that is used, as well as the visual representation of ‘breast’ only. I wonder if patients have the potential to be coerced in this environment that is so strongly weighted in the direction of breastfeeding promotion. It is important to note that there are a wide variety of sources that women may use to educate themselves in the process of decision making around infant feeding. Nelson (2006) discusses the widespread availability of information and postulates: “The many reported benefits of breast feeding are often relayed to mothers by breastfeeding advocates in an effort to convince them to breastfeed, sometimes to the point that mothers feel coerced” (p. 13). She goes on to state: “The current push to promote breastfeeding may be experienced as paternalistic by mothers who feel coerced to breastfeed or are pushed beyond their commitment to do so” (p. 11). Both statements point to perceptions of coercion that can result from breastfeeding promotion that is not cognizant of an individual’s situatedness. The implications of these understandings served as an important foundational impetus as I planned my research project.
Chapter Three

Approach to Inquiry

Hermeneutic phenomenology is highly suited to answering ‘what’ and ‘how’ questions about human issues and concerns but does not aid in prediction. It can provide a better understanding of what the issues and concerns are and, thus, help to anticipate future events, and can develop understanding of the significance of an event or topic to the person or family. (Whitehead, 2002, p. 514)

The Research Question

It was challenging to articulate a research question that succinctly reflected the complex nature of my inquiry. Many layers of possible contingencies surfaced, when considering the experience of motherhood, the experience of mental health challenge, and the current culture of maternity care.

Interpretive inquiry is informed by, and perhaps is a response to taken-for-granted beliefs about ontology as an empiric body of knowledge that represents truth according to the natural science tradition (Jardine, 1998). It seemed, therefore, that interpretive inquiry was an ideal framework into which the context of my question could be located. “The goal of interpretive work is not to pass on objective information to readers, but to evoke in readers a new way of understanding themselves and the lives they are living” (Jardine, 1998, p. 50). Jardine’s words have significance when considering the empiric evidence that shapes the rhetoric around breastfeeding superiority. In my quest to better understand the issues involved with supporting perinatal mental health, I believe it is important to identify what meaning our taken-for-granted practices may hold. It is also important to note that the “superiority of
breastfeeding is widely disseminated among the lay population” (Murphy, 1999, p. 187), confirming speculation that the effects of the dominant discourse are visible in the community as well as the hospital setting. The meaning of these influences is potentially intricate, and part of the wonder that underpins my inquiry. For example, I am uneasy about the possibility that for women with depression, it may not be easy to maintain self-authority over a decision to formula feed, when bombarded with so much information that negates its value. I was eager to explore what constituted ‘unease’ for me, hoping that my exploration would take me to a place of heightened understanding regarding the experience of women with mental health challenge.

Because the research aspires to explore the experience of these women using qualitative (hermeneutic) methodology, I attempted to locate my research question within the literature by deconstructing the various influences that comprise the issue, knowing that the context of inquiry would be among women with diagnosed mood disorders. The question I formulated was: “What is the experience of feeding infants with formula among women with mental health challenges, given the current culture of breastfeeding promotion?”

Hermeneutics

I proposed to engage qualitative hermeneutic inquiry by interviewing approximately six women who were registered with the Perinatal Mental Health Program at VIHA, and who had chosen to feed their infants with formula. Polit and Beck (2004) describe hermeneutics as using “lived experiences as a tool for better understanding the social, cultural, political, or historical context in which those
experiences occur. Hermeneutic inquiry almost always focuses on meaning and interpretation—how socially and historically conditioned individuals interpret their world within their given context” (p. 249).

Briefly stated, qualitative research is the “investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design” (Polit & Beck, 2004, p. 729). Hermeneutics, which is located in the qualitative tradition, takes its root in appreciation for understanding, which is expressed in the metaphor of the circle. “The notion of a circle here, is not a mathematical or geometric one, but one that describes the idea that every interpretation draws on an anticipation of understanding” (Phillips, 2007, p. 90).

Dialogue is crucial to the collection of data, as well as the ‘fusion of horizons’ between the researcher and the participant (Koch, 1995; Fleming, Gaidys, & Robb, 2002; Whitehead, 2004; Phillips, 2007). Phillips (2007) states: “Fusion occurs as a dialogical event in which one’s own horizon is expanded through the conscious assimilation of the horizon of another” (p. 91). Data are analyzed, using a hermeneutic approach, which involves the ongoing reflexivity in dialogue that occurs during the interview, repeated review of the interview text, recording of personal reflections, and ongoing review of literature (Koch, 1995). Whitehead (2004) identifies key principles for guiding analysis of data which include “entering the hermeneutic circle to engage in a process of moving from the part to the whole, allowing emerging data to remain open to divergent interpretations, and recognizing the temporality of truth and the horizons
of the interpreter and the text” (p. 515). I have aspired to incorporate those principles in the descriptions and interpretations that follow.

Phillips (2007) says: “The process of understanding is a dynamic hermeneutic project of anticipating, modifying or replacing already existing concepts” (p. 90). The intention of my research is to achieve greater understanding of the experience of formula feeding an infant among women who have mood disorders. As previously described, the analysis of the data in hermeneutics is a complex undertaking, resting when the investigator has ascertained that meaning and further understanding has been established as a result of the research.

Hermeneutic inquiry relies on understanding that the chief research ‘instrument’ is the researcher (Koch, 1995). Interviews with women were conducted using my research question, and a design that featured a spontaneous and flexible dialogue that was aimed at uncovering meaning between the investigator and the participant. A question is asked at the outset, and serves as the underpinning for the interchange that occurs.

Other questions arise during the interview, based on the nature of the dialogue that ensues. As is consistent with the hermeneutic research tradition, the interview process has the potential to be unstructured, and lead in unexpected directions, while maintaining the underpinning of the research question throughout. Indeed, my experience as a researcher offered a panacea of creativity and challenge throughout the interview process, and throughout the interpretation of data.
A brief history of hermeneutics. Heidegger, a student of Husserl, moved away from “descriptive phenomenology” into the realm of interpretive or hermeneutic inquiry of human experience. Heidegger’s understandings stretched beyond concepts of “psychologism” and “historicality” that had been characteristic approaches of both Dilthey and Schleiermacher before him, and to which were attributed the limitations of a human science approach (Johnson, 2000). Instead, Heidegger moved towards conceptualizing ‘understanding’ as being the way that humans “exist in the world” (Johnson, 2000, p. 13). Gadamer was a student of Heidegger, who in turn interpreted Heidegger’s main achievement “to be recognizing that understanding is the original character of human life” (p. 14). Gadamer proposed the importance of conceptualizing theory and practice as inseparable, and thus moved philosophy in the twentieth century “away from the Cartesian emphasis on self-consciousness” (p. 1). He also introduced the notion of a “dialogical nature of philosophy and of human existence” (p.1). According to Koch (1996) Gadamer’s philosophy extends Heidegger’s exploration of understanding by providing an emphasis on language. Gadamerian hermeneutics has shaped my interpretation by drawing me into the experience of another. When referring to ‘hermeneutics’, I refer to conceptual frameworks developed by Gadamer, and how the tenets of hermeneutic inquiry are described by him and interpreted by others. Fleming, Gaidys, and Robb (2002) illustrate important aspects of Gadamerian hermeneutics. They explain that Gadamer “emphasized the notion of historical awareness and valued it as a positive condition for knowledge and understanding” (p. 115). Applying that notion to my own research, the historical situatedness of women in
the midst of breastfeeding fervor has served as an important appreciation before, during and after the research process. The authors also state: “Because Gadamer believed that understanding could only be possible with historical awareness, it therefore carried certain prejudices.” (p. 115). They go on to describe Gadamer’s consideration around the importance of ‘preunderstanding’ (or prejudices) as it leads to ‘understanding’, thus connecting the notion of prejudice with enlightenment. In my own research process, I have proceeded at every turn by embracing my own prejudices (which have been previously described and explored) surrounding the current culture of breastfeeding promotion, wherein I identify potential for marginalization. My prejudices and preunderstandings have been challenged and replaced with newer and deeper levels of understanding along the way that have transformed my thinking by allowing hopefulness. In my writing, I have embedded the evolution of thought that evolved for me in the process of relating the encounters with participants. The circuitous nature of uncovering meaning is assumed in the interpretation that I present.

My research. In hermeneutics, there is a sense of “emergent” design that is reflective of the discourse that occurs during research, and an opportunity for interpretation of the discourse. Kvale (1996) states: “The research interview is a conversation about the human life world, with the oral discourse transformed into texts to be interpreted” (p. 46). Prior to the onset of the research process, the potential for unpredictability in the data struck me as a challenging, yet authentic way of conducting research, given the potential for meaningful and spontaneous
interpretations gleaned from data collection. Kvale’s description of the ‘hermeneutic circle’ is a process whereby “explication of the text is an infinite process, while it ends in practice when one has reached a sensible meaning, a valid unitary meaning free of inner contradictions” (p. 47). Even now that my research is complete, I anticipate that the richness of this method will provide me with fodder for future “hermeneutic spiralling”; the process wherein the interpreter reflects on prejudices that are present at the outset, and which become replaced with new understandings and interpretations (McDonald, 2005). The possibilities for considering new understandings, and further questions incite a sense of anticipation as I embarked on the academic journey of discovery.

One of the aspects of hermeneutic inquiry that has been fascinating to me is at the heart of hermeneutic pedagogy; the ‘permission’ to interpret situations which embody the texts of human experience. Jardine (1998) states: “Bringing out these living interweavings in their full, ambiguous, multivocal character is the task of interpretation” (p. 34). Another personal resonance involves what Jardine refers to as ‘severances’, referring to the objectification of inquiry, finding roots in the works of Descartes, Thomas Aquinas, and others. With hermeneutics, the importance of embracing the “ambiguous allure” of the instance is celebrated as integral to the state of being fully present. Polit (2004) discusses the concept of “bracketing” in research. She explains: “Bracketing refers to the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study” (p. 253).

Hence, in my hermeneutic research, I entered the project without “bracketing” my pre-
conceived notions of dysfunction in breastfeeding promotional practice, knowing that I was placing myself in the position of discovering the unexpected, while exhibiting transparency about my position at the outset. Kvale (1996) states: “Attention will also be paid to the influence of the presuppositions of the subjects’ answers as well as the presuppositions of the interviewer’s questions” (p. 135). The challenge of interpreting and making meaning of the data was one that I approached eagerly.

**General Description of Methods**

*The hermeneutic interview.* It was my hope that the interview process would serve the women who participated by giving them an opportunity to voice their experiences, and engage in meaningful dialogue. I found fulfillment of that hope abundantly as a result of the research process, for each participant was eager to share her experience in the hope that others would benefit.

Because of its complexity, the complete description of the hermeneutic interview, as a method, is beyond the scope of this work. However, to summarize, the nature of the hermeneutic interview is unstructured, possibly employing a set of leading questions that will help guide the process of uncovering and revealing (McDonald, 2005). Van Manen (2002) introduces the concept of ‘reflective experiences’ where one can be transported to a new and original way of thinking, while simultaneously reflecting on something familiar. The challenge of the interview process throughout the research lay in the skill required to keep the ‘hermeneutic circle’ flowing, and the ability to take advantage of new and unexpected directions for understanding. Creativity in interpretation, language, and interplay between ‘part’ and
‘whole’ also have the potential to comprise meaning in the context of the hermeneutic circle (Smith, 1994). Phillips (2007) draws on the metaphor of the sentence to illustrate meaning around the ‘anticipation of understanding’. He says: “For instance, a sentence is not calculated mathematically from all the parts, but is understood in its wholeness as a sentence” (p. 90). The promise for participants to lead the conversation in ways that was transformational for them and for me was revealed in many instances. Jardine (1998) values the opportunity for transformation during the hermeneutic interview, and embraces the inclination to change and accommodate as a result of exposure to the “instance” of the moment. McDonald (2005) describes the paradoxes of the interpretive, and the need to invoke “interpretations that will invite you through a door while providing you with only a glimpse of the place to which you might proceed” (p. 39).

**Description of Recruitment**

After receiving approval from the ethics committee, I embarked upon my intention to interview six women, for approximately one hour each. Consideration around my inexperience as a researcher, combined with the process of reading other hermeneutic works, created awareness around what might be an appropriate sample for my initial experience. In consultation with my research supervisor, I concluded that six participants was a number large enough to provide a rich database, but at the same time, maintain manageability. The strategy for recruitment necessitated women contacting me following the dissemination of an information sheet by colleagues in the Perinatal Mental Health Program at VIHA. The information was given out to women
who were eligible for my study; those who were registered in the Perinatal Mental Health Program, were at least three months post partum, and who were feeding their babies with formula. The process of acquiring participants for my study took several months, and it proved to be challenging to attract participants. According to my colleagues in the Perinatal Mental Health Program, who were assisting me with my recruitment, many women apparently expressed interest in participation at the time that the information was given to them. However, I had interviewed only three women after several months. I reflected on why this difficulty may be occurring, and I suspected the implications of infant care, combined with context of the mental health challenge was perhaps a factor in why women had not initiated contact with me. I wrote to, and received approval from the Joint UVic/VIHA Ethics Committee (Ethics Committee) to amend my recruitment strategy to include their permission for me to contact them. This amendment proved to be a very successful, and my six interviews were completed shortly afterward.

One of the six participants was still pregnant at the time she was recommended for my study (therefore not fulfilling the requirement to be at least three months post-partum). By this point in my interviews, I was becoming immersed in many aspects of the experience, and valued the opportunity to approach inquiry from the perspective of a pre-natal decision to formula feed. The woman suffered from bi-polar disorder, and had made her decision during pregnancy as a result of exposure to information about risks because of medications and sleep hygiene. Again, I contacted the Ethics Committee, and was given permission to include data from that interview.
Following our initial contact by telephone, I met with participants at a mutually convenient place and time. Consent was signed at the time of the interview. An understanding was reached with each participant that she had the option to withdraw at any point during the interview without explanation, or without using any data that may have been collected up to the time of withdrawal. Following the interviews, I followed up with a phone call approximately one week later to ensure that the interviews had not created any undue angst.

**Implications for health care and nursing; the anticipation.** Even before the research began, I had embraced the notion that women’s experiences would be valuable to me as a practitioner, no matter what interpretations I would make, and how those interpretations might change over time. Phillips (2005) offers insight about the experience of understanding from a hermeneutic perspective. He says: “We are simply thrown into a process of understanding the world that is already there. We grasp at understanding the experience of others drawing on what we already have” (p. 93). With the importance and quality of the perinatal period for mothers and babies at the forefront of my consciousness, I proceeded; knowing that what I initially anticipated as problematic for women may or may not be described as such. But the passage down the hermeneutic path promised fascinating bends and twists that were as yet unknown to me, and I ventured forth.

I reasoned that the implication of increased understanding has the possibility to influence care at a number of levels. Theoretically speaking, the consequence of my research includes the potential to promote a higher profile around the concerns of
women with mental health challenge in the perinatal setting in ways that are far reaching. Most importantly, increased or new understandings could influence or inform practice or the way in which we engage in practice. The possibilities for a broader impact also exist, given the context of the BFHI, and its national stature among Canadian health care policy makers and providers. Extending meaning yet another level, there is potential for the WHO and UNICEF to benefit from heightened understanding around the needs of a population of women who share challenges globally.

**Challenges Articulated**

A desire to further understand the experience of women with mental health challenge was at the forefront of the research I proposed. However, I considered a number of issues about the experience of researching vulnerable groups.

*Risk of stress among participants.* James and Platzer (1999) outline the need for protecting vulnerable groups when engaging in qualitative research such as interviews. Among other concerns, the authors warn against ‘doing harm’ in the process of the research. They list risks of further pathologizing, deepening the stigma attached to their culture, and misrepresentation, among others. The authors also caution about jeopardizing emotional status, if the interview becomes emotionally charged, as it had the potential to do in my case. If an interview resulted in expressions of needs, and expectations for support that I was unable to meet, there could be potential for distress. James and Platzer warn: “This can have the effect of leaving researchers feeling helpless and hopeless and the participants distressed” (p. 76). I knew it would
be important for me to be mindful about these potentials throughout the research process with each and every participant. This understanding was underscored by the meticulous analysis of my research proposal by the Ethics Committee, whose recommendations reflected a keen sense of the need to protect the vulnerable population of women with mood disorders.

I was fortunate to have the support of the Perinatal Mental Health Program at VIHA as I undertook my research, as well as the support of my thesis supervisor. Kvale (1996) cautions: “A research interview can come to approximate a therapeutic interview, depending on the extent, the topic and subjects of an interview” (p. 155). In conjunction with the requirements of the Ethics Committee, I was prepared to enlist emergency health care assistance in the event of being sufficiently concerned about a participant’s well being during the time of the interview, or at the time of my follow up phone call. Whitehead (2004) underscores the practical and ethical potentials for conducting research on a vulnerable population. She says: “I was aware that I should not be involved in a therapeutic relationship with participants and always ensured that boundaries were respected, reminding participants, when necessary, that I could not offer advice on symptom management or provide emotional support” (p. 516). Her words resonate with me as I recall the challenge of integrating my historic nursing presence with my newfound role of ‘research instrument’.

The Plan

The clinical nurse specialist (CNS), in collaboration with the psychiatrist (Program Director; Perinatal Mental Health program) agreed to assist me with my
research by doing preliminary identification of possible participants for my study. All participants were assured that confidentiality and anonymity would be preserved according to professional ethical standards, and that their decision around participation in my study would not affect the care they received with the Perinatal Mental Health Program.

*The process of data analysis.* Following collection of data from taped interviews with the women, it was my interpretive task to make meaning of the data, while contemplating the ‘intimacy’ of language, and the power of poetic language that is intrinsic to the hermeneutic process. I engaged in this process by actively listening to dialogue during the course of the interviews, reflecting in a diary my impressions of the interview, and returning to those reflections repeatedly over the course of the research process. Taping the interviews, and transcribing them later provided the text. The transcriptions were revisited in written form on a repeated basis, and personal responses to the text were introduced to the text. In addition, non-verbal signals were included as part of the text where significant. The taped versions of the interviews were reviewed in isolation, and with the written text accompanying. Fleming, Gaidys, and Robb (2002) caution: “In analyzing these, however, the researcher must take care not to be totally reliant on the written transcript, but to read these while listening to the words on tape where the two partners are working together to create a common understanding” (p. 118). Those authors go on to outline important components of data analysis that include finding expression that begins with the ‘whole’ interpretation and include the need to challenge preunderstanding, and the need to intricately examine
each sentence. Finally, passages are identified that represent the fusion of horizons between participants and the researcher. This process of data interpretation proved to be complex. The challenge around ‘making meaning’ of approximately six hours of interview data seemed a daunting endeavor. However, as time went on, the process of hermeneutic understanding began to unfold, and it was through the process described above that I was able to recognize the significance of the experiences that were shared with me.

Throughout the research process, the notes that I took and the ongoing reflections that I recorded served as a way of grounding me in my interpretation. They also served as way of reflecting trustworthiness in a qualitative process. Fleming, Gaidys and Robb (2002) recount that “steps of the research process must be clearly identifiable by interested parties; that is auditability is a criterion of truth in qualitative research” (p. 119).

Koch (1995) compares traditional expectations around research such as the concept of rigor, wherein the trustworthiness of a study is at question. Her words offer insight into the foundational understandings that shape qualitative and hermeneutic methodology. She states:

In the last two decades the issue of rigor (initially referred to as reliability and validity) in qualitative research has persisted as an hegemonic legacy of empirical-analytical research, and continues to challenge new researchers as they shift from a conventional empirical-analytical paradigm to alternative paradigms. (p. 178)

According to Phillips (Wood & Gidding, 2005), the topic of rigor in the context of interpretive research bears explanation. Phillips explains that it is how the
interpretation occurs that creates rigor in hermeneutic research. “It was about being able to show how history influenced interpretation, and there was a fusion of horizons, and what you held open and put at risk in a dialogue with a participant” (p.9). In my research analysis, it is through the ongoing expression of interpretive possibilities that rigor is revealed.

In hermeneutics, there is always the possibility for interpretation that goes beyond what is directly articulated by a participant, and found in the text. Instead, it is possible for the interpreter to recontextualize what has been said using “a certain distance” (Kvale, 1996, p. 201) and a theoretical stance, with consideration for the specific conceptual perspective that may be present. For example, in my research personal understandings concerning the post partum environment shaped interpretation of comments that were made. Analyzing the data from hermeneutic inquiry proved to be particularly salient to my process. The potential to disrupt the taken for granted meaning of words, in our world of steeped ideologies (McDonald, 2005) surfaced where terms such as ‘bonding’, ‘evidence’ and ‘good mother’ were concerned. Therefore, I believe there are possibilities for creating ongoing meaning as a result of exploring the experience of women amidst the taken-for-granted, and ideologically driven practice in maternity care that was explored during my research. McDonald (2005) states: “Hermeneutic inquiry invites us through an opening to a beyond, a place other than the ordinary, the taken for granted of our lives” (p. 54).

Confidentiality and anonymity. All participants were assured that confidentiality and anonymity would be preserved according to professional ethical standards. Storage
of information such as the interview tapes, consents, and contact information occurred in a locked and secure location in my home. Participants were informed that the information would be destroyed at the completion of my thesis requirements. Participants were also informed that pseudonyms would be used in the text of the thesis, in order to protect identity, and that any details that could connect them to identification would be altered or omitted.
Chapter Four

Presentation of Findings

The responsibility lies with the writer to show the way in which a study attempts to address the issue of rigor. It is for the reader to decide if the study is believable. (Koch, 1996, p.178)

The Encounter of Participants; the Nucleus of Understanding

In an attempt to honor the individual experiences of my participants, I now describe the six women that shared their thoughts with me during the inquiry process. Throughout the text, I comment and interpret, sharing my personal evolution of understanding that unfolded throughout the process of conducting research.

Alicia; Suffering and Empiricism

My research began with the encounter of Alicia. Alicia proved to be an exceptional start to my research process for many reasons. Her bright and forthcoming manner eased my way into hermeneutic inquiry, and in fact, put me at ease more than I had hoped was possible. During our initial telephone exchange, for example, she alluded to the fact that she wanted to participate in this research because ‘someone had to get the word out there’ that something was amiss around the approach towards infant feeding. These words gave me the confidence and impetus to plunge into the unknown experience of research with a sense of validation that I had identified something important for women even before our interview had begun.

As we settled into our conversations, and she spoke, I was struck with how many of her observations and impressions were reflected in my research proposal. Indeed, her perceptions reflected much of the thinking and wondering that had shaped
my inquiry. She gave the initial impression of being an extremely thoughtful and intelligent women; a very high achiever with highly organized environment. In fact, the more I ‘took in’ her environment, the more I questions I had about the reality that pervaded Alicia’s experience of the post-partum. The meticulous surroundings, fashionable and minimalist in nature, stood in sharp contrast with the complexity and mental anguish that was subsequently revealed. It also became clear during the interview that Alicia still required significant support from her husband, her parents, and extended family. During the interview, her brother-in-law was there the entire time caring for the infant, and at mid-point through our conversation, her husband dropped in briefly from his workplace to check-in with her. Alicia’s parting comments to me suggested that she had been someone who had done well at everything all her life, and yet the infant feeding issue was something that had made her feel like ‘a failure’. My concern as I recall the interview is that Alicia was consumed with guilt over her inability to persevere with breastfeeding. At one point in the interview she shared:

And I can imagine that, you know, twenty years from now, if the baby gets whatever, stomach cancer, I’ll relate it back to breastfeeding, I’m sure. I’m sure that, you know, I would blame myself for this for the rest of his life. Whatever consequence, you know, whatever physical consequence he has in the future, I will, in the back of my mind say is that because of something I did? And my friends say well, that’s all part of motherhood you know you’ll always feel guilty about something but that’s a pretty big one, you know, that’s not accidentally bumping his head or something else.

Alicia, at the time of our interview, described activities that made it clear she continued to spend inordinate amounts of time researching the topic online and through other resources; looking in desperation for some confirmation that her decision to formula feed was a legitimate choice. She described her perceptions of the
challenge, and offered an insight into the culture of breastfeeding among working mothers.

And so there’s this underground thing happening and -- um -- I think a lot of women do not consciously choose to bottle feed their child. It’s not like they formula feed their child out of any kind of selfish desire, you know. Even my friends that are working, they would pump like mad, -- you know, for the entire night before they’d have to get up and go to work the next day. And you know I -- I haven’t heard of anyone who said well, it’s just inconvenient for me and so I’m going to stop breastfeeding. Formula feeding is expensive. You know if I could breastfeed, I would by far choose that.

Her comments conveyed the ambivalence that pervaded her reality around infant feeding. On the one hand, she describes the challenges of breastfeeding and pumping, and the demands that could be involved under even the best of circumstances, such as the ones her friends describe. On the other, her grief over her inability to breastfeed was evident. Her comments offered a window of understanding that reveals the commitment that many women demonstrate in order to do what is ‘best’ for their infant.

Alicia stated she was able to find only minimal references to the safety of formula; at one point stating that the references to formula seemed tantamount to feeding the child poison.

Because a book that they give you -- um --, *Baby’s Best Chance*; if you read under formula feeding, it says for a very few reasons that a mother should formula feed and if you’re thinking of formula feeding, contact your doctor. That’s it, period. It’s about six sentences long. And I’m wondering, well what kind of formula should I be using? What’s the difference between already made formula or powdered formula --You know, and what’s the future about the fatty acids and......
She went on to describe an in-depth understanding of nutritional components of ideal infant food. Alicia further outlined the effect that her own research had on her understanding:

And so, you know, it’s these vague kind of illusions to the, you know, the kids that are breastfed for at least a year, have, you know, the benefit of less cancer, -- um -- less -- ah -- chances for -- um -- SIDS, you know, stomach problems, and eye sight, brain activity, intelligence is related to breastfeeding. And I mean for someone like me who approaches things in a fairly academic sort of way, I look at these sorts of things and I think what -- what are we giving our kids?

Later in the interview she elaborated:

And you don’t know what sources to trust, you don’t know, you know, because most of the time you look up formula feeding, and find it’s just a whole bunch of garbage about how awful it is, you know?

I wondered if it may be important to equate the sacred nature of the maternity experience, and how breastfeeding practice garners reverence and societal approval based on primal kinds of valuing of motherhood. Alicia reflected on those words with references to the primal act of feeding for which breastfeeding is equated.

I am grateful to Alicia for sharing her experience around the nightmare of her illness, and how it unfolded. Her description gave me a deeper context against which to understand the infant feeding challenges that she experienced.

And then for the week that I was in the hospital, I was having really bad baby blues where I would just think about things. Then I felt ‘manic depressive’ and it gave me an idea of what it would be like as a manic depressive and why some people maybe chose maybe not to take their meds. Because I looked at my baby and my husband and I was just on the top of the world, like fantastic, I couldn’t be happier. But then the lows were really low and you know I would imagine my husband not lying next to me at night and him dying and what would I do and oh my god, you know, and my baby, something happening to my son.
Yet, as the interview progressed, I was aware of the increased social isolation that she faced in those early weeks, as a result of her fatigue, and her continued attempts to breastfeed.

The public health nurse came over to see if everything was working properly and -- um -- my husband and I, at this point, had been home for about a week and a half and every three hours with the syringe and tubes and everything like this and it still really wasn’t working. And this nurse said, ‘If he’s latching properly, there shouldn’t really be a problem’ but he was screaming and he -- he wouldn’t take it. So he would maybe latch for a minute, two minutes, and then he would pull away and just be hysterical, hysterical. And so it was starting to get upsetting for me –

The image of Alicia and her husband facing all these challenges in the middle of the night, and in the context of a worsening depression is a haunting image indeed.

As I reflect on my interview with Alicia, many months later, I am aware of how my interactions with the participants evolved over the course of the interviews. For example, I discovered that my ability to share my ‘authentic self’ with participants opened us both to the potential for a deeper level of discourse than was possible with the more ‘detached’ stance that I recognize as surfacing during this first interview. In other words, as the interviews progressed, my own comfort level increased around my role as a researcher attempting to uncover meaning. Phillips (2005) explores the hallmark of dialogical process that is a priority in hermeneutic interaction. “The intention of the interviewer is not to discover the understanding of the other person (in which the interviewer’s understandings are therefore made inaccessible) but to truly understand by putting one’s own ideas at risk” (p. 92).
From my own perspective, I was aware that I had to consciously avoid slipping into the familiar nursing role of reassurance and information sharing. It was important for Alicia to lead the conversation, but her words were difficult to hear.

Alicia: But I just I think oh god, is there going to be a consequence later on for this formula, you know? It may not happen immediately but --
Me: Do you think that occupies a certain amount of your consciousness?
Alicia: I think so. Of course because that’s your baby, and you think about it all the time, right?

Alicia’s comments were cerebral, and did not directly expose any feelings that may have accompanied her current reality. I am also cognizant of the fact that I was conversing with someone who was recovering from depression, and it was important for me to exercise caution around the depth to which I should probe. It was at this point that I experienced a deeper understanding of the recommendations of the Ethics Committee around having a strategy to deal with unexpected distress from a participant. By the time the interview had concluded I had moved to new understanding surrounding the experience of sinking into the certainty of post-partum depression. I was also overcome with appreciation that Alicia would include me in her journey to recovery, and that she had done so with such trust.

I wanted to ask her how ‘it felt’ to feed the baby with formula, but something held me back because the question felt ‘too invasive’ at the time. I was reluctant to augment her pain. I determined to ask another participant more about the visceral experience of feeding an infant with formula.

Alicia seemed very open about her fascination with reading and researching in the hope of discovering something positive about formula. Later, I found myself
speculating about the realization that she was consumed by the empiric science reflected in the breastfeeding promotional information. She was trying to find comfort by accessing literature that might reassure her about the safety of formula. Another pivotal insight involved what I had identified as an issue regarding ‘evidence’ in my initial musings regarding evidence-based-practice and the devotion of health practitioners with empiricism. I am reminded about earlier concerns about the ethics of disseminating ‘evidence’ about the benefits of breast milk to a lay audience. As Alicia pointed out, it seems impossible to find comments in the literature about formula without the caveat that suggests that it is to be considered a second best choice; wording that appeared to create considerable angst for her.

Brenda; Suffering, Anger and Guilt

I was only partially prepared about what my conversation with Brenda might hold when she emailed me about her desire to participate in my study. She wrote:

When the psychiatrist told me you were doing this research it made be extremely happy as I experienced such guilt for switching from breast feeding (well, pumping every 3 hours and giving it in a bottle) to formula. Also, some people, of course, were "you should do it for as long as you can because it's the best." Even the in the books put out by the government (Baby's Best Chance and then the toddler one) they totally refer to breast-feeding more than formula feeding. Anyway, I've babbled enough; looking forward to our meeting.

However, in spite of Brenda’s friendly introduction, my meeting with her uncovered a decidedly darker and more intense glimpse into the reality of her experience. We met in a meeting room at the hospital cafeteria. The curtains were closed to ensure privacy. Brenda arrived on time with her baby girl in tow. During the interview Brenda was attentive and loving towards her infant, but our discourse
revealed a steely resolve that injustice had been done. Brenda’s revelations could not
disguise the anger that she felt towards ‘the system’ that had failed her. She began:

Well, right from the start, she wasn’t latching on. Um -- I worked with her for
about six or seven days -- and it came to sort of -- you know so many nurses
were pawing at me saying” It’s okay, she can do it, she can do it”, and then she
never really could do it and so we were supplementing, which is fine. And then
because she was a couple of weeks early, everybody kept saying, ‘Oh, wait until
she reaches her due date and she’ll just do it.’ Well that came and nothing was
different. And the Public Health Nurse kept pushing and pushing it and pushing
it; nurse again! I was pumping every three hours for two months just because
there was such a big push to breastfeeding. And -- um -- I finally had it. My
husband was home for five weeks with me this seems like an incredible
expectation and went back -- went back to his job -- and when he went back to
work I broke down, I cried for two days straight. I just wanted to stop pumping
so badly and I just felt –such- guilt. Just pure guilt because you know all the
books say you should breastfeed your baby, breastfeed your baby. So I went to
my doctor then and that’s when she said, ‘Okay, we need to get you in for help
for postpartum depression, because she’d been watching me.’

As I listened to Brenda’s conversation, I was overwhelmed with the intensity of
her disappointment with the nursing care she had been exposed to, and by the pain of
the experience that she demonstrated with the intensity of her speech. She continued:

Everywhere you look, like in the literature, even that the government puts out,
you know those books ---- Baby’s Best Chance and then there’s the toddlers
one. Well I was reading through the toddlers one about feeding and it says
continue to breastfeed your baby all the way through. It doesn’t say or formula
feed. And I find that very frustrating ---- because it was the hardest decision I’ve
ever had to make. Like I thought I was taking away the best gift ever that I
could give to her. And I knew that once I stopped, that was it. So there was
extreme guilt and I struggled whole heartedly with it. But when they put me on
the drug, I said okay no, I’m definitely not pumping anymore because I don’t
want that going into her.

I reflect on the guilt that she expressed, as well as the profound sadness and
disappointment that she is experienced because of her decision. She talked about her
perception around judgment from the Public Health Nurse:
So yeah, that’s been my experience. And when I told the Public Health Nurse that I really wanted to stop pumping because I couldn’t have a life, right; I was tied to that pump, she kind of went sideways and you could tell that she was not impressed and so that just cut me right off from her, because it felt like that was obviously not a good enough reason for her. I don’t care for that kind of ‘support’. And I got tired of people pawing at my boobs.

We talked a bit more about the experience of pumping.

Me: Can you tell me a bit about what it feels like, and what your experience was around pumping?
Brenda: You feel like a cow. Like you feel like you’re a cow producing milk -- and you’re hooked up to this machine and I mean I don’t regret -- like I wanted to do it for her.
Me: Of course.
Brenda: And my doctor said try and make it the two months, which I did. Um -- but obviously, I'd be up pumping at three in the morning. And there’s some shows I can’t even watch anymore because they remind me how I was so alone. I was sitting there pumping.

I speculate about how often women discount their feelings of shame (such as feeling like a cow) and consider them unimportant in the grander scheme of breastfeeding promotion. I suspect there could be a tendency to intellectualize the experience and bury such visceral reactions to a dark and private emotional place. I wonder about the implications of that possibility, and whether those kinds of metaphors hold a deeper and more painful meaning for women. I also ponder the wisdom of the advice to breastfeed for two months. The two month mark is based on empiric understanding of the quality of breast milk, but I question if that aspiration discounts the many other issues that may be surfacing for women. Listening to Brenda’s account of frequent pumping around the clock, I contemplate the effects of sleep deprivation without the rewards of knowing you have breastfed your baby. I interpret the emptiness that surrounds Brenda’s experience of pumping and then
feeding the baby with a bottle. We talked about the concept of ‘support’ for formula feeding:

Well even when I was in the hospital. Like I know, I guess, they’re supposed to help you-- but there are tons of posters around saying breastfeeding is that, breastfeeding is this. But nowhere does it say anything about formula if you can’t do it. So it’s all around you. And they talk about Breast is Best-- yeah, it’s -- it’s hard to hear that. And I don’t know when the next one comes; I don’t know that I’ll even try. I mean I’d like for the next baby to get my own milk when it comes in but it just really brings back horrible memories of her trying, me trying, just extreme frustration. Cause it hurt.

We continued:

Me: Can you envision what could have been more supportive, you know, what would have helped?
Brenda: Um -- I don’t know, it’s hard to say because with the postpartum depression which I didn’t know I had. I mean I don’t know! Even if someone had said to me when she was three or four weeks okay, just switch to formula because we were supplementing anyway, I don’t know if I would have had the mental ability to do it. I think the guilt still would have kicked in, so I would definitely need support earlier on. And say that it is okay for you to formula feed. And get healthy out of that.

We talked about the experience of formula:

Brenda: Yeah, and so it’s sort of like when we did switch her to formula, ---- I was kind of embarrassed out in public to be whipping out her bottle and her formula and have people looking because she’s so young. That was hard.
Me: Can you tell me what it felt like when you kind of initially started feeding your baby with formula? Like the actual feeding part of it?
Brenda: We’d been doing that all along. I think she latched on one time for a half an hour ---- and that was it. And then I had to go pump the other side.
Yeah. So -- so once I was on the drugs, -- um --the counselor I was seeing said ‘You’re stopping pumping now because you don’t want these drugs in your baby’, and that was it --and I stopped cold turkey -- well not cold turkey-- but I stopped giving her my breast milk. And then after that it was just, ah, I have a life, I can go out with her in public and feed her whenever. Yeah, it was a huge stress off me. And, I wasn’t allowed to do night feedings for probably about a month and a half. Because I was diagnosed with postpartum depression--and my mom and husband alternated nights and that kind of thing.

Brenda continued her reflections:
Brenda: I don’t know if I felt like a failure because it wasn’t happening but whenever we tried breastfeeding, it was not successful; she was frustrated, I was frustrated. And that was when I was trying to latch. But now she looks up at us ---- and she seems happy even though I felt like a horrible mother when I wasn’t breastfeeding her.

Me:  Did you?
Brenda: Yeah. Oh gosh, they were horrible feelings; I thought I was the worst mother.

Me: What was the biggest thing that helped you get through that?
Brenda: My counselor saying, “Now that you’re on the drugs, stop.”

Me: You’d been given permission for something.
Brenda: Yeah, I just needed to hear it.

After the interview was finished, I was aware of feeling somehow personally ‘altered’ and unsettled as a result of my meeting with Brenda. For one thing, the validation of my concerns felt blinding. The awareness that what I had thought was a ‘hidden’ kind of coercion that might need to be ‘teased’ out of women appeared anything but submerged. Brenda revealed a significant anger along with her guilt to an extent. Another impression was reinforced as a result of my interview with Brenda. It appears that the topic of infant feeding remains very raw for Brenda.

I was now entering an awareness that the two women with whom I had spoken indicated a more intense level of angst than I had anticipated around their experience with the infant feeding issue. Again, I was struck with the privileged position in which I had been entrusted; wherein women who are currently or recently ill share with me the depths of their experience. I mused about the rationale as to why women could be so profoundly affected by their experiences, and so decidedly angry. Certainly, the effects of the marginalization around infant feeding have the potential to be somewhat magnified in the context of mood disorders. But what I was seeing was taking the form
of a clear stance from the two women that I had met so far; a stance that uncovered a sense of being misunderstood. Both cited initial misgivings about the breastfeeding support they were receiving. And in both cases, they felt betrayed by the rhetoric that denoted judgment around their inability to succeed with breastfeeding. I continued to speculate about the meaning of my interactions. A picture was unfolding; of well informed women wanting to do the best for their babies and reaching desperation and remorse over their inability to enact breastfeeding in spite of heroic efforts. The hermeneutic process was beginning to reveal itself. In both cases, it was possible to identify sleep deprivation and tendencies to do their very best that perhaps made the process more difficult. In particular, the description of the two hourly pumping, and strategies to promote “latching” erupted in the telling. I began to wonder if it was possible to suggest that the ramifications of the attempts to breastfeed had not only contributed, but also caused depression in these women.

My instincts told me to exercise caution, and not to prod so deeply as to create a scenario where emotions escalated uncomfortably for Brenda. However, I was challenged to ‘get to the bone’ of inquiry, without becoming too invasive and perhaps too painful. The delicate balance that was required in my interviewing was palpable. It was important for me to acknowledge women’s situatedness along the road to recovery.

An emerging quandary was unveiling. Both my participants had detailed the experience of receiving nursing care aimed at supporting women to great extents. My understanding of that process had now expanded, as I contemplated the meaning of
receiving unconditional support for breastfeeding success; support that is unquestionably well-intentioned and coming from a place of evidence-based-practice. However in both cases, the optimism about the ability to succeed with breastfeeding had resulted in disappointment and anger directed at those who had misled them about their potential for success. What was unraveling about the dilemma?

I began to consider the possibility for employing “crystal ball” metaphor, wherein I acknowledge that no one can predict what the outcome will be for any woman in terms of her breastfeeding success. How might this understanding impact on breastfeeding support? In other words, a dilemma exists for both the mother and the health care provider when neither is able to predict the outcomes of breastfeeding support. A wave of new awareness swept over me, and I began to incorporate this uncertainty into further interviews; at first resting with this initial awareness, and then allowing for a deepening meaning to unfold with time and reflection.

The experience of bonding and the experience of suffering around the act of feeding was a query that evolved when listening to Brenda. I contemplated the possibility that the process of bonding is actually interrupted by the expectations to breastfeed successfully.

*Clarice: Challenging Preunderstanding*

As I approached the third interview, I mused:

Both women that I have interviewed so far have expressed indignation and hurt as a result of the perceived attitude of judgment from the public health nurse over their decision to stop breastfeeding. This leads me to question the understanding that nurses may have about the impact of their behaviors around stigmatization, prejudice and discrimination. Women obviously feel the sting of the rejection of nurses. This leads me to question and contemplate the
role that we play with this issue. The public trusts nurses and women seem to see nurses as a “lifeline” of sorts. I know this from my experience as a Labor Delivery nurse, and from my work in the Gestational Diabetic Clinic. How many times have women said to me: “I couldn’t have done it without you guys!” How, then, must it feel to be ‘let down’ by the lifeline, or have the perception that one is disappointing that group of trusted care givers?

Clarice and I had met in a coffee shop as per her request. She arrived with her baby daughter in a stroller, and immediately exhibited a demeanor of energy and confidence. As she settled in her seat, and after attending affectionately to her baby, she turned her attention to our interview. Within moments of commencing this interaction, however, I was blindsided by the unexpected response to my initial question, “What has your experience been with formula feeding?”

“I’ve found the experience pretty -- pretty good” she said.

My initial mental response included a momentary panic at what surely must represent the heart of hermeneutic inquiry; the ability to truly live ‘in the moment’ and respond dialectically and authentically. For I was not expecting to hear this positive perspective around formula feeding. Later, in my journal I wrote:

Well, the thing that my research supervisor suggested might happen just happened! My participant was glowing in her description of the formula feeding experience! I’m glad I had anticipated that someone might steer the conversation in that way. It was also helpful to review my journaling just before I left for the interview because some of the questions were close to my mind, and I was able to contour my questions from the perspective of a positive experience instead of a negative one.

Clarice went on to describe a process of decision making around the choice of formula that had begun in her pregnancy and had not wavered significantly.

My impression was of a very happy Mother-Baby dyad. This was interesting to note in the context of Clarice’s decision to formula feed which was, in part, based on her desire
to avoid the constraints of caring for an infant such as lack of freedom, uncertainty about how and/or whether bonding would occur, given her aversion to breastfeeding.

If I had had my conversation with Clarice without the baby being present, I might have wondered about the bonding aspect of the maternal child relationship. However, I was very reassured that all was well as I delighted in their contact. I wondered later about the concept of ‘expectation’, and its meaning around satisfaction with infant feeding.

It seems that Clarice had made her decision to formula feed before the birth for reasons that seemed ‘relaxed’. Clarice exuded a personality that belied any self-recrimination. She was very open about her lack of interest in breastfeeding for reasons that refuted any empiric evidence that she had read. In other words, Clarice seemed to have the desire to interpret for herself the meaning of the evidence around breastfeeding superiority; instead employing a set of rationalizations that defied research. For example, she expressed her understanding about the advantages of breastfeeding around immunities:

So when they said with breastfeeding the child gets some of your immunities I thought well, you know it’s not going to do him any good because I still get sick, right? It seems like I’m chronically sick. Like a cold or a cough or something. I always feel a little under the weather. Always. And -- um -- so I figured well that (the issue of immunity being passed to the infant) really wasn’t a concern to me because I thought, you know, her immunities need to kick in as well and I feel that her body needs to adjust to what’s going on in the world as well.

Clarice referred to the fact that she did not like her breasts fondled sexually, and did not see herself as being generally ‘healthy’ enough to provide optimum nutrition to her infant. She mentioned about a period of feeling guilty because of the opinions of others, but her words and her manner did not imply ambiguity around her
decision. In a straightforward manner, Clarice described the reason for her decision to formula feed in the following way:

The first hospital admission I had a bladder infection and I thought I was in labor. That’s when they asked me all the questions and at that point I already said -- um -- I’m going to formula feed. And then ever since that day, I never had that question asked again and they knew right away and they didn’t even pressure me to breastfeed afterwards. I had no pressure whatsoever to breastfeed or to even try. And I’ve heard horror stories about people actually being pressured by the nurses in the hospital to breastfeed or to at least try. And I thought I’ve never had that happen to me and I was really -- that was one of my concerns too, you know. After giving -- having given birth, being in a distraught state, having somebody pressure me on top of that to breastfeed, I don’t know how I would have felt about that. But I was lucky that nothing was said afterwards and so I think that was also a cause to be concerned about when you’re pregnant because you have all these emotions that are going through your head anyway about breastfeeding or not breastfeeding and then on top of that you have some nurse telling you that it’s best.

She mentioned that her spouse was supportive, and how helpful that was.

Clarice addressed my query around ‘bonding’ and how the visceral response to bottle feeding was experienced by her:

After she was born my husband just grabbed her. At the hospital he did everything. You know I didn’t have to worry about the whole boob thing while I -- you know I could just rest and relax. You know and it -- and it was good for him as well because he -- he was in the hospital helping me take care of her and stuff. Well, with a baby, the way you hold them in your arms the first couple of times when they’re born, you cradle them like you would if they were on your boob. And they still look up at you exactly the same. Actually you can see their faces better because it’s not being obstructed by the boob. Um -- and you can actually look into their eyes and they’ll look back at you. So actually I’ve got a lot closer to her cause I can lift her up closer to my face. I can snuggle her, I can rub my hand on her face, you know.

Clarice’s words spoke to me of the possibilities that unfold wherein insight around personal capacities have the potential to shape experience in a positive way. Clearly, Clarice appreciated and needed the support of her spouse, and was
prepared to entertain the advantages of bottle feeding where the issue of infant bonding is concerned. It seems that her expectations ahead of time had led her to anticipate a positive bonding experience, and judging by our dialogue, her anticipation had not ended in disappointment.

We did not delve too much into her mental health issue other than the fact that Clarice shared that she did suffer from anxiety in general, and that her psychiatrist suspected she may have had some degree of anxiety prior to getting pregnant. It was only when I specifically asked Clarice about her mental health issue in the context of infant feeding that she shared perceptions around it. We explored on a superficial level what effect the decision to formula feed might have made on her recovery. I wanted to follow up on some comments she had made about the advantage of being able to sleep at night and give the baby to the father so she could go out and visit friends. I wondered if her recovery had been *enabled* because of the infant feeding decision. She speculated about the same thing, saying:

> But if you hear people already say something about having a hard time weaning off their child, ---- I wonder how it would have felt for me ---- if I was breastfeeding and had to wean her off --and going through all these emotions already and I’m already in a fragile state. And it was good to be able to --step away from her. You know? And I think if you do have depression of some sort --- you do need your time ---- and just to step away. Like she was so easy; she doesn’t cry or anything. But it was just the -- it was just the way she looked at me that really affected the way I felt for her. And then it was nice to be able to step away or go out with the girls or just to go for an hour or two and know that my husband can feed her and take care of her and not having to worry about anything like that.

Clarice appeared to have achieved clarity around her comfort without self-recrimination. This was a different encounter than the one I had experienced with the
other two participants. I speculated about the meaning of this. Clarice was not swayed by the conventional wisdom of empiric science; she formed her own conclusions about the priorities and dismissed much of the rationale that underpins the Breast is Best rhetoric. I sensed a certain irony around Clarice; she exuded a kind of straightforwardness that precluded attempts on my part to delve deeper in order to achieve better understanding of why she experienced such confidence around her decision; confidence that did not match the conventional wisdom of current evidence. The irony of that observation emerges as I consider the many areas of nursing presence where support for ‘evidence-based’ empiricism guides the recommendations. In this situation, however, Clarice was able to distill all the information into a decision that offered her a basis for decision making that seemed logical to her. Her knowledge of ‘self’ going into the experience of motherhood was evident. Her apparent simplistic perspective of life contrasted with the other women who had reacted so strongly to the feelings of guilt and marginalization around formula feeding. Clarice also alluded to the importance of nurses not pressuring her once she had declared her feeding choice. The implications of that realization offered me reassurance that there are some women who do not experience the kinds of pressure to breastfeed that my preconceptions, and the experience of my first two participants had suggested.

How was I to interpret my encounter with Clarice? The unexpected comfort that she described around her infant feeding choice, while reassuring, did not fit with my bias of what her experience would be.
Phillips (2005) says: “It is the experience of the unexpected that evokes questions leading to the potential for new understandings.” (p. 91) Yet, after considering the significance of our encounter, over time, I came to an understanding that her experience was a satisfying one. Apparently, the importance of honoring client choice was demonstrated, and those efforts were appreciated by Clarice. The possibilities for considering implications for practice, based on the approach that offered Clarice peace of mind around her decision, extended my understandings from the inner circle of the specific preconception of possible angst around her decision to formula feed, to a broader sphere of understanding where the acceptance and support by health care providers is exposed. Clarice experienced support for a decision that bypassed the current culture of wisdom around breastfeeding practice, but which resulted in a positive experience.

For several months that have passed since my encounter with Clarice, I have speculated about what motivated her to participate in my study. Unlike the other participants, she did not appear to have had any kind of negative experience that she wanted to share. Phillips (2005) discusses the interpretation of interview records. He says: “(That is), the notes and transcripts afford a means to consider the original interaction through a different lens” (Author’s emphasis, p. 92). After much speculation and contemplation about Clarice, and after repeatedly revisiting the text of our interview, and listening to the tape of our encounter, I have considered the possibility that Clarice appreciated the opportunity to ‘explain herself’ regarding the decision she made. After glimpsing through a different lens of understanding that has emerged
since completing my research, and the ongoing reflections that I have written, new
conjecture unfolds for me around our encounter. As Phillips acknowledges: “The
understandings we derive from reflection upon clinical notes are not the same as those
developed within our earlier interactions that gave rise to the notes.” (p. 92).

The ruminations continue.

*Dana: Pain and a Depleted Capacity to Cope*

As I approached the fourth interview, I wrote:

Another thing that I need to remember going into this interview is that I am
looking to move beyond having women describe their experience to a place
where women are able to reflect on the *meaning of these experiences* in their
lives.

My cogitations around the ‘meaning’ that was emerging as a result of the
research were moving in directions in and out of the circle; from the specific to the
broad. While I yearned for more and different details around specific aspects of
women’s experiences, I was also aware of a more holistic understanding leading me
forward in ways that I was still unable to articulate. In other words, I found myself
immersed in the possibility that I was being led somewhere, or nowhere, but there was
momentum around a process that I had ‘relaxed into’. I was aware of a certain
tranquility that engulfed me as I approached the prospect of interviewing my last three
participants; and I knew that the intrigue surrounding the circuitous motion of knowing
and wonder would sustain me.

Because of Clarice’s comments around her insight into needing to create space
between herself and the babe, I was led into questioning the experience of how it
would feel to experience a focus that centered on the baby’s needs; perhaps to the exclusion of the mother’s needs. I wondered if women perceived the need for rest, peace of mind, and more balance in life than is possible when pumping every three hours for weeks at a time. I wondered if the natural transition that occurs when motherhood dawns could be interrupted by an imbalance wherein the woman feels that the emotional ‘well’ is dry and she does not have the wherewithal to establish a connection with her infant. This question related to my interest around what it is to feel successful about mothering, and I was intrigued about the impressions that Clarice had shared around expectations. Her expectations had been different from the other two women I had interviewed, who expected to breastfeed exclusively. I wondered about possibilities for self-loathing, and I wanted to further explore the whole issue of ‘bonding’. Is it possible that women’s expectations are fed by the breastfeeding movement, and that they equate the bonding experience in its entirety with breastfeeding? It seemed important to delve into the experience of bonding, and perhaps explore the possibility of suffering around the act of feeding.

My encounter with Dana occurred in the context of a stressful time; her husband was away on business and her baby was fussy throughout the interview. She began our conversation by describing the first few moments after the birth.

So during that time, they were trying to get him to -- to breastfeed immediately to help with the bleeding. And even though he was out, I was still trying to deliver the -- the placenta. And I had the nurse going through breastfeeding. And she’s talking to me about the latch. And I’m like okay, and right now I’m in a fog, and I didn’t even have a good moment to even really realize that I had a baby.

From there, Dana’s description flowed.
They kind of put him on my chest but it was so painful. It immediately hurt. I didn’t know it was going to feel like that and yeah, it is painful. I didn’t really know that there was going to be in so much pain associated with breastfeeding. And -- um -- so then, when I was in the hospital, I only had like six different nurses tell me six different ways. I wanted to breastfeed -- of course I just wanted to breastfeed and do the best job I can and all that kind of thing. So I was very overwhelmed and very frustrated that they didn’t know which way was the right way to be doing it - all that kind of stuff.

Dana’s comments hearkened to former comments that outlined my interest in acknowledging a call for better assessment around the wants and needs of women. The expectations for women loom large; Dana described a traumatic birth with complications and hemorrhage, and still there was an expectation that she participate in breastfeeding immediately after the birth. She also explored the feeling of being ‘pawed’ by strangers with no regard to personal privacy; particularly as she recalled her initial experience in the labour delivery suite.

During our encounter I had the feeling that I had entered into a recollection that a voice that had been silenced, and perhaps a voice that had been misunderstood right from the beginning of her mothering experience. It seems that in her immediate post partum period, no one heard, or asked Dana about how this trauma was being experienced by her. Certainly, it sounds as though there were no clear choices presented; for example, was it acceptable to be ‘thrown into’ the breastfeeding experience in the context of the emergency? Empiric science tells us that breastfeeding releases oxytocin, a hormone capable of contracting the uterus; and minimizing a hemorrhagic event. And yet, in the context of new motherhood, and the hemorrhage, Dana’s introduction to breastfeeding emerges as an unfortunate and unwanted
attempt, with benefits that did not prove successful as far as the hemorrhage was concerned. The trauma of the initiation into the breastfeeding experience remains with her months following the birth. I wonder how that experience shaped her journey towards depression and the eventual decision to feed with formula. Knowing what it is to care for a woman in the midst of a post-partum hemorrhage, and how urgent the need for interventions of many descriptions, I reflect upon how it could feel to be a woman experiencing such a health crisis. Phillips (2005) offers a perspective that resonates. He says: “The experience of the differentness of the other person happens through consciously standing within one’s own horizon rather than attempting to stand outside it, or attempting to adopt the horizon of the other person, or to somehow bracket off our preconceptions” (p. 91). I muse about the context of emergency care from the perspective of a health provider, where ‘success’ can be measured in immediate biophysical outcomes. It has been revealed in this situation, however, that the ramifications of the experience have haunted Dana for weeks and months following the event. What meaning underlies this understanding; an understanding that has been repeated in the telling among my participants? Hearing women describe their experiences months after the event grounds me with the possibility that feelings of isolation and misunderstanding accompany the memories of these first attempts to feed; unhappy feelings that are barely beneath the surface even with the passage of time.

The text of the interview also includes the description of difficulties around the act of feeding, pumping, and in Dana’s case, painful breastfeeding. I think about the
culture of maternity care where women are told that breastfeeding ‘shouldn’t be’ painful. How might it feel to experience the pain that Dana describes, only to be told by health care professionals to persevere, or to assume responsibility that there must be something wrong with her latching technique? Dana’s narrative exuded a sense of indignation regarding the frustration she experienced around these impressions. We touched on the possibility that women’s need for nurturing becomes overcome by the demands of the baby and the pressure to do what’s best for the baby. Dana described her early post-partum experience:

But I was so engorged and I was in so much pain that I just sat there and cried. And you know my mom was there and my husband, he didn’t know what to do, right? And then I was breastfeeding pretty much every hour. Um -- I just -- I -- I started to feel – desperate feeding him. I was like -- just start praying that he’d feed longer. Like just ‘stay latched’ so I don’t have to go through that pain. And -- um -- and I tried, because of the pain, there was some guideline where you know the fifteen breaths, okay, make sure my shoulders are down, and the feeling that I’m making it worse because I’m not relaxing and I felt like it really -- it’s very -- like it kind of cycles, right? And so it was stressful was when my mom wasn’t there to be my support system. My husband works out of town it was like how am I going to be able to do this?

Later in the interview she stated:

And -- um -- and then I was trying so hard; like I did everything in the book. And so I went to the breastfeeding clinic to see if they could help with the engorgement. So then my son started to teethe and so I was just pumping. And I was pumping and it was excruciating for me to pump and then I -- I couldn’t keep up.

Dana’s words revealed an image that was familiar to me as I reflected on my own practice. I have assisted many women with breastfeeding and encountered challenges similar to the ones Dana described. However, while listening to Dana’s account I became immersed in the depiction of ‘desperation’ that accompanied the
rendition of her attempts to achieve breastfeeding success. Images of isolation, frustration, and a sense of ‘failure’ loom large in the portrayal of her experience. The experience of post-partum depression emerges in her expression.

He (the baby) would really start freaking out. He would scream with his fists clenched and he was getting so frustrated. So I don’t know -- I don’t know exactly what was happening but it was becoming clear that someone needed to talk with me about the bonding. Because, I mean, I was really ready for the feeding. Right, but he didn’t want the feeding because of --And then he is now crying --and so I was feeling like a failure, and I was feeling guilty, and I was feeling overwhelmed, and I was like I can’t, I don’t -- I don’t know how to cope with this.

I wondered about her experience of ‘bonding’ and the associations that were possible in the face of so much frustration while feeding. What relationship between mother and baby is forged when feeding is fraught with feelings of frustration and personal failure? We touched on the possibility that women’s need for nurturing becomes overcome by the demands of the baby and the pressure to do what’s best for the baby.

Um -- when I came home with my husband, although, you know, he tried his best, he didn’t have a clue. Do you know what I mean? There was no like wow, like you’re on pain medication, you must need help! But my mom was here and she supported me. Um -- because she’s had children. But other than that, it’s just ---- you just go, go go, right? And it’s the expectation that’s always been that way. I’d never been in the hospital before; I’d never had surgery and that experience that was quite traumatic. And when I came home, he just -- my husband didn’t know what to do. And I remember him standing at the door -- um -- and I’m crying as I’m trying to breastfeed him (the baby) and he just felt really helpless. And -- and then I’m not feeling all motherly, and warm, and happy, and he’s kind of looking at me like well, you just had a baby, and you wanted that baby. Why are you not happy? You know you have a baby and everything should be fine. And -- um -- like why are having problems? Why are you upset or why are you crying? Why are you in pain? You know.
Tentatively, I ventured into the arena of decision making, sensing that the recollection was painful for Dana.

Me: When you were struggling with your breastfeeding issues, and thinking about making a decision to switch to formula, can you tell me a little bit about what it was like?

Dana: Yeah, it was nothing positive even going in the direction of formula. You know they (public health nurses) don’t go anywhere near that but -- um -- some of the things that -- that kept going through my mind that were worrying me, right? And, you know, try and keep going. You know -- um -- breastfed babies are more intelligent than formula fed babies, right? So I’m thinking oh my god, right, you know! Like I forget what the -- the actual stat was, you know, but they’re more intelligent. You know if you -- if you don’t breastfeed, then you’re just not giving the right start to your child. You know these things and you want to do that, you know, and I didn’t even know if there were going to be learning disabilities and that kind of thing, right?

Dana’s candor had taken me to a place where it seemed that I could ‘walk alongside’ as she described her situation. With that vantage point came a deepening sense of personal disquiet. Dana appeared to be struggling with so many questions; all of which were veiled in the milieu of sleep deprivation as she described how she continued to try and feed her voracious babe every two hours around the clock.

Dana described her descent into depression. As I consider her words, I am overcome with the realization that her experience of those early days of clinical depression is inextricably linked with her anxiety around the decision she faced regarding infant feeding.

Dana: I think that was the biggest thing is that, you know, -- ah -- mentally, I know that I shouldn’t be having such a hard time to make an informed decision. Like my mind would be telling me one thing --and every emotion would be telling me something else. Again, like even going to formula, I’m thinking okay, it’s time for me to switch; I haven’t slept for five days straight and it’s like okay, let’s -- I need to call the doctor --I need to get some help and I had the wisdom to pick up the phone and say to my friend, I’m not being alone can I come over?
And -- and I didn’t recognize that I have depression. Like, at that time, I was reluctant to ask for help, right? And I was exercising and, you know, doing all these other things and it was really hard to get through it. But when it’s happening to you, you need a professional’s perspective --to actually move you through the emotional part --when I don’t want to admit it; it’s just no, I’m just having a bad day. And then I’m like maybe I’m more in denial --going oh no, I don’t want to go, I don’t really want these medications. Um -- and you know what you’re saying; you don’t really need them but in fact you really need them. Me: Yeah, it’s true isn’t it? And just sometimes it’s just a relief of just giving over and letting somebody say “here’s what you need to do”. Sometimes that can be helpful and just remove the responsibility of second guessing and making all the decisions around your own health.

Dana: Oh, yeah, absolutely because I didn’t do a lot of reading before about the breastfeeding. Like -- like just everywhere around you ---- in society there’s expectations of what -- how you’re supposed to be as a mother --especially on the basis of breastfeeding.

And then at last; relief, as Dana explained:

Yeah, the switch (to formula) was good. You know it’s busy but -- but with the formula feeding, there’s a real bonus -- um -- a real positive experience; even though my husband works out of town, that proved to be more beneficial because with him coming -- like he works ten days out five days in --so when he comes home he gets that bonding time. He will feed, you know, many feeds, maybe not all but --you know as many as he can and so --then that gives me a break and it gives him a chance to feel --bonding.

_Evelyn; Marginalization Embodied_

Evelyn’s story began many years ago when she was diagnosed with bi-polar disorder. On the day I met with her, she was at home alone, and welcomed me into her cozy suite that was filled with artwork that she and her partner had created themselves. Early in Evelyn’s pregnancy, she had made the decision to feed with formula after considering information she had received from the Perinatal Mental Health Program. At the time of our interview, Evelyn was still pregnant, and in her third trimester. Evelyn did not meet the criteria of being three-four months post-partum, as
was suggested by the Ethics Review Committee as an attempt to create some emotional distance from the decision to formula feed. Evelyn’s situation was unique, however, because of her bi-polar disorder, and because of this her decision to feed with formula was made during her pregnancy. There was therefore a significant distance from the decision at the time of our interview. Her emotional condition was deemed stable by my colleagues in the Perinatal Mental Health Program, who recommended her for my study. Fortunately, consultation with the Ethics Committee resulted in an amendment to my initial ‘inclusion criteria’ so that I could include data from my interview with Evelyn. In retrospect, I am aware that my own journey of exploration and interpretation had shifted by this point to include the experience of one who has not yet delivered her child, or even fed her infant in any way. Rather, Evelyn’s situation represented a focus on a specific aspect of infant feeding; the decision to formula feed. Our interview focused on what had transpired for her as a result of the disclosure around her infant feeding choice. Johnson (2000) explains Gadamer’s perspective around the fusion of horizons of understanding and states: “We cannot remove ourselves from the situation to which we belong, but we can move around within that situation and so change our horizons.” (p.39). In essence, then, I found myself immersed in the experiences that were increasingly leaning towards interpretations around the decision to formula feed. Evelyn’s disclosures reflected my evolving thought processes, and the shifting nature of my horizon of understandings. She described the rationale that she had used to make her choice:

The decision I made was pretty easy to justify, what with the psychiatrist talking to me and knowing that possibly I could have toxicity issues from the
medications I take. I could try and breastfeed (which I think is what I was initially encouraged to do by my G.P.) But yeah, I decided that wasn’t --a good idea. Because it’s too hard and I wouldn’t be able to go back on my medication -right away after the baby was born. You have to wait two months, or something like that. So I thought that was dangerous -- for both of us. So I came to the decision to use formula that was pretty much based on information I had to ask for or -- ah -- like I’ve had to inquire about everything because no one talks about it.

Throughout our conversation, Evelyn’s sentiments poured forth spontaneously. Immediately into the conversation, Evelyn was anxious to share her experience of attending pre-natal classes and the sense of social isolation that she perceived, because of her decision to formula feed. Her sense of hurt and outrage was obvious as she described her experience:

Evelyn: Like during the preliminary class they talked about breastfeeding all throughout and how the babies look if they are developed properly from breastfeeding, and the statistics say that the baby will be more likely to have leukemia if fed with formula!
Me:   Oh my.
Evelyn: But comments like breastfeeding ‘properly’ -- -- those are things that made me feel really bad. Like I was a bad mother before I’ve even ever done anything.
Me: Yeah, yeah. Were you able to kind of express that to anybody or --
Evelyn: I didn’t think there was much point. Like I told the prenatal instructor-halfway through I told her I wouldn’t be attending the breastfeeding class -- I kind of felt like she gave me like a stern look and she was very short and I was kind of like well, I don’t want to put myself through that again because why would I? It was the gang mentality. And I didn’t feel like I shouldn’t have to get into why I made that choice.

Evelyn and her partner did not return to prenatal class. Many impressions arising from Evelyn’s comments surface; including the ethical implications of citing statistics that link formula with leukemia to a room full of women who have not yet delivered their babies. I am also cognizant of Evelyn’s hurt and outrage following her
disclosure to her instructor and the class that she would not be attending the class on breastfeeding because she would not be breastfeeding. Her sense of ethical awareness was also illustrated in the way that she identified that she shouldn’t have to explain to the group why she had made her choice. I think about the courage that Evelyn embodies. She was candid with me about the fact that she had been “through hell” with the mental health world because of her condition. I believe the fact that she had the courage to become committed to a relationship, and commit to becoming a mother, is a wonderful tribute to the hopefulness for the future she was finally experiencing in the context of her bi-polar illness. But as a result of her experience at prenatal classes, and because of the general societal pressure to breastfeed, it appears that she suffered a blow to her confidence; that her hard-won optimism about her ability to enter the mainstream experience of mothering had been called into question.

I consider the responsibility that Evelyn demonstrates by making what she admits is a difficult decision; to put her mental health needs at the forefront of all else. She exhibited insight around the fact that she will not be too capable of caring for her baby if she is unwell herself. She went on to describe her experience of prenatal class, and the sense of isolation that followed:

> When we went and weighed everything out; like tiny baby steps for what the first twenty-eight days of life would be like if you breastfed. Like the baby should feed; I don’t know twelve to fourteen times a day, and when he should double his birth weight, but they didn’t talk about even like how much formula you’re to give them. I paid the same money as everyone else, but she never talked about how to use formula.

> I suspect no one in the prenatal class would have intentionally created this feeling of segregation for Evelyn, but her situation leads me to consider the broader
implications of making assumptions about a group. For example, presenting
information about breastfeeding superiority and assuming that no one in the group will
experience complications such as mental health challenge in the post-partum period
represents a restricted approach. In fact, the failure to acknowledge the possibility for
complications has the potential to undermine the effect that a condition may have on
infant feeding choices. Navigating the perimeter of the hermeneutic circle more widely
creates more questions. What might be the effect of offering this restricted approach
during the prenatal period, when a complication such as depression surfaces during the
post partum period? The implications for angst surrounding the memory of prenatal
recommendations loom as a possible consequence, and I move into the inner circle
once again, considering the experience of Alicia and Brenda, who suffered considerably
as a result of feeling that they had not met expectations that they had prepared for.
Again, the dilemma of health providers being unable to predict about outcomes
following a limited encounter with a client is highlighted. Yet the meaning of infant
feeding for an expectant mother appears to assume a large profile, exposing a need for
attention to the topic. How can the needs be met? Evelyn ruminated about the
upcoming months following her delivery:

I talked to a few girls (as a support thing) who breastfed for a while. They were
mostly like complete strangers. Now I think I’ll have to wear a tee-shirt to say
I’m not breastfeeding! Everybody asks me too many questions about it. I
learned more at that support group and talking to the other girls. And there
were girls who were breastfeeding but having a hard time with the public health
nurse coming and being strict, and I think well, I can really be in the fire here
too with them. From what people have told me I’m kind of afraid of them.
I ponder Evelyn’s experience of worrying about the potential for judgment from peers and health care providers alike. Through the lens of her experience, and because of her feelings of shame, I am again drawn toward aligning of the state of motherhood with infant feeding. I reflect on earlier speculation about the relationship between the two, and what meaning others have drawn, as reflected by the quotes and references offered earlier in this writing. As a result of my conversation with Evelyn, however, my insight has deepened. Moving towards the center of the circle, I reflect that Evelyn and I mused about the wonder of universal and historical experiences of motherhood. I shared stories of my grandmother, and she volunteered her excitement about joining the ranks of mothers everywhere who represented for her a fulfillment that she was hoping to enjoy. I was saddened by the description of the hurt she experienced at prenatal class over the infant feeding debacle. She was already disappointed about not breastfeeding, and the reaction of others seemed to deflate her confidence about the larger experience of motherhood. Traversing through the radius of the inner circle, and moving outwardly toward the perimeter where my view is expanded, I wonder if there could be value in entertaining an attitudinal shift among health care providers, wherein there is a will to acknowledge and support a woman’s sense of disappointment that she is unable to breastfeed. Such an approach perhaps holds promise for a common horizon of understanding from which to proceed, rather than reinforcing the disappointment by exuding attitudes that are perceived as judgment.

I ruminate further on the whole issue of why the infant feeding topic is so important to so many; women, prenatal educators, and health care providers alike. I
am struck with the need to distinguish what makes the breastfeeding issue different from other health promotion initiatives that nurses espouse; especially when considering the possibility that ethical tenets of informed choice are being compromised in prenatal education. I am moved to explore the horizon of understanding that distinguishes the issue of infant feeding from other health promoting approaches. Johnson (2000) states: “Gadamer emphasizes that the practice of understanding and theoretical reflection on that practice are inseparable” (p. 15).

Our understanding around the profile of breastfeeding promotion may lie in our ability to tease out the deeper meanings associated with women’s connection of infant feeding to successful mothering, and the need to recognize that women have a strong inclination to do what is generally considered to be the best thing for their baby. Is it possible that the unique aspect of infant feeding (compared to other initiatives such as healthy eating or smoking cessation) surrounds the deeper association among all women about the importance of this issue? Also, there is a need to ‘commit’ oneself to the choice; once the decision is made to stop or not start breastfeeding, it is usually impossible to ‘go back’ and change that choice. So the opportunity for self-recrimination and second guessing the choice is ever-present for women. I suspect that a perception of righteousness around the breastfeeding movement has the potential to fuel a significant feeling of ‘swimming upstream’ for a woman who is feeding with formula, or considering that decision. All of these speculations have relevance for Evelyn in her prenatal state, where she may have the inclination to torture herself with self-doubt about the decision she has made, but has not enacted. The implications of a
large degree of stress expenditure towards some kind of emotional resolution among women with mental health issues raise concern for me. I think about the extra burden that Evelyn carries as she considers her ongoing challenge with bi-polar disorder:

I’ll be going into labor soon and so I worry about how I’m going to handle everything emotionally to begin with; like when you’re not feeling good, and so many things –thinking and worrying about feeding my baby formula and how people are going to look at me is just one more thing.

Fiona; a Trauma Revisited

Fiona’s demeanor exuded a sense of confidence, humor, and friendliness. We had met at a mutually acceptable time and place and she was clearly enjoying the opportunity to step outside for an hour or so, and leave her daughter with her husband so she could enjoy some time discussing her experience with me. She was anxious to talk. However, as she told me of the first months following the birth of her baby, it became clear that the darkness that she had endured as a result of her depression and her experience in hospital had left a residual effect. In the case of Fiona and her husband, the trauma of the hospital experience, and the experience of breastfeeding while there had left them with significant unease. In fact, Fiona explained that her experience had been so unhappy; it was only the paralyzing effect of the depression that prevented her from documenting her concerns in the form of a letter to the nurse manager. Her comments led me to deliberate about other women, who may not able to communicate about negative experiences because of the nature of their post-partum depression (wherein the ability to muster the energy to take on such a task would not likely be possible).
It was after reviewing the text of Fiona’s comments, that my circuitous route around the experience of formula forged new meaning; in effect hermeneutic spiraling was occurring, whirling me around the circle to a new dimension, and returning me back to the same plane of origin. I ponder the possibility that the journey towards formula for women can be centered on what the experience of *breastfeeding* has been. In effect, it dawned on me that the experience of formula feeding is very much concerned with the experience of *coming to the decision*.

Fiona’s depression had resolved at the time of our interview, and her insight into the layers of complexity around breastfeeding support and the road to formula feeding proved to be illuminating. Fiona’s perspective was indeed unique and rich. Her experience as a health care professional surfaced and retreated as we spoke, offering an unexpected and welcome depth of exploration. Throughout the interview, she was able to speak with candor about her emotional response to her experience, while simultaneously musing on dynamics in a way that illustrated her professional understandings. She spoke about ‘best practice guidelines’ around breastfeeding and of the expectations:

I believe in the best practice; that’s valuable to me, and that’s what I would want for my child and my family and that. But with the information that I was given, I went into having my daughter with the plan to have the most natural birth possible, but if I needed medicine, that sort of thing, that would be fine. But I didn’t think that I would ever have any issues or thought that I would have needed a C-section or anything like that, but low and behold my daughter was trapped sideways and a C-section had to happen. So, the first time that I had to breastfeed her I remember that physically I didn’t even want to touch her. At this point I was so tired and so done. I was in the recovery room, and then there’s this stranger on my breast. I was numb from my nipples down. And we were supposed to get going and get trying it. And I knew in my head that this
was important and this was supposed to be different — supposed to be this wonderful bonding experience, and frankly it was a huge disappointment.

Fiona went on to describe the first few days. A powerful image was evoked as I recalled my own experiences working with women in the early post partum days, and learning how Fiona would interpret her experience in retrospect. A sense of indignation surfaced as she explained:

It was all very, very technical. Because of the C-section, I didn’t realize; they hadn’t told me that, but I guess my milk was late coming in. Um, the first couple days I felt quite strong and willing to keep on trying. I was determined. But by day three — the hormones crashed and -- the herds of people coming in and out, and I worked at hospital so I had constant visitors who had gotten wind that I was there and wanted to say hello. Within the first three to four days I think I had maybe 20 minutes to myself. But my milk wasn’t coming in. And I guess it was by the third day — I had the nurses shut the door and put a sign on the door saying, “No more visitors”. And then at that point they were worried that my daughter was getting jaundice. My prenatal classes said don’t ever give your child sugar water. That’s bad. That’s - that’s gonna be the beginning of the end. And they won’t learn to latch on and —And you are told that you need to lactate, so don’t let them- don’t let them convince you. And it’s bad, and ‘old school’: people who decide to give sugar water.

I muse about the countless times where I have wondered how difficult experiences during the first few days following delivery are interpreted by women later, and what meaning those recollections hold for them. Phillips (2005) stresses the importance of acknowledging personal historical nursing experience. He says:

Hence, our understanding proceeds from an idiosyncratic historical situatedness, entering into a hermeneutic circle where preconceptions are progressively replaced or amended with more suitable ones in order to reach a coherent understanding of the person we are caring for. (p. 91)

Listening to Fiona’s recollections, many of my personal concerns appear justified. Fiona described her experience pumping her breasts in order to stimulate milk production:

The pumping started pretty quickly cause I think it was supposed to stimulate the breasts to let them know that my baby’s been born, or whatever. I - I remember – I – I cried, sobbing hooked up to, um, this machine that made this
horrible sound and, I felt like a cow! If I had been pumping and that was the best outcome, then okay. Then I have no problem of you pushing me towards that. But now that I actually look back I don’t think it was — the best thing.

Gadamer explored the relationship between technology and our ability as humans to function. Johnson (2000) explains: “Gadamer says that this relationship of science to technology in modern life has obscured concern for if and how work actually benefits people and for whether or not the achievements of technology actually serve life” (p. 68). Fiona’s memories of the experience of pumping ‘technology’ remained vivid. Her resentment was raw as she recounted the events. It’s as though Fiona was re-living the humiliation of exposing her breasts:

My family was in and out — And here — here I am with my mother-in-law who had never seen my breasts — or anything before. But she needed to be there as well for my husband. I’m sitting there feeling so exposed and like a milk machine. And I sat there and pumped for nothing. Because there is no milk. So it — uh, it — it was enormously frustrating because I only have produced this little amount, of what do they call it, this liquid gold. You’re supposed to focus on this tiny little amount and I’m feeling the feeling that I read from my literature which is, which is you know, ‘disembodied’. And you’re so vulnerable.

At this point in the interview, Fiona shared comments that were based in her own clinical practice. She described a model of evidence-based-practice that had been foundational in her own education, called “Sackett’s Model”. She described the three circles that comprise the model; one that denotes ‘empiric knowledge’, one that represents ‘clinical expertise’ and one that honors ‘client preference’. Where the circle intersects is the space that Sackett sees appropriate evidence-based-practice. I contemplate the meaning of the imagery in the context of infant feeding, and see possibilities for enlightenment among nurses so as to include a more holistic model of decision making while supporting women. Fiona was clear that she felt the only ‘circle’
of evidence that she had experienced was one reflecting ‘empiric knowledge’. Fiona was curious about what lay ‘beneath the surface’ of nurses’ presence and wondered why her own preferences around pumping, privacy, and sleep had not been considered. A sense of irony prevails as I consider the eloquence with which Fiona identified conceptual dilemmas of nursing practice, although not a nurse herself.

She described the end of her hospital experience by saying:

And that was it. And then from there on I was crying. And then finally we were able to go home. And that was happy news for me.

I was saddened, listening to Fiona’s perceptions. I considered the efforts of nurses to emulate ‘best practice’ and how Fiona has interpreted it. I am moved to speculate yet again on the nature of breastfeeding support, such as the encouragement to pump, and how it can be taken up by women.

Fiona explained that her breastfeeding challenges resolved when at home, creating a sense of confusion for her over what appeared to her to be a set of practices in hospital that were unnecessary and traumatic. Her decision to feed with formula coincided with the manifestations of a clinical depression several months later. She did not elaborate on the intricacies of that decision, or too much about the experience of her depression, other than to revert once again to her early experience, and speculate as to what she might encounter in future if she were to announce a decision to formula feed at the outset, which is a possibility she considers in order to prevent the trauma of those first few days following birth. As I consider all these revelations, I speculate about the descent into Fiona’s depression. I think about the experience of recovering from her hospital experience, and I wonder what part her early trauma influenced the depression that set in a few months later. She also reflected on the community of women who share experiences around birthing:

It’s very hard um, I think where it is affecting me more now is the history in the hospital. I think about planning on going back to the hospital someday to do it again. When I get together with my friends who have babies, we talk about
different nurses. There’s one in particular whose name comes up. And it’s now somebody that we tell people to watch out for when they go in the hospital. I mean you think that you feel the passion that the nurses have about breastfeeding. So you want to believe that. But if you can’t relate to their expectations, then you feel like a failure.

Fiona ended our interview by integrating her own clinical experience as a health care provider and discussed the role of nurses:

If they could just look back at who the client is. And what the definition for ‘client’ is: the person you’re treating as well as their family. The nurse needs to figure out who the client is. Are you treating the baby as the client? Then breastfeeding is best for them. Are you treating the Mom as a client? Then they should support the mom. But I think if the client is a unit, you’re going to make different choices, based on how the ‘unit’ will benefit from it. You know?

Reflections from the Perimeter

The experience of conducting hermeneutic research with six women who suffered from depression, and who made the decision to formula feed their infants has given me both expected and unexpected findings. I expected to learn that as a result of the impetus around breastfeeding promotion, there could be potential for marginalization among women feeding their infants with formula, especially given the context of their illness. However, as a result of conducting the research, I found a decidedly deeper degree of anxiety, disappointment, and unhappiness surrounding the experiences of women than I anticipated.

Johnson (2000) summarizes the insight of Gadamer around the implications of language and dialogue and says: “We are not beings alienated and isolated from the past. Rather, we are a living part of an ongoing conversation.” Her words resonate with me about the promise of understanding that is held in hermeneutic process, wherein
the flow of language and conversation allows for shifts in understanding. My conversations fused horizons of understanding concerning the need for women to rationalize their decisions, and the sense of injustice that they experience around perceived misunderstandings of their intentions towards motherhood. Often, it was only after much reflection and review of the interactions that meaning was uncovered; for it seemed at first that it was my own inexperience as an interviewer that had allowed a diversion from the interview question that I posed. However, as McDonald (2005) states: “More than once I have taken a frantic side trip to find the structure on which to hang the inquiry. There is tension that exists between creating an interpretive account and maintaining the recognisability of a ‘traditional format’” (p. 50). Her words offer both comfort and challenge as I contemplate the nature of meaning that has been uncovered as a result of my research.

My exposure to their pain has been truly transformational to my understandings of what it is to experience depression in the post-partum period, and the implications that are inevitable for the family who are caught up in the crisis. In particular, my thoughts settle on the innocence of the infant; coming into an environment where there are many difficulties, and much pain that has arisen as a result of his or her arrival. An overarching understanding pervades my interpretations, and it concerns the infant feeding debacle in the context of mental health, and how those two realities intersect with many aspects of the current culture of maternity care, and how they intersect with each other. Descriptions that were revealed around the birthing experience and post-partum period among my participants were usually
fraught with descriptions of complexity and pain. Their experiences exposed a need for these women to feel acknowledged; especially learning that their dream of ‘what should be’ had been compromised. Many indicated that the experience of participating in the research was a way of having their voices’ heard. All of the women shared their experiences generously, and they thanked me for highlighting and exploring the impressions they had.

_Profound Pain and Loss_

In all but the case of Clarice, it would be difficult to overstate the experience of emotional pain that poured forth from women as they described the road to the decision to formula feed. Statements were frequently made about the guilt that was felt, and the perception of being judged by health care providers and society at large. There was a sense of being ‘misunderstood’; the need of wanting to make clear to others that they, too, had an intense desire to care for their infants with a fervor that is equal to women who breastfeed. Palpable angst and regret was expressed regarding the way that the perinatal period had been experienced to date. There were many comments that exposed a deep struggle to rationalize and explain their disappointment about what they were experiencing around their need to formula feed. Some individuals appeared to have ‘moved through’ some of this angst, and were able to reflect philosophically on their feelings. Others, however, appeared immersed in the pain at the time of the interviews.

The experience of sharing the pain of these women has created a personal sadness for me, and evoked a sense of concern around many aspects of their
mothering experience. For example I wonder about the possibility for having the early perinatal experience ‘taint’ the overall experience of motherhood over the next months and years. I wonder, therefore, about the effect of the suffering that has been endured during these early months, and what effect those memories will have on the ability to mother joyfully. I also wonder what it might be like to remember the beginnings of the motherhood experience as painful, and what the meaning that pain may hold over time. For women who experience depression, and who have experienced emotional turmoil around their infant feeding experience, there will surely be a need to explore that loss with a view to moving forward in the mothering experience.

_Bonding and Successful Mothering_

Because each of the women who participated appeared to be intelligent, well read, and capable of participating in the research, they were able to describe their feelings according to the language that is well understood by me, and I suspect, by many other health care providers and members of society who have researched the perinatal experience to some extent. Topics such as ‘bonding’ and ‘successful mothering’ were revealed in the course of the interviews. Participants understood breastfeeding practice to be perceived as synonymous with infant bonding and superior mothering skills. Yet, it was also clear that several women had moved through those commonly held understandings, and had come to appreciate alternate and deeper meanings to include the joy of interacting with their infants while feeding with a bottle. Their comments highlighted the importance of ‘bonding’ for women, and
reinforced my own musings about the importance for women to share the experience of maternal bliss that accompanies our images of motherhood throughout the course of history.

*The Desire for ‘Permission’*

A fascinating consistency was uncovered in the texts of the interviews that pointed towards a need for women to experience ‘permission’ to make a different decision around infant feeding. Repeatedly, the participants identified moments in their experience where an opportunity was lost by a health care provider; where there could have been comfort and a sense of closure had the nurse entertained a possibility that formula feeding could be a better practice in the context of their challenges. In each case the decision was eventually made to switch from breast to formula, but participants articulated regret that they perceived judgment instead of support, and that it would have been so much better had they received ‘permission’ earlier on in the process. Interestingly, the need for permission seems to emulate from relationship with nurses. The active role that physicians played once the problems of breastfeeding commenced was less important than the relationship with public health nurses. Yet, in some cases, participants expressed gratitude that they had received some kind of permission or acceptance from their other health care providers to formula feed, and they were grateful for that. I postulate that interaction with nurses in some cases proved to be less supportive than women hoped it would be.

Often in the texts, appreciation can be found for the attempts that the nursing staff had initially made. However, in retrospect a dilemma surfaced. Alicia was
describing her early breastfeeding attempts that included a need to feed and pump every couple of hours. She stated:

The nurse put a sign on my room saying ‘don’t disturb her, let her rest’. You know she knew what I wanted when I wanted it. She was just phenomenal. But in retrospect, I think it was too much. And I wished that someone had said, you know, you’ve just went through a pretty traumatic experience and maybe it’s not a great idea for you to be getting up every hour and a half because it wasn’t just the breastfeeding. I was doing feeding and after I was doing the feeding, I was pumping.

I wonder if women are identifying the nurses they encountered in a relationship of ‘power-over’; and if so, I speculate about the meaning of that possibility. Is the expertise of nurses who are serving women in the context of perinatal care is perceived as representing authority or one of trust? Could it be that the perception of nurses’ place in the perinatal sphere has been taken up by clients as ‘directive’ in nature? It was made clear to me as the interviews progressed, that the profile of nurses in our community is an important one among the perinatal population. Comments indicated a local awareness of nurses’ attitudes, and participants described the experience of discussing attitudes of nurses with their peers. In some cases these conversations produced anxiety for women; it appears that there is a propensity for women to enter the experience with significant anxiety concerning their contact with nurses throughout the perinatal period. It may be important to examine the impetus behind the strong desire among nurses to carry on with breastfeeding in the context of mental health challenge. I explore this idea later in this writing through reference to ‘new literature’.
Coming to Terms with Personal Capacity

At some point during the course of my research, it became apparent that women were exposing a pattern of regret over their perceived inability to anticipate their capacity for stress and anxiety over breastfeeding. For example, some women had wanted to breastfeed, and then found that the challenges were overwhelming because of the need to pump every two hours in order to stimulate milk production, or the difficulty of achieving a latch with the baby. In some cases, in spite of the fact that women were employing support from the public health nurse, their partners, their families and friends, the breastfeeding challenges were not resolved. For these women, there was a time when they opted to ‘come to terms’ with their inability to carry on with the process of attempting to breastfeed.

Listening to their descriptions of the experience suggests an overarching consideration around expectations and the advantage of being able to “anticipate”. Often, the lens through which women made decisions was an altered one, given the nature of the mental health challenge that shaped their experience. I have come to consider possibilities for contouring awareness around the nature of ‘personal capacity’ for stress and frustration in the perinatal period. By cultivating self-awareness, it seems there could be potential to lessen the anxiety of women in the context of breastfeeding challenge, or other responsibilities that confront new mothers. A resounding cry for support in the face of the unexpected resonates throughout the texts of my interviews, and I reflect on the nature of support that could occur in order to maximize a woman’s sense of self-awareness and personal boundaries for stress and anxiety.
Conspiracy of Silence

Women experienced a lack of resources around formula feeding, which added to their confusion and distress around the possibility of not breastfeeding. In one instance (Alicia), the desire to find information about formula on the internet had reached a level that could be described as obsessive. At night, when her husband and baby were asleep, she would search online for any kind of information that would ease her mind about the safety of formula feeding. Instead of reassurance, however, all she found was information relating to studies that suggested lowered intelligence, increased risk of SIDS, and other health challenges. All of these findings fed her feelings of guilt and isolation around her situation.

Participants expressed their dismay around the lack of information and instructions about how to prepare formula that were available to them. One participant mused about the important role that a pharmacist had played when she needed to buy formula; it seemed the pharmacist was the only health care provider that she had encountered that was willing to help her learn to mix formula safely. The implications of this understanding are provocative. What is the meaning for women about the difficulty that can accompany a lack of about formula?

The responses to my research questions were complex and rich. Certainly the questions that were asked evolved in the course of each interview, and evolved as the process of interviews unfolded with different participants. In each interview, I discovered a sense of both the expected and a sense of the new. I found myself embroiled in circuitous self-questioning between interviews. The experiences of
women and their willingness to share their insights during a difficult part of their journey has left me humbled and inspired. I am humbled by the magnitude of complexity and emotional turmoil that accompanies their experiences, but inspired by their desire to overcome. Once again in life, I am amazed at the capacity for women to navigate feelings of desperation out of profound love for a child.
Chapter 5
Hermeneutic Circling; Findings in Relation to the Literature

Several months into the research process, I wrote:

Something has just occurred to me, as I am reflecting on what is ‘jumping out’ regarding the work I have done so far. The concept of women’s desire to obtain ‘permission’ to feed with formula keeps standing out as an important underpinning of the dilemma. One thought is that the concept of ‘permission’ is the concept that probably drew me to this project in the first place, because I have sensed a gap in nurses’ abilities to support women holistically; instead imposing a set of values on patients instead of really listening and collaborating with them. And here I am; halfway through my research and this is being uncovered as if it is a new concept. So, I think I am witnessing the concept of a hermeneutic circle, only this time around the circle I am back around where I started, but one cycle deeper.

Resonance with the Familiar

As I engaged in reflective dialogue during the course of the interviews, there were times during which I was reminded of the literature that I cited as part of my personal passage towards the desire to conduct the research. I experienced many occasions of resonance with the comments of women; not only because of the recognition of the experiences they were articulating, but on a deeper level, because of the literature that I had processed on my own journey towards reflective thought concerning my research questions. I outline some of the deepening spheres of understanding that transpired.

BFHI in practice; questioning knowledge translation. References to the Baby Friendly Hospital Initiative were embedded in the comments of the participants on many occasions. Although women did not refer specifically to the document, their comments reflected the impact that has followed the use of the document as a guide in
health care settings. For example, women were familiar with the recommendation that no information about formula should be given during prenatal teaching. They noticed that there were no images of babies and bottles; that all posters, artwork and logos on literature displayed mothers who were breastfeeding their babies. Many quoted the rationale for breastfeeding that is prominently posted in maternity settings indicating that breastfeeding increases intelligence and is associated with a lowered rate of SIDS. Indeed, I believe my intersection with women’s pain and guilt during the course of my interviews created concern about the effect of the literature that is distributed and accessible to women, and how much of that is causing an unintended complication for women who are formula feeding.

I was also reminded of the ethical difficulties surrounding the concept of patriarchal practice that I identified in the literature before starting my research. Again, women identified for themselves the sacred trust with which they viewed their relationships with nurses; both in the hospital setting and from the public health nurses. The way that women described some of their interactions with nurses elicited disappointment for me on some occasions; especially when women described that they had felt ‘shunned’ by their nurse, or when they described the disapproval that they perceived after informing a nurse that they had begun formula feeding. The context of depression magnifies my concern around these perceptions. Phillips (2005) reminds us: “Nursing practice deals with the experience of distress as it is uniquely expressed by people. How the experience of nursing care becomes understood at this time impacts on the decisions people make about their health care” (p. 90).


**New Directions; New Literature**

The common experiences conveyed by exemplars are derived from multiple data sources, and I continue to move in directions which are fruitful in developing further understanding through reading a wide range of literature. As read, I incorporate these literatures to fuse with my own understanding. (Koch, 1995, p. 181)

During the research process and as a result of the immersion in which I was engaged relating to the experiences of women, it became clear that there was more literature to research and assimilate as I proceeded. The need to explore more about what I was seeing, hearing, and interpreting became an urgent extension of the research process in order to enrich the reflection that resulted from the conversations that had occurred. It was also an important way of framing possible directions for the subsequent interview. It became imperative to acknowledge the need to challenge and stretch my preunderstandings by exploring the literature further. As Phillips (2004) states: “If we do not put our preconceptions at risk, we limit our understanding of other- and of ourselves” (Author’s emphasis, p. 93). The value and the luxury of exploration that is part of the process that occurs in hermeneutic inquiry moved my thinking in ways that were truly transformational for me. I identify these new directions of thought.

*Disembodiment.* Many repetitious references from several women surrounded the frustration associated with pumping breasts, and how ‘unnatural’ and mechanized the procedure seemed to be. Women expressed consternation about the experience of being hooked up to tubes and pumps; often doubling the amount of time a feeding would take, and adding significantly to the burden of exhaustion. I have wondered
about the possibilities for bonding with the infant in the context of pumping, because of, for example, the anxiety associated with retrieving milk, saving it, and feeding it to the baby. My wonderings were reflected in my dialogue with Dana who remarked on the irony around pumping, and how that was somehow supposed to be connected with the bonding experience associated with breastfeeding. Instead, she experienced pumping as an activity that created a feeling of frustration with her baby. The essence of the concept of ‘disembodiment’ settled within me. I believe there is a connection to be explored around the topic of “embodiment”. Wilde (1999) describes embodiment as “not a theory, but a different way of thinking about and knowing human beings, one that is in contrast to our usual Western thinking of mind and body as separate [dualism]” (p.25). Wilde also states that embodiment also means “being situated within the world and being affected by social, cultural, political and historic forces” (p.27).

McDonald and McIntyre (2001) further develop Wilde’s (1999) notions of dualistic thinking. They challenge nurses to unseat the valuing of certain types of knowledge, and say:

The implication for nursing is that one part of our nursing practice, the technological empirical scientific practice becomes valourized, and another part of our practice; the subjective, embodied, relational delivery of caring is lost. (p. 235)

A sense of irony accompanies the identification that women express about their loss of autonomy around the attempt to breastfeed. Indeed, descriptions of breastfeeding ‘support’, while the client lies passively and voiceless in the name of ‘best practice guidelines’, conjures questions about how those efforts may be taken up by women. Discomfort was expressed about exposing breasts to strangers, or family
members who have never seen their breasts. Women spoke of the impersonal experience of having nurses touching, squeezing, and handling their nipples in their attempts to achieve the latch with the infant. What may be missing here is the ‘relational delivery of caring’ to which McDonald and McIntyre refer. For those of my participants who experienced pumping, the experience was consistently described as dehumanizing; wherein tubes and pumps were attached to them and body fluids measured as if ‘liquid gold’ (Fiona). My thoughts turn to the images of women trying to pump at home in the early hours of the day, amidst the exhaustion, isolation, and frustration that accompany the experience. I perceive the irony that pervades as echoing the thrust towards ‘de-medicalizing’ the birth experience that underpins much of the theoretical justification for the evolution of maternity care to its current status. And yet, the methods that we employ have many associations with unnatural and medically inspired strategies to assist with breastfeeding. I wonder about the effect of disembodiment that was generated as a result of ‘breastfeeding support’. As stated earlier, the movement towards early discharge, rooming in, and exclusive breastfeeding practice are examples of health care initiatives that can in part, at least, be attributed to the desire to normalize the birthing experience. Where breastfeeding is concerned, however, it is clear that many of the strategies employed to promote its practice have in fact created a mechanized and disembodied experience for the women I spoke with. The practice of pumping breasts was described and experienced by several participants in a way that denoted a powerful perception; expressed by both Brenda and Fiona as making them feel “like a cow”. One interpretation that follows
recognizes the disconnect that accompanies the practice of pumping breasts every few hours with the mental health challenges that are also part of these women’s reality. Knowing the importance of rest and sleep to mental health, and knowing the challenges that all women face with sleep deprivation surrounding the care of a newborn, I consider the meaning of prudence around what is reasonable to expect of a new mother. The notion of disembodiment, and the exhaustion and frustration that ensues, I reason, may not be helpful to a woman who is depressed or who is showing signs of becoming depressed. What can be the impetus that inspires nurses to persist and insist with the encouragement to pump, even when it appears obvious that it is causing distress?

*Breastfeeding and the treatment of depression.* My queries lead me to a body of literature that in part reflects the theoretical stance that has been taken up by health care providers where breastfeeding and maternal depression are concerned. The exposure to this literature has in turn deepened the meaning that unfolds for me around the experience of women who are situated in the center of this challenge.

One of the published benefits of breastfeeding practice is that it improves outcomes for depressed mothers. I have been exposed to the results of such research in some of the literature that is disseminated for new mothers, and I have heard statements from public health nurses that promote the research. Indeed, several of my participants quoted their public health nurses around this topic. The comment was also brought forward by one of my participants (Alicia) who was privy to the information, and who was experiencing distress as a result, because it had created questions for her
about her ability to recover from her mental health challenge, given that she was now feeding with formula. I was led to make meaning of this information. According to Johnson (2000) Gadamer acknowledges the importance of natural science data, and does not preclude the natural sciences from philosophical hermeneutic approaches to inquiry. Johnson says: “Indeed, Gadamer holds that philosophical hermeneutics includes all forms of human understanding. The problem that hermeneutics addresses are universal. The natural sciences also need to ask hermeneutical questions” (p. 57). Buoyed by Gadamer’s willingness to engage in exploration of the natural science perspective, I proceed with my journey of interpretation around the relationship between mental health and breastfeeding.

Empirically, it appears that there is data to suggest that psychoneuroimmunological (PNI) studies have identified a protective advantage to breastfeeding (Groer and Davis, 2006). Briefly stated, PNI research explores the inflammatory process that is heightened in women during the last trimester of pregnancy and the post-partum period. It is believed that there is a correlation between the inflammatory response in the body, and the presence of stress. Yet, nowhere in the findings is the possibility entertained that frustration over breastfeeding challenges can induce stress among women.

According to Kendall-Tackett (2007), it is the inflammatory response to the stress associated with conventionally accepted risk factors for post-partum depression (such as lack of social support, marital difficulties, low income, etc) that is
responsible for the symptomology of depression. She suggests that the act of breastfeeding offers protection against dysphoric moods “by inducing calm, lessening maternal reactivity to stressors, and increasing nurturing behavior. The PNI approach is relevant to lactation specialists because it demonstrates that breastfeeding can protect mother’s mental health and is worth preserving whenever possible” (2007, p. 2).

There is much to consider around the empiric wisdom attributed to these discoveries, which involve an increased understanding of the sympathetic response, the hypothalamic-pituitary-adrenal (HPA) axis, and the production of proteins (cytokines) from the immune system (Kendall-Tackett, 2007). While it is important to be abreast of the science of the body’s response, I believe it is also important to connect the lived experience with the ‘empiric’ in the case of post-partum depression and breastfeeding behaviors. For example, in Kendall-Tackett’s article, there is considerable attention to the bio-physical response to sleep deprivation, and the deleterious effect of fatigue in the context of depression. Yet, there is no correlation between breastfeeding and the increased risk of sleep deprivation, wherein there is no opportunity for the partner to feed during the night and give the mother a rest. This is especially true if there are challenges with nipple confusion, whereby mothers are encouraged to feed with the breast only (the BFHI discourages the introduction of rubber nipples for that reason) or milk production (where a women is encourage to feed or pump every three to four hours during the night). The author, however, concludes the article by stating:

However positive these results, I must issue one caveat: they only apply when breastfeeding is going well. As noted earlier, when breastfeeding that is not
going well, particularly if there is pain, it becomes a trigger to depression rather than something that lessens the risk. Mothers’ mental health is yet another reason to intervene quickly when breastfeeding difficulties arise. (p. 9)

Her words offer optimism about a heightened understanding around infant feeding matters in the context of empiric inquiry. However, the comment is included in the research as a summative comment without prior reference to the possibility; almost as an afterthought. It seems that there could be value in expanding this ‘caveat’ into a profile of understanding that plays a larger part in clinical judgment. In the case of Kendall-Tackett’s research, although specific stressors such as sleep deprivation were not addressed, the author summarizes by alluding to aspects of the lived experience; the stress associated with breastfeeding challenge. I am moved to consider the possibility that ‘breastfeeding challenge’ belongs in the list of identified risk factors for post-partum depression; a list that has previously not acknowledged it as a significant stressor. It is possible that by identifying ‘breastfeeding challenge’ as a stressor, the profile of angst could be raised, and approached more holistically in the context of the post-partum experience. This alternative suggests a promise of insight and implications for practice that has the potential to relieve suffering for women.

Interestingly, in the course of analyzing the differences between breastfed and bottle fed babies, Kendall-Tackett (2007) touches on the bonding experience. She describes research that suggests that breastfed babies have a lowered risk of adult depression. Kendall-Tackett states:

The authors explained their findings by noting that the depressed/breastfeeding mothers did not disengage from their babies the way the depressed/bottle-feeding mothers did. The depressed/breastfeeding mothers continued to look
at, touch, and stroke their babies because these behaviors are built into the breastfeeding relationship. (p. 9)

Yet, therein lays a possibility for hope. Why is it that ‘these behaviors’ are built into interpretations of the breastfeeding relationship, but not associated with a mother who feeds with a bottle? I speculate that in many cases they are present, or could be, as illustrated by the comments of Brenda and Clarice. Perhaps supporting such gestures among bottle-feeding mothers could provide a strategy that could optimize the bonding experience. I reflect on comments made by participants that suggest the pumping and breastfeeding routine serves as a deterrent to bonding. By attending to these understandings, a supposition that surrounds formula/bottle feeding could be exposed. In other words, there could be value in critically examining the assumptions we currently hold about women’s bonding behaviors.

Questioning the future. The privilege of exposure to each woman’s situation has filled me with a sense of humility that I had been trusted to cross the threshold of fragility. However, the pain and complexity of women’s journeys is also very apparent, and I speculate about the effect that the experience of depression could have on the long-term dynamic and relationship between mother and child. This concern, in conjunction with the disappointment, guilt, and feelings of stigmatization around formula feeding have led me to speculate about the effects of post-partum depression over time and explore what has been stated in the literature about its importance. As I was well into the process of research, I wrote:

Following some of the reading I’ve been doing, I am thinking about the concept of ‘stigmatization’ and how it may or may not have been experienced by participants. Delving into the issue of stigma may have profound importance
here because of the implications that result from worsening the depression due to fear of judgment in social situations, and the propensity for further social isolation, leading to further marginalization, guilt and worsening depression. Pinto-Foltz & Logsdon (2008) postulate that stigma (as it relates to the issue of stigmatization of mental illness) is often associated with some kind of manifestation of ‘unacceptable social behavior’. They go on to suggest that the inability for nurses to identify stigma among themselves is a barrier to empathetic practice. Their comments point to the potential for a kind of ‘double-dose’ of stigmatization among my participants. Not only do they have to deal with the effects of stigmatization having to do with their mental health challenges, but they are telling me how painful it is for them to deal with the feelings of judgment and stigmatization from nurses relating to their infant feeding choice.

Kendall-Tackett’s (2007) findings associate infant stress with electroencephalogram (EEG) patterns of right frontal asymmetry (a pattern that is also found in chronically depressed adults). Attention to infant stress, combined with attention to the stress of mothers with mental health challenge assumes a large profile for me as a result of my intimate glimpse into the experience of my participants.

My own experience as a maternity nurse and mother, and the observation of the experience of the participants, offers the impetus to examine the significance of the early days and months following birth, the pregnancy, and how that period of time affects the future experience of motherhood. The quest for this understanding follows a profound fascination that exposes my desire to better understand the complex experiences of motherhood. As a result of that interpretation, the hermeneutic spiraling of inquiry deepens speculation that breastfeeding challenge, or any angst around formula feeding has the potential to complicate and worsen a post-partum period.

*Delving deeper into evidence-based practice.* Doane and Varcoe (2008) explore
the notion of ‘knowledge translation’ as it relates to the relationship between ontology and epistemology in nursing practice. They say: “This article was inspired by our deeply felt concern with the profound disparity that often exists between what nurses know and what nurses do” (Authors’ emphasis, p. 283). They then describe the divide that occurs in nursing when theoretical concepts are not integrated into practice. It is possible to link their observations to my uncertainty around the role of how evidence-based practice (such as the adherence to the BFHI) has been taken up by my participants. They go on to explain:

Moreover, little consideration has been given to the way in which existing ideologies and in particular the ontological foundations and ways of relating to and around knowledge may be contrary to embodying our nursing goals and furthering the interconnection of theory, evidence, and practice. (p. 287)

Their words expose the tension that can occur when one body of knowledge (such as the empiric thrust towards breastfeeding superiority) confronts an ‘embodied knowing’ around a patient’s despondency in response to breastfeeding challenge or another decision to use formula (knowing that a holistic view of the woman is necessary to assist with her dilemma). The holistic view may include the possibility that a woman needs support and reassurance around a decision to exchange breastfeeding with formula feeding; a decision that is clearly within her ethical right to make and therefore reflective of nursing goals. The embodied knowing in the context of mental health challenge is at the forefront of insight.

Fiona introduced me to “Sackett’s Model” of evidence-based practice as a possible improvement to the nursing presence she had encountered in her
breastfeeding experience. A literature search yielded a plethora of references to the
author. Sackett (Sackett & Rosenberg, 1996) emphasizes the importance of integrating
individual clinical expertise with “the best available external clinical evidence from
systematic research” (p. 71). He says:

> Increased expertise is reflected in many ways, but especially in more effective
> and efficient diagnosis and in the more thoughtful identification and
> compassionate use of individual patients’ predicaments, rights, and preferences
> in making clinical decisions about their care. (p.71)

His words suggest the importance of incorporating the many features of
embodied knowing to which Doane and Varcoe (2008) refer. But cogitation around the
concept of ‘permission’ has given way to new possibilities for understanding nurses as
well as patients in the context of how nurses take up best practice guidelines. In other
words, I have begun to question whether nurses believe they also ‘need permission’ to
support formula feeding for infants. The rhetoric in the maternity setting, being what it
is, may have the potential to affect nurses by creating feelings of insecurity and
perhaps questions around their own credibility in asserting clinical expertise (which
may direct their support to a choice for formula). I also wonder if there could be
trepidation about reprisal by other nurses who espouse Baby Friendly initiatives in a
literal and assertive way. As a result of continued hermeneutic spiraling, I
have arrived back to a place that offers insight. I realize that in reality, the seeds for
nurses to intersect with their clients with confidence, and arrive at mutually satisfying
outcomes with infant feeding have been long planted. When considering the rich
history of holistic and ethical underpinnings from which the discipline of nursing has
arisen, it seems the ‘model’ of comprehensive evidence-based- decision-making
already exists. I wonder if nurses perceive that in the context of breastfeeding, there is 
a need for ‘permission’ to practice amidst the expanded framework that already exists; 
a framework that includes not only empiricism, but also the ethical and holistic 
elements of nursing practice.

Perhaps it is an interpretation of practice expectations around ‘evidence’ that is 
at the core of current practice; an interpretation of rhetoric that invites challenge. I 
believe an extension of our understandings around evidence-based-practice offers 
many possibilities for navigating the uneven trail towards formula feeding.

**A New Literature Search; Guilt and Formula Feeding**

After conducting research, it seems appropriate to revisit and discover any new 
literature relating to my initial questions that has been published since the onset of my 
own study. When searching for new literature, I was met with many articles that were 
new to me; many of which promoted the importance of breastfeeding. In reading these 
articles, I was reminded of the many questions that have arisen for me before, during, 
and following my research. In particular, I was called again to reflect on the impact of 
literature that grounds current practice, and becomes the seed for widely disseminated 
information to women. Statements from newly found research articles resonate in a 
more profound way, based on fused horizons of understanding that resulted from my 
terviews. As I reviewed some of the literature that was unfamiliar to me, I realized 
that I am viewing data through a heightened lens. Although many of the statements 
are not unique in comparison with other literature that promotes breastfeeding 
practice, it is clear that the experience of conducting research has given me a deeper
insight into women’s possible responses to the literature. I cite the following statement as an example of the way my evolution of thought has evolved:

For example, it is rare for a woman to be medically unable to produce a sufficient milk supply, but without adequate social support women may lack confidence in their ability to breastfeed and thus turn to formula to cope with the uncertainty. (Frerichs, Andsager, Campo, Aquilino,& Dyer, 2006, p.97)

When I read such a statement I muse about the message that may be taken up by women and nurses. Certainly it is important that women receive support. It is also important that women feel confident. Milk supply is crucial; as are all of the physical kinds of challenges (including latching) that some women are confronted with in the course of breastfeeding initiation. However, my interviews illustrated the intense efforts that are lived by women around physical challenges associated with breastfeeding. Is the ability to overcome a practical challenge the only issue worth addressing around breastfeeding difficulty? Other issues such as sleep hygiene or other obstacles (such as medication, or emotional lability) loomed large in the experience of the women who participated in my study; yet it is difficult to find these issues addressed in the literature promoting breastfeeding practice. Rather, the solutions to breastfeeding challenge seem to be based in the assumption that increased ‘support’ will enable successful breastfeeding (Frerichs et al, 2006). However, the experience of some of the women who participated in my study was that the support was unwanted, or of the wrong variety, as evidenced by their desire for ‘permission’ to stop their attempts at breastfeeding. I imagine that a woman may feel especially frustrated, for example, if she is unable to achieve the milk supply she needs despite encouragement and empiric evidence that suggests she should achieve success. In many cases this
evidence (such as the possibilities for all women to produce enough breast milk) is widely available, and used to underpin supportive breastfeeding practice. But how might that information be interpreted by women who are struggling? I suspect the kind of reasoning based in superficial and empiric offerings compounds the feeling of frustration and failure that are already ripe among women whose experiences do not comply with the average. Importantly, in many cases, the information does not change the outcome; only the interpretation of failure with which the outcome is reached. Many circuitous streams of possibilities confront my deepening and evolving consideration of the journey towards formula.

*Resonance with new literature.* One study that I recently discovered (Shakespeare, Blake, & García, 2004) addressed the connectedness between perinatal depression and breast-feeding difficulties. Their findings sustain my own emerging thoughts around the possibilities that exist; possibilities that were not articulated for me prior to my research, but which evolved as the process unfolded. The design of the study authored by Shakespeare et al (2004) included qualitative in-depth interviews, and employed qualitative thematic analysis. The authors endeavored to explore the experience of breastfeeding difficulties. Their interest in the topic reportedly arose unexpectedly during routine screening with the Edinburgh Depression Scale. They concluded:

> In this study breast-feeding difficulties were common, caused emotional distress and interactions with professionals could be difficult. Current breast-feeding policy, such as the ‘Baby Friendly Initiative’, may be a contributing factor. This needs to be explored in a further study. (p. 251)
Like my study, these authors (Shakespeare, Blake, & Garcia, 2004) found that there was a high level of commitment to breastfeeding, and high expectations of success among their participants. They also cited examples among the participants around unexpected difficulties with breastfeeding and how that led to feelings of loss of control and failure. Examples of behaviors from health care providers that were perceived as important included supportive, non-judgmental and positive kinds of presence. Some women felt judged by their caregivers when the decision was made to feed with formula. Others, like women in my own study, expressed desires for permission to stop breastfeeding. Perhaps most significant for me were comments that reflected my own musings about the relationship between breastfeeding difficulties and the onset of depression. Shakespeare et al (2006) stated: “The women in this study attributed their distress and even depression to the breastfeeding difficulties they experienced, whether or not they continued to breastfeed. The findings from this study clearly need replication” (p. 259). Implications for practice, according to these authors, includes the following comment:

Learning how to bottle-feed safely is an important public health issue that should not be neglected, although this in no way challenges the importance and priority given to breastfeeding. ‘Baby Friendly’ may need to consider ways in which it can become more ‘mother friendly’. (Authors’ emphasis, p. 259)

The discovery of this article, after my research and writing has been completed has reassured me that my own sensibilities and connections are shared by others. It is my hope that a collective consciousness is emerging around the importance of the issues associated with perinatal mental health and infant feeding.
Limitations; Gulf or Gift?

It can be acknowledged that a limitation exists in my study around the nature of the self-selection design. Women could be attracted to the study because they felt that they had a particular bias, and something they needed to say. In other words, the women I interviewed had a need to have their voices heard. It seemed, at times that the voices appeared to rationalize or explain; perhaps even defend their decision to formula feed, and the process that was involved in the decision.

As previously stated, a significant shift in my understanding occurred as a result of an insight that was gleaned long after my research was complete; the data I collected reflected meaning that was not reflected exactly in my research question, which was “What was your experience of formula feeding?” Again, I was aware, as I reflected on the text of the interviews, that it was the experience of coming to the decision to formula feed that occupied them. However, the articulation of that understanding, and the fullness of its meaning presented itself to me quite recently. I realize that on a more subconscious level, the dialogue with women was leading me there all along. So, while some women were able to talk about the actual experience of feeding with formula, and using a bottle (the comments often centered on the bonding issue, and sometimes related to the mechanistic act of mixing and choosing the formula), the process of decision making around infant feeding was foremost on the minds of my participants. Sometimes the text of the interview was comprised primarily of a description around the experience of breastfeeding, and the description of the journey that had led them to make a different decision around infant feeding. As a
result of this revelation, my own horizon of understanding evolved, and I came to
realize how tortuous that road of decision-making can be, and how important it was for
women to explain and rationalize their experience towards that end. In fact, by shifting
that horizon into yet another plane of understanding, it appears possible to interpret
that it is the issue of infant feeding in general that bears consideration. In other words,
my participants did not experience the acknowledgement for which they yearned
about the importance of incorporating infant feeding challenges. The path of decision-
making seemed to occur in isolation in some cases, and in other cases resulted in a
perceived lack of support. I wonder how their experiences would have been altered for
the better had the profile of infant feeding in the context of mental health challenge
been more developed among health providers.

Extending that understanding one dimension further it is possible to construe
that women who did not experience those inclinations would have led my study in a
different direction. Does the fact that I realize my research question was not addressed
in its entirety signify a ‘limitation’? I suggest that the same set of circumstances that
suggests a limitation in the research gives rise to acknowledging the tenets of
hermeneutic study. Phillips (2005) explains: “The process of understanding is a dynamic
hermeneutic project of anticipating, modifying, or replacing already existing concepts”
(p. 90). His words suggest the perfection of garnering understanding based on what is,
as opposed to what was expected. The interpretation that evolves as a result of that
understanding therefore embraces the paradoxical; because both the limitations and
the possibilities have been revealed as a result of my hermeneutic quest.
Chapter Six

Forging the Horizon

There is a continual recombining that is also part of the process of understanding. The two horizons are never completely separated, yet, there is a fusion that takes place. (Johnson, 2000, p.34)

Recommendations for Further Research

The experience of conducting this research has exposed possibilities for further exploration at every point, as the prospect of spiraling above the circle and reaching new dimensions of understanding dawns. Johnson (2000) describes the fusion of horizons as including the past and the present, and culminating in the formation of a new level of meaning. I briefly describe possibilities that could enhance understanding of the initial glimpse into women’s experiences as a result of my research.

*The fall into darkness and infant feeding.* As I spoke with women, I became aware that the descent into depression has both predictable and unpredictable aspects in the context of the perinatal experience. It seems that there could be value in exploring in singular isolation, the exigencies that are part of the experience of perinatal mental health challenge. For example, I am curious about the part that breastfeeding challenge, as described by several of my participants, played in the emergence of depression. Were the demands of frequent feedings, and the requirement to pump breast milk inherent to these women’s mental health challenge? The implications for preventing the depression may be enhanced by understanding more about the triggers that have the potential to catapult a woman into despair.
Personal capacities for dealing with challenge. My ruminations have also moved me to a place of considering the value of promoting self-awareness regarding the ability to deal with the unexpected challenges of motherhood, and especially where infant feeding challenges are concerned. Women who spoke of their suffering around breastfeeding issues disclosed a sense of shock that they were experiencing the unexpected. As I reflect on my encounter with Clarice, who seemed most at peace with her experience, I am reminded that I identified a sense of self-knowledge around her own boundaries for frustration that appeared to lessen the burden of her mental health challenge. I am interested in learning more about how women may view their personal capacities for angst in advance of the birth and what implications for mental health such awareness could bring to women and health care providers alike.

Expanding the question. I believe there is value in exploring the experiences of women who formula feed, but who may not be suffering from mental health challenge. The insight that I have garnered as a result of my encounters with six women suffering from mental illness leads me, in the spirit of hermeneutic inquiry, to expand my understanding one dimension further. There is potential to create another circle that may intersect with the one that I have already created, but which summons a new horizon of understanding.

Focus on the Fallout

The ability to conceptualize into a ‘whole’ from the ‘parts’ of the interface that has occurred is the quest of the metaphor of the hermeneutic circle. The movement in and out of the particular to the general and back to the specific has indeed occurred
during the course of the study. The beginnings of the circuitous and unending route of understanding occurred sometime in the past; at a time and place that I cannot identify with any sense of exactness. And yet, my journey around the circle of inquiry regarding my concerns expanded and evolved, then stalled, and at last shifted as I settled into a ‘knowing’ that the questions that I had around women’s experiences in the context of mental health challenge and breastfeeding promotion were important to explore. Am I the person to explore these complex and deep issues? Humility at the magnitude of what I undertake responds with a resounding reluctance. And yet, my attempt to give voice to women, and to myself, pays homage to the spirit of research, where increased understanding is the hope. The seed of a thought that wondered about what women with mental health challenge experience when swimming upstream against the wave of breastfeeding promotion has taken root. I have moved to a place of ethical distress that has deepened as a result of being allowed to pass through the window that divides understanding from misunderstanding, and see with clairvoyance that is unbidden, the pain of a fractured dream of new motherhood. The ruminations continue, in circuitous persistence.

The process of gathering understanding has garnered an almost sub-conscious profile in my everyday dealings; meaning and appreciation punctuating my waking state at unpredictable junctions of thought and action. The prospect of providing insight as a result of my research feels humbling.

**Major Conclusions; Imagining Beyond the Horizon**

In the case of medical science, it helps us to recognize that medicine stands within the whole of life.........This self-understanding can facilitate concrete
choices that reduce domination, provide for well-being, and acknowledge the role of nature in recovery. (Johnson, 2000, p.76)

A Shift in Practice

A horizon of understanding has fused for me around the ‘fallout’ of a movement that has captured the attention and best efforts of health care providers in Canada and throughout the world. I have heard the voices of women with perinatal mental illness who have willingly given of themselves and exposed the nature of their experience. They have spoken with eloquence of the valleys through which they walked with the hope that other women may be spared any descent into despondency around the issue of infant feeding. In my conversations, a current of acceptance lay beneath the surface of our encounters. A sense of knowing for them and me surfaced and retreated; but was never altogether absent. I refer to the recognition that existed among each of us that their experiences had led them to a place that is other than the place enjoyed by so many of their peers. Their culture is unique; they suffer from mood disorders, and they come to feed their babies with formula instead of breast milk. They do not ride the wave of breastfeeding fervor, but they are mothers nonetheless. They courageously traverse the distance; willingly putting forth their attempts to be the best mothers they can be.

Their reality urges me to imagine something different for them. I envision a maternity culture wherein women who feed with formula are accepted and embraced by health care professionals, who look holistically at their situations and understand what might be unique and important for them; thereby interpreting the rhetoric of evidence-based-practice with enhanced understanding. I wonder how the act of
formula feeding would be experienced by women if they perceived that their situation was not viewed as an unwanted statistic of breastfeeding failure, but rather as a plausible reality that meets the needs of mother and babe.

I imagine prenatal settings where rejection and exclusion around infant feeding choices are replaced with acceptance and sustenance. I think about the angst, rationalization, and worries of being misunderstood that pervaded my encounters, and wonder how it might feel for women to focus proudly on their motherhood, and attend to recovering from a mood disorder, rather than experience shame associated with an infant feeding decision. My ruminations around the hermeneutic circle nudge me to consider again the meaning that infant feeding holds in the context of perinatal mental health challenge, for I have seen with a deeper level of understanding the burden with which mental health challenge magnifies its importance.

I believe a dilemma has been uncovered; an impasse between what is empirically accepted around breastfeeding superiority, and how that rhetoric has been taken up by women with mental health challenge. The cavern of uncertainty is significant for women, nurses, and other care providers, because no one can know what the consequences of breastfeeding support, as it is currently practiced, will be. It is important to consider that there are many women for whom the strategies to achieve successful breastfeeding are successful and appreciated. How, then, can both women and nurses understand more fully the spectrum of choice that will ease suffering, and better recognize signals to guide choice? I am called to imagine greater understanding around the complexity of the experience of motherhood, where the
challenge of integrating empiric data into practice incorporates the special needs that exist for women with perinatal mental health challenge. I wonder what needs might be met if those special needs were honored, and revisited by guiding bodies such as the WHO and the BFHI. I visualize a community of support for women whose mental health challenge complicates the decision-making process around infant feeding.

I wonder, too, what might serve women best when difficulties with breastfeeding surface; so that that breastfeeding challenge is not remembered as something traumatic, but as a possible passage into another method of lovingly mothering a child. Bonding would be celebrated as part of the loving relationship between mother and child no matter what the infant feeding method. In the process of this passage, perhaps there could be a map forged for health providers to assist in the decision-making, using a holistic perspective, and which integrates the clinical expertise of the provider as well as the preference of the client. Stress around breastfeeding could be understood and acknowledged as a risk factor for depression, and integrated into the strategies for decision making around infant feeding. The profile of infant feeding among women with mood disorders could be heightened. I visualize literature that substitutes the slogan “Breast is Best” with the phrase “Rest is Best” so that women with mental health challenge can be assured that they are doing the best thing for themselves, and therefore their baby, by getting the rest that they need, but which may lead them to the decision to feed with formula.

Finally, I ponder the burden that was born by each of the participants who shared their experiences of infant feeding in the context of perinatal mental health
challenge. I wonder how their yokes could be lightened, and have come to interpret a multi-layered meaning about infant feeding that is held by women. The circle of understanding widens and spirals as I consider the participants of my study, and all women who struggle with their venture into motherhood.

Hermes was the messenger. The privilege of interpreting and delivering the messages of the women who opened their hearts and souls has illustrated a sacred trust between the participants and me. The meaning around these women’s experiences is profound and complex, but it is meaning rooted in unending opportunity for future understanding and hope.
References


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Breastfeeding Committee for Canada. (2004d). *Affordable health care begins with breastfeeding support and the use of human milk.* Retrieved from
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APPENDIX 1
CONSENT

Mental Health Challenge and the Experience of Formula Feeding

You are being invited to participate in a study entitled “Mental Health Challenges and the Experience of Formula Feeding” that is being conducted by Joan Humphries RN. Joan is a graduate student in the department of Nursing at the University of Victoria and you may contact her if you have further questions by telephoning her @ 250-598-0051 (home) or 370-3114 (work).

As a graduate student, I (Joan Humphries) am required to conduct research as part of the requirements for a Master of Nursing qualification. The research is being conducted under the supervision of Dr. Carol McDonald. You may contact my supervisor @ 250-472-5280.

The purpose of this research project is to better understand how the decision to formula feed your infant has been experienced by you. Research of this type is important because it is essential to honor the choices of all women, and understand how the choice to formula feed your infant has impacted on your experience as a mother. You are being asked to participate in this study because you have chosen to feed your infant with formula, and because you are registered in the Perinatal Mental Health program.

If you agree to voluntarily participate in this research, your participation will include a telephone conversation with me, during which time any questions that you may have about your potential participation can be addressed. Following that conversation, an interview with me will occur, at which time you will have an opportunity to describe your experience around the infant feeding topic. The interview may last up to one hour, and can occur in your home or at the hospital, depending on what is most convenient for you. Approximately six participants will comprise the study. After the interviews are completed, the data will be analyzed and interpreted, and used as an integral part of research that is required towards my Masters in Nursing credential.

Participation in this study may cause some inconvenience to you, including the time commitment of one hour, and a possible need for child care (if you so choose). There are also some potential risks to you that may occur as a result of participating in this research, such as emotional upset as a result of describing an experience that was unpleasant or frustrating for you. To prevent or to deal with these risks the following steps will be taken. First, you will have the right to withdraw from the study at any time. Secondly, every attempt to exercise sensitivity towards your experience will be
made during the course of the interview. Finally, I will telephone you following our interview to ensure you are feeling comfortable about our conversation. In the event of significant emotional upheaval either during the initial interview or the follow-up telephone call, I am prepared to accompany you to the Emergency department and wait with you until you have been seen by a Health Professional.

The potential benefits of your participation in this research include the possibility of giving you, the participant, an opportunity to express your feelings and observations about infant feeding choices, and the impact that it has had on your experience of motherhood. Publishing results of this research will contribute to disciplinary knowledge, and possibly encourage dialogue among health care providers about the way that we can support women in their infant feeding choices.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. Information that has been gathered up to and including your decision to withdraw from the study will not be used. Any decision to participate in this study will not have any effect on the health care you receive with VIHA.

Using a pseudonym in the data analysis will protect your confidentiality and the confidentiality of the data. It is also possible that any unique identifying aspects of your identity will be altered when reporting data in an attempt to foster confidentiality. I will personally ensure that secure placement and storage of the research data will occur during the research project. Only the minimal amount of relevant data will be utilized, and a restricted number of people (such as my research supervisor) will assist with data analysis and interpretation. It is important for you to know that there are between 160 and 170 women registered in the Perinatal Mental Health Program at any given time. It could be helpful for you to have this background information about the size of the program if you feel a need to address concerns around the anonymity of your participation.

Please note that I am required by law to report any suspected cases of child abuse, or concerns about the safety or well-being of the infant or the mother. In those situations, it would not be possible for me to assure anonymity.

It is anticipated that the results of this study will be shared with others during my thesis defense, and possibly with a published article in a scholarly magazine, and presentations at scholarly meetings.

Destroying the audiotapes and deleting the computer files will dispose of data from this study upon completion.
In addition to being able to contact me, the researcher, and Dr. Carol McDonald, the research supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545) or Peter Kirk, Director of Research and Academic Development at the Vancouver Island Health Authority (250-370-8620)

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

________________________________________  ______________________________________  __________________________
Name of Participant                      Signature                          Date

_A copy of this consent will be left with you, and a copy will be taken by the researcher._
You are being invited to participate in a study entitled “Mental Health Challenges and the Experience of Formula Feeding” I am currently a graduate student in the Masters in Nursing Program in the department of Nursing at the University of Victoria.

The purpose of this research project is to better understand how you have experienced the decision to formula feed your infant. I am interested in interviewing women whose babies are developing typically and whose babies are 3-12 months of age. Research of this type is important because of the need to honor the choices of all women. It will also be helpful to understand how the choice to formula feed your infant has impacted on your experience as a mother. Participation is voluntary. Your decision regarding whether to participate or not will have not impact on the services you receive from the Perinatal Mental Health Program.

If you are interested in participating, you may contact me, and we will arrange a time whereby an informal “interview” will take place, lasting up to one hour in length. The interview can occur at the hospital (in a different location from where you have your appointments with the Prenatal Mental Health Program) or perhaps in your home; depending on your preference. During this time, you will be invited to describe your experience around formula feeding. An honorarium of $20 is available to participants to defer potential childcare costs.

You may contact me if you are interested in participating, or if you have further questions, by telephoning me @ 250-598-0051 (home) or 370-3114 (work). Thank you in advance for your interest and support for this research!

Sincerely,
Joan Humphries RN BSN
humphriesj@camosun.bc.ca
Permission to Be Contacted

I hereby give permission for Joan Humphries RN BSN to contact me regarding possible participation in the study entitled “Mental Health Challenges and the Experience of Formula Feeding”. I understand that I am under no obligation to participate as a result of being contacted. I also understand that my decision around participation will not affect the services I receive from the Prenatal Mental Health Program.

Signature ............................................................................................................................................

Phone Number ......................................................................................................................................

Email contact .......................................................................................................................................