A Narrative Analysis of Breastfeeding Counselling

by

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A NARRATIVE ANALYSIS OF BREASTFEEDING COUNSELLING

Abstract

In, this study, I examined what the experience of receiving breastfeeding counselling is like from the mother's viewpoint. I held conversational interviews with four mothers who had recently breastfed to elicit their stories of receiving breastfeeding counselling from a healthcare professional. Narratives were evoked from the conversations and analysed according to three contexts of interpretation: Self-Understanding, or the participant's own viewpoint; Critical Commonsense Understanding, in which the context of counsel received was compared to current breastfeeding literature; and a Theoretical Understanding, in which three narratives corresponded with popular socio-cultural narratives, biomedical, and lay accounts. A counter-narrative resulted when one participant's experiences did not fit with these three prevalent accounts, although the participant modified her final paragraphs to include the prevalent lay accounts about breastfeeding.

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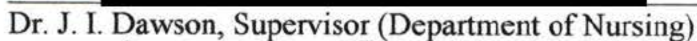

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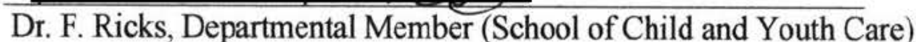

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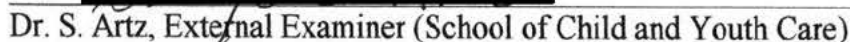

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A NARRATIVE ANALYSIS OF BREASTFEEDING COUNSELLING

Introduction

Scenario 1: The Public Health Nurse (PHN) calls Amy, as requested in the memo left on her desk, offering to do a home visit that afternoon. Amy sounds receptive on the phone and says she has lots to talk about regarding breastfeeding. When the PHN enters the house, the TV is on full blast, the baby is alone on the couch with a bottle propped in his mouth, and Amy and her partner are sitting and smoking on the floor beside him. They immediately begin to vent some very strong feelings about the conflicting advice about feeding their baby received while in hospital, at their doctor's office and from friends. Amy pulls up her shirt to show the nurse her breasts, which are hard, swollen, red and obviously very painful. She says she has been pumping every four hours, and giving the baby the expressed milk in a bottle, but she has had enough! She bursts into tears and begins to swear at the PHN.

Scenario 2: Susan has been a maternity ward nurse for four years, and has helped untold women with their infants. Her own baby was born three days ago. Recently she decided to take a Breastfeeding Counsellor course at her local community college and is looking forward to taking her baby to class. Her assigned nurse for the day shift comes into her room, and sees the baby is making hunger cues.

"Oh, you're going to feed her now? You don't need any help, I guess. You've been doing this for years." She smiles at Susan and goes quietly away.

Susan picks up her daughter and bursts into tears. Her nipples hurt, her baby is crying and she feels totally inadequate. Mary, a fellow student, enters the room. She sits down beside Susan on the bed and rubs her back. She starts off by telling Susan what a

wonderful thing she is learning to do with her baby. Mary begins talking about breastfeeding basics, as she would with any mother who had never breastfed before. She tells Susan that every new mother cries and that learning breastfeeding skills takes time, practice, and lots of support.

Susan tells this story at her next class, as she breastfeeds her baby easily and comfortably. The other women in the class have tears in their eyes as they listen and watch.

Scenario 3: Dinah is 18. Her boyfriend is thrilled with their little son. In fact, he is off celebrating the birth with his buddies right now. She welcomes the PHN who arrives for a planned visit just as the baby begins to breastfeed. Dinah has many, many questions, but she is a quick learner. She tells the nurse that she is "freaked" by the sudden responsibility of being at home alone with a newborn and is scared that she will do something wrong and kill the baby. Her doctor asked the nurse to visit on Saturday, and Dinah was sure this meant that the baby would be apprehended. After an hour with Dinah and the baby, the nurse leaves. All three are feeling better.

The nurse sits in the car and writes in her notes that "Mum and babe breastfeeding to satiation with good technique. Phone tomorrow for support. No urgent problems."

With each of the above scenarios, the breastfeeding support (or lack thereof) received had a major impact on the feelings and outcome for breastfeeding for the mother and baby concerned. From my perspective as a nurse and breastfeeding counsellor involved in situations like these, I recognize that breastfeeding counselling sessions

sometimes go wonderfully, and sometimes do not. I assume that the mothers also feel this way (whether or not this is their first child, as each mother-babe dyad is unique). I've observed that mothers often retain long, strong, emotional memories of the breastfeeding advice that they received. My mother, for instance, can recall the exact words of the nurse who lifted my brother to the breast for the first time 50 years ago. Those words still rankle, even after half a century and half a dozen breastfed babies. (They were "My dear, you are a Jersey cow. No wonder your baby has an upset tummy.")

During postpartum home visits, new grandmothers or aunts often tell me of their own history of breastfeeding infants, and what the doctor or nurse said and did:

"She mentioned it was no wonder I was having problems, since I'm fair-skinned."

"He told me I didn't have enough milk and gave me a formula sample."

"She said it took her a few weeks to get the idea of breastfeeding, too."

These stories can still bring tears or smiles as these women speak. Breastfeeding and breastfeeding counselling appear to leave long-term impressions on many mothers. While I believe that health care professionals participate in breastfeeding counselling on the assumption that doing so affects results and satisfaction positively, I wanted to explore whether mothers see counselling sessions in the same light.

There are numerous well-documented socio-cultural and personal issues which affect infants, their families, and the choices those families make. I believe that mothers/families have the right and responsibility to make fully informed choices (including whether or not to breastfeed) and I think that most mothers make the best

decisions they can under their circumstances. Health professionals have a responsibility to provide accurate information and knowledgeable support so that people, and especially babies, receive the best possible care.

I define "breastfeeding counselling" as that transfer of advice, support, and knowledge which happens either in person or over the telephone between a breastfeeding mother and a health care professional who has some measure of formalized breastfeeding knowledge. Thus, breastfeeding counselling can occur when a Labour and Delivery Nurse assists a mother to breastfeed on the delivery table, when a new mother visits her family doctor, or when a PHN phones or makes a house call.

I wanted to come to a better understanding of women's experiences of breastfeeding counselling and what asking for breastfeeding support entails and means to these mothers. In order to make any changes, or even initially assess whether the status quo is adequate, a basis in understanding mothers' sense of breastfeeding consultation needs to be explored, then extrapolating ideas which could enhance counselling techniques or skills may occur. Could better breastfeeding counselling ultimately improve breastfeeding rates and duration?

These questions engendered my choice of topic for my Master's in Nursing thesis and the decision to use a qualitative, feminist approach to explore the experience of breastfeeding counselling from the perspectives of four women.

Context of Breastfeeding Counselling

In Literature

Why is the issue of breastfeeding counselling relevant? What is the social context in which it takes place? This section explores how literature discloses the cultural setting in which breastfeeding counselling occurs and why it is important.

For most of human history, babies were breastfed or died. Near the cusp of the nineteenth and twentieth centuries, modifications in technology, popular perceptions of infants' needs and personalities, and changes in women's societal roles coalesced to cause a transposition from breastfeeding as paramount to the widespread dominance of bottlefeeding in Western nations. Commercial advertising and the growth of industry with its reliance on clocks, schedules, and efficiency were influential. Faith in the superiority of modern science and its technological utilizations was pre-eminent. Infants were seen as needing routine and order. "Modesty" discouraged breastfeeding in public. Upright feeding bottles and rubber teats became more common. Childbirth was displaced from an at-home setting to a hospital phenomenon, where routines, anaesthesia, and bottle-feeding by nursery staff were the norm. Mothers in industrialized nations began to feed their infants manufactured food products under the direction and recommendation of (predominantly male) physicians. More women began to work outside the home (Coates, 1999; Coburn, 2000). All of these factors contributed to an attitude that breastfeeding was "un-modern" and bottle-feeding moved into the status symbol role. Studies cited by Coates from 1905-1934 show that breastfed infants were healthier than bottlefed babies, but the common position was that breastfeeding and artificial substitutes were equivalent

nutritionally, while bottle-feeding was contemporary, progressive, liberating, and less bothersome (Coates, 1999; Coburn, 2000). The art of breastfeeding became outmoded, and new mothers lost role models or family members who could demonstrate breastfeeding expertise (Kuzyk & Woolgar, 1995; Newman & Pitman, 2000).

Breastfeeding rates rapidly declined in industrial nations after World War Two, and the practice of using artificial substitutes was exported to developing nations by health care workers who recommended infant feeding methods and trained hospital personnel (Coates, 1999). The dangers of marketing infant formulas to developing nations (hazards such as a lack of clean water, inadequate money to buy sufficient formula, and a dearth of sanitary conditions to mix up powder and clean bottles) were exposed in Western media in the 1970s (Newman & Pitman, 2000; Palmer, 1988). Concomitantly, breastfeeding rates in Western nations began to increase (Coates, 1999), although the repercussions of formula marketing practices on impeding breastfeeding persist.

The impact of business on breastfeeding and breastfeeding counselling is immense. Newman and Pitman (2000) say, in their Guide to Breastfeeding (which is directed at mothers seeking practical information about breastfeeding) that "many breastfeeding advocates feel that the inappropriate marketing of formula is one of women's biggest barriers to successfully breastfeeding" (p. 26). The assumption that bottlefeeding is the normal and acceptable way to feed a baby (a primary advertising tactic) is so ingrained in many healthcare providers, parents, and researchers that most often differences are phrased as the "advantages" of breastfeeding, rather than more significant wording about the risks of bottle-feeding (Newman & Pitman, 2000).

Coburn's (2000) article in the self-described "natural family living" magazine Mothering, lambasts this attitude at its source: "The campaign to normalize artificial feeding gains a great deal of its effectiveness from an unholy alliance between the pharmaceutical industry and the medical establishment" (p. 60).

There is a good reason why the pharmaceutical industry wants to persuade the medical establishment to normalize artificial formula feeding. Baby formula is big business. Dykes and Griffiths (1999) warn that "the economic and political power wielded by the baby milk companies within our consumerist society cannot be underestimated" (p. 3). The makers of artificial breastmilk substitutes spend millions of dollars promoting their products and reap massive profits from their five to seven billion dollars (US) in sales every year (Coburn, 2000; Hefti, 1992; Newman & Pitman, 2000; Palmer, 1988). Hefti (1992) cautions that "formula companies have infiltrated the health-care system" with access to hospitals, physicians' offices, and sponsorship of research, speakers, conferences, literature, entertainment, travel, and renovations (p. 97). Products are marketed to new mothers through a multitude of means: promotional materials, free samples, and "useful items" such as pens and tape measures with prominent logos used in healthcare offices and hospitals, via seminars, and on television, in women's magazines, and in free "babypaks" given to new mothers through stores, newspapers, and often through the healthcare system (Newman & Pitman, 2000). Palmer (1988) even cites the example of the formula company Abbot-Ross, which provided free architectural advice to hospitals for planning and layout, the purpose of which was to build bottle-feeding into the facility by separating mothers and infants and, thus, making breastfeeding less

convenient for the hospital staff (p. 26). Practices such as these impact new mothers and those who counsel them, both directly and by affecting attitudes which may then colour the words used when health-care workers are counselling mothers about breastfeeding. There is an element of endorsement if the product logo is on articles used by health workers around babies and on the bottles of formula given to babies in hospital, which may not even be recognized by the health professionals involved. However, this tacit promotion is recognized by the manufacturers.

Competition amongst formula manufacturers is fierce because of the profits of success, and companies will offer hundreds of thousands of dollars to ensure that hospitals use their brands of formula. Mead-Johnson, for example, landed an exclusive contract with Toronto's Women's College Hospital for $1 million dollars initially and $350,000 per year for a decade (Coburn, 2000, p. 61). Studies show that 93% of women will continue to feed their infants the same brand of formula that was supplied in hospital (Coburn, 2000, p. 61; Hefti, 1992, p. 97; Newman & Pitman, 2000, p. 28). Returns are high: "every dollar formula makers charge their retail distributions outlets cost them a mere 16 cents on production and delivery" (Coburn, 2000, p. 60). Calculating that families will spend between $100-400 on formula per month and that babies are recommended to continue on formula for the first year, one can see why rivalry for medical endorsement is so vehement (Eisenberg, Murkoff & Hathaway, 1996, p. 347; Hefti, 1992, p. 96). Breast milk, meanwhile, is not marketed or promoted by any advertising agency for profit to near the same intensity (Rundell, as quoted in Dykes & Griffiths, 1999, p. 3).

Breastfeeding, however, is negatively affected by formula marketing practices. There is no denying the impact of these factors on the cultural acceptance of bottlefeeding and, hence, the decline of breastfeeding. Breastfeeding and bottlefeeding rates are affected by commercial advertising. The Baby Milk Action (1998) briefing paper The UK law comments that European countries with little or no advertising by baby food manufacturers show high breastfeeding rates (e.g., Norway with 99% and Denmark with 98%). In contrast, in France, where the "bulk of health information is provided by the baby food manufactures", rates are 50% (p. 4). In some parts of Glasgow, breastfeeding rates are 7% or less (p. 4). The pro-bottlefeeding attitude has penetrated parenting resource literature; in the very popular first-time American parenting book What to expect the first year, for example, the section on formula-feeding starts this way:

> Bottle-feeding, oddly enough, comes more naturally–or at least more easily–than breastfeeding. Babies have little difficulty learning to suckle from an artificial nipple, and mother (and fathers, too) have little difficulty at the delivery end....With the help of your baby's doctor, select a formula....*Do not* use any formula or formula-substitute without the approval of your baby's physicians....Today's commercial baby formulas are designed to imitate mother's milk as much as is scientifically possible and are a safe and appropriate choice in baby feeding. (Eisenberg, Murkoff & Hathaway, 1996, p.54)

However, as Newman and Pitman (2000) explain, formula is only a "rough approximation of what we knew several years ago about what goes into breastmilk, and it

is based on the milk of an entirely different species" (p. 19). These authors elucidate that breastfeeding is the normal way to feed a baby and what a baby's body is designed to expect. There are risks to feeding a baby anything but what Mother Nature destined for him, even in a society where medical treatment is readily available (p. 9). Coburn (2000) quotes M. Tompson, one of the founding mothers of La Leche League (LLL): "I think anyone with half a brain would realize that human milk is species-specific. No one ever suggests that I feed my kittens with milk from the cocker spaniel next door" (p. 60). Yet, many health care professionals who counsel new parents do not fully inform them about breastmilk's "pros" versus formula's "cons".

The risks of not giving babies breastmilk are legion, and the benefits are equally well-documented by research and literature. "Breast milk has been demonstrated to be an unequalled source of nutrition to support normal growth and development and promote optimum infant health" (Hefti, 1992, p. 95). Newman (1990) describes breastfeeding as "the perfect system for feeding the human infant...exquisite and amazing" (p. 59). Research within the last three decades has shown that mankind's attempts to create a chemical formulation to mimic breastmilk have not achieved what Mother Nature evolved over millennia. Coburn (2000) states that there are 400 nutrients in breastmilk that cannot be recreated in a laboratory (p. 60). "Breast milk is a biologically active, living tissue which contains many cellular and humoral factors that are impossible to provide in breastmilk substitutes" (Kuzyk & Woolgar, 1995, pp. 99-100).

In addition to its human specificity and unlike artificial imitations, breastmilk's composition changes throughout the feed, the day, and as the baby grows. The breasts

also respond to the baby's individual needs; the mother and baby's environment, growth spurts, and exposure to illness influence the composition of breastmilk. Human breastmilk provides specific anti-infective properties, antibacterial protection, and bioactive components such as enzymes, growth factors, hormones, taurine, and anti-allergenic properties (Hamosh, 1996; Riddell, 1992; Riordan, 1999b).

Documented benefits to breastfeeding include enhanced immunological, intellectual, and neurological development; decreased morbidity and mortality for infants; maternal protection against postpartum haemorrhage, certain cancers, and osteoporosis; natural birth-spacing advantages; and multiple economical and environmental benefits (Hefti, 1992; Walker, 1992; Crase, 1995, 1996; Hamosh, 1996; among many others).

Successful breastfeeding promotes a mother's feelings of pride at her mature female body's ability to sustain her baby: "One of the most obvious benefits to the breastfeeding mother is the psychological satisfaction of providing something unique and worthwhile for her infant. Bonding is often enhanced" (Kuzyk & Woolgar, 1995, p.101). Akre (1996) points out that recent research has linked oxytocin, the hormone involved in the milk-ejection reflex, with bonding (pp. 22-23). Renfrew, Fisher and Arms (1990) explain: "Mothers say that breastfeeding gives them quiet, relaxing times together with their babies throughout the day" and "The repeated positive feelings of nurturing and physical closeness are the best possible foundation for a good relationship between mother and baby, and for building the confidence and self-esteem of both. This, in turn, will help promote the development of healthy relationships within the whole family" (p. 8).

Moxley, Sims-Jones, Vargha and Chamberlain (1997) state "breastfeeding advocates say that breastfeeding is health promotion in its purest form" (p. 35). Canadian nurses have a Code of Ethics (1997) which stipulates that nurses "assist clients to achieve the maximum level of health and well-being possible" and nurses "support and advocate a full continuum of health services including health promotion and disease prevention initiatives" (p. 8). Research abounds that breastfeeding is both a health promotion and a disease prevention initiative. For example, breastfeeding reduces otitis media, respiratory, and diarrheal illnesses; enhances intellectual and neurological development, allergy protection, and antibody response to oral and parenteral vaccines; and has a lower potential for dental caries and malocclusion (Crase, 1995, 1996; Walker, 1992; Zeretzke, 1998). Ergo, as a nurse, I feel I have an ethical and professional responsibility to advocate for breastfeeding.

Professional healthcare organizations advocate breastfeeding. The World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the Nutrition Committee of the Canadian Pediatric Society recommend exclusive breastfeeding for at least the first four to six months of an infant's life and that breastfeeding "continue into the second year" (Hefti, 1992, p. 96). Health and Welfare Canada's Brighter futures: Canada's action plan for children (1992) highlights a commitment by leaders at the World Summit for Children to promote breastfeeding (p. 21). This document groups "breastfeeding as the preferred method of infant nutrition" with "better standards of prenatal and postnatal health care [which] have improved the well-being of Canadian mothers and their children" (p. 8). In 1981, WHO and UNICEF developed the

International Code of Marketing of Breastmilk Substitutes. This "WHO Code" was prompted by "world wide concerns about aggressive and unethical marketing practices that contributed to declining breastfeeding rates and subsequent health of children" (Hefti, 1992, p. 97). The WHO Code is endorsed by the Canadian Pediatric Society, the Canadian Medical Association, the Canadian Hospital Association, the Canadian Nurses Association, and the British Columbia Ministry of Health among many others (Hefti, 1992, p. 97) .

Notwithstanding these widespread professional and governmental endorsements, breastfeeding rates in BC do not approach the recommendations. In a guest editorial in the British Columbia Medical Journal, Livingstone (1992a) states that "despite a Canada-wide promotion program in the early 1980s, which resulted in a high initiation rate of partial breastfeeding in British Columbia, the number of infants who are exclusively breastfed in hospital is less than 30%, with only 10% of babies receiving human milk at one year" (p. 84). A 1996 study, which questioned Vancouver parents about their infant feeding practices, showed that while the overall rate of breastfeeding initiation was 82.9%, by nine months postpartum only 18.2% of mothers were still breastfeeding (Williams, Innis & Vogel, 1996).

These numbers are not atypical. In the United States, fewer than one half of all babies are exclusively breastfed during their first day or two in hospital. This decreases to19% of six month olds, and 2% of one year olds who receive any breastmilk at all (Coburn, 2000, p. 60). In the United Kingdom, 1995 breastfeeding initiation rates of 66% dropped to 42% by age six weeks, and 27% by four months of age (Dykes & Griffiths,

1999, p. 1).

Hence, although health professional organizations endorse breastfeeding as optimal infant nutrition for the first year of life, statistics do not reflect success at maintaining breastfeeding rates throughout the recommended time. What are the reasons for this? Lack of skilled support and misinformation have been noted as two reasons why women are often prevented from breastfeeding when they would like to do so. In the United Kingdom, for example, "many women abandon breastfeeding during the first two weeks when midwifery care is still intensive. The World Health Organization have [sic] accepted that the vast majority of women (97% or more) are physiologically capable of breastfeeding their babies successfully. The discrepancy between those who are capable and those who succeed may pinpoint weaknesses among those who support them rather than the women themselves" (Royal College of Midwives (RCM), 1991, p. xi).

A review of breastfeeding literature points to a similar explanation for the less-than-ideal North American breastfeeding rates: "Women are simply not being given the accurate information and skilled support they need to carry on" (Renfrew, Fisher & Arms, 19990, p.17). Panetta (1993) concurs that breastfeeding failure for many women is caused by inadequate information and support. Auerbach (1999) and Renfrew, Fisher and Arms (1990) indicate that these causes are socially mediated, not individual, causes. Palmer (1998), in her emotional and powerful book The politics of breastfeeding comments that:

> Health workers' experience of breastfeeding failure is often greater than their experience of success. They all know the mantra that breast is best, which is as useful as knowing that potatoes are edible without ever

> learning how to cook them. In fact in Brazil it was shown that the *more* breastfeeding instruction women received, the *less* likely they were to breastfeed because bad information does more harm than none at all. Health workers who really know how to explain, encourage and help position the baby on the breast save hours of future work as well as the health and lives of babies. (p. 53)

Human beings have breastfed successfully for thousands of years, as the survival of our species prior to the advent of artificial breastmilk substitutes demonstrates. As hospitalization and increased medicalization of birth became more common, much of the traditional knowledge and mentorship around breastfeeding was lost (RCM, 1991, pp. xv-xvi). Bocar and Riordan (1999) state that:

> In traditional societies, an inexperienced woman turns to her mother, aunts, or grandmothers for emotional support during childbearing and breastfeeding. Breastfeeding 'education' involves lifelong immersion in a culture in which seeing a baby at breast is a normal, welcome sight. Even though formal breastfeeding and parent education is common in many parts of the world, it is still only a replacement for a time-honored family function (p. 241)

Hefti (1992) says that "women who choose to breastfeed need knowledgeable help and support from physicians, hospital staff, and community programs" (p. 95). However, like many women in North American society, many of the clients I have seen have never held a newborn before their own and have not seen another woman breastfeed;

they seek professional assistance for something with which women in other times/cultures have years of familiarity and exposure. Often, healthcare professionals are among those who have had little immersion in breastfeeding traditions and techniques: "Most health professionals received little or no lactation education in nursing or medical schools. Few understand what is required for successful initiation or have the time or expertise to assist with breastfeeding management" (Heft, 1992, p. 96). Healthcare workers, especially doctors, tend to be educated from a pathological and therapeutic perspective. Healthcare practice, policies, and attitudes reflect this and may undermine breastfeeding (Ellis, 1992a). Healthcare professionals often need to take additional courses in the rapidly expanding academia of lactation in order to support and counsel women who choose to breastfeed in their right to do so.

Greiner (1998) points out that "lactation management is a new science" (p. 4). Although breastfeeding demands skill and knowledge, he stresses that the support needed is not for expertise with the physiological processes nor the benefits of breastfeeding. It is Western minds that have codified "a natural and even instinctive behaviour in traditional societies...[where] learning about it takes place in subtle ways that are integrated into the culture and at early ages" into *lactation management* because it "sounds scientific [and] ....implies that it will increase the realms of human health over which health professionals will be able to exert power" (p.1). He associates what is happening in breastfeeding to the history of increasing medical intrusion in childbirth, to the point that "child birth was viewed as a virtually pathological process" (p. 6) and cautions against the same trend in breastfeeding management.

It is interesting that, although anthropologists have been collecting breastfeeding data for years in societies where breastfeeding was essential for survival and observing what works in action, much of this information has been ignored (Thompson, 1996, p.164). This philosophy of learning about breastfeeding through personal support (one mother to another) spawned LLL, a network of breastfeeding resources which has grown since 1956 to become a respected international resource for health care professionals and families alike (Mohrbacher & Stock, 1995).

LLL is one of the resources breastfeeding mothers in the Victoria area may approach for assistance. Other health care professionals focussed on breastfeeding are International Board Certified Lactation Consultants, PHNs, both directly and through breastfeeding clinics at local health units, and the doctors, midwives, and nurses involved in their care. What is the experience of local mothers who receive breastfeeding counselling from these healthcare professionals?

Personal Context

I come to this research with wonderment for the beauty, achievement, and emotion of successful breastfeeding. It is an exquisite delight to see a satiated babe smile dreamily and fall asleep in his mother's arms after a comfortable feed. I grew up in a breastfeeding family and only learned how to prepare and give formula to babies during my education in Nursing. I became enamoured of breastfeeding counselling while working as a PHN in Ontario, in smaller communities where dairy farming was common. One new mother there told me that if a newborn calf did not suckle successfully within the first four hours, not much hope was held out for it because farmers knew ingesting the

colostrum was essential for the calf's survival. However, bottle-feeding human babies was the accepted norm in the area.

I felt I needed to study human lactation in order to be more useful to the women who wanted to breastfeed their newborns. The more information I gleaned about breastfeeding, the more incredible and amazing I found the whole process. At the same time, I recognized some of the techniques and attitudes in breastfeeding literature as familiar because I had had exposure to such knowledge in action when my friends and sisters breastfed or when my mother and aunts shared stories about breastfeeding. The dichotomy of breastfeeding intrigues me: the "mother culture" and the healthcare research culture meet in the art/skill of breastfeeding in a unique way.

I see breastfeeding's advantages and benefits and am frustrated by the variables which nullify many women's attempts to breastfeed when they would choose to do so, in our present scientifically-based, white male-dominated, consumerist healthcare system. I am interested in what helps some women feel successful about their breastfeeding experiences when other women, who would seem to have fewer discouraging factors, feel so badly about not breastfeeding when they wanted to do so. Some of these women, like my mother, can remember verbatim comments about breastfeeding from healthcare workers far in the past. What sorts of things do women remember and count significant in their own memories of receiving breastfeeding counselling? These questions spurred the focus of this study.

In addition, after I began this research, but prior to meeting the participants, I birthed a baby girl whom I chose to breastfeed. It was interesting to undergo for myself

the realities of breastfeeding from "the other side of the stethoscope". I include my own story of receiving breastfeeding counselling in this paper (Appendix E, p. 143) because I believe that who I am and what I went through influenced the way I conducted this research, from establishing a common bond with the participants, to sharing stories with them, to what anecdotes about breastfeeding counselling they chose to tell me, to the way I analysed the conversational interviews we had, interpreted them, chose which parts to examine, and how the women's narratives of receiving breastfeeding counselling evolved with shared input.

I first wrote down my own postpartum breastfeeding counselling experiences when my daughter was about three months old, prior to meeting the participants in this study face-to-face, but after speaking briefly with them by phone, introducing myself and my research focus, and telling them some of the details of my story. I added the last paragraph to my narrative when my daughter was just under a year old. My memories of receiving breastfeeding counselling from other healthcare professionals only served to increase my motivation to come to a better understanding of other mothers' experiences of receiving breastfeeding counselling.

Research Design

Rationale for Narrative Analysis Methodology

Qualitative Methodology

Breastfeeding is rich in jargon (Phrases like "a good latch" or "hunger cues", for example, have particular meanings in breastfeeding.), has specific skills and processes which are utilized by those in the breastfeeding culture (e.g., manual expression of milk, baby-led feedings, etc.), and is an important, practised, and efficient art/skill which women employ daily for months at a time. It is an intricate and specific interdependent interplay between a woman, her baby, her involved support systems (like her family, PHN, or midwife), and her social culture (e.g., her community's resources, how local business practices support or detract from breastfeeding while working, even how the society in which she lives views breasts and their functions). Breastfeeding has both personal and socio-cultural components, and each breastfeeding mother will have a unique situational view of aspects which affect her breastfeeding.

My focus in this study is to gain a better understanding of some of these situational viewpoints, that is, local women's experiences of receiving breastfeeding counselling. Those using qualitative research describe, or strive to understand, the world from another's point of view and to unfold the meaning of experiences to those living them (Kvale, 1996, p.1). Qualitative research is the only methodological fit for this study's exploration of the non-quantifiable experiences of receiving breastfeeding counselling.

Feminist Approach

Gender is central to breastfeeding, and current societal practices and attitudes which surround the symbiotic art of breastfeeding are greatly influenced by the womanly nature of the phenomenon in a male- and business-oriented milieu, especially in the often patriarchal Canadian health care system. Baker (1996), for instance, presents an essay examining the pressures she felt, after the birth of her son, from social conventions and attitudes, marketing tactics, health-service practices, and governmental policies which promote bottlefeeding. Feminist research approaches strive to challenge gender domination within a patriarchal society and employ research methods such as establishing collaborative relationships between researcher and participant, situating the researcher within the study to avoid objectification, and conducting research with the aim of fostering change (Creswell, 1998, p. 83). My aim is to give voice to women's recent experiences of receiving breastfeeding counselling, a marginalized perspective; this is emphatically a feminist research stance.

Feminist researchers need to "consciously and systematically include their own roles or positions and assess how they impact their understandings of a woman's life" (Creswell, 1998, p. 84). Reinharz and Davidman (1992) agree that "utilizing the researcher's personal experience is a distinguishing feature of feminist research" (p. 259). Recognizing this, I shared my own position and stories with the mothers in this study, in the "epistemology of insiderness" (Reinharz & Davidman, 1992, p. 261), thus aligning my thesis inquiry with feminist research philosophy. I feel this not only helped to forge a common bond, but served to foster comfort and ease of conversation, allowing the

participants to impart their narratives in a safe atmosphere.

The narratives of this study disclose the realities of breastfeeding, breastfeeding support, and receiving breastfeeding counselling for these four women in local society and the present health care system. I compare what the women describe being told about breastfeeding with what current recommendations are. One of my aims in doing this study is to unveil some of similarities and differences which exist between breastfeeding references and actuality. I think that documenting the present situation is a first step to advancing change/improvement, and this also brings this study under feminist research philosophy.

Narrative Analysis

Cortazzi (1993) describes narrative analysis as "opening a window on the mind, or, if we are analysing narratives of a specific group of tellers, as opening a window on their culture" (p. 2). Narrative analysis is an approach well-suited to feminist, subjective revelations about social life (Riessman, 1993, p. 5). "Narrativization tells not only about past actions but how individuals understand those actions, that is, meaning" (Riessman, 1993, p. 19). Narrative analysis is relatively new to nursing science, but the methodology of systematically evoking and examining narratives is "a powerful way of capturing consumers' struggles to obtain health care" because it utilizes people's everyday ways of expressing significant life events (Stevens, 1993, p. 40). Stories incorporate the context, chronology, and meaning for the storytellers within larger cultural attitudes (Stevens, 1993, p. 40).

Moules and Amundson (1997) expand on this view by saying that "stories are not

mirrors of reality; they constitute, map, and shape our lives over time. Narratives that describe peoples' lives represent revelation of personal 'truths' and expressions of personal experience" (p. 2). Sandelowski (1994), writing of the function of narratives in nursing practice, depicts narratives as representations of peoples' "efforts to explain life events, to sustain and/or to protest certain images of self; to justify behaviours; and to come to terms with illness, crisis or transition" (p. 2). Breastfeeding is a life event which impacts one's image of self, involves specific behaviours, and occurs at times of major transition. For example, some transitions may include relocating one's self from childless woman to mother, to co-parent, and to nourisher; from a somewhat dependent role as a patient in hospital to an independent care-taker; or from a neophyte with many breastfeeding questions to a knowledgeable support for other breastfeeding women. Thus, the narratives which the participants form around receiving breastfeeding counselling represent these women's explanations of events, the changes in their self-images as they came to terms with their own passages and breastfeeding histories, and the stories they told me in answer to my research question.

Question

Riessman (1993) proposes that facilitating a narrative, a "natural, and apparently universal" impulse, is encouraged by interview questions which "open up topics and allow respondents to construct answers" (p. 54). She suggests that prospective interviewers develop an interview guide of five to seven broad topical questions, with a supplement of "probe questions" such as "Can you tell me more about that?" or "What was the experience like for you?" (Riessman, 1993, p. 55). Heeding this advice, I printed

off a page which I read out to each participant during our first phone call and which I placed on a flat surface near us when we were having our conversational interviews, right beside the consent form which was signed at that time. This allowed the participants to consider the questions before agreeing to partake in the study and to refer to them at any time they wished during our meetings. The page looked like this:

PLEASE

1. Tell me a/the story of your experience with breastfeeding counselling.

2. Tell me about a time when you felt a strong emotional reaction to a breastfeeding counsellor's session with you.

3. What do you tell other new mums who ask you about breastfeeding support?

4. What stories will you tell your daughter/son if s/he asks about being breastfed?

5. When you think about asking for help with breastfeeding, what do you remember about your meeting with the counsellor?

(Probe questions) -Can you tell me more about that?

-What was the experience like for you?

I found that all four participants had done some thinking about the questions after our introductory phone call and had their stories ready for our first meeting. An unexpected development occurred during one meeting when the participant responded to one of my statements with "Oh, yes, X told me you talked about that." I had not considered that soliciting participants through pamphlets and word-of-mouth might mean

some of the respondents would know each other. This participant had mulled over how she would have answered this question, and I decided that discussing our conversations with her friend was another way of forming a story out of events to constitute her narrative.

Reissman (1993) determines, encouragingly, that "provided investigators can give up control over the research process and approach interviews as conversations, almost any question can generate a narrative....Tellers can make events reportable in any interaction by making a story out of them" (p. 56). I think the skill with which these participants told their stories makes their narratives highly reportable and worthy of study.

Participants

I began my search for participants through word-of-mouth with other nurses, community social workers, other breastfeeding mothers, and classmates at the University. I gave women the "Request for Participants" sheet (see Appendix A, p. 125) to give to their friends or any other interested women they encountered. I received a phone call from a community nurse who wanted more information before she posted this sheet in her facility, and so I sent her a page outlining my background and motivation (see Appendix B, p. 126). I chose to limit my respondents to local women who have received breastfeeding counselling from a healthcare professional, such as a nurse, doctor, or lactation consultant, and who: (a) had breastfed and received breastfeeding counselling within the last three years, (b) wished to share their stories, (c) were fluent in written and spoken English, (d) were willing to participate in at least two conversations about

breastfeeding counselling, of approximately an hour each, plus reading and commenting on the written narrative, (e) were available within the time frame proposed, and (f) agreed, in writing, in advance, to being tape-recorded, with the knowledge that confidentiality will be maintained and no identifying information will be dispensed in any manner.

In all, seventeen women expressed an interest in participating. I chose to limit this study to four participants after assessing the time commitment involved in doing narrative analysis and considering the value of this thesis compared to the amount of work required for other course-units in my Master's in Nursing program. The chosen participants were the first four women who contacted me and met all the criteria. They all initiated communication with me by phone within days of pamphlet distribution. We were able to begin our conversational interviews within a few months.

Conversational Interviews

The women who were interested in participating in this study initiated contact with me by phone after reading the pamphlet and/or the letter described above and left messages. Unfortunately, they all called while I was hospitalized unexpectedly with pregnancy complications. I returned their phone calls after my daughter's birth, at which time I was able to go over the research focus and question with each mother and, more importantly, establish an initial bonding over shared experiences. The difficulties which resulted in my hospitalization turned out to be a blessing in disguise, because the delay meant that I came to our conversations as another new breastfeeding mother, rather than simply as a breastfeeding counsellor/researcher. I think this had an influence on the shape

of the women's stories.

Cortazzi (1993) describes the interviewer's influence this way: "The teller is not the only person telling the tale. The listener also shapes the story" (p. 21). Being another breastfeeding mother who had recently birthed moulded the conversations I held with each participant. Giving the participants a brief explanation of why there had been a delay in getting back to them allowed me to share some of my experiences with them in our initial phone conversations, during which I learned some things about them, such as their children's names and some of their experiences. This meant that we already knew a bit about each other when we met face-to-face and knew we had feelings, breastfeeding jargon, and certain skills in common. We started our conversational interviews from a more comfortable and companiable place than we would have had I asked the same research question during a formal interview without disclosing my relevant personal history.

I reiterated to each participant the research questions and parameters (which they had been introduced to in the printed request for participants) during our phone calls so that each woman had an opportunity to clarify the topic with me ahead of time. This way, also, each woman had some time to think about the theme of her breastfeeding counselling again before our initial taped conversation.

Each woman was given the choice of setting for our conversations, and each chose to have me come to her home. We chatted in the kitchen or living room, often over refreshments and with a baby actively involved. This helped create a mood and communal feeling which I believe allowed the women to reveal their stories openly to someone

whom they knew comprehended their experiences, in a more intimate way than possible if a male researcher had asked the same questions of them in a waiting room at the University, for instance. Additionally, the setting of, or events during, the conversations in each woman's home prompted connections and revelations. For example, I entertained P1's baby while she dried her hair after her shower, and we talked about getting ready and going out with a small baby, and the difficulties one can encounter doing so when breastfeeding. I think she then felt freer to share her frustrations about having to stop during outings to feed her infant, and this led on to her anecdote about her crisis in the kitchen.

I learned a bit more about P2's family through conversations around the pictures in the photo albums she brought out to illustrate how tiny her infant was. We drank a pot of nettle tea as we flipped through the photographs. I think our discussion about, and mutual enjoyment of, a herbal tea allowed her to feel comfortable in disclosing that she took the herb fenugreek following a suggestion from a LLL member, because she knew I was accepting of natural remedies.

P3 had decorated her house with strong, bold colours, and we began our conversation by discussing the natural origins of some clothing dyes, moved on to gardening magazines, and then to magazines which support breastfeeding. This opened up the conversation for her comments about cultures, and she revealed that "reading about how indigenous women care for their children...was a real inspiration for me."

P4 and I sat on her living room floor to talk, while her baby played around and over us. We discussed breastfeeding positioning and trying to get those slippery rubber-covered

hospital pillows to stay put. She knew that I shared some of her experiences about trying to learn breastfeeding in hospital and could identify with some of her difficulties.

Kvale (1996) states that "a research interview is based on the conversations of daily life" and that "through conversations we get to know other people, get to learn about their experiences, feelings, and hopes and the world they live in" (p. 5). Mishler (1986) explains that stories are more likely to be found in unstructured interviews, where respondents can control the introduction, flow, and extent of their responses, but stories can also be elicited by direct questions as long as the interviewer does not try to interrupt (p. 69). I attempted to keep my interruptions to a minimum throughout the conversations, at times leaving long spaces of silence on the tapes, in the hopes that the women would feel able to continue their stories at their own pace. These silences did not feel uncomfortable. However, when it was natural, I did share my own experiences or ask questions to clarify.

Kvale, (1996) continues further that:

> When spontaneous stories appear during interviews, the interviewer can encourage the subjects to let their stories unfold. The interviewer may also help the subjects to produce a coherent story....Furthermore, the interviewer can work toward narrative forms during the interview, for example by directly asking for stories and trying together with the interviewee to structure the different happenings recounted into coherent stories....The result may be a good story, providing new convincing insights and opening new vistas for understanding the phenomena investigated. (pp. 200- 201)

I asked directly for specific stories related to the participants' experiences of breastfeeding counselling, but, during the ebb and flow of our relaxed conversational interviews, other subjects and experiences were discussed. Often, these sidebars served to explain the mother's attitude towards a specific occurrence, and, sometimes, my sharing of my experiences prompted further disclosures from the participant or proved to be a communal bond, sometimes not. At other times, moving away from the topic and covering daily minutiae let us both take a break from some emotional memories. I found that the mothers who volunteered for this study were eager to be helpful and share their stories and did so in a trusting and easy-going manner. The conversations flowed, ebbed, and gained momentum depending on the moment and external variables (like the baby crying or the cat needing to be let out) but remained focussed primarily on the research question previously introduced. This reinforced the appropriateness of utilizing a qualitative, feminist, narrative analysis approach in this study.

Considerations and Ethics

There are some considerations which readers of this study need to keep in mind. The participants in this study were all from the same geographic area of Victoria and all had birthed their babies at the same hospital. Three were still breastfeeding at the time of our initial conversational interview, when their babies ranged in age from six to eighteen months. For all the participants, their first breastfeeding experience was the focus of their stories. All had only one living child at the time of our initial conversation. Each participant mentioned her baby's father as active and supportive in co-parenting during our conversations. I do not know, nor did I ask, any further demographic details. These mothers' stories are their own, and are valuable.

I have chosen not to use rich, thick descriptions of participants, details, settings, and characteristics because doing so would, I feel, allow the participants to be identified in the small and communicative breastfeeding culture of Victoria. I do not want my participants' confidentiality to be breached in any way and have chosen to err on the side of caution by not revealing too much.

Each woman gave multiple examples of receiving breastfeeding counselling. One mother cited eleven instances of receiving counsel; the three others gave fourteen examples each. When participants used a non-specific label in their anecdotes, for instance when P1 says "each nurse on the ward was different in terms of what they told you to do", this was counted as one example of breastfeeding counsel. When P1 continues and says "Then there was this one nurse...", this was counted as a second example of breastfeeding counsel.

Each woman received breastfeeding counsel from nurses in hospital and in the community (PHNs). Three mothers accessed their doctors and LLL for breastfeeding information. Nurses in the Special Care Unit, prenatal instructors, breastfeeding clinics, and community mother/baby groups were mentioned in two narratives. The facilitator of one of these groups, a midwife, a LLL leader, and a hospital breastfeeding counsellor each appeared in one narrative. Three women commented on videos; two as helpful and one as not helpful. Three mothers had done extensive reading about breastfeeding during their perinatal experience, but only one participant included a pro-breastfeeding magazine as a recommended source of support.

I had met none of the mothers prior to our initial phone calls, nor did I know of any of them socially, through work, or school.

Throughout this study, I have tried to keep each woman's narrative voice as true to her own meanings and original words as possible within the bounds of clarity, but I recognize that who I am and my behaviour (which is dependant on mood, amount of sleep, health status, etcetera and, thus, is changeable) on the days we spoke framed our conversations. Additionally, each woman's narrative of the same events might have differed if it was told to another researcher, under other circumstances, and/or at another time. Riessman (1993) says that "narratives are laced with social discourses and power relations, which do not remain consistent over time...There is no reason to assume that an individual's narrative will, or should be, entirely consistent from one setting to the next" (p. 65). Each woman told her story to the researcher I was on the day we conversed.

Additionally, my feelings around my own birthing and breastfeeding experiences

inevitably influenced how I handled the data, and I include my own breastfeeding counselling story so as to present my predispositions clearly. I attempted to minimize these effects by encouraging the participants to adjust, add to, or delete from the formation of their stories as I had extracted them from our tape-recorded conversations as many times as they wished until they were happy with them. I recognize that the participants may have found it intimidating to alter what I had already printed out, even if it was meant to be their own words and stories.

During the time I was researching this study, I was a participant in another study. This, too, shaped the way I handled the transcripts from my own participants. I found that the way the other researcher recounted my story did not articulate what I felt I had told her, but I found it was hard for me to express this to her face. I had to gather my courage to assert my own wording on *her* research. I tried to keep this experience in mind when I was working on my participants' stories so I "cut and pasted" their own phrases as much as possible, only substituting specific words in the transcripts for clarity (e.g., putting "*Breastfeeding* was crazy" in P1's narrative where the verbatim typed transcription reads "It was crazy"). I offered each participant the chance to review and make changes without me present and to return her story via e-mail or via home mailbox so that she did not feel confronted.

In order to ensure that participants were fully informed about and consented to the research, each woman signed a consent form (see Appendix C, p. 128) which described the research at the beginning of our first meeting. Each woman had my phone number, and that of my thesis supervisor, and was welcome to call with any questions, withdraw from

the study, or refuse to answer further at any time. In order to ensure confidentiality, no last names or identifying demographics were used during our conversations, and the transcriptionist was instructed to use an initial only for any proper names revealed by the participants during conversations on tape. The tapes were returned to me when the transcriptionist had completed typing them out. Tapes and transcriptions were kept in a locked place at all times when not with me, and the tapes will be destroyed at the completion of this thesis.

The research proposal was given ethical approval by the University of Victoria Human Research Ethics Committee on August 31, 1999 (Project No. 268-99). I can foresee no negative consequences for participants. In fact, there may be benefits. As the narratives of the participants of this study illustrate, there is a special advocacy and encouragement breastfeeding women find in sharing their stories with other mothers. In addition, following her reading of the final format of her narrative, P2 wrote to me that she felt "honored to be able to tell my story" and that by doing so she had experienced a "healing that this process brought about" (Personal communication, 2000). Riessman (1993) notes that individuals primarily make sense of a difficult life transition or traumatic experience by portraying it as a narrative (p. 4). Mishler (1986) discusses the work of the anthropologist Early in 1982, who ascribed narratives a therapeutic, ritual function in how people try to develop shared understandings of significant events by linking unique episodes with cultural knowledge (p. 152). As P2 and I worked through her story three times to render it down to its final formation (the one acceptable to her for use as data), the language she chose changed dramatically. One wonders if it was in the modifying of the

language that the healing and understanding for P2 occurred or was demonstrated. This would be an area of interest for further study.

"I want to know the truth," Sidda said.
"We don't deal in truth," Caro said. "But I've got some stories.
Will that do?"
"That'll do," said Sidda (Wells, 1996, p. 298)

The Trustworthiness of This Research

Riessman (1993) discusses how to evaluate a narrative analysis, pointing out that "the historical truth of an individual's account is not the primary issue. Narrativization assumes point of view" (p. 64). She suggests that providing information that will make it possible for others to determine the trustworthiness of narrative work is done through a) describing how the interpretations were produced, b) making visible what the researcher did, c) specifying how successive transformation were accomplished, and d) making primary data available to other researchers (p. 68). Other authors suggest other methods for establishing trustworthiness which incorporate similar steps. Verification procedures to enhance trustworthiness of research outlined by Creswell (1998) include:

1. Establishing trust with participants, discerning the culture and constantly examining for misdirections

2. Utilizing a peer reviewer who will read over transcripts, data, analysis and interpretations and play "devil's advocate"

3. Clarification of researcher predispositions which may affect the inquiry as the study initiates, by having the researcher comment on past experiences, influences and orientations that likely shaped the interpretation and approach to the study

4. Frequent and consistent member checks to rouse respondent's views and

criticisms of the authenticity and interpretation of findings at all stages of research

5. Frequent audits to follow process and product to see whether each part follows logically and is supported by given data. (pp. 201-203)

I attempted to incorporate these procedures into this qualitative study, although modifications were necessary. For instance, re Creswell's first point: I believe that the participants and I established a mutual trust, which is evidenced to me by their willingness to share intimate and emotional details during our conversations. Re points 2 and 5: I used my thesis committee and supervisor as reviewers and auditors, and incorporated their suggestions. Re point 3: I shared my past experiences and orientations with the participants through my introductory letter (telling them about my history of being a PHN, doing breastfeeding counselling, and being a graduate student), when I shared my own breastfeeding stories with the mothers, and in this report via the copy of "Gaby's Story" (see Appendix E, p.144). Finally, re point 4: each participant was offered the opportunity to review and change her narrative as I had formatted it, in private, and as many times as she wished. Each was also offered the opportunity to read the finished thesis report.

Kvale (1996), in his book about qualitative research interviewing, posits three "communities of validation" which respond to the three interpretational contexts he proposes: the interviewee (who corresponds to the first interpretation context, that of the subject herself), the general public (who correspond to the second interpretation context of a critical, commonsense understanding), and the theoretical community (who correspond to the third and theoretical interpretation context of understanding (pp. 214- 217).

Kvale (1996) suggests validating the first interpretational context by checking with the participant: "When the interviewee's own understanding of a statement is asked for, the validity of the researcher's interpretations is, in principle, decided by the subject" (p. 217). By taking my formation of each narrative back to each participant until she expressed approval, the criterion for validity for this section was met.

In Kvale's (1996) second critical, commonsense context, the validity of interpretation does not "depend on the acceptance of the subject interpreted, but upon the fact of whether the documentation and the argumentation are convincing to members of the general public" (p. 217). The criterion for validity here, where I compared the context of the breastfeeding counsel given to the participants to recommendations for counsel in breastfeeding literature, was met by having this section reviewed by members of my thesis committee (as representatives of the general public) until they were satisfied.

Kvale's (1996) third community for validation is interpretations within the theoretical context. These are credible if "the theory is valid for the area studied, and whether the specific interpretations follow logically from the theory" (p. 217). Again, my thesis committee acted as a community of researchers who judged that the interpretations were reasonable and competent.

All of these contexts for interpretations of the participants' narratives are based on the women's own words. If one's respondents are invited to tell stories, how does a researcher ascertain "the facts"? My aim is not to find out the ultimate truth about breastfeeding counselling. Rather, I am hoping to gain a better understanding of these women's experiences of the phenomenon and their understanding of the meanings

inherent for them. There is no way for me to ascertain that what they tell me is factually inviolate, nor do the "facts" really matter; it is how the women construct their own narratives to make meaning of the events which is important in this study. I had to trust that what the women chose to communicate during the conversational interviews and subsequent work-up is true to them. I can see no motivation for someone to voluntarily expend such a great deal of time and energy participating in such research in an effort to mislead. I recognize that stories may, and probably will, change over time, and as the contexts in which they are relayed shift. Riessman (1993) notes that "a personal narrative is not meant to be read as an exact record of what happened" (p. 64). Rather, a narrative is one possible version of events, which may come to be viewed in different lights according to changing social discourses, relationships and settings (p. 65).

There are some other suggestions in the literature for ascertaining trustworthiness. Kvale (1996), for example, suggests the concepts of generalizability, reliability and validity are the cornerstones of qualitative research's trustworthiness (pp. 229-230). He target three types of generalization: the *what is*, the *what may be,* and the *what could be* (pp. 234-235). Since this breastfeeding counselling research is based on the personal experiences of only four participants, it only establishes *what is* for these woman. Logic dictates that one cannot apply the experiences here to the population at large as the sample number is so small, but the experiences of these four women *may be* applicable to others. More research would be needed to verify this. The target of *what could be*, Kvale says, are ideal and exceptional situations, which could be studied as a means of transforming culture. These women's situations are not ideal. However, if, as they expressed, the

respondents themselves agree that the final format of their stories corresponds with their own ideas of what they meant to relay (a totally subjective meaning within the contexts of their positions as breastfeeding mothers receiving breastfeeding counselling), then the stories are reliable and valid. They are trustworthy.

Bailey (1996) acknowledges the difficulties of ensuring quality in narrative analysis, and maintains that "to date, the predominant strategy in narrative analysis of the confirmation or validation activity is simply to make the research process visible, allowing systematic scrutiny" (p. 3). The focus of interpretive interest is not truth, but meaning, and, thus, the researcher must "clearly outline the research methodology, and ... present the findings so that fellow researchers and consumers may participate in the evaluation of the researcher's analysis" (p. 4). By including every step of the methodology I followed in this study, illustrated with verbatim examples from the participants' stories of receiving breastfeeding counselling, I have attempted to do just that in the next section.

How the Narratives Evolved

Transcriptions

Riessman (1993) states "a series of interpretive decisions" confronts all researchers (p. 54). Since talk is transformed into text jointly by the investigator and the participant in narrative analysis (p. 57), "analysis cannot easily be distinguished from transcription" (p. 60). For this reason, I chose not to discriminate between "methodology" and "data" and have called this section "How the Narratives Evolved"; the stories were developed from a conversation, shaped, and modified over time, in a number of interactions, to become condensed narrative accounts of each woman's experiences of receiving breastfeeding counselling.

Riessman (1993) explains that there are a minimum of five levels of representation in the research process: a) the participant attends to the experience, thinks about it, and chooses what to notice, b) she tells her story by representing herself in a particular way to a particular audience, in this case, to me (a researcher, another breastfeeding mother, and counsellor), on tape, c) the story is transcribed from an audiotape (which misses out all the non-verbal actions, requires interpretation and choices about whether or not to include details such as silences, false starts, overlapping speech, "ums", and also requires choices about how to arrange and display this written representation), d) analysis, which includes decisions about editing, ordering, style, detail, and the shape of what gets included and discarded to create a metastory, and e) the reading about the experiences, which involves the reader's interpretation, and is influenced by her situation, viewpoint, historical context, personal experiences, and recollections. Each level is incomplete, partial, and selective

(pp. 8-15).

When reading these stories, the context must be kept in mind: The women were speaking in a relaxed manner to someone who was recording their words, with whom they had only a brief relationship, but who shared certain aspects of breastfeeding history and culture with them. For the most part, the conversations were relaxed and easy-going. I laughed more than I expected to throughout these conversations and left each woman's home feeling privileged that she had shared such personal and emotional details with me.

The language is, therefore, conversational, not literary, in the verbatim transcripts and includes incomplete sentences, pausers such as "um", flash forwards to another thought, asides not related to the research topic, and so on. This conversational ambiance persisted in the first format of the stories I pulled from the transcripts because I used the women's original wording as much as possible. Three of the mothers commented after reading the first format of their story that they were surprised at how many colloquialisms, "ums", and "you knows", came through. Many such utterances were deleted by the participants when they were perusing the printed versions of their own stories. P3 comments on the difference between a conversational account and a statement written to be read (in a literary style) in her second interview, saying about the first formation of her narrative from our previous conversational interview together:

> In some places the language is more enthusiastic than I would have probably done if I had sat down and written it, but I would still have felt that that probably best got across the way I felt. And the people who are going to be reading it are going to be reading it for understanding that it

> was an interview. That I wasn't sitting down to tell, writing, writing the story. So I didn't want to take away from, I guess it's the difference between reading, reading prose and reading a play. (P3)

However, a conversation that is written verbatim is difficult to read, especially, I found, in terms of coherence and flow. I needed to modify the verbatim transcripts to extract the breastfeeding counselling narratives and to make the women's narratives a bit more literary in style. Below are the steps that I went through in formatting each mother's narrative from the conversational interviews. The final formation of each evolved narrative appears in Appendix D (pp. 130-143).

At out first face-to-face meeting, after we greeted each other and settled into comfortable positions to chat, I asked the participant to read and sign the consent form and re-familiarize herself with the research question set out before her if she wished. Then, I asked permission to turn on the tape recorder and to take notes. As it turned out, I took few notes during the conversations because I found I lost my train of thought when doing so. In the end, I only jotted down specific brief words, such as the date and room. I added to these notes after each meeting as soon as I had returned to my car. For P1, for instance, the notes I jotted down after our meeting read:

> January 20, P1I1
>
> Living room, tea & cookies, baby playing on mat
>
> Medical background, many ?'s re technique
>
> "Go with your heart"
>
> Baby as soother

Emotional times

Cannot teach

Support, stories, emotional support

This gives me an instant mental picture of the ambiance and gist of the conversation we had, and gives me a "rough transcription, a first draft of the entire interview that gets the words and other striking features of the conversation on paper" which is the initial step recommended by Riessman (1993, p. 56).

When all four initial conversations had been held, and recorded, I took the tapes to a professional transcriptionist, with instructions to type out each conversation verbatim, including swearwords, pauses, laughs, overlapping conversation, and other sound effects as much as possible. To preserve confidentiality, I asked the transcriptionist to type only initials when participants revealed any proper name on tape.

Kvale (1996) indicates that the usual procedure for research analysis is to transcribe the taped interviews into written format, which are then regarded as "*the* solid empirical data in the interview project" (p. 163). He points out, however, that transcripts "are artificial constructions from an oral to a written mode of communication", with each step encompassing judgements and decisions (p. 163). The transcriptionist was not familiar with breastfeeding jargon and, at times, needed to make decisions about what statements to attribute to whom (apparently the participants and I sounded quite similar to her through the squall of babies, kettles, telephones, and baby's videos). To reduce errors from the transcriptionist's interpretation of each tape recording to her written textual configuration, I listened to each tape twice while reading through the typed transcription,

clarifying misheard words, adding anything that I remembered to the typed version (such as P4 shrugging her shoulders to emphasize a point), and crediting the proper speaker. In one transcription, for example, the typist had written "Big John movements" when what had been said was "big jaw movements", breastfeeding jargon for a sign that the baby has grasped the breast well and is suckling efficiently. In addition, I replaced the transcriptionist's use of an initial for any proper name with an anonymous noun such as "my husband" or "the midwife". Every time the participant's baby's name was mentioned, I replaced it with "Baby". P3 commented in our second conversational interview that this "sounded Victorian", but in the interests of clarity, we chose to leave it that way.

In doing this, I realized more fully how much of human communication is hard to put into words. P4, especially, often used sarcasm and non-verbal sound effects or indicators, such as rolling her eyes, pursing her lips, or hand movements, to illustrate her meaning. For instance, when she says "He's not crying, the milk is flowing, it's perfect", this reads as if she is happy with the situation, but her tone was frustrated on the tape. I remembered that her hands were up in a "stop" motion and her shoulders were up near her ears, strongly belying the literal transcription.

In another example of clarification, in one transcript the cat's name was interpreted erroneously by the transcriptionist as a negative sidebar comment by the participant on her story in progress. The mother said "Here comes our 'Problem'" (the cat), and the transcriptionist had written this into the flow of the anecdote as if the participant was predicting trouble with the counselling she was receiving at that time (e.g., "Here comes a problem"). In fact, the participant was talking in an aside to the cat as she removed it from

the baby's reach and continued telling me her anecdote. Rectifying this error put a completely different tone to the written account.

Once the transcripts were "polished" to the best of my recollection, I copied each of them in its entirety to a new file. Any statements which were extraneous to the participants' breastfeeding counselling experiences were then deleted. I found I had to go through and do this at least three times with each woman's transcribed conversation, as the topics we had covered were so interesting, I wanted to leave everything in. Only by stringently comparing each part of the conversation with the research question was I able to reduce the narratives to an apposite span. Examples of deletions included whole conversational segments about participants' birthing stories, weaning stories, demographic details, my breastfeeding experiences, and any identifying words such as names, locations, and dates. I believe these were integral parts to the flow and spontaneity of each conversation and were vital to establishing rapport and comfort for each participant to reveal her stories, but are not requisite to the final narrative of each participant's experiences of breastfeeding counselling.

There appear to be numerous schools of thought on ways of analysing narratives: sociolinguistic, sociological, anthropological, deconstructive, hermeneutic, even quantitative research and narrative investigations in law and medicine (Cortazzi, 1993, p. 25; Riessman, 1993, pp. 5-6). "Traditional approaches to qualitative analysis often fracture [the] texts in the service of interpretation and generalization by taking bits and pieces, snippets of a response edited out of context. They eliminate the sequential and structural features that characterize narrative accounts" (Riessman, 1993, p. 3). I did not want to

break each woman's conversation down into tiny bits and then analyze those because I am interested in the sequence and complete anecdotes of each woman's experiences of receiving breastfeeding counselling; I wanted to examine their stories as entities. However, informal conversations, by their very nature, jump around in time, focus, and topic. P2, for instance, brought out photographs to illustrate her daughter's weight gain, and the topic of our conversation jumped about as the different photographs came up before P2 found the one she wanted. Then, our talk returned to her daughter's breastfeeding during her first few weeks of life.

I needed a way to put each transcript into an order. Mishler (1986) states that "temporal ordering is a central problem in narrative analysis" (p. 78) and cites Labov and Waletzky (1967) as defining narrative as a representation of a past experience which matches a verbal sequence of clauses to the order of events which actually occurred (p. 78). Labov-Waletzky's method was most often referenced in the narrative analysis studies I read. A fully-formed personal narrative has six structures:

1. Abstract : the initial, optional, summary of the point or statement of the general proposition, signals the narrative's start via past tense reference, the "about what"
2. Orientation : the background / context details of who, when, what, where
3. Complication : the series of narrative clauses giving the event sequence, the "then what?"
4. Evaluation : the "so what?" which highlights the point, reason and

importance of the narrative unit, signal from the teller about how others should receive the meaning of the narrative

5. Result : the resolution or what ultimately happened.

6. Coda : (optional) returns listener to the present, obviates the close of the story which is now complete. (Cortazzi, 1993, pp. 44-47; Mishler, 1986, pp. 77-87; Riessman,1993, pp.18-19)

I decided to use this format as a guide to put each woman's conversation into temporal order. Accordingly, I began looking at the condensed transcripts through the lens of the six conversational clauses outlined above.

Each participant made an introductory summary of the point of their narrative, akin to the "Abstract", which occurred early in our conversational interview and which gave a summary of the participant's general view of breastfeeding via a past tense reference. For P1, it was her initial sentence on tape: "It was crazy - wild and overwhelming and frightening and wonderful and nurturing but...". P2's Abstract statement came after she had given me a bit of family background:

P2: Anyway, I got the idea of breastfeeding...well, I've always wanted to breastfeed - it's just been in me, I guess

G: ...because? What attracts you to it? or

P2: ...I think the closeness...and the fact that our little girl can have that really good milk - you know...and that immunity and...all kinds of things - it just feels absolutely right and - natural - and pure and...everything...yeah...

P3's introductory summary also occurred within our first few minutes of conversation: "Was it what I imagined? No, it was much more intense than that". Likewise, for P4, the Abstract was the initial sentence on tape: "Well, I had trouble with breastfeeding right from the start...like I couldn't get him to latch on".

Mishler (1986) notes that "typically, the elements of a complete narrative are sequentially ordered, from Abstract to Coda" although the Orientation and Evaluation clauses may appear at various points (p. 80). I found that, for the majority of the time in the transcriptions, this was so, and that anecdotes were separated from each other by spacing words, such as "so" or "and then".

For example, from P1's initial transcript:

> So, four days later we went home and...um..I was still having to breastfeed him - to wake him to breastfeed him..and the Public Health Nurse came and she did the same thing - okay, you have to be comfortable - okay, so I got comfortable - and for me, actually lying in bed was comfortable - lying on my side - but also sitting up and I had my little breastfeeding pillow...and um..I never had any problems with sort of - cracked nipples or anything like that because he was such a good latcher and he would really get quite a bit in his mouth and it was "Make sure you do this and you got that...." The actual technique itself - I don't particularly have a lot of problems with. It was the frequency and how often was I supposed to be doing this? (*baby getting louder and louder in the background*) Oh hello! Want to come sit up here with mum?)

G: ...that's a hint, isn't it, baby? (*laughs*)

P1: (*baby gurgling away*) - it's not your time to eat, though. This isn't your time to eat, no. You usually don't eat till later - do you want to have a little nibble now?

G. It's a fairly blatant hint...(*laughs*)

P1: Yeah - which he was really good doing. He rooted like crazy in the beginning so, you know (*pause while baby settles in to breastfeed*)- so she talked about...um..you know, making sure that he's latched properly and how do you do that? You make sure the lip is drawn back. To listen to him actually swallowing - to see if he's...um..actually getting milk and not just sucking and not getting anything. It was actually pretty good - you know...

G: ....did you feel supported?

P1: ...Oh, totally...

I decided this was an anecdote because it starts with "*so*" which is a conversational lead-in to a description about what happened when P1 went home from hospital. It is separated from P1's next anecdote by the phrase which follows-- "*and then*, of course, because baby was a preemie we had to go and see our GP"-- which initiates another anecdote which occurred in a different time and place.

I re-transcribed the above section of P1's conversation by deleting the verbalizations not from the participant and those parts irrelevant to her experience of receiving breastfeeding counselling:

So, four days later we went home and...um..I was still having to breastfeed him - to wake him to breastfeed him..and the Public Health Nurse came and she did the same thing - okay, you have to be comfortable - okay, so I got comfortable and it was "Make sure you do this and you got that...." The actual technique itself - I don't particularly have a lot of problems with. It was the frequency and how often was I supposed to be doing this? Yeah - which he was really good doing. He rooted like crazy in the beginning so, you know- so she talked about...um..you know, making sure that he's latched properly and how do you do that? You make sure the lip is drawn back. To listen to him actually swallowing - to see if he's...um..actually getting milk and not just sucking and not getting anything. It was actually pretty good - you know...

In this, guided by Labov's model, I can find:

1. the Abstract or initial statement about the *general proposition* via a past tense reference (So, four days later, P1 was still having to wake the baby to feed),

2. the Orientation, which gives the *who* (P1 and her baby), the *what* (the difficulty with knowing feeding frequency), the *when* (four days later), and the *where* (when P1 and her baby went home from hospital),

3. the Complication, which gives the *then-what* (the PHN visited, what she said), which is followed by

4. the Evaluation, the *so-what* ("It was actually pretty good").

I spent time re-reading the condensed transcripts, and, where the anecdotes were not sequential chronologically, I put them into succession using clues such as the baby's age. For example, P3 and I began our conversation by talking about weaning, as she settled her child in with a video and a drink, then we started speaking about breastfeeding and breastfeeding counselling. I rearranged the portions of our conversation into chronological order according to the stated age of her child or time frames included (i.e., "I was so excited...nursing in the Hospital" was placed before "at 10 days it wasn't quite right and then").

Kvale (1996) notes that transcribing involves translating –and thus decontextualizing and abstracting--from an oral language to a written language, and both forms have their own sets of rules (p.165). He observes that transforming conversations into a literary style "facilitates communication of the meaning of the subject's stories to readers" (p. 166). Since this is the goal of this research, to communicate the meaning of each participant's breastfeeding counselling story, I chose to make the stories easier to read, by deleting some of the repetitions, pauses, ums, and "you knows", but keeping the original words as much as possible. In the final formation of P1's story, the previous section has been re-worked into a more literary style, and appears this way:

> So, four days later we went home and I was still having to wake him every four hours to breastfeed him. The Public Health Nurse came. She was really, really good. She said, "This is what you need to do. You need to be comfortable" –okay, so I got comfortable and it was "Make sure you do this and you got that..." The actual technique itself I don't particularly have a lot

> of problems with. It was the frequency and how often was I supposed to be doing this? that I had problems with "You make sure the lip is drawn back. You listen to him actually swallowing to see if he's actually getting milk and not just sucking and not getting anything." It was actually pretty good. (P1)

The Resolution, or *what happened* ultimately, is the next sentence: "I remember feeling that there's someone there that I can call–which is great!" (P1).

I proceeded in this manner throughout all four transcripts, and ended up with a three to four page long, single-spaced typed representation of each woman's narrative of receiving breastfeeding counselling (Appendix D, pp 130-143). I needed to ensure that I had not included or left out any parts which the women themselves felt were crucial to a portraiture of their experiences and contacted the participants by phone to tell them their stories were ready for their perusal. The women were offered the opportunity to review my version of their narrative without me present and to make any changes, deletions, additions, and/or adjustments they wished until they were happy with their story. This offer was relayed verbally, by telephone, and /or in person when I handed them the papers and again in writing if I dropped off their stories at their homes or e-mailed them.

One participant was comfortable with reading her written narrative for the first time during our second meeting. She was satisfied with the initial format of her story as it was, saying that "That was what I wanted to say. Those are my stories". She made no changes at all. She decided that it was not necessary to have the tape recorder turned on for this second meeting.

The other three participants chose to have me drop off the completed stories for them to review alone. A second participant agreed to a second conversational interview and, prior to this, had made minor modifications to her story (i.e., formalizing some of the wording). This second meeting was tape-recorded, transcribed as described above, double-checked, and used as data. The changes, just as requested, were made to her written narrative.

A third participant made substantial alterations to her story's first formation, which I incorporated in their entirety. When given this second formation to review, she made further extensive changes. All her revisions were included exactly as she wished, without dispute or comment. I noticed that through these re-writings, her language changed dramatically, and she included passages which had been part of our initial conversation. She was happy with the third formation.

The remaining participant made one set of changes and commented on her story via e-mail. Both these latter participants declined a second meeting.

Comments from the participants received via notes, e-mails, answering machine messages, and phone calls are also used as data, with permission. All four narratives are left entirely as they were when the participants expressed satisfaction with them. I consider them direct quotes and have left any grammatical errors as is. Three of the participants wanted copies of their final formation, and these were given to them. One woman wishes to read the thesis when completed, and I agreed to facilitate this.

Cortazzi (1993) offers two critiques of Labov's model. He says that evaluation is often distributed throughout the narrative and that Labov does not place narrative within

the social organizations of conversation, excluding such conversational norms as "flashbacks, flashforwards, embedding and subordination", cognitive structures, or processes (p. 49). He suggests that, to offset this, evaluations be compared to "similar structures of other narratives on the same topic" (p. 50). In accordance, once the participants' narratives were in their final formation, I began data analysis, incorporating the three contexts of interpretation suggested by Kvale (1996) and including a comparison of the women's narratives to each other. During this analysis, I noted some relevancies between the participants'experiences, and collated the narratives to elicit a "cultural perspective" shared by these four breastfeeding mothers, evident in a number of narratives, a "commonality" (Cortazzi, 1993, pp. 51-53).

Three Contexts of Narrative Analysis

Kvale (1996) explores three contexts of interpretation of text:

1. *Self-Understanding,* or "a rephrased condensation of the meaning of the interviewee's statement from their own viewpoints as these are understood by the researcher",

2. *Critical Commonsense Understanding*, which "may include a wider frame of understanding than that of the subjects themselves, be critical of what is said, and may focus on either the content of the statement or on the person making it", and

3. *Theoretical Understanding*, which employs "a theoretical frame for interpreting the meaning of a statement" which may go beyond the subject's self-understanding and also exceeds a commonsense understanding. (pp. 214-216)

In exploring the four narratives extracted from my conversations with women about receiving breastfeeding counselling, I used Kvale's three contexts as a framework. First, I rephrased and condensed the women's stories, and compared them. Then, I compared the content of the breastfeeding counsel the women remember and related it to breastfeeding literature. Finally, I employed a system of narrative exploration used by Miller (2000) in her longitudinal childbirth research in which she addresses how constructing narratives helps mothers make sense of transitions associated with biological and social change.

The stories in their final formation, as approved by each participant, constitute the

data analysed in this section, along with participants' comments, verbal and written, which were made while this final configuration was being ratified.

Self-Understanding

The participants' narratives are "first-person accounts by respondents of their experiences" (Riessman, 1993, p. 1). The narratives may be read on many levels, the first of which is in the context of each individual's own viewpoint (Kvale, 1996, p. 214). One execution of this is a condensation of each participant's narrative, using the original wording as much as possible, which follows.

P1

P1's first sentence is a vivid description: "Breastfeeding was crazy--wild and overwhelming and frightening and wonderful and nurturing but...". P1 describes herself as "frantically worrying"about how often to feed her newborn baby, feeling overwhelmed, angry, and "just helpless [with] tears just streaming down my face" as her baby cries. She says "there were many points where I was just so beside myself" looking for an answer. She received timely emotional support and salient tips from her PHNs, which "made the whole world of difference". She found sharing with other mothers in a mother/baby group was a valuable source of assistance: "It wasn't the technical aspect of what to do with breastfeeding, it was that emotional support that 'Everything is going to be fine, don't worry about it, hang in there, we're here to help you.'"

By the latter half of her story, P1 describes breastfeeding her baby this way: "There is such a bond between us that it's almost like a special comfort time with just the two of us." She found that "You can't teach breastfeeding. You just have to go through it

and be supported." Her last sentence is "I love breastfeeding still and it's such a nice thing to have for the two of us."

P2

Equally vividly, P2 describes breastfeeding as feeling "absolutely right and natural and pure" and says she "had always wanted to breastfeed". However, her first experience "felt uncomfortable" as she tried to nurse her baby in the Special Care Unit. She was "shocked" by one nurse's remark about how little milk she was able to pump. This comment had a major impact on P2, who had miscarried a baby the previous year and was "very much afraid that this baby was going to die" too. P2 says that the nurse's "comment really bothered me because I didn't think I was going to be able to provide for our baby as it was". She describes "her biggest worry" as not having enough milk and so she kept a precise chart of what she could measure (how much she was able to pump, when, and how much baby fed and when), weighing her baby at every opportunity. Even tiny differences between the hospital weigh scales, the midwife's scales, and the PHN's scales added to her anxiety: "For us at that moment, every ounce meant so much." These fears persisted for a month and contributed to her feeling "very short on confidence".

Through the support of her midwife, a hospital breastfeeding counsellor, LLL, and the assurance and encouragement of her PHN, eventually P2 was able to "relax, trust our ability and let it come". Her baby began to gain weight, and, by the end of her story, P2 is feeling positive, more mentally and emotionally grounded, and is once again looking forward to breastfeeding her next child. She ends by saying "I now know where my resources are and I know when to contact them. I know how far to let things go if there's a

problem and how to ask for help."

P3

P3 describes herself as initially "enthusiastic" and "excited" about breastfeeding, but found the reality was "much more intense" than she had imagined. She ran into problems with cracked nipples and hyperlactation in hospital. She found support at the Public Health Unit, but also conflicting information which left her feeling "kind of stuck". Her baby was colicky and, when she took him to the doctor, the physician's stern words and attitude left her feeling "chastised", "inadequate" and "awful! I felt like I was failing Baby". She articulates five experiences of receiving negative or unhelpful counselling from health care professionals. Despite this, she felt that she "had been educated enough before [her baby] was born to see the benefits of nursing" and she persisted. P3 commented that "All of the advice and interventions that people would say...I know it was very well-meaning, but I think it was counter-productive".She continued to seek, and eventually found, the breastfeeding support she needed through LLL and media. Her baby thrived on breastmilk, and she says "Nursing is just so amazing, knowing now, physiologically, what the breasts do". She says she will tell her baby "just how much I enjoyed [breastfeeding] and how close I felt...how special it was".

P4

Like the other participants, P4 also found that what she had imagined about breastfeeding and her lived experience with it were quite disparate. She had "envisioned breastfeeding being this wonderful bonding time where we would gaze into each other's eyes and it actually happened that way but I've got to say mostly it's 'You're hungry

again??'" Tears, confusion and fear were frequent elements of her story. She describes herself needing to "get her head together" in hospital while the nurse fed her baby sugar water after a day of unsuccessful latches and unhelpful advice. Her frustration is clear: "I had trouble right from the start"; "I'm thinking 'I'm never going to do this'"; "It just seemed so complicated"; "After six latches that are just 'ugh' you're thinking...'It's okay if I cry. Don't mind me'"; "But nobody ever told me-...'Give your self some mental health time'"; and "Nothing about breastfeeding Baby was easy".

A visit to the breastfeeding clinic helped her to understand her breasts "a little better and how they worked", and she persevered despite the pain she felt. Her baby weaned at just over a year old. P4 does quote her doctor as saying "Congratulations for sticking with" breastfeeding, but this is the only instance of frankly encouraging words from a health professional she includes in her story. However, P4, too, concludes her breastfeeding narrative with affirmative feelings about breastfeeding: "I'm really glad I stuck with [breastfeeding]... When he looks up from your breast & smiles at you, it is worth all the trouble you went thru [sic] to get there. Every woman should try it... Breastfeeding is a precious time that truly is unique".

P4's portrayal of the counselling she received is less positive. She includes phrases such as "You can see that half his mouth is telling you what you need to know as his patient, and the other half is telling you what his lawyer's told him he has to tell you", "If there were one piece of information I would like to have been told by a health professional", and "You shouldn't be made to feel like a failure as a woman and a mother if you are unable to breastfeed exclusively for an extended period of time". Her search for

breastfeeding counsel left her wanting "the human answer: I understand what you are going thru & [sic] if something helps you get thru [sic] it then use it".

When reading the participants' narratives about breastfeeding counselling, it can be seen that although each woman had a unique course, there are some shared experiences and resolutions. These are discussed in the next section, which explores commonalities of the four narratives.

Comparison

There are a number of resemblances among the stories shared by these four participants. The four women were open and descriptive in their narrative stories of receiving breastfeeding counselling, often unveiling close emotional memories with lyric and evocative language. Each told her story from a retrospective viewpoint. The participants' stories took place in parallel time periods and places (within the last three years, first in a local hospital, then at home, then in public health units, and/or community group meetings). Each woman birthed her baby in hospital and had some negative comments about the breastfeeding assistance received there. All of the women left the hospital for home breastfeeding, but each had some problems, such as painful latching, positioning difficulties, questions about feeding frequency, milk supply, weight gain, discomfort, and/or lack of knowledge about using breast-pumps. Each woman repeatedly sought breastfeeding counsel from different sources with varying success and reactions. Specific female health professionals were singled out as supportive. The narratives include verbatim recollections of particular remarks made by health professionals and the women's responses to these. Each woman stressed the significance of emotional support,

and three women commented on their need for mother-to-mother support through sharing stories.

All the participants continued to breastfeed for months. All felt that, by breastfeeding, they had accomplished something beneficial for themselves and their babies. Their explanations of why they felt this are beautifully expressed.

The role of encouragement and empathy. Three of the mothers in the study emphasized the important role for them of encouragement and empathy. For these three participants, cheering words made a huge difference to their feelings at the time and were remembered verbatim. Sources of motivation were particular nurses, a midwife, a LLL leader, and other mothers in community mother/baby groups.

The heartening words of one nurse in hospital made a significant contribution to P1's breastfeeding progress: "She was just so good because she kept saying 'Oh, you're doing a grand job...That's excellent.' It was good! That's what I need to hear. I needed to hear that because the other [nurses] were like, 'Well, you're doing okay'".

P2 also found one individual nurse on the ward who was helpful in getting her baby to latch. She says this "got us going and we were grateful". Later, P2 describes her community group facilitator as "another incredible support person" with "welcome humor". She notes as well the significance of the emotional support she received from her PHN: "It was her confidence in me, her relaxed personality, and her character that really helped me. It was her encouragement, 'Oh, your position's perfect–see, just like that!' she'd say. 'That's great, that's all you need'". P2 calls this PHN "an incredible woman", describing her as "the loveliest person, the sweetest person", and says that her help was

one of three things which formed the answer to sorting out her breastfeeding troubles.

P3 says her LLL leader was "terrific. She bends over backwards for people and she's totally respectful of where you're at. She just offers support". P3 found that joining LLL helped her "to put things into perspective", which was helpful to her.

P4 says her (male) doctor congratulated her for "sticking with" breastfeeding, but does not recount any instances of a nurse giving her encouragement or empathy, although she does single out a PHN at the breastfeeding clinic who "was really good". The PHN showed her how to use the breast pump and "some tricks" for getting her baby off the nipple shield. P4 describes the interaction this way:

> Instead if just making me feel like "You've got to stop using it", it was: "Let him just play with your nipple for a few minutes. He doesn't necessarily need to be eating but he can get used to the feel of it." And she showed me with the pump that I don't have one full letdown, but that many of the ducts have little letdowns. So I got to understand my breasts a little better and how they worked. (P4)

This example also illustrates that the tone of the counsel given to the mothers was significant. P1, P3, and P4 indicate in their narratives that suggestions were more appreciated than absolutes. The participants did not appreciate being judged, by being told that they were doing something wrong: "Until you do it–no matter what, you can't teach breastfeeding. You just have to go through it and be supported and have someone say, 'Have you tried this, have you tried this, have you tried this?'–...not 'This is going to work' or 'You're not doing this right'" (P1). P3 represents the conflicting advice given to

her at the health unit re her hyperlactation as "don't do that" and "you shouldn't be doing that". She is graphic in depicting her negative reactions to being told that it was wrong that her baby had so much gas: "I was trying really hard, I was burping him and burping wasn't helping. I was hardly getting any sleep and I was exhausted. I felt awful! I felt like I was failing Baby, like I wasn't doing something right. I felt inadequate". She preferred the supportive perspective of LLL: "Well, this is what he's doing right now, but it's going to change and don't worry".

It is intriguing to note that P3 was told by people that if she joined LLL, she would become a "Nursing Nazi", and that P4's pre-natal group called the PHNs "The Milk Nazis". Nonetheless, each of these participants accessed and found the support they needed to carry on breastfeeding in that respective group.

Lay breastfeeding support. For three participants, community-based mother/baby groups were important sources of breastfeeding support, and were enthusiastically endorsed:

> That was a lot of support because all those moms there breastfed. They were all great and everybody had their own story–and everybody had heard my story....It was great to go into an environment where all the other women were also breastfeeding and going through the same sort of emotional things with the breastfeeding and the problems and what

[illegible]

"in hindsight [this was] a long time to wait for support. The moms were open to talk about

breastfeeding and their complications and to share ideas. It was like co-counselling sometimes".

P3 found that when she joined LLL, "it was supportive just hearing other moms' stories and being in the company of moms that were nursing kids that were three years old". P3 also spoke in her second conversational interview with me about a group of friends whom she met through community mother/baby classes. She describes her relationship with them as "very close", and calls them:

> A wonderful network...We would talk about what works, what doesn't work, how to get your kids to sleep, how things work and they're just, they're really wonderful. I probably kept nursing longer than I anticipated that I would because of them. And the information that we would share. I hope to be going to these kids' wedding and graduations and you know, onward. And I never want to lose touch with them. And oh, heavens, no. (P3 I2)

She found being with this group of women empowering, revealing this through an anecdote: "But even when they were little babies we used to all go out together as a gang and we'd hang out in Starbuck's and tell labour and delivery stories and nurse and nobody would dare come up and say anything to ten nursing women" (P3).

P4 is the lone participant whose story does not include mother-to-mother sharing as a source of support and she is also the one participant who expressed that she wished she had received more understanding, "human answers" in her recounting of receiving breastfeeding counsel.

Not getting clear answers. P1 told me that "each nurse on the ward was different in terms of what they told you to do" about breastfeeding and that "sometimes my questions weren't answered and I still wasn't quite clear". Her experience was not unique. The other three participants also received problematical breastfeeding counsel in hospital. P2 noted that "help was not readily available initially" in the Special Care Unit where she first tried to nurse. She commented on the "general lack of compassion and reassurance experienced" in hospital. P3 said, "I can't say that I got assistance from the nurses in the hospital about caring for" her cracked nipples. P4 expostulated "Every single one of the nurses in the hospital had completely different advice". She recounts continued difficulty throughout her days in hospital, trying to latch her baby multiple times without comfort, and she too remarked on receiving contradictory advice from various nurses on the same ward on different shifts.

Conflicting advice about specific interventions and techniques from health professionals (especially from assorted people under the same umbrella organization of the Capital Health Region) was a recurrent topic and one which provoked confusion and frustration. P1 and P4 found that recommendations for techniques and timing varied widely among nurses on the same ward and that this advice diverged from other sources such as the PHNs and their doctors. P1 describes her husband and herself "frantically worrying" whether to follow the hospital's recommendation that feeds be every four hours, or the PHN's recommendation that feeds be every two to three hours. She says that "we read every book" but all were "slightly different" which added to her angst. P3 notes that two nurses she spoke with at the health unit gave her opposing advice about whether or not

to pump off foremilk for hyperlactation, while her doctor advised supplementation. In the end, she chose to follow the advice of another doctor seen in a breastfeeding video, which helped resolve the situation.

P4 says that she was "living in fear" that the PHN would know that she was using a nipple shield (which had been recommended by her night nurse and decried by another nurse in hospital). The issues with the nipple shield persisted when P4 went home from hospital. She "spent the whole day without [baby] being able to eat" with or without the shield and ended up calling her PHN after "excruciating pain. I was in tears every time I tried to latch [baby] on". The PHN visited within the hour and advised giving a bottle of formula. P4 remembered from prenatal class "that once babies had a bottle of formula, that was it, they were never going to breastfeed" and so felt that it was just not an option to supplement. She portrays the turmoil she went through trying to resolve this: "Now that I have some perspective I can see how silly that seems, but when you're living it, that's your entire existence, putting food in this kid's mouth. Every tiny, little impression is a big impression on you". She did end up giving her baby evening bottles, but the negative feelings left are evidenced by her comments: "You shouldn't be made to feel like a failure as a woman and a mother if you are unable to breastfeed exclusively" and "Let's face it, an entire generation of people grew up relatively healthily on formula. It isn't poison and it does have its place. It shouldn't be considered a dirty word".

P4 says, in fact, that "the biggest impression I have about every professional person that I asked about breastfeeding is: there's what they're instructed to tell you by the present guidelines of Capital Health or Health Canada or whoever, and the human

answer".

For each of these new mothers, receiving inadequate support, contradictory advice or breastfeeding counsel which lacked the reassurance, clarity and consistency they needed in hospital, contributed to feelings of frustration, failure, and painful breastfeeding.

Effects of timely support. Once the new mothers were at home with their babies, receiving breastfeeding support quickly when they were feeling overwhelmed proved crucial for P1 and P4. Both participants complimented their PHNs' rapid responses to (literally) cries for help. P1 had found her first PHN visit "really, really good" and felt comforted knowing that there was someone whom she could call anytime for help. P1 did call the PHN one morning, in tears, and had a return phone call within ten minutes. The nurse offered tips during the phone call and also phoned back later in the day to see how P1 was doing, which P1 found "really nice...they were there to help and support me".

P4 called her PHN at 9 o'clock one morning, weeping, and "she was [there] by 10". P4 felt that her PHN was "the one voice of reason that I'd encountered". Later on, she describes the PHN as "pretty human actually –I think she went out of the envelope a little bit". I interpret this last statement to mean that, by this point in the first couple of weeks of her baby's life, P4 was no longer expecting sympathetic counsel, but rather rote answers: "there's what they're instructed to tell you by the present guidelines". The fact that her PHN advised her on what type of soother to buy showed P4 that the nurse was going against the guidelines P4 had come to expect only to hear.

Intuition/self-trust. Being encouraged to trust the natural breastfeeding process, or to rely intuitively on themselves and their babies' abilities to succeed at breastfeeding, was

imperative to three participants. P1 started off by seeking numerical answers to her questions about frequency and spacing of feeds. She said "There were many points where I was just so beside myself–looking for, 'Look, someone's got to give me an answer, someone's got to help me, someone's got to give me an answer'". Eventually, she found that her PHN's direction to "do what feels right to you" was "a good piece of advice...to believe in yourself–like believe that you know as a unit what the two of you need for this". She continues by saying that learning "to actually trust my own instincts as a mother, as a new mom, and as a unit, the two of us together, that made the whole world of difference to me".

P2 notes that "At times, I felt baby knew what she was doing more than I did. She helped my confidence a lot. All I needed to do was relax, trust our ability and let it come".

P3 displays similar appreciation for innate abilities: "I have great respect and awe for the whole process of birthing and nursing", honouring her own body and its accomplishment of sustaining her baby. She repeatedly demonstrated this self-trust; initially, when hyperlactation was a problem and she was receiving conflicting advice, P3 resolved the situation herself through use of her own video and persistence. She chose to ignore one physician's recommendation to supplement, another's to quit nursing, and persuaded a third doctor concerned about her baby's weight "plateau" that this is normal for breastfed babies and that a referral to a specialist was unnecessary.

In contrast, P4 does not speak at all about a confidence in her or her baby's inborn abilities around breastfeeding. Near the coda of her narrative she states "nothing about breastfeeding baby was easy".

Critical Commonsense Understanding

Kvale's (1996) second context for interpreting text includes a wider frame of understanding than what the participants themselves say, may focus on general knowledge, and be critical of the content (pp. 214-215). In this segment, I examine how the counsel the mothers received when they sought assistance with breastfeeding may have affected the course of their breastfeeding story, by comparing the specifics of the counsel received with recommendations in current breastfeeding literature.

When comparing the narratives of these four new mothers, one can see that, as the participants relate, new mothers receive a barrage of advice from health care professionals about breastfeeding, but not all of it is helpful. Much of the counsel these participants recount is not supported by the research in breastfeeding literature. Much breastfeeding promotion has been done in the last four decades, but health care education still emphasizes pathology and therapeutics, and bottle-feeding mentality and practices persist in our healthcare system (Coates, 1999; Ellis, 1992a; Hefti, 1992; Moxley, Sims-Jones, Vargha & Chamberlain, 1997; Newman, 1998; Newman & Pitman, 2000). In the following section, I explore how some of the specific advice given these participants may have interfered with establishing, maintaining, and promoting breastfeeding for these women.

Early Lactation Promotion Versus Separation

P1 says that "it was about four hours after baby was born that" she went into the Special Care Nursery to breastfeed him for the first time. P2 comments that her baby was born at 2:00 p.m. but she was separated from her until the following morning. P4's baby

also did not breastfeed right away in the Delivery Room and had trouble breastfeeding during the first day. Breastfeeding experts recommend that breastfeeding be initiated within the first two hours of life, before instincts which help baby find and effectively latch onto the nipple weaken and when the mother's areolar and nipple tactile sensitivity is most pronounced. Delaying breastfeeding gratification and reinforcement by separating mother and baby interferes with physiological factors and learning essential to establishing successful latching, suckling and milk production (Akre, 1996; Auerbach & Riordan, 1999a; Ellis,1992a; Livingstone, 1992b; Newman & Pitman, 2000; Riordan, 1999a; Woolridge, 1986). P1, P2, and P4 had problems with latching, feeding frequency, discomfort, and/or slow weight gain which may be traced back to, or have been exacerbated by, an initial separation from their babies during this critical learning phase.

Latching

All four new mothers experienced difficulties in the first days with latching their babies effectively at the breast. P1 says that at first she "didn't quite get" how to latch her son and that she found the nurses on the ward all gave her different advice. Her baby also took an hour and a half to feed, which suggests that suckling and latching were inefficient. P2 says she did not know how to latch her daughter, but found that the nurses were too busy and lacked the compassion and reassurance to teach her how to breastfeed. P3 had cracked nipples, which evidences latching problems as an effective latch is pain- and trauma-free. P4's nipples were also damaged (bruised and purple), and her baby was constantly hungry, which again point to latching problems. She found that the nurses told her one thing about the way she should be latching her baby but did another; one nurse

told her to wait for an her baby's mouth to open wide to accept the nipple, but another nurse pinched P4's nipple into a point to get it into her baby's mouth, which contravenes the principles of good latching with a wide-open mouth (Akre, 1996; Auerbach & Riordan, 1999b; Newman & Pitman, 2000; RCM, 1991). These four mothers did not receive the breastfeeding counsel they needed to learn and establish effective latching in the first days of breastfeeding, when doing so may prevent further problems.

Positioning

P1 describes having difficulties with learning positioning and worries about her baby getting enough milk despite feeds which lasted an hour and a half. P4 says that "every single one of the nurses in the hospital had completely different advice. They all suggested different holds", which left her confused and pessimistic about ever mastering positioning, an essential component in learning to breastfeed. Supporting baby's head and body in a comfortable and well-aligned manner promotes a good latch and pain-free, effective breastfeeding; it is one of the core principles of getting breastfeeding off to the best start. Incorrect positioning may cause protracted feeds, nipple damage, poor weight gain, and a fussy baby who is constantly hungry (Auerbach & Riordan,1999b; Newman & Pitman, 2000; RCM, 1991; Livingston,1992b). Poor positioning may have been a contributing factor to P1's and P4's troubles with breastfeeds. It is probable that imprinting good positioning techniques in hospital might have prevented some of P1's and P4's breastfeeding distresses and feelings of inadequacy about getting breastfeeding "right".

Feeding Frequency

In P1's narrative, her baby was taken to the doctor frequently because of concerns

about her baby not gaining weight "as fast as they thought he should". P1 and her husband were very worried about whether their baby was breastfeeding often enough. In hospital, she remembers the advice given them was to feed every four hours, but the PHN's recommendation was to feed every two to three hours. Regulating feeding frequency is not endorsed by breastfeeding advocates. Breastfed infants require more than six feeds over 24 hours (i.e., more than one feed every four hours), and many breastfed babies clusterfeed multiple times after a long sleep. Scheduling feeds is modelled on non-biologic, bottle-feeding standards, and can set the mother and baby up for breastfeeding failure. It does not address the root problems of insufficient latch or positioning, and can interfere with the demand-and-response of infant-regulating breastmilk supply (Auerbach & Riordan,1999b; Ellis,1992a; Newman & Pitman, 2000).

<u>Initial Weight Loss</u>

P2's baby dropped weight in her first few days and this worried P2, prompting her repeatedly to seek advice from a variety of health care professionals. Her baby initially lost 5.5% of her birth weight, going from 7.2 pounds to 6.8 pounds [(7.2 - 6.8) / 7.2 X 100 = 5.5 %]. A range of between five to ten percent post-birth weight loss is often cited as normal, although some unrestrictedly breastfed babies lose no weight (Akre, 1996; Mohrbacher & Stock, 1995; Newman & Pitman, 2000; RCM, 1991). Although some sources would not have considered P2's baby's weight loss abnormal, nonetheless this drop is significant to P2 and a huge focus of worry for her, compounding her already-present fear of not having enough milk to sustain her baby. P2 may have derived some badly needed reassurance during this stressful time from being told about breastfeeding

research re normal weight loss parameters.

Pumping and Milk Supply

P2's fear about sustaining her baby was amplified by an insensitive remark from a nurse about the small amount of milk P2 was able to pump when she was trying to learn to feed her baby the first time. However, it is unrealistic to expect a new mother, only a day or two post-birth, to produce large amounts of milk. In the first two or three days, colostrum is the concentrated nourishment produced by the breasts and this is produced in very small amounts, ranging from ten to 100 millilitres/day, with approximately seven to fourteen mls at each feeding and an average of 30-37 millilitres over the first 24 hours (Akre, 1996; Mohrbacher & Stock, 1995; Riordan, 1999b).

It is also unrealistic to expect a new mother to produce copious milk via pumping after being separated from her baby for hours after a difficult birth (P2 was isolated from her baby for almost 19 hours), since both separation (as discussed) and pumping interfere with establishing breastfeeding. Pumping does not mimic adequately the suckling action of a nursing baby, and the emotional interaction between mother and baby which promotes milk ejection is missing. In addition, anxiety about how much she is able to pump can also be detrimental to the mother's milk supply (Auerbach & Riordan, 1999a; Hefti, 1992; Kuzyk & Woolgar, 1995; Mohrbacher & Stock, 1995; Moxley et al, 1997; Newman & Pitman, 2000; RCM, 1991).

It is clear that P2 was very worried about her milk supply: "I wondered 'When will this begin to happen? I need to get this milk supply up!'". P2's alarm about her milk supply was exacerbated needlessly by a lack of knowledgeable explanations and expectations

from those who should have been providing supportive breastfeeding counsel.

Weight Patterns

Once home, P2's baby was weighed frequently by various people, and the differences between the assorted scales contributed to P2's stress. A baby's weight on a scale may vary with the calibration accuracy of the scale, the person who is weighing and her judgement as to when the scale is balanced, the baby crying or being active while on the scale, and if baby has emptied her bowel or bladder (Newman & Pitman, 2000, p. 65). The PHN recommended that P2 come in every Friday and use the same scale to weight her baby weekly. Her knowledgeable reassurance did much to overcome P2's stress.

P3's narrative also includes an anecdote which centres around her baby's weight gain, which is perceived by her doctor as insufficient. P3's baby gained weight well fully breastfeeding, weighing twenty-three pounds by five months of age. In fact, P3 had to persuade her doctor that his growth curve was as expected, when his weight plateaued as his height increased. Standard weight charts are based on artificially-fed babies, which exhibit a different weight-gain pattern, gaining more slowly than breastfed babies during the first three months and then increasing weight more hastily than their breastfed counterparts (Auerbach & Riordan, 1999b; Newman & Pitman, 2000). P3 knew this, but her doctor did not. The doctor wanted to send P3's baby for tests and a referral to a pediatrician, both of which were unnecessary and again evidence an unfamiliarity with breastfeeding norms in a health professional who frequently sees breastfeeding mothers.

Artificial Breastmilk Substitutes and Teats

P1's baby had been “topped-up” with formula in hospital because of concerns

about his weight gain. P3 was advised to start supplementing her baby with formula. P4's problems with her baby not latching or suckling efficiently were compounded when a nurse gave her baby a bottle of sugared water and advised her to purchase and use a nipple shield. Although P4 interprets these actions as beneficent, in order to give her time to "get her head together" and circumvent her latching difficulties, breastfeeding advocates do not support this. Artificial breastmilk substitutes interfere with the supply-and-demand modality of breastfeeding and can undermine breastfeeds, both by impairing effective lactation and by marring the mother's confidence in her own ability. In addition, bottle teats and nipple shields require a different kind of suckle than breastfeeding. Using these items with a newborn may inhibit the infant's learning to suckle effectively at the breast and may lead to complications for the infant such as insufficient nursing, dehydration, poor weight gain, and the risks of latex exposure; and complications for the mother which may include poor breast emptying, a reduced milk supply, severe pain and nipple trauma, engorgement, lactation failure, feelings of failure for the mother, and a decrease in pleasure for both mother and babe (Akre, 1996; Arsenault, 1993; Newman, 1990; Newman & Pitman, 2000; RCM, 1991, 60; Walker & Auerbach, 1999; Woolridge, 1986).

Using artificial supplements and teats may also lead to further interventions because healthcare professionals trained in pathology and therapeutics tend to use technological interventions to deal with problems, even if the problems were caused by hospital routines and technological interventions in the first place (Ellis, 1992a). P4's story illustrates this. P4's baby was given one bottle of sugar water because of latching problems, then, because there had been no changes to her latch and thus no improvement,

a nipple shield was suggested, and, later on, a breast pump, bottles and formula were touted. Once again, knowledgeable assistance with latching, positioning, and expectations may have prevented some of the painful complications which ensued for P4 and the other participants from breastfeeding counsel which went against current research.

Growth Spurts and Pacifiers

P1 was much disturbed at about three or four weeks post-birth, when her baby was "constantly attached to" her nipples, falling asleep after five minutes of suckling, but inconsolable when off the breast. At this time, her PHN encouraged her to give her baby a soother, thinking that this was a baby who liked to suck for comfort. Using a pacifier may lengthen time between feedings, and possibly is useful for those babies who fill up on breastmilk before they have fulfilled their need to suck. However, the baby must be breastfeeding well before resorting to a pacifier, and it is best to refrain from pacifier use until past the first two to four weeks as the infant may substitute non-nutritive sucking for breastmilk intake, resulting in poor weight gain and nipple confusion (Newman & Pitman, 2000; Auerbach & Riordan,1999a).

However, an alternate explanation may be that P1's baby was trying to build up the milk supply during a growth spurt, one of which commonly occurs at two-to-three weeks, and, during which, babies nurse much more frequently. Many mothers are unfamiliar with growth spurts (Elbirt, 2000; Hodges, 2000; Morhbacher & Stock; Vickers, 2000). For P1, using a pacifier was successful (in part, I believe, because she was adhering to her PHN's advice to trust her own instincts and thus was letting her infant regulate the breastfeeding frequency already, which is what is recommended for coping with growth spurts).

Hyperlactation and Colic

P3 sought help a number of times for her cracked nipples, with the latch, for hyperlactation, and for her baby's gas and colic. She says she did not receive much assistance with remedying the latch in hospital, nor with hyperlactation and colic from the PHNs and doctors. She received suggestions which contradicted each other, such as to pump and not to pump off the foremilk. She was chastised by one doctor for the amount of gas her baby had, which left her feeling inadequate. Another doctor recommended supplementing breastmilk with formula at night, feeling that P3 was "getting too upset".

It is possible that all of P3's breastfeeding problems were interrelated. Statements such as "I was just like a fountain", "sometimes the letdown was extremely painful. It was a toe-curler", and descriptions of her milk "spraying all over the place" show evidence of a forceful milk ejection. Her baby was "swallowing a lot of air", had gas but gained weight well, and developed colic. An over-active milk ejection reflex results in a forceful, fast letdown, and babies of mothers with hyperlactation are often plump, pull off and choke while feeding, and are colicky. The recommended prevention/treatments are a good latch and positioning from the very first days of breastfeeding (which helps baby control the flow of milk), using gravity for the same purpose, offering one breast per feed, pumping off just enough milk to relieve ductal pressure, baby-soothing techniques, and stopping certain foods in the mother's diet (Livingstone, 1992b; Newman & Pitman, 2000; Riordan & Auerbach, 1999a). P3 mentions that the PHNs attempted to help her with improving latching, but changing positioning, offering one breast, or adjusting her own diet do not appear in her narrative as options which were explored by her healthcare professionals and

which some authors indicate may have proven beneficial.

Around three to four months of age, the problem of colic often dissipates (Newman & Pitman, 2000; Riordan & Auerbach, 1999a), which happened to P3: "We just sort of kept up with it and enough time passed that Baby got over his colic and his digestive system seemed to mature enough and my milk sort of leveled out and everything was fine". Again, it is not clear that anyone told P3 to expect this to happen.

Drugs and Breastfeeding

When P3 approaches a doctor for medication to combat insomnia, she is told "You've got to quit nursing". This attitude is definitely not supported by breastfeeding research. Newman and Pitman (2000) call this idea "a myth", and state: "This is almost never true. Breastfeeding and breastmilk are very important to the health of the mother and baby. Even if the baby gets some of the drug his mother is taking through her milk, breastfeeding is not more hazardous than giving infant formula" (p. 173). Remarkably few drugs are contraindicated for breastfeeding mothers (Riordan, 1999c, p. 163). P3 might have been able to take medication for her insomnia without weaning her baby, but the doctor to whom she spoke was not knowledgeable about this.

Mother-to-Mother Support

Three of the mothers found that sharing stories with other mothers was very important to their feelings about breastfeeding. P1 illustrates the inter-woman support she found at her community baby group: "Everybody had their own story–and everybody had heard my story–and a few of the women had gone through my experience of being used as a soother. So that was great to have that as a support". She found the environment in this

mothers' group profoundly favourable for breastfeeding, as did P2 and P3 with their own breastfeeding women's groups. P2 noted she did not start going to her group until her baby was five or six weeks old, which she felt was "a long time to wait for support". P3 commented that LLL "was super for support. They really just helped me to put things in perspective". It appears that formal health care systems often overlook the invaluable support breastfeeding mothers can offer each other when they share their stories, although many breastfeeding experts endorse independent groups such as LLL (Auerbach & Riordan,1999a; Bocar & Riordan, 1999; Ellis, 1992a; Hewat, 1992; Newman & Pitman, 2000; RCM, 1991).

Breastmilk-enhancing Strategies, Trust and Confidence

P1's narrative credits one older nurse in the hospital who encouraged P1 by telling her she was doing a "grand job" and that her baby knew "what he was doing". P1 felt this was something she needed to hear. She also credits her PHN with giving clear suggestions and includes an anecdote which she counts as very important to her breastfeeding success, that of her PHN advising P1 to believe in her own feelings and trust herself. P1 says that this "made the whole world of difference to" her.

P2 received encouragement and support from her midwife, who reassured her that she was going to be able to breastfeed, and from another ward nurse, who coached her with the latch. With suggestions from LLL, such as taking fenugreek, staying in bed together for 24 hours skin-to-skin, cup-feeding, and kangaroo care, which are endorsed by breastfeeding advocates (Mohrbacher & Stock, 1995; Newman & Pitman, 2000) she found that her milk supply was increasing and went to see her PHN. The PHN offered P2

confidence in her ability, a positive, relaxed personality, and encouragement, which P2 found vital to her breastfeeding success and her baby's subsequent weight gain.

What P3 found was helpful was having a LLL leader who was "totally respectful of where you're at". LLL helped P3 by putting things into perspective. She found that knowing that things would change and were not worth worrying about was very helpful.

This encouraging and supportive counsel is advocated by many breastfeeding experts. It is documented that trusting in her ability to provide enough breastmilk for her baby can affect a mother's milk supply (Akre, 1991; Hodges, 2000; Mohrbacher & Stock, 1995). Hewat (1992) calls encouragement "essential" especially during breastfeeding's initiation (p. 89). This is the conclusion P2 reached as well, when she realized that the key to providing milk for her baby was to "relax, trust our ability and let it come".

P4 said she wishes she had received the type of counsel which let her know someone understood what she was going through and encouragement to use whatever works.

Comparing Literature, Counsel and Effects

The mothers in these four narratives appealed to a number of health care professionals for breastfeeding advice and support. While all the mothers breastfed for extended periods of time, due in part to salient counsel, three of the mothers credit especially the encouragement and support they received from knowledgeable, empathetic professional breastfeeding counsellors (such as PHNs, LLL, specific nurses, and a midwife), and from sharing stories with other breastfeeding mothers. All participants received suggestions multiple times from healthcare professionals which were not in step

with recommendations from current breastfeeding research. Sometimes, the mothers were counselled to bottlefeed, despite their expressed preferences to breastfeed. Reviewing breastfeeding literature reveals that a number of interventions commended to these mothers interfered with breastfeeding, as did not receiving sufficiently knowledgeable support in the early days of initiating breastfeeding. Occasionally, the mothers and counsellors interpreted interventions, such as supplemental bottles, as beneficial, but the results were detrimental in the long run: "Well-meaning nurses do not see the long-term results of what they thought was helpful advice in the hospital" (Hefti, 1992, p. 96).

Each of these mothers received breastfeeding counsel from a variety of sources and in a variety of ways, but at some point in each story each participant made remarks which seem to show that she felt that her inability to breastfeed successfully right away was her own fault. P1 says "I didn't quite get it" and "I still wasn't quite clear". She describes herself and her husband as frantic with worry about whether their baby was getting enough to eat. P2 also experienced similar self-doubts: "I didn't know how to do it. I felt like I should know how to latch her". Her fears of failing were so profound that she dreaded her baby would die because she did not have enough milk. P3, too, experienced feeling at fault: "I felt like I was failing Baby, like I wasn't doing something right. I felt inadequate". So did P4: "I couldn't get him to latch on" and "I'm thinking 'I'm never going to do this'". She vents her regret clearly when she says that healthcare professionals should not make a mother feel like a failure "as a woman and a mother" if she is not able to breastfeed exclusively for a long time. All the women talked to me about these feelings months and years after they happened as if the sentiments incurred were still fresh.

I find these revelations sad because these feelings were tied into inappropriate suggestions and actions from the health care professionals whom the participants approached expecting knowledgeable support and assistance with breastfeeding. I think patients have a right to expect health care providers to be informed and up-to-date about the things which they profess to endorse. As the participants relate, new mothers may be left with negative feelings which persist for a long time when breastfeeding counselling falls short.

Newman (1997) explains that what is needed is "promotion of breastfeeding coupled with good, knowledgeable and skillful support" (p. 2). Three of the mothers eventually found the informed and empathetic support they needed to feel positive about their breastfeeding experiences. P4 expresses her desire for more compassionate and knowledgeable support from health care professionals, and her narrative does not contain the positive "glow" about breastfeeding that the other three narratives hold.

Theoretical Understanding

The third of Kvale's (1996) contexts for interpreting the meaning of a statement is the incorporation of a theoretical framework (pp. 215-216). Two of the frameworks which are apparent when examining the data in the narratives of these four breastfeeding mothers are the metaphors they use and the other narratives which guide their own stories. These two frameworks are dealt with separately.

Metaphors

People plot their own stories, incorporating culturally familiar narrative models to arrange and provide a sense of connection to other people and between life events.

Common metaphors include journeys, battles, sports, machination, and references to the economy. Storytellers usually adhere to certain cultural rules, and often frame their experiences as romances, comedies, tragedies, or dramas (Sandelowski, 1994, pp. 2-3). In listening to the full transcripts of the conversational interviews with each participant, these framings were somewhat more clear than in the written format, through voice, sound effects, laughter, tears, or non-verbal body language reinvoked while listening. P1 told her story as a drama, for instance, in a sequential and organized manner. She spoke in paragraphs, with clear beginnings and endings to situations and settings. P2's narrative came across as more of a romantic journey, as she moved through trials to a better understanding of her strengths and possibilities. P3's story was also clearly thought out and moved as a drama through the tribulations she and her baby encountered to an admiration for her body's abilities. The tape of P4's conversation with me caused the transcriptionist to complain repeatedly that she had trouble extracting the words through the maelstrom of laughter and comedic vocal sound effects and yet, in the manner of many comedies, much of P4's data is poignant, rather than comic. It is in her final resolution and recommendations that P4's pathos appears most clearly, when she says what she wishes had happened in her breastfeeding counselling experiences and how she feels about breastfeeding her next baby.

Metaphors, as explanatory devices or comparisons, can also be seen in each narrative. When P1 talks about being told "Here's what you do for breastfeeding. *This is how you do it"*, seeks a precise numerical answer to the frequency needed for feeds, says "we settled into a *pattern"*, "Baby *attached to* my nipples", talks about "the *technical*

aspect of what to do with breastfeeding" or having someone say "this is going *to work*", I perceive that she is relating to a mechanical model of breastfeeding: do A and B at this time and C occurs.

P2 uses positional metaphors: "we were separated", "I felt really uncomfortable there", "led us to seek help carefully while *in there*", "get this milk supply *up",* "that got us *going*", "to get us *together and out of there*", "I knew we were never going to accomplish it there", "we weren't really *progressing at a rate*", "get my energy *back*", "that was *a setback*", "*very short* on confidence", "my milk now *increasing*", "for me to *let that go*", "let *it come*", "when baby got to be older *and sitting up*", ".it got us *through*", "I am looking *forward to*", and "*grounded,* both mentally and physically. It's as though physically, I feel *more solid,* and emotionally, I feel *more solid* too". These all analogize placement.

P3's phrasing included "much *more intense*", "fairly *progressive*", "I would nurse *on one side* and I'd have to have a towel *on my other breast*", "I was kind of *stuck*", "I had her *to a point*", "getting this *in balance*", "my milk sort of *leveled out*", "all of a sudden, he *plateaued*", "he *went up, falling arc, then he plateaued* and then he *started to rise again*", "my sleep *cycle* was so *screwed up*", "then *at that point*", "she *bends over backwards*", "put things *into perspective*", "*pushing us away from* our children", "take Baby and me *away from each other*", and "it was *counter*productive". These are all balance metaphors.

P4 uses phrases like "*on-again, off-again*", "now I have *a hang up* about using it", "it was *working*", "He couldn't get *it to come out* of me", "now I have *some perspective*",

"every tiny, little *impression*", "I just can't *keep up with*", "it was *put in* my head", "I had *envisioned* breastfeeding being this wonderful bonding time where we would *gaze into each other's eyes*", and "he made the *final switch*". These metaphors speak of a photographic/light analogy to me.

I believe these metaphors are meaningful because they provide an insight into how each woman viewed her experiences and how she made sense of them. For P1, although she sought them from health professionals and in literature, getting mechanical answers did not assist her to resolve her questions about breastfeeding. This is significant because P1 had a health education background and had been extensively instructed in the biomechanical model of human body function. It was the way she herself was used to thinking about her body. It was not until she looked elsewhere for answers that she was able to find resolution. For P2, getting herself and her baby out of hospital and situating herself at home was crucial to accomplishing breastfeeding, and it is interesting to see how often positional phrases cropped up in her narrative. P3's equilibrium analogies align with her interpretations of how important support was to her breastfeeding and the primacy of achieving a balance in life throughout her narrative. For P4, what she had envisioned about breastfeeding, and what she saw in her experiences are reconciled in the sentence "when he looks up from your breast & [sic] smiles at you, it is worth all the trouble you went thru [sic] to get there". This is a "viewing" memory, involving her baby's vision, and recapitulates how she had pictured breastfeeding before she encountered many obstacles. The metaphors and the conclusion ally in each narrative.

Another Theory of Narratives

Although there are a multitude of narrative analysis theories, I found many cogent parallels between Miller's (2000) narrative study of women becoming mothers through childbirth, and the experiences in this study of new mothers who received breastfeeding counselling. Like childbirth, breastfeeding occurs at a time when biology and culture converge. Breastfeeding is also a "professionally defined, but personally experienced transition", as Miller (p. 3) defines becoming a mother for the first time. She says that:

> The event of childbirth and the process of women becoming mothers have major significance for individual biographies and are publicly defined. Before and during this period of transition, women are confronted with an array of metanarratives (culturally embedded expectations), public narratives (medically or professionally defined), and individual narratives (lay or informal), which can be clearly discerned before, and long after, a child is born. It sits at the interface between the biological and the social, and it is this unique positioning that can influence how women make sense of the event and whether and how they are able to organize their experiences into a coherent narrative. (p. 3)

Breastfeeding, too, has major significance for many women's biographies. One of the core topics most women discuss about new babies is how the infant is being fed. Many older women have long memories of the problems they had trying to breastfeed and what was implied if they could not or chose not to breastfeed. Breastfeeding status is queried at every doctor appointment and public health visit until the child is weaned. Breastfeeding

holds many cultural and social implications about mothering (consider P3's and P4's statements about breastfeeding "Nazis" and the innuendoes of coercion and fanaticism), and, although breastfeeding itself has a "medical definition", it is an event which is experienced intimately between mother and child and which abuts cultural expectations about where and when it is appropriate to breastfeed. There are individual histories which contribute to each woman's view of breastfeeding. Her own expectations and those of other people in her life, for instance the baby's father, the woman's mother, her mother-in-law, and her friends, all affect the new mother's view of breastfeeding, the support she feels, and thus the story she tells.

As Miller (2000) explores women's stories of becoming mothers, she notes that "narrative construction does not take place in isolation, but people make sense of what is happening to them in relation to past events and future expectations and in relation to other actors" (p. 2). Similar relations for constructing breastfeeding counselling narratives can be seen in the narratives of the four participants in this study. Prior to birth, the women held almost idealized views of breastfeeding, influenced by expectations of breastfeeding as "wonderful and nurturing" (P1), "close, absolutely right and natural and pure" (P2), beneficial (P3), and idyllic. P4 describes her prebirth expectations of breastfeeding as mother and baby gazing "into each other's eyes". These are analogous to the publicly acceptable narratives of eager and positive anticipation of motherhood which Miller references.

After birth, however, the breastfeeding narratives change reference, incorporating what the health professionals around the women are saying about breastfeeding. Most of

these instructions are based on a biomechanical reference to breastfeeding: "This is the best position. Have a support in here", "Okay, you've got to tickle his feet, you've got to make sure he's not too warm", "Here's what you do for breastfeeding. This is how you do it" (P1); "I recall a nurse who came in at one point and said "Is that all the milk you've got?'", "Even though I had read a fair bit about breastfeeding, I didn't know how to do it. I felt like I should know how to latch her and how to make things just right, but it's a learned thing, it's not automatic" (P2); "Well, don't do that because you'll just be increasing your supply and you're making it worse", "She would sort of tap his stomach and say, 'Drum! Drum! Drum!'" (P3); "One of the videos they showed you in the hospital tells you to lie down with him and put a pillow between your knees and one under your back and one under your head and one under him", "They all tell you to 'Wait for the open mouth and get the proper latch'", "Oh, your nipples are flat–throw it [a nipple shield] on" (P4).

However, at this point, early in their breastfeeding experience for all the participants, neither the socially acceptable and expected narrative of blissful breastfeeding, nor the biomedical mechanically-based versions were congruent with what the participants were experiencing themselves. The mothers all had difficulties trying to reconcile what they were being told (which was not "working" much of the time) with what they had anticipated and what was actually happening: "For some reason, I didn't quite get it" and "I still wasn't quite clear" (P1); "I felt like I should know how to latch her", "It's not automatic", "I was concerned. I wished I had known at that time that even women who adopt can breastfeed. I thought 'Oh, well, it's just me'" (P2); "A lot of the

lactation consultants' concerns are with 'Do you have enough milk?'", "I had one nurse telling me to pump off some of the foremilk and then I had another nurse saying 'Well, don't do that...'–and I was kind of stuck" (P3); "The first day, I was up for 24 hours and he's trying to latch on and he can't. I couldn't get him on and the Night Nurse goes, 'Gee, if it were the day time I could send you downstairs to the little store and you could buy a silicon nipple shield and that would help a lot but -gee, I don't know what you can do now!'", and "One nurse told me to buy it, the next nurse told me, 'Don't use it unless it's absolutely, positively necessary.' So now I have a hang-up about using it" (P4).

Miller (2000) says that "the difficulties of giving an account that does not resonate with the expectations of those around you or with your own expectations" were "all too clear" (p. 7) in her participants' narratives. She notes that disclosing a new parent's true feelings is risky soon after the birth (p.7). The same can be said of the narratives of these four newly-breastfeeding women. I noted that, despite recognizing that neither what they had expected about breastfeeding, nor the prominent healthcare workers' biomechanical model of breastfeeding, allied with what they were feeling at the time, none of the participants in my study speak about disclosing their feelings of failure and inadequacy to the health professionals around them soon after birth -even though, in retrospect, months later the mothers were quite emotional about how awful they felt at that stage. Nor did any participant speak of confronting those from whom they received inadequate support while in hospital. I realized that I had not confronted anyone either, even though I was angry about the lack of breastfeeding counsel I received on the ward after my daughter was born. Perhaps in the mix of biomechanical breastfeeding narratives and popular narratives of

being "the good mother", the risk of countering the professional and publicly-supported narrative of being a "good patient" is being demonstrated here?

Besides being influenced by expectations from other narrative forms which did not fit with their experiences at the time, there are additional factors and intuitions which play prominent roles in these participants' breastfeeding narratives. This newly-post-birthing time was a period of tears and fears for the breastfeeding women, compounded by the effects of various past events, future expectations, and other actors, similar to those explored by Miller (2000, p. 2). For example, P1's worries about her baby's weight were compounded by her own reading and biomechanically-based health education (past events), her expectations about breastfeeding (future expectations), a premature baby who was not gaining weight as anticipated, a husband who worried about this, and a doctor who could not give her advice about breastfeeding (other actors).

P2 had miscarried a baby the previous year (past event), and she was very afraid that she would lose her newborn daughter as well because she did not have enough milk (future expectations). A nurse's comment about her milk supply magnified the differences P2 perceived between herself and the other women on the ward who had "way too much milk". This nurse, her midwife, and another supportive ward nurse were preeminent "other actors" who influenced P2's narrative.

P3 had done a lot of reading about breastfeeding. She experienced a sleep deficiency, which started to affect her personality and made her feel desperate (past event), was very committed to breastfeeding and had imagined herself breastfeeding (future expectations), and had motivated friends and a prenatal instructor who encouraged her to

breastfeed, but doctors who did not (other actors).

P4's expectations about breastfeeding had been shaped by her imagination, fueled by her prenatal instructor's attitudes towards supplementation, which were shared by one of her friends, and her knowledge that "an entire generation of people grew up relatively healthily on formula" which conflicted sharply with the PHN's recommendations. Other actors in her narrative are her anti-formula doctor, her prenatal group, and their attitude toward the PHNs as "The Milk Nazi's" [sic].

It can be seen that each of these mothers shaped their breastfeeding counselling narratives around what had happened to them, what they were expecting, and the influences, actions, and expectations of other people in their lives. When the mothers received support from someone (another actor) who endorsed their breastfeeding efforts, by allying what was happening with an account that this was good, normal, or expected, their relief is evident: "Then there was this one nurse, sort of an older nurse and she was just so good because she kept saying 'Oh, you're doing a grand job. You're doing a grand job–that's excellent....Oh, look at the little one. He knows what he's doing'" (P1); "'Oh, your position's perfect –see, just like that!' she'd say. 'That's great, that's all you need.' And 'Oh, yes, you've got a healthy baby there, she's going to be fine'" (P2); "They just really helped me put things in perspective, like 'Well, this is what he's doing right now, but it's going to change and don't worry'" (P3). Finally, their breastfeeding experiences were ratified by another person's account, accounts which tended to be from another woman, informal, and encouraging. In like manner, Miller (2000) establishes that, after the baby is born, "the new mother's account of her experiences is constructed with reference

to more informal lay narratives, interpersonally constructed with reference to family, friends, mothers and sisters" (p. 6).

The women describe the feelings they got from this sharing in enthusiastic terms. P1 called this participation "great" and describes how supportive it was to be able to hear other women's stories and to share her stories, thus deriving emotional support and learning what she calls suggestions for "tricks you can do". She was very pleased when she was able to share her trick with the soother with another mother who was having problems similar to P1's experiences with her son.

P2 called her community baby group's support "co-counselling". P2 eventually resolved her anxieties through constructing a narrative which referenced other women's experiences, and seeking strength within her own and her baby's instincts. Her individual narrative allowed her to resolve her breastfeeding story with feeling "grounded" and "solid".

P3 said she found LLL "super for support", and describes being with other mothers who were nursing and being able to hear their stories "supportive".

It is at this point in these first three narratives that the mothers' stories move into positive resolutions as they approach the codas of their narratives and speak about the benefits of breastfeeding and the pleasures they derived. I compare this to P4, who does not include lay narratives in her story. Most of her story elucidates the troubles she went through with breastfeeding. P4 says in her closing paragraphs: "I understand that breastmilk is extremely important to your child, but you shouldn't be made to feel like a failure as a woman and a mother if you are unable to breastfeed exclusively for an

extended period of time".

Miller (2000) points out that women who find that their own experiences do not fit with public or lay narratives may feel it is unsafe to disclose their own, different experience (their "counternarrative") and feel pressured to conform: "Public narratives of childbearing may reinforce the biologically determinist rhetoric that women naturally know how to be and want to be mothers. The stakes can be high for those who admit to personally experiencing something other than this dominant, public account" (p. 6). There is a need to avoid giving a negative impression and also to give a coherent account of being a good mother (p. 8). Some of the participants in Miller's study regulated their interactions in public because it was "too risky" to be seen as an incompetent mother (pp. 8-10). I think P1 touches on a similar feeling for a breastfeeding mother when she speaks about feeling differently about going out in public with her son after the PHN had given her advice to try a soother: "As soon as we were able to get him to take a soother, we were able to go for distances without having to stop and feed him, we could go to places and I didn't feel like I constantly had to stop and feed him–he would take a soother and be happy".

P4 illustrates that the need to have one's narrative conform may also apply to breastfeeding when she avows in conclusion that breastfeeding "is a precious time that truly is unique". She follows this with "even with all of the trouble I had with my first baby, I am planning to nurse any others that I have as well", thus modifying her counternarrative and conforming it to the ideal of being seen as a "good" breastfeeding mother.

I can see multiple similarities between the narratives of Miller's childbirthing participants and the breastfeeding women in this study, which is not surprising as both events are intertwined. For all the breastfeeding participants, their prenatal blissful breastfeeding narratives did not work for them after birth, nor did they ally with the biomechanical models used by many healthcare personnel during their first days of breastfeeding. This discrepancy was accompanied by eloquently expressed emotions of fear of failure and anxiety. Through exchanging lay narratives with other mothers, three of the participants were able to resolve their own narratives to a satisfactory conclusion. For P4, who did not mention sharing lay narratives, her counternarrative contests the acceptable blissful breastfeeding account, but she modifies this by expressing her plans to breastfeed subsequent babies, thus bringing her narrative in line with cultural expectations of breastfeeding.

In summary, in this section the data from the narratives of the four participants about their experiences of receiving breastfeeding counselling were discussed in the light of three contexts, based on Kvale (1996): a condensed Self-Understanding of what happened from each participant's viewpoint, in her own words, which was followed by a comparison of what the women said about the breastfeeding counselling they received; a Critical Commonsense Understanding of the context of the breastfeeding counselling each woman received, compared to recommendations in current breastfeeding literature; and a Theoretical Understanding which looked at the metaphors used by each woman and how breastfeeding narratives are constructed with reference to social, biomedical, and lay or interpersonal narratives. For the one participant whose experiences aligned with none of

these three reference narratives, constructing a counternarrative was modified by following it with a wish statement which conforms to a cultural ideal of breastfeeding.

Implications and Potential

I began this research as a breastfeeding counsellor and completed it as a breastfeeding mother. My interest in the research question of what it is like to experience breastfeeding counselling when you are the mother and not the person doling out advice arose when I was working as a PHN, experiencing emotional visits with new mothers who asked for help with breastfeeding. (I should have remembered my very first breastfeeding visit as a PHN, to a new mother who was helpless with tears because her four day old baby was not sleeping enough to allow her to complete her PhD thesis!) Until I requested (and was able to identify with) new mothers' narratives of receiving breastfeeding counselling, I was not fully cognizant of how intense the emotions are which being a breastfeeding mother and soliciting support entail. Nor was I sentient of the strong feelings of anger that arise from receiving insufficient counselling resulting in toe-curling pain and a profound fear that you are failing your baby. It was almost reassuring to be a researcher having tea with another recently-new mother who had tears in her eyes and who knew exactly why I was pressing my hands to my leaking breasts when she spoke of trying to latch a young baby without adequate breastfeeding counsel. At the same time, it was extremely gratifying to know that heartfelt, timely words of encouragement are remembered and treasured as making a significant difference when new mothers hear them from a healthcare professional.

The surprise to me in this research, and as a new breastfeeder, was that I, and four out of four of the other new mothers I spoke with, had had troubles stemming from inadequate breastfeeding counsel received in hospital. The early hours and days of

breastfeeding are crucial to establishing, maintaining, and promoting breastfeeding and equally importantly, to feelings of success. Hospitals and health care professionals proclaim to be supportive of breastfeeding, but there are multiple examples in these four mothers' narratives of counsel and practices which interfered with, or did not support, breastfeeding. Just the fact that individuals were specifically singled out in each narrative as encouraging demonstrates to me how infrequent it was for these breastfeeding mothers to feel adequately supported by health workers in their choice to breastfeed.

The biomechanical model of the human body, which *may* work well in its applicability to other areas of healthcare in hospitals, falls far short when it is applied to the symbiotic art and skill of breastfeeding, which furthermore involves two people interdependently interacting in a life-sustaining process. Being cared for in hospital by professionals who persist in using a biomechanical model, telling you to do A and then B to achieve outcome C or who recommend interventions which incorporate bottle-feeding protocols such as feeding by the clock, causes harm.

These mothers' narratives demonstrate that breastfeeding counsel in hospital, and in the community, is appreciated and effective when it involves encouragement first of all, knowledgeable and accurate sustained support, and, at a transcendent time, mothers sharing stories. Fortunately for three of the mothers in this study, they were able to find resources in the hospital and in the community (such as a midwife, PHNs, LLL, or other mothers in mother/baby groups) who were able to give them the support and advice needed at a time when it was useful to them. Due to this good counsel from specific counsellors and from other mothers, three participants complete their breastfeeding

narratives with positive evocations of their own abilities, the beauty, and bonding of breastfeeding. One participant did not receive equivalently positive breastfeeding counsel, and she expresses her frustration about this, pointing out what support she would have liked to receive. She takes the risk of expressing a counternarrative, which does not align with popular accounts of breastfeeding, but modifies it at the end by saying that she too believes breastfeeding contributed something unique to her baby and that she wishes to breastfeed any other children she may have.

I believe that this study exemplifies that, when women find the encouragement and knowledgeable counsel they need for breastfeeding at crucial times, they can emerge from less-than-ideal breastfeeding initiations with positive feelings and can keep breastfeeding beyond recommended durations. Without empathetic and enlightened support, a new mother may be left with long-term negative emotions and anger about her unsatisfactory breastfeeding counselling experiences. There must be improvement within our healthcare system's approach to applying the recommendations for breastfeeding support in practice endorsed by most professional healthcare organizations.

What would it be like for new mothers if their experiences with receiving breastfeeding counselling in hospital were unequivocally positive? I can imagine a narrative (based on my own experiences) describing a scenario of a first time mother birthing her baby in a hospital in which all practices followed breastfeeding promotion policies:

> You have just had an unanticipated Caesarian section following an unexpected hospital stay of four days in your ninth month of pregnancy.

You are extremely tired and stressed at this unscheduled turn of events, but very, very happy that your baby has been born healthy and well. While the operating procedures are being finished up below the curtain, a nurse holds your baby over your shoulder where she can reach your nipple and where you can see and cuddle her. She opens her eyes and looks straight at you and begins to nuzzle at your nipple.

"We had to suction her, but we were very gentle, and she shouldn't have any trauma to the mouth which might interfere with nursing," the pediatrician says. "We will hold off doing anything which isn't immediately necessary, like weighing and measuring your baby, so you can nurse her." Your daughter has her first breastfeed right on the delivery table and you are thrilled that you are able to do something successful after so many technological interventions. "You are doing a great thing for your baby," the staff say. "And for yourself. Hormones released through breastfeeding are helping your uterus contract and stop bleeding, establishing a nourishment supply for your baby, and releasing relaxation factors which help both of you get much-needed rest." They smile with pleasure that you are doing so well already. This makes you feel very good.

You remember that your best friend's baby had to spend the night in the nursery under observation after a Caesarian delivery. You are worried that you will be separated from your newborn. "Oh, no!" the nurse says. "We know how important it is for mother and baby to be close right after

birth. We bring the nursery to you. You two will be together as much as you want." During that night, a cheerful nurse is always near, keeping a close eye on your baby, but she encourages you to have the baby in bed with you, explaining that being near her mother's body encourages temperature regulation and breastfeeding as well as bonding and relaxation. Any special equipment needed is brought to your room.

You are pleased to see that the bed is extra-wide, with specially-modified side-rails, which would not allow a tiny infant to slip through. The room is dark and quiet. You fall into a deep, restorative sleep with your baby cuddled closely. She falls asleep, too.

In the night, you awake, and you are not sure why. Your baby has not yet stirred. The nurse leans over you and says very softly, "Isn't that amazing! I still find it wonderful that mothers' bodies react to such subtle signs when their infants' sleep cycles are changing to awakening. See, your breasts are already preparing for this breastfeed and you aren't even aware that your baby is thirsty." She goes on to explain the wonders of colostrum and point out to you your daughter's cues that she is getting hungry. The nurse fetches a horse-shoe shaped pillow, designed especially for breastfeeding and helps you get into a comfortable position. She helps you position the baby, with her tummy facing yours, her head level with your breast, and her mouth opposite your nipple. She tells you to wait for a wide-open mouth, and then pulls the baby on. You have to wait what seems like

a very long time, almost a minute, before the baby opens her mouth wide-enough, and you try and pull her on quickly.

The nurse asks you if this latch hurts. It does, a little, but you decide it is not too painful. Anyway, you expect breastfeeding to be uncomfortable. The nurse however, shows you how to take the baby off, explaining that it is important that breastfeeds not hurt, as pain is a sign that something is wrong. "Mother Nature designed breastfeeding to be pleasurable, so that we would do it as often and as long as baby needs," she says, "It is vital that the baby and you learn and enjoy it right from the start. If there is something just a little bit wrong now, it might get worse over time and become a bigger and more painful problem. Your baby may pick up on you preparing yourself to cope with that 'little bit' of pain, and be reluctant to come onto the breast, starting a whole cycle of difficulties. Let's spend a little bit of time now, while she's not frantic and hungry, to get everything right and prevent lots of missed sleep and pain in the future." This explains something else you had wondered about. Your friend had been encouraged to get a full night's sleep after her Caesarian, but this nurse has motivated you to wake at night for your baby's breastfeeds, saying that research shows that doing so prevents much more missed sleep in the next few weeks, as breastfeeding problems are prevented, and mother and baby get into a synchronized sleep/wake rhythm.

Your baby has a short feed and falls asleep again. The nurse takes

your vital signs and checks your incision and so on while you are awake. You admire your baby for a little while and then sleep yourself. The nurse checks on you frequently, but does not intrude when you are having some close-time with your baby. You realize in the morning that you did not need the call bell once during the night.

The day nurse follows the same principles for establishing good breastfeeding as her peer, even though her style is a bit different. She has an instant-picture type camera and takes photos of you while you are breastfeeding with good technique, so that you can take them home with you for reinforcement. She, too, stays cheerfully with you throughout a feed, helping you position and latch your baby, and encouraging and complimenting you frequently. When your daughter is in an alert state, she offers to bring the baby bathing paraphernalia to your room and show you and your husband how to give baby a bath, during which she shows you your daughter's reflexes and innate abilities.

You realize there are many things that are different from your friend's hospital stay. There are no stacks of boxes of formula in the hallways of the ward. Your baby's name is on a hand-lettered sign on your bed, rather than on a card with a manufacturer's name on it. Even the measuring tapes and pens have no logos on them. In fact, you have not seen a bottle or soother at all in here. You ask for a schedule to keep track of your baby's feeds, but instead the nurse describes to you what cues a baby

gives when hungry, what behaviours show that she is satiated, and explains that watching a clock instead of your baby is less effective and more likely to cause problems. When your baby has her next feed, the nurse points out all these signs, such as falling asleep with milk dribbling out of the corner of her mouth and having a wet diaper with a bowel movement with a feed. She gives you a pamphlet which tells you exactly the same things as you have just discussed with phone numbers you can reach from home for any breastfeeding questions.

Part-way through your hospital stay, a woman with an older baby comes softly into your room. She gently explains that she lives in your neighbourhood and that her son is five months old. She is breastfeeding as well and tells you she remembers having tons of questions when she first came home with a totally-dependent human being in her arms. She offers you her phone number and says she will be available any time with support and encouragement. She volunteers to come over the day your husband has to go back to work and hold the baby while you take a shower, and bring tea and muffins to boot. She has a sense of humour about breastfeeding which you find heartening. It is a great relief to you to know that other mothers have come through this time successfully, even though they were unsure and felt completely disorganized too. You feel motivated.

By the time Day Four rolls around, you have breastfed your baby many times, and the nurses were with you as often as you felt comfortable

with them there. You have done most of the latter feeds independently, but every time they say something complimentary about your style of holding and nursing your baby, you appreciate it. You feel you have a handle on the general principles of good positioning and latching, when to know your baby is ready for a feed, and if she is getting enough. Your milk is just starting to come in, and you are surprised that you are not engorged like your friend was. You remember her breasts were enormous, hard, red, and so sore that she was crying. Your breasts are full and heavy and tingly, but there is no redness or pain. Engorgement, the nurses explain, is not a normal part of breastfeeding, but is a sign that there are some unaddressed problems with baby stripping the milk, the latch, and/or positioning. In this hospital, engorgement requires the nurses to fill out an incident report, as it is a totally preventable complication. Your breasts are not painful, your nipples are not bruised at all like your friend's, you are actually looking forward to each feed, and the feelings of fulfillment and relaxation that go along with nursing. Your confidence builds.

When you are discharged, the nurses give you a "Mummy-Pak". It contains some bath-salts, a candle, a sample of maternity vitamins, some muffins and juice, and a humorous reminder to take care of yourself so that you have the resources to care for and nurture a baby. There are coupons for a "breastfeeding-friendly" meal from a local restaurant (already cut-up so you can eat with one hand), coupons for free pick-up and delivery of four

loads of laundry from the local launderette, and an inflatable horseshoe-shaped breastfeeding pillow. There is no free tin of powdered formula or baby bottles, and so you ask the nurse what brand she recommends you have on hand at home. "You don't need one," she says. "You are completely providing for your baby right now, and your body's ability to make breastmilk for your baby depends mainly on how often and well she suckles and your own confidence. Mothers have breastfed triplets well into the second year. You have plenty of wonderful breastmilk. If you get over-tired you might have a drop in milk-production though, so it is very important that you pamper yourself. Just be responsible for caring for you and your baby. My mother told me not to do anything when the baby was asleep that I could do when the baby was awake, which means when my son slept, I did too! Let somebody else do the chores around the house for a little while, while you continue to excel at the most-important job of nurturing your beautiful, healthy, breastfed daughter." She gives you a list of phone numbers for breastfeeding resources and emphasizes that you may call the ward at any time with questions. You leave for home a bit nervous about being responsible for another life, but feeling that there are people who are more than willing to help out if you just pick up the phone.

That night, you receive a phone call from your hospital nurse at home. She asks how things are going, to which you answer "fairly well". She answers your two questions about why your milk looks a different

colour than before and how to stop leaks from one breast while baby is nursing at the other. She tells you it was a pleasure to be your nurse and that your baby is lucky to have you for a mother. It is nice to have someone tell you this.

Next day, another nurse comes for a visit. You are still in your pajamas at noon and are feeling a bit embarrassed. She tells you she is very glad to see that you are taking it easy and offers to hold the baby for you while you run the dog outside. She reinforces what a wonderful thing you are doing to give your baby the healthiest and best nutrition possible. When she leaves, you feels cheered and encouraged. She says she will phone you tomorrow and come back if you wish. You do wish, and she again arrives bearing a aura of support, encouragement, and enthusiasm. She tells you stories about when her children were breastfeeding and leaves you laughing.

You continue to nurse your baby for months, at times meeting with other mothers through the woman around the corner, at other times accessing LLL or your PHN for support and suggestions about such things as going out with baby or growth spurts. Your doctor weighs the baby occasionally, but, for the most part, judges how well your infant is doing by her behaviour and daily activities, complimenting you about breastfeeding, and describing in detail why what you are doing gives your baby so many health advantages. You realize that every healthcare professional you've

met has assumed you would succeed at breastfeeding, was encouraging and commendatory, was knowledgeable about breastfeeding and was able to offer tips on techniques or suggestions about things to try when questions arose. When your baby has tripled her birth weight by five months, you feel incredibly proud that every calorie of that superb nutrition came from your body and that you did this yourself.

There are a number of differences between this imaginary narrative and the four narratives of the participants. Firstly, the imaginary healthcare staff are uniformly supportive, knowledgeable, and encouraging about this mother breastfeeding and make what is best for baby and mother precedent over routines, schedules, and measuring. It is more convenient for hospital staff to have babies who need observation in the nursery overnight, but it is better for breastfeeding (which is best for babies) if newborns and mothers are not separated and early breastfeeding is facilitated. In the imaginary narrative, interventions which might interfere with breastfeeding (like aggressive suctioning, for example) are kept to a minimum. The mother's hospital bed is designed for infant and mother to sleep safely together. A nurse is there when baby starts to stir, rather than the mother having to wake, ring a call bell, and wait until the nurse can come to help her position and latch her infant, by which time the baby might be frantically hungry. All the nurses on all shifts use the same techniques and advice to help establish breastfeeding, and, at no point, are artificial methods promoted, displayed, or subtly endorsed. Mother-to-mother sharing is actively encouraged. Such support continues in the community when mother and babe are discharged home.

Secondly, and possibly of more importance, is the difference between the way the imaginary healthcare professionals and many of the healthcare professionals in the participants' narratives view the human body. I think one of the most profound threads common to the three study narratives in which the participants came to enjoy and honour breastfeeding, was their acceptance of counsel which advised them to trust their own bodies and to rely on their babies knowing what to do. Most healthcare professionals in the Western world are trained to view the human body as a biomechanical system. This view vastly underrates the complexities, abilities, and adaptability of the human body. I think it is kind of arrogant (and severely limiting) to envisage our bodies as comparable to something which we humans designed, and, for breastfeeding especially, this biomechanical metaphor does not apply. There is much not yet known about the intricacies of breastfeeding. Viewing breastfeeding as a cause-and-effect system is inapt.

What helped P1, P2, and P3 in learning to breastfeed was discovering that their bodies' and their babies' knowledge of breastfeeding was greater than their own preconceived ideas or their counsellors' knowledge about breastfeeding. Relaxing and trusting the process were integral to these participants' success at breastfeeding. It makes evolutionary sense that adeptness to something as necessary to human survival as sustaining babies would be ingrained and would not require the interference of external clock-watchers, technical interventions, scheduling, monitoring, or measuring. These latter skills are territories in which healthcare professionals excel when there are problems with human bodily functions. Howeevr, breastfeeding is not a functional problem which needs objective solutions or interferences. It is a natural role of women's bodies and breasts, and

trying to measure, schedule, and control breastfeeding does not assist mothers who are learning, subjectively, about their bodies' abilities to sustain offspring.

When the three mothers were able to relax and trust the breastfeeding process, and received support for doing this from other mothers, LLL, or insightful PHNs, they succeeded at breastfeeding. One of the big lessons about breastfeeding counselling that I see in these four narratives is that our bodies' knowledge about breastfeeding is superior to our knowledge about our bodies. I think the way in which breastfeeding is viewed by many women and healthcare workers speaks, in part, to the way in which numerous women consider their bodies as imperfect and in need of adjustment from the outside, through dieting, measuring, scheduling water intake or exercise, and keeping to an eating and sleeping frequency governed by the clock and dependent on what experts recommend. Many women are not experienced with trusting their bodies to know what to eat, or when to sleep, or how much to exercise. It is, therefore, not surprising that, in breastfeeding, learning to trust their bodies and their babies, to "give-over" the process so that the baby leads when and how much to nurse and to sleep, and to believe that their breasts will accommodate however much baby needs is a precept with which many new mothers and breastfeeding counsellors struggle.

Perhaps, for breastfeeding counselling to be really successful, what is needed is not only that healthcare practitioners begin to practice the policies which breastfeeding experts advocate, but to change the ways in which women's bodies, intuition, and innate knowledge are viewed. At present, what can be controlled, measured, scheduled, or otherwise objectively assessed is more highly regarded and teachable than what is

subjective, ingrained, immeasurable, and not programmable. Trusting a little baby to guide the breastfeeding process and his mother's body to know how to respond takes a big leap of faith, especially if you are a health care professional who was educated and exposed mainly to bottle-feeding, from a culture in which human bodies are viewed as malleable machines which need expert guidance. Add to this mix the loss of breastfeeding culture passed mother-to-mother through generations, and one can see that there are multiple barriers to breastfeeding. The fact that three of the four mothers in this study felt so successful about breastfeeding, and that all four of the participants breastfed their babies for months, speaks volumes to a mother's ability to succeed at breastfeeding despite multiple cultural obstacles.

Recognizing that this study is limited by constraints of size, locality, and demographics (four local, literate, adult, first-time mothers, and an equivalent researcher), there are still cogent areas for discussion and reflection about breastfeeding counselling practices at present in Western Canadian culture. Each mother had idealized views of breastfeeding pre-birthing, which they sourced in reading, prenatal classes, cultural expectations, and imagination. Some days after birthing, when three of the participants shared their breastfeeding stories with other mothers, they were able to begin reconciling the discrepancies between their own experiences, their expectations about breastfeeding, and what they had been hearing from some of the healthcare professionals they had approached for breastfeeding counsel.

Frequently, the professional advice these four mothers received from nurses and doctors about breastfeeding was not congruent with breastfeeding literature. Difficulties in

breastfeeding arose and engendered some negative and harsh feelings. However, for at least one of the participants, working and reworking her own story for this study allowed some resolution of the adverse emotions incurred whilst she was receiving inadequate breastfeeding counsel from some healthcare professionals.

Specific women gave breastfeeding counsel which was imperative to the participants' feelings of accomplishment and achievement in breastfeeding. These recommendations tended to be timely, emotionally supportive, and encouraging, emphasizing the mother's and baby's innate abilities to succeed, and were often worded as tips or behavioural observations based on shared experiences. The impact of this counselling was substantial for the mothers. The implication is that wording of breastfeeding advice needs to be suggestive, heartening, and built upon observations and positive descriptions of physical actions which promote breastfeeding. The mothers' stories also point to the need for rapid accessibility of breastfeeding counsel, as this was described in two narratives as much appreciated.

The implications from these four narratives for Nursing Practice related to breastfeeding counsel are that nursing practices in hospital should be au courant with breastfeeding literature, that a biomechanical perspective does not fit with breastfeeding reality, that encouragement and empathy are critical, and that being able to hear and share breastfeeding stories is indispensable. The implications for policy based on practice (beyond the obvious ones of bringing hospital practices in line with breastfeeding research by not separating mothers and babies after birth, by knowledgeably supporting and promoting breastfeeding within the first two hours of life and throughout the hospital stay,

and by not promoting artificial formulas and teats, all of which are well-documented in nursing literature) might include such things as buddying women who want to breastfeed with other breastfeeding mothers perinatally, instituting practices in hospital which support sharing among mothers, clarifying with postpartum ward staff the long-term implications of inadequate breastfeeding advice, and furthering the availability of immediate response to breastfeeding mothers in crisis.

There are four areas for further research and investigation which stand out for me in relevance to the terrain covered in this study:

1. How might increased contact prior to birthing with breastfeeding mothers who share their stories and experiences affect the "blissful breastfeeding" narratives which each of these participants formulated before their own babies were born? Would having a more realistic picture of breastfeeding's give-and-take decrease negative emotions resulting from preconceived ideals which do not fit with actuality in the first few weeks of breastfeeding?

2. How would consistent, available, knowledgeable breastfeeding support from healthcare professionals in an environment which fully encourages breastfeeding affect women's feelings after birth, especially during the first few weeks when tears and feelings of failure were common elements in the four participants' narratives? Would a congruence between the professionals' narratives about breastfeeding, literature, resources, and the women's own experiences make a difference?

3. How does sharing one's breastfeeding stories with other breastfeeding mothers, or hearing such stories and breastfeeding tips, impact one's own narrative about breastfeeding? Does the method of sharing make a difference at certain time-frames after baby's birth? For instance, P2 shared her stories with other mothers weeks after her baby's birth but also in writing almost two years after she had struggled to initiate breastfeeding. Yet, she found both were valuable to her resolution of negative feelings.
4. How would the women's narratives change or not change if one were to ask them the same research question which prompted these narratives immediately after, or two, four, or ten years after they had weaned their babies?

Simkin (1991,1992) investigated women's long-term memories of childbirth, questioning mothers immediately after, and then fifteen-to-twenty years later, about their labours and delivery. She found that women's vivid memories remained generally consistent, but that the significance of negative events increased and intensified over time and that specific caregivers were authority figures whose words and behaviours had an impact on how each woman remembered her experience. I think it would be interesting to do a parallel study in terms of women's narratives of receiving breastfeeding counselling to ascertain whether negative events also increase in significance as time passes and whether counsel from specific caregivers has a continued impact through the years.

Conclusion

Breastfeeding can be a wonderful time in a new mother's life, sharing with and bonding to her baby, sustaining and nurturing an original little life with a substance so natural and unique that it is formed from her own body. Most professional health organizations recommend exclusive breastfeeding for the first six months of life because of the many health benefits to mother and baby from breastfeeding, concurrent with the documented risks of giving artificial breastmilk substitutes. However, many women in today's society are not familiar with, and lack experience and cultural support for, breastfeeding. Trying to learn to breastfeed without knowledgeable, encouraging, and empathetic counsel can be difficult, painful, emotionally overwhelming, and exhausting. It is suggested in breastfeeding literature that a common reason for breastfeeding difficulties and premature weaning is lack of informed breastfeeding counsel. Mothers often approach nurses and other health professionals for advice on breastfeeding issues. This study focuses on examining what the experience of receiving breastfeeding counselling, herein defined as advice, suggestions, recommendations, or support, from a health professional is like from the mother's viewpoint.

Conversational interviews were held with four local mothers who had breastfed within the last three years to elicit their stories of receiving breastfeeding counselling from a health professional. These narratives were evoked by the researcher using Labov and Waletzky's (1967) structural approach, as cited in Riessman (1993), Cortazzi (1993), and Mishler (1986), from the verbatim conversational interview transcripts. These narratives were modified by each participant until she was happy with the format and then analysed

using Kvale's (1996) three contexts of interpretation: Self-Understanding, or a condensing of the participant's own viewpoint which was then compared to the other three narratives; Critical Commonsense Understanding, in which the context of the breastfeeding counsel was compared to current literature; and a Theoretical Understanding, in which the women's narratives were viewed in the light of metaphors, and then in view of popular socio-cultural, biomedical, and lay breastfeeding narratives. The participant who was unable to fit her own narrative into these three prevalent narrative-forms created a counternarrative, which she ultimately modified to conform to the acceptable cultural ideal of breastfeeding, consistent with Miller's (2000) findings about narratives of the transition to motherhood.

An imaginary narrative was written in which a new mother received ideal breastfeeding support in hospital and in the community from healthcare professionals and lay mothers who shared stories with her. Differences between the imaginary narrative and the participants' narratives were briefly discussed, and two primary distinctions were noted. The first was that in the imaginary narrative healthcare staff were uniformly supportive, knowledgeable, and encouraging about the imaginary mother breastfeeding and, thus, made what was best for baby and mother precedent. The second distinction was that the human body was viewed as knowledgeable and intuitively capable of breastfeeding in the imaginary narrative, rather than a biomechanical system in need of expert guidance as in the participants' narratives of the study. Suggestions for areas for further study about breastfeeding counselling were explored.

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Appendix A: Request for Participants Pamphlet/Flyer

LOOKING
FOR A CHANCE
TO TALK ABOUT
THE BREASTFEEDING COUNSELLING
YOU EXPERIENCED
??

**Have you breastfed within the last three years?
** Are you a woman who would like to tell your OWN story of receiving breastfeeding counselling?

A University of Victoria graduate student in Nursing is looking for volunteers for a research study about YOUR EXPERIENCES with breastfeeding counselling from a health professional. Did you seek help from a Nurse, your Doctor, or a Lactation Consultant? Would you be willing to talk about your story?

I want to get a better understanding of what happens when a breastfeeding mother invites someone to help her. I'm not connected to any health practitioner or institution, and talking to me will have no impact in any way on your receiving health care now or in the future.

Confidentiality and anonymity will be maintained. No one will know who told which story or be able to identify you in any way.

Time commitment will be approximately two one-hour interviews, which will be tape-recorded, and includes time to read and comment on my writing of your story.

If you are willing to volunteer, or wish to ask any questions, please contact

Gabrielle @ — ----

Appendix B: Letter to Community Nurse

Date

Hello_________,

Thank you for calling me back! We seem to be playing telephone tag this week, so I thought that dropping off some written information for you to peruse might be a more efficient way of letting you know about me and my thesis project.

I am a UVic Nursing grad student, and am hoping to start on the interviews for my thesis soon.

I have worked as a Public Health Nurse in Ontario and Victoria, doing breastfeeding classes, drop-ins, and home visits, all of which I really enjoyed. I would like to gain a better understanding of women's experiences of receiving breastfeeding counselling, specifically from a health professional. I am interested in women's stories of what it is like to invite someone to help you with breastfeeding.

My aim is to have one-on-one conversations with women who have received breastfeeding counselling within the past three years, and hear about what happened in their own words. I'd like to write up each woman's story as a narrative, and then take it back to each participant so she can read and make comments on it. I expect each of these two conversations/interviews will last about an hour, and each would be taperecorded. So total time commitment for each woman would be about two hours. Participants would need to sign a consent, but no identifying information would be included on the tapes or in the write ups of their stories. There is no money or consequence involved, other than the opportunity to tell your story.

I'm expecting our first child later on this month, and so anticipate that the interviews would occur sometime before then or at any time mutually agreeable between now and ----

.

I'd be very grateful if you would agree to having the included ads available to postnatal women to read. My phone number is_______, and if any one is interested in participating, or has any questions, please call and leave a message. I'll get back to you ASAP.

Thanks again for your time and trouble

Gabrielle Leja

Appendix C: Consent Form

I hereby give my consent for my participation in the study entitled **A narrative analysis of breastfeeding counselling experiences**.

I understand that the persons responsible for this Master's in Nursing Thesis research are Gabrielle Leja and her thesis supervisor Dr. Isobel Dawson, Department of Human and Social Development, University of Victoria, Victoria, BC. Gabrielle Leja has explained to me that the objective of this study is to fulfill requirements for her thesis and to increase understanding of women's experiences of breastfeeding counselling.

Gabrielle Leja has explained to me that she will tape record and possibly take notes during at least two interviews with me. It is expected that each interview will be about one hour in length. I will have a chance to review and comment on my interviews.

I will not be identified on tape or in print at any time. Confidentiality and anonymity will be assured by using a number code instead of my name during the entire duration of this study and in the written report. Only Gabrielle, the transcriber and Dr. Dawson will have access to the tapes, which will be kept locked in Gabrielle's home when not in use and will be erased at the completion of the thesis. The transcriber will not have access to any identifying information for any participant.

I understand that I can withdraw at any time from this study, and may refuse to answer any question(s) at my discretion, without explanation, during interviews. I understand that there is no monetary compensation for my time during this research, and that participation in this research will have no effect upon current or future medical / health care in any way

I can contact Dr. Dawson's office at _______-or Gabrielle at________ if I have any questions about the study, or ask Gabrielle any questions during interviews.

My signature indicates that I have read this consent, and my willingness to participate as outlined above. Gabrielle and I each have a copy of this consent.

SIGNATURE :

DATE:

WITNESS:

COPY TO PARTICIPANT :

Appendix D: Participants' Stories

P1 (Participant 1)

Breastfeeding was crazy–wild and overwhelming and frightening and wonderful and nurturing but...

It was about four hours after Baby was born that I went into the Special Care Nursery to breastfeed him for the first time. One of the nurses took me to a sort of a little tiny side-room, set me up in a rocking chair and told me "You know, this is the best position. Have a support in here..." And for some reason I didn't quite get it but I was really lucky because the little guy knew what he was doing and he latched right away.

Each nurse on the ward was different in terms of what they told you to do. So I tried this, tried that--well, he didn't suck very much and so they'd say, "Okay, you've got to tickle his feet, you've got to make sure he's not too warm". They bring you the little pieces of paper that say "Here's what you do for breastfeeding. This is how you do it." And they had a little breastfeeding video that I watched. It was actually pretty good. But sometimes my questions weren't answered and I still wasn't quite clear.

Then there was this one nurse, sort of an older nurse and she was just so good because she kept saying, "Oh, you're doing a grand job. You're doing a grand job--that's excellent." It was good! That's what I needed to hear. I needed to hear that because the other ones were like, "Well, you're doing okay. Well, just keep at it. That's okay." But she was more "You're doing a grand job. Oh, look at the little one. He knows what he's doing. Oh, he's sucking away there."

So, four days later we went home and I was still having to wake him every four hours to breastfeed him. The Public Health Nurse came. She was really, really good. She said, "This is what you need to do. You need to be comfortable" –okay, so I got comfortable and it was "Make sure you do this and you got that..." The actual technique itself I don't particularly have a lot of problems with. It was the frequency and how often was I supposed to be doing this? That I had problems with. He rooted like crazy in the beginning so she talked about making sure that he's latched properly and how do you do that? "You make sure the lip is drawn back. You listen to him actually swallowing to see if he's actually getting milk and not just sucking and not getting anything." It was actually pretty good. I remember feeling that there's someone there that I can call–which is great! She said she'd be back in a couple of days but this is the number to call, and I could call anytime.

And then, of course, because Baby was a preemie we had to go and see our GP a little bit more frequently, because he wasn't gaining as fast as they thought he should. So, now I'm frantically worrying–thinking, "You know, am I not feeding him enough?" –because I'm still having to wake him every four hours and then in the book it says "every 2-3 hours". The doctor, she couldn't give me any advice about breastfeeding itself. When I was in the hospital it was every four hours. When I got home the Public Health Nurse said it was every 2-3 hours. So, now my husband is frantic because I haven't been feeding Baby every 2-3 hours. I've been feeding Baby every four hours and when I fed him it was long,

it was an hour and a half and he'd fall asleep. I didn't know how do I get him interested in it again and if he's had enough.

And we read every book. We got all these books and they all say–you know "Do this, do this, do this"...All slightly different. And he was so teeny, so we were worried. They had topped him up with formula in the hospital, to make sure he was gaining enough. And my husband kept saying, "You should give him formula"–because he was worried he wasn't growing fast enough and maybe he wasn't getting enough. That was really hard for me because I didn't want to give him formula. I really wanted to continue with the breastfeeding.

By now Baby's a week and a half, two weeks old and he's now getting into where he's actually letting me know when he's hungry. But it's still longer than the every 2-3 hours that they say and I have this sort of internal feeling. One of the Public Health Nurses–and I should think this was the second visit when she came to see me–said to me, "Do what feels right in your heart"–because we were talking about length of time and I was crying. She came to see how he was doing and weighed him and we sat and talked and I kind of was post-partum and crying and overwhelmed. I said, "I just don't know. Do I wake him? He looks happy and then when I wake him up, he doesn't feed as well and he doesn't look like he's hungry and yet I think I'm starving him." And she said, "Just do what feels right inside yourself. You know, you'd be surprised at that that is like and yes, there are certain patterns to follow and yes, all these books give you the information but do what feels right to you. He's gaining and he's poopsing and peeing–see, he's doing his thing." Then, I kind of relaxed a little bit and if my husband said, "You haven't fed him for such a time," I'd say, "Well, but I think he's okay–I'm just going to leave him for now. I think he'll be fine."And you know, I went with my feelings. Some days I didn't, but most times I did. That was a good piece of advice from her; to believe in yourself–like believe that you know as a unit what the two of you need for this.

After a couple of weeks we settled into a pattern. It was after about three or four weeks the problem became that he wanted to breastfeed constantly. It was like I was constantly having the baby attached to my nipples and he fussed and I'd think "He just ate...and I know he ate a lot because I could hear him swallowing. We had a good session of breastfeeding. He can't be hungry again. We would go for a walk into town and we'd get a few blocks and I'd say to my husband, "Maybe he's hungry again"–and I have to sit on a bench there and feed him.

One day I was standing in the kitchen and I wanted to take a load of laundry down. Every time I put him down, he'd start to cry and just wail. This little tiny thing, who I'd worried about because he didn't make enough noise when he was first born, he was wailing at the top of his lungs and his hands would shake and tears would come out of his eyes, and my heart would just crack into a million pieces. Then I'd put him on my breast and he'd be happy–but within five minutes he'd fall asleep. Then I'd try to move him and he would wake up and he'd cry and I'd put him on my breast and he'd be happy. So, I didn't know what to do and so I was standing in the kitchen holding him but he was still crying and crying. I stood there and I was so angry at him and felt awful about it–like, he's

a little baby, you know?–but just helpless and tears just streaming down my face and me saying to him "What am I supposed to do? What am I supposed to do? I can't have you attached to my breast constantly."

So I phoned the Public Health Nurse–right there and then. I looked up the number through my tears and I'm crying. I'd looked up the LLL and I got an answering machine...so, I said, "Okay, well...I'll call the Public Health Nurse"–and I get through and I'm kind of composing myself, but I think the receptionist could hear in my voice that things weren't great. She said, "I think she's busy right now with a client–do you want to go to her voicemail?" I said "Maybe I'll leave a message" and she said "If she hasn't called you back within five minutes, give me a call back and I'll get a hold of her for you"–and I felt great. I said, "That's wonderful." She didn't call me back right away, so I called and the woman said, "She'll call you within 10 minutes–I'll get in touch with her, don't worry about it."

Within five minutes, the nurse had called. I was sitting on the couch and started to cry and she said, "Wow, it sounds like things are pretty overwhelming right now." I said, "Yeah" and she said, "Tell me what's going on." So, I explained to her about how he's always hungry and I was worried because he was prem and is he getting enough?– but it seems like I'm constantly feeding him. The whole time I'm crying. She says, "It sounds like he's using you as a soother. Some babies are sucky babies. They like to suck. Have you thought about trying a soother?" I said, "Well, I tried, but he doesn't like it." She said, "Well, try it. Be persistent–he's going to cry but see if he'll take it. Be persistent." So, I did and you know what?–he took it within about an hour–he finally took it.

And it was like night and day. I could feed him. I knew when he was done and then when he got fussy, I thought "He's just eaten, he can't be hungry. Maybe he just wants to suck." I'd give him the soother and he'd suck and be happy. But if she hadn't been there to say to me, "Be a little persistent–you know he's not going to starve. Keep offering it to him. Keep putting it in his mouth. He's going to cry, he's going to wail. If you can. Bear with it." She said to me, "I have to do this clinic this morning. If you want, I'll see if I can come after work."

It was really nice. I said, "No, I think I'll be okay." She said, "I'll call you later this afternoon to see how things are going"–and she did. And I told her how I had gotten some laundry done and things were okay. As soon as we were able to get him to take a soother, we were able to go for distances without having to stop and feed him, we could go to places and I didn't feel like I constantly had to stop and feed him–he would take a soother and be happy.

They were there to help and support me and the Public Health Nurse came again or a third visit. So they came as many times as I wanted, which was great.

But that one nurse who said to me "Just really go with what feels right in your heart", to make sure you still were feeding them every 3-4 hours, that you would never let them sleep for more than this length of time–the safe part–but to actually really trust my own instincts as a mother, as a new mom, and as a unit, the two of us together, that made the whole world of difference to me. And then the other Health Nurse, when I called her

and she said, "It sounds like he's using you as a soother."

There is such a bond between us that it's almost like a special comfort time with just the two of us. The biggest thing was the bond with him. I don't think there was ever a point where I thought I would stop but there were many points where I was just so beside myself–looking for, 'Look, someone's got to give me an answer, someone's got to help me, someone's got to give me an answer"...

Then I started going to the Community Baby Group and that was a lot of support because all those moms there breastfed. They were all great and everybody had their own story–and everybody had heard my story–and a few of the women had gone through my experience of being used as a soother. So that was great to have that as a support for the breastfeeding, to continue the breastfeeding, to feel comfortable about it, to feel positive about it, to feel that I had made the right choice in continuing to do it. It was great to go into an environment where all the other women were also breastfeeding and going through the same sort of emotional things with the breastfeeding and the problems and what solutions they had gone through.

It wasn't the technical aspect of what to do with the breastfeeding, it was the emotional support that "Everything is going to be fine, don't worry about it, hang in there, we're here to help you." Even still today, the technical stuff–if someone said to me, "So, how do you breastfeed?" I'd go (*shrugs shoulders*)...but call me if you're ever frantic and I will be there to support you and say, "Look, you know...keep at it. Have you tried this?" There are tricks you can do, you know, like the whole idea about the soother, like the nurse saying to me "It sounds like he's a sucky baby"–you know, she was the first one that said that and then, of course, after she said it I read in a book about babies who suck and get a lot of pleasure out of sucking and that they just use your nipple as a soother constantly. That's obviously what he was doing.

Just before Christmas time, a mother had come into the group who had a new baby and she described my story with Baby–what was happening with her and her son. And she said, "I can't seem to go anywhere without having to stop and feed him, stop and feed him" and I said to her, "Have you tried a soother?" I was like this old hand now, you know. "Oh, I've been there, done that...My baby was exactly like that, but he doesn't take a soother at all any more–he doesn't want one, he gave it up on his own."

Until you do it–no matter what, you can't teach breastfeeding. You just have to go through it and be supported and have someone say, "Have you tried this, have you tried this, have you tried this?"....not "This is going to work" or "You're not doing this right". Just what that nurse said, "do what feels right to you." And the soother advice really helped us–and Look, this is the end result! He's a big boy!

I love breastfeeding and it's still such a nice thing to have for the two of us.

P2 (Participant 2)

I've always wanted to breastfeed. It's just been in me, I guess because of the closeness, and because our little girl can have that really good milk, the natural immunity and all kinds of benefits. It just feels absolutely right and natural and pure.

Our baby came 3 ½ weeks early. She was born naturally at 2 p.m.. Afterward there was a lot of intervention and antibiotics were administered. We were separated right away and I didn't see her until the following morning in the Special Care Unit. I felt really uncomfortable there, trying to learn to nurse and to feed her with the tiny bit of milk I was able to pump in the beginning. It was difficult as help was not readily available initially. I recall a nurse who came in at one point and said, "Is that all the milk you've got?" I was shocked. Her comment really bothered me because I didn't think I was going to be able to provide for our baby as it was. This was the general lack of compassion and reassurance experienced that led us to seek help carefully while in there.

Even though I had read a fair bit about breastfeeding, I didn't know how to do it. I felt like I should know how to latch her and how to make things just right, but it's a learned thing, it's not automatic. It takes some practice.

Sometimes, Baby could latch on but she was so sleepy she couldn't keep sucking. I didn't think she was getting enough, although she wasn't crying. She didn't cry a lot. I kept thinking "I'm not going to have any milk", because she was early and because there was some trauma, and then the separation. I just couldn't feel anything happening at all and I was concerned. I wished I had known at that time that even women who adopt can breastfeed. I thought "Oh, well it's just me." I saw other women on the ward with way too much milk and I wondered "When will this begin to happen? I need to get this milk supply up!"

It continued to be my biggest worry. I had miscarried a baby the year before and subconsciously, I was very much afraid that this baby was going to die. Our midwife kept saying to me, "No, you don't have to resort to a bottle, you don't need to go to formula with her. You're going to do it, you're going to be okay." Then we asked a friend of hers nursing on our ward to help in getting Baby to latch. During a couple of her shifts, on those days, she spent some time with us coaching. That got us going and we were grateful.

Baby was in Special Care for 3 ½ days due to hospital delays, before we could get her up into my room. I finally realized that I was the one that needed to take control of our separation and that the hospital staff were too busy to, and not always able to have everybody's best interests in mind. I needed to assert myself to get us together and out of there.

We left the hospital on the fourth day with Baby. Baby was latching sometimes, sometimes not, but I had no fear about leaving because I knew we were never going to accomplish it there. We came home and she had lost some weight. She went down to about 6.8 lbs from 7.2 and then she just wasn't gaining well during the first month, only very slowly. In order to keep her going and to keep my milk coming, we would nurse and

then I would pump afterwards. This was suggested by a breastfeeding counsellor and breast pump specialist at the hospital. She felt this would continue to bring my milk in. Baby drank the pumped milk from a cup too. She was very vibrant and willing to drink now but still very slight.

Our midwife was making home visits every few days and saw that we weren't really progressing at a rate that we should so she phoned the LLL member. They suggested that I start taking Fenugreek caps, which I did. This was a really big help along with Kangaroo Care; staying in bed for 24 hours together naked, bathing together and nursing her in the tub. The antibiotics began to clear out of our systems and my milk began to come in, a huge improvement, at around 14 days.

I was taking an iron tonic to get my energy back and was really glad my partner had a month off - very glad. Our parents came to visit in there too and I think that was a setback. I was amazed at how sensitive my milk flow was. I think I was still very short on confidence at that time too.

With my milk now increasing and Baby's weight to get up, we went to see our Public Health Nurse, who was also a breastfeeding consultant. Fenugreek, relaxation and the Public Health Nurse's help were the answer. She was the loveliest person, the sweetest person. She was an incredible woman.

It was her confidence in me, her relaxed personality, and her character that really helped me. It was her encouragement, "Oh, your position's perfect - see, just like that!" she'd say. "That's great, that's all you need". And "Oh, yes, you've got a healthy baby there, she's going to be fine". She was so sincere and positive. I thought we would only visit her a few times but she kept saying to us, "Just come and weigh in every Friday if you want to, so that you can use the same scale." We were trying to account for hospital and our midwife's scale readings. Now the PHN had one and they all registered a little bit different. For us at that moment, every ounce meant so much. We kept going every Friday to weigh in, for a month. All of a sudden Baby was plumping up - 6, 7, 8 ounces a week by the third week. The PHN was thrilled, and so were we. I could hardly believe my eyes, and she was happy too, Baby was.

We started seeing the PHN when Baby was about two weeks old. Baby was about a month when she started gaining. I kept a chart of how much milk I pumped and when, and how much she fed and when. After we got going, it really took something for me to let that go; a month's record of progress and relief. At times, I felt Baby knew what she was doing more than I did. She helped my confidence a lot. All I needed to do was relax, trust our ability and let it come. A good reminder about all life's challenges.

We started going to the Community Babies Group when Baby was about 5-6 weeks old; in hindsight a long time to wait for support. The moms were open to talk about breastfeeding and their complications, and to share ideas. It was like co-counselling sometimes. Baby was nursing so much then that she hardly showed her face to the group. Our facilitator often said, "Oh, that's just where she should be!" She was another incredible support person. When Baby got to be a bit older and sitting up, our facilitator said, "Well, Baby, now we know what you look like!" It was welcome humor.

We received breastfeeding counselling in so many ways from so many people and it got us through. We learned so much about the reality of being in such a sensitive situation. Before Baby was born I knew that I was a person who wanted to breastfeed and I knew I would have that relationship with my baby. Then at her birth there was a lot of confusion and intervention. Now, I'm pregnant again and I am looking forward to how it's going to unfold this time. I know now where my resources are and I know when to contact them. I know how far to let things go if there's a problem, and how to ask for help. I feel more grounded -- I definitely feel more grounded - both mentally and physically. It's as though physically, I feel more solid, and emotionally, I feel more solid too.

P3 (Participant 3)

Was breastfeeding what I imagined? No, it was much more intense than that. I was very committed to breastfeeding before Baby was born - there was no question. I had a very good prenatal instructor. She gave us just really terrific information about how breast milk benefits the baby and also I had a lot of fairly progressive and motivated friends and we were all going to breastfeed. I had read all the documentation about how it benefits the baby's body and the growth and stuff so I was really keen.

I was enthusiastic but I did have some problems in that I had hyperlactation. I had so much milk it was unbelievable. To begin with though, I was so excited, nursing in the hospital. I had Baby in my bed and everything - but I had such cracked nipples! I can't say [illegible] when my milk came in, it really came in and I had so much milk! I would nurse on one side and I'd have to have a towel on my other breast because I was spraying all over the place. In the middle of the night, I had to have towels on the bed because I was just like a fountain and because of that, Baby had trouble because he was swallowing a lot of air.

The public health unit has lactation consultants and they were very supportive. They helped me with the latch but we weren't quite getting it right. Baby continued to have a lot of gas and he developed colic. At 10 days it still wasn't quite right and then I went again a week or two later. That's one thing that I found; a lot of the lactation consultants' concerns are with "Do you have enough milk?" - and to check the diapers and what have you. I didn't have that problem and I found that they weren't as prepared for hyperlactation as they were for hypolactation. They gave me a couple of brochures but there wasn't any really useful information in them. I had one nurse telling me to pump off some of the foremilk and then I had another nurse saying, "Well, don't do that because you'll just be increasing your supply and you're making it worse" - and I was kind of stuck. I kept getting conflicting advice. I had some people say, "Well, you shouldn't be doing that because you're going to increase your milk supply and you've got too much milk already" - but then, on the other hand, if there's too much foremilk then he's not getting enough hind milk. Eventually I ended up rewatching the Verity Livingstone video and they talked about taking off some of the foremilk first.

My GP doesn't do Maternity, so I had her to a point and then I had another doctor in her clinic. After Baby was born, I went in to see her about the one-month and the two-month check-up and she chastised me about Baby having so much gas in his stomach. I was telling her he was colicky and she would sort of tap his stomach and say, "Drum! Drum! Drum!" She'd say, "You know this is wrong. He shouldn't have so much gas". Yes, she was really stern with me and not very helpful.

I was trying really hard, I was burping him and burping wasn't helping. I was hardly getting any sleep and I was exhausted. I felt awful! I felt like I was failing Baby, like I wasn't doing something right. I felt inadequate. Also, because of the hyperlactation, sometimes the letdown is extremely painful. It was a toe-curler, you know, it would just come on and it would hurt. I was trying to get some advice from her about trying to get

this in balance and everything and she just was sort of shaking her head and chastising me about his being so gassy...I didn't like her attitude and I left feeling inadequate.

I went to the physician who did the delivery and he was a nice enough guy. He had kids of his own and his wife had breastfed, but his advice to me was to start supplementing and getting my husband to feed the baby in the middle of the night and stuff like that. He just felt that I was getting too tired and getting too upset about it, and he thought that maybe if I had more sleep, that that would help. But I wasn't interested in supplementing at all.

So, really, we just sort of kept up with it and enough time passed that Baby got over his colic and his digestive system seemed to mature enough and my milk sort of leveled out and everything was fine.

Baby was thriving, he was huge: when he was five months old he weighed 23 pounds. He was a Buddha Baby, like a little Michelin Man with big ripples. On the growth curve, he was big, big, big, big - and all of a sudden he plateaued and then he started growing again. The doctor was really concerned about this plateauing and she wanted me to take him to a pediatrician and I said no. She wanted to do all kinds of tests because she was afraid that there was some kind of life-threatening disease that was starting to show up and I said, "No, he's just fine." Because she hadn't been his birth doctor and hadn't been with him for the first 9 months of his life, she didn't know him when he was the Buddha Baby and so I had to bring in photographs and show her. "See, he was huge! You know, this is normal." Finally, I convinced her enough to believe me. But she was really concerned about the arc, the bottle-fed arc...you know, baby gets fed 10 bottles at 8 ounces a day, and that's what you expect to see. But my baby, he went up, falling arc, then he plateaued and then he started to rise again, perfectly normal for a breastfed baby...

My other doctor experience that I wanted to tell you about was this. Because of Baby's not sleeping through the night, my sleep had become very erratic and very irregular and I ended up quite insomniac. I didn't know what to do about it and I was getting quite desperate because my sleep cycle was so screwed up. Eventually, his sleeping was starting to become a lot more normal but I was wide awake after waking up with him for 2-3 in the morning. I had a really hard time with sleep deprivation, I must say. It started to affect my personality and there were times when I was so sleep-deprived, where I shouldn't have been driving because I wasn't coherent. That was kind of scary. We tried all kinds of things to make him sleep and it didn't work. I was desperate and a girlfriend of mine said that after her baby was born, she had been given a sedative that she was told was safe for breast milk so I should just go see a doctor. She said "Go today, go to a drop-in clinic." I went to the little clinic over in the mall here and the doctor said, "So, what's the problem?". I told him, "Well, I'm having trouble sleeping but I'm a breastfeeding mom." And he said, "Why are you having trouble sleeping?" I said, "Well, my son isn't sleeping through the night and I've developed insomnia, etc." He said, "Well, the solution is, you know, you've got to quit nursing. I can't give you anything. There's no drug that you can take that's safe. You've got to quit nursing."

Baby was a year and a half. I just said, "Well, that's not going to happen!" And he said, "Well, I can't do anything for you." And I said, "Fine!"

It was just not an option in my mind, you know, and for him to say, "Well, you've got to quit breastfeeding"! In our culture, what I found was there's lots of support from Public Health Nurses and such, encouraging to breastfeed to six months. I guess they're realistic because most mothers will nurse to six months and then at that point, as soon as the child's on solid food, they begin to wean. That's often when they go back to work so it's not very often that you find moms nursing past a year. When Baby went in for his 18-month shot, the nurse was putting information in her database and she asked me if I was breastfeeding still and I said yes and she put that down. She said, "Wow! That's not very common." It surprised me.

When I was having trouble with Baby and sleeping, that was when I joined La Leche. I wasn't part of La Leche from the beginning when Baby was born because people had told me all kinds of things about La Leche. You know: "You're going to become a 'Nursing Nazi'" and all this. But that wasn't the case. I had a terrific leader. She bends over backwards for people and she's totally respectful of where you're at. She just offers support. It was supportive just hearing other moms' stories and being in the company of moms that were nursing kids that were three years old. To be honest, I had in my mind thought, "Yes, I'm going to breastfeed" - but I never imagined I would nurse beyond a year, and then when I came to Baby being a year old, I thought "Well, why should we stop? This is really working for us."

I just found the lactation consultants through the public health unit were great for information, and LLL was super for support. They really just helped me put things into perspective, like "Well, this is what he's doing right now, but it's going to change and don't worry". My GP wasn't necessarily that supportive or informed but I must say that the community health nurses were supportive and I felt that I had been educated enough before he was born to see the benefits of nursing. I had some good literature. Mothering magazine was one of my support lines. It just seemed as though every month I would get the magazine through friends and there would be an article dealing with some issue that I was just going through. It would support me. Mothering magazine was a really strong voice for me to feel strongly about nursing.

There's so much in our culture that's pushing us away from our children and just reading about how indigenous women care for their children and how the children don't cry and how happy and content kids are, that was a real inspiration for me. That would often get me through the tough times, just thinking that "You know, I'm not the first to do this." All of the advice and interventions that people would say, "Well, you should try this and try that", when they would try to take Baby and me away from each other. I know it was very well-meaning but I think it was counterproductive. He was a very needy child in a lot of ways. He really liked nursing, he really needed nursing, he really needed the closeness.

I just knew my baby really well and I knew myself really well and I matured immensely. I have great respect and awe for the whole process of birthing and nursing. I'm still in awe of my body and what it's done. I can't believe, looking at him, that he came

from inside of me and that I fed him, fed him with my body! I must say while I was a nursing mom I was pretty smug. Nursing is just so amazing, knowing now, physiologically, what the breasts do, especially in regard to the immune system. I'm just in awe of that! - really in awe of that. Those special moments when they're three or four months and you're feeding the baby and they start looking up at your face and your eyes and touching you and stuff, there's so much communication. I'll tell Baby just how much I enjoyed it and how close I felt and how good it was for him. I'll tell him how special it was and how good it was for his body.

P4 (Participant 4)

Well, I had trouble with breastfeeding right from the start. I couldn't get him to latch on. In all the videos they say, "Wait for the baby's open mouth and then just pull the baby to the breast." I would like to watch those videos again and see how old that baby is - because it's certainly not a 3-hour-old baby!

Every single one of nurses in the hospital had completely different advice. They all suggested different holds. With him the Football Hold just didn't happen. Everybody said, "Try this, it's much easier." No. One of the videos they showed you in the hospital tells you to lie down with him and put a pillow between your knees and one under your back and one under your head and one under him. And I'm thinking "I'm never going to do this- - I don't have that many pillows!" It just seemed so complicated. My husband got a breastfeeding pillow and that helped a lot.

Baby didn't feed right away in the Delivery Room, and during the first day it was sort of "on-again, off-again ". It didn't work. The Day Nurse was very good about coming in and pinching my nipple into a point so that he could get it into his mouth and latched, but nobody helped me to do it on my own. They all tell you to "Wait for the open mouth and get the proper latch." "Don't accept anything less than a perfect latch...", but Baby would never eat if that's the case! I couldn't get him on at all. You know, after six latches that are just "ugh" you're thinking, "This is perfect! This is a perfect latch. He's not crying, the milk is flowing, it's perfect. It's okay if I cry. Don't mind me." The first day, I was up for 24 hours and he's trying to latch on and he can't. I couldn't get him on and the Night Nurse goes, "Gee, if it were the day-time I could send you downstairs to the little store and you could buy a silicon nipple shield and that would help a lot but - gee, I don't know what you can do now!" That wasn't a big help. She ended up giving him sugared water while I went to the bathroom and got my head together. That satisfied him until the next day when my husband went and bought the nipple shield.

The whole nipple shield thing was complicated: one nurse told me to buy it, the next nurse told me, "Don't use it unless it's absolutely, positively necessary." So now I have a hang up about using it. They wouldn't let me out of the hospital until breastfeeding was established, and I was dying to go home, so I'm thinking, "Well, let me at least try the nipple shield - right?" Finally I got a nurse to come in to show me how to use it and she says, "Oh, your nipples are flat - throw it on." It was another big emotional day: "Oh, my God! It's never going to be the same!" When I was leaving, the nurse looks at my chart and says, "Oh, I see you're using the breast shield, the Public Health Nurse isn't going to be happy about that!" So I'm living in fear of the Public Health Nurse now. "Oh, no! - maybe I just won't tell her - although she's going to know anyway." When she did come in, all she said was, "Well, try every day time you feed him to not use it; and if it doesn't work, then use it." Not so scary after all.

At home, Baby just wanted to eat every half-hour, and my nipples were purple, they were so bruised. He slept well but when he was awake -- and especially from dinner time till bedtime--, he just has to eat...eat, eat, eat. That was all okay and it was working with a

breast shield but then they tell you "Don't use a breast shield for too long because then your letdown won't happen properly." Guess what, they're right. Babies do those sharp, little sucks until the letdown happens. One day, he'd do those sharp, little sucks for 10 minutes and not get anything but a couple of drops. I could express milk, but he couldn't get it to come out of me with the nipple shield or without the shield. It just wasn't happening. I spent the whole day without him being able to eat. He got a little bit of milk but was just constantly hungry. I was in excruciating pain. I was in tears every time I tried to latch him on.

I felt that the Public Health Nurse that came in actually was the one voice of reason that I'd encountered. I called her at 9 o'clock that morning and she was here by 10, I think, and I got her voicemail when I called. I was crying. She was the one that said "Do you have any formula? Let's give him some." But she didn't make it clear that you can give him a bottle of formula now and try breastfeeding tonight. Myself and this friend of mine both lived under the impression that once babies had a bottle of formula, that was it, they were never going to breastfeed. We both really had that impression, maybe because we both had the same prenatal instructor. We believed that we can't give them formula because then they'll never breast-feed-- which is ridiculous, you know. Now that I have some perspective I can see how silly that seems, but when you're living it, that's your entire existence, putting food in this kid's mouth. Every tiny, little impression is a big impression on you. I just didn't feel like I could supplement at all, that it just wasn't an option.

My doctor had come into the hospital and asked if I had any bottles at home and I said, "Yes." He said, "Well, throw them all away." I said, "Well, I can't because they've all been given to me." He said, "Do you have any formula?" I said, "No." He said, "Okay, good." He told me something like 50% of the women who leave the hospital breastfeeding aren't breastfeeding after a week. But nobody ever told me - "Give him a bottle of formula, give yourself some mental health time, and then go back to breastfeeding"...nobody said that. Even now in the evenings I just can't keep up with his hunger. So since he was three months old he gets a bottle of formula, once a day...but he still gets every drop of breast milk I can possibly produce without being in excruciating pain.

So I went to the breastfeeding clinic when he was in his second week. The Public Health Nurse there was really good. She showed me how to use the breast pump properly, which was something that I didn't know. Who has five minutes to read instructions when you've got a kid crying? I was still using the shield at that time and she showed me some tricks for getting him off from it. Instead of just making me feel like "You've got to stop using it," it was : "Let him just play with your nipple for a few minutes. He doesn't necessarily need to be eating but he can get used to the feel of it." And she showed me with the pump that I don't have one full letdown, but that many of the ducts have little letdowns. So I got to understand my breasts a little better and how they worked.

Soothers were another issue. It was put in my head that "If you give him a soother, you're never going to breastfeed." Baby woke up one day in the first couple of weeks at 11 o'clock in the morning and from 11 o'clock until 1:00 he wanted to nurse. He wasn't hungry - he's not getting anything more after two hours, right? I asked the Public Health Nurse "Can I give him a soother?" and she was pretty human actually - I think she went out

of the envelope a little bit and even told me what soother to get.

As a matter of fact, the people in my prenatal group called the Public Health Nurses "The Milk Nazi's" (from the Sienfeld episode with the soup nazi.) I told her that and she just thought that was hysterical.

The biggest impression I have about every professional person that I asked about breastfeeding is: there's what they're instructed to tell you by the present guidelines of Capital Health or Health Canada or whoever, and the human answer: "I understand what you are going thru & if something helps you get thru it then use it." Even with my doctor, my husband said, "You can see that half of his mouth is telling you what you need to know as his patient, and the other half is telling you what his lawyer's told him he has to tell you."

The doctor kept saying, "Congratulations for sticking with it." I had envisioned breastfeeding being this wonderful bonding time where we would gaze into each other's eyes and it actually has happened that way but I've got to say mostly it's "You're hungry again??"

Nothing about breastfeeding Baby was easy, but he's been a real easy baby in every other regard and I think and hope that some of that is partially to do with the bonding and the breastfeeding.

Looking back, if there were one piece of information I would have like to have been told by a health professional, it would have been that there is no harm in supplementing the breastfeeding occasionally, or even on a regular basis. I understand that breastmilk is extremely important to your child, but you shouldn't be made to feel like a failure as a woman and a mother if you are unable to breastfeed exclusively for an extended period of time. Let's face it, an entire generation of people grew up relatively healthily on formula. It isn't poison & it does have its place. It shouldn't be considered a dirty word.

In closing, I just want to say that Baby is weaned now. Three days after his first birthday he refused to latch on at all. We had slowly been increasing the amount of bottles he had been getting because I had gone back to work in the evenings. He made the final switch on his own. I am really glad that I stuck with it. Nursing is something completely unique between you and your baby. It is something even his father cannot do. When he looks up from your breast & smiles at you, it is worth all the trouble you went thru to get there. Every woman should try it. If you can't succeed it's ok, but if you can it is a precious time that truly is unique.

Even with all of the trouble I had with my first baby I am planning to nurse any others that I have as well.

Appendix E

Gaby's Story

I have been interested in breastfeeding for many years, and was looking forward to breastfeeding immensely. My family doctor, my husband, and my mother are all staunch breastfeeding supporters. The physician who monitored my pregnancy and birthing was very knowledgeable and supportive and in fact was breastfeeding her baby, which was encouraging.

However, when I went for my first prenatal check-up at around twelve weeks, I was given a video about pregnancy by the receptionist. The video's box contained a sample of formula. I was surprised at myself, because my immediate thought was "She doesn't think I can breastfeed!" I gave the video back at my next check-up. It was pretty disheartening in a subliminal way about breastfeeding being best, but harder and more painful and fraught with difficulties than formula-feeding.

Once our daughter was born, the extremely nice older nurse who was with us put her to the breast as soon as possible. It was exquisite, and my baby did beautifully. I really enjoyed that first, sweet experience of breastfeeding.

On the post-partum ward, however, the situation was completely different. The nurse wanted to take my baby to the nursery for the rest of the night, but I wanted her close by, and stipulated that I didn't want her to get any bottles. Clearly, this nurse did not agree with me. When the baby started making cues that she was hungry again, I rang for assistance. I couldn't change the bed's position by myself. The nurse came in, rolled the head of the bed up but did no other positioning, seized my nipple between two fingers, squished it flat and shoved it into my baby's barely-open mouth. "We call this a 'nipple sandwich'," she said. I said I'd never heard of it, and she said "It works." I remember thinking that she would know the latest techniques, but it went against everything I knew of good latching. I could see the baby was suckling, but it was quite uncomfortable. I told the nurse the latch hurt. She said "Well, breastfeeding does," and that I should expect it to as I have fair skin. She left the room. When I rang the bell for her to help me put the bed down to sleep, she wrote an "F" for "Fair" on the feeding chart.

The next feed also hurt, and was rated "P"–for "poor", I guess. I felt bad when I read that, because I felt I should know how to make it better and I couldn't figure out what I was doing wrong. The latch looked fine to me and I was conscientious now about waiting for baby to make a wide-open mouth before pulling her on.

When I asked for help to breastfeed that evening, another nurse arrived with a bottle of glucose in her hand. She tried to convince me to let her give it to my baby, but I said no. Then, before I realized what she was doing, she dripped some of the solution onto my nipple and shoved my baby on. Again I told her it was very uncomfortable, but she didn't respond. Instead, she tried to persuade me to let her take the baby to the nursery so I could sleep, but I resisted.

The nurses never came in and talked about breastfeeding voluntarily, suggested that it was time for a feed, or that they had time to help me with one. Looking back at my

daughter's chart later, I see there were almost seven hours between feeds that first day.

When I asked another nurse for help with my sore nipples, she arrived with some lanolin-based cream in her pocket and applied that. I had an allergic reaction to it, which didn't help matters at all. That third day, though, one nurse complimented me on the good thing I was doing for my baby by breastfeeding her. This nurse had taken a breastfeeding class with me, and I was so buoyed by what she said. I know this, but it was great to have someone say it to me. She wasn't able to help me with the painful latch, however. Another nurse was also encouraging, but didn't know why the feeds hurt so much. I began to feel like a problem, a complainer.

On the fourth day there, another nurse I knew did help me with positioning while sitting in a chair, but she also didn't stay with me for a feed, nor could she offer any advice on why the latch was painful when my positioning looked good. She gave me Tylenol #3s. She did spend a lot of time showing me how to bathe the baby (without even finding out that I used to teach this myself), and then put the baby in the bassinette and told me "She needs to cry herself to sleep now." Again, I was angry with myself for succumbing to something I shouldn't have agreed with, but let the professional convince me to allow.

Throughout my four days on that ward, I was told that I had inverted nipples (I don't); that breastfeeding always hurts; that it was surprising I had milk at my age; that the woman who had given birth the same night as me in the next room had way too much milk-- but then of course, she was much younger (you can imagine how much this helped my sagging confidence!); that my baby should go to the nursery so I could sleep; that it wouldn't hurt her if she was given a bottle or two; that nipple-confusion is a myth and the nurse had never seen a baby who was nipple-confused (not surprising when most infants are out of there by Day 2-4); and over, and over again, that the latch was fine even when I was literally curling my toes in pain and my nipples were cracked, bruised and bleeding. I was frustrated because I could not figure out what I was doing wrong, and the baby was losing weight, although she was breastfeeding way more often than the eight feeding spaces allotted per day on the hospital-issued feeding chart.

Every night, the nurses came to take baby into the nursery and I had to assert myself quite forcibly to keep my daughter in the room with me. Not a single nurse helped me position and latch baby and then stayed with me for a feed or came back spontaneously during the feed to check with me.

I was discharged on Day Four. Baby had never had a bottle (as far as I knew) in spite of the nurses' interference and recommendations. I had very sore nipples and full breasts. I was really tired, and anxious to get home where I wouldn't have to feel like I was alone, battling against authority. My milk came in that day and I became painfully engorged. I had to express milk in the shower, because the baby could not strip my breasts, they were too big. I think if I'd had a bottle at home that first night, I would have been really tempted to give it to my baby, because she was hungry and unsatisfied and I was so, so uncomfortable.

The next morning, a visiting nurse came to my bedroom, and the first thing she did was tell me that she was impressed that my baby had only received breastmilk despite my caesarian, and that she expected me to feel weepy, exhausted and sore after my experiences. I could have kissed her! She invited me to breastfeed while she watched, and

she listened to me. I felt like this was the first nurse to listen to me. When she told me that my positioning and latch looked fine from where she was, and why, pointing out the baby's big jaw movements, I told her that the latch still hurt. And bless her, she got down on her knees beside my bed to take a better look, saying that if it hurt, then obviously something wasn't right. She craned her head to see baby's mouth on the underside of the breast. She noticed that the baby's lower lip was curled under on itself and she flipped it out to a flanged position with one finger. The relief was immediate and immense!! I couldn't believe that it made such a difference to the way the suckling felt.

I told her the story of the "nipple sandwich" and she was annoyed, for me. She was splendid and so sympathetic and encouraging that I felt renewed and really heartened. The baby nursed, swallowing audibly, and rolled satiated off the breast with a little dribble of milk in the corner of her mouth–and she slept. It was wonderful!

I felt really angry about that "nipple sandwich". I still do. The name even sounds belittling.

My delivering doctor was a good resource and most motivating. She was right on the ball with uncommon breast complications as well. She diagnosed Reynaud's of the nipple subsequently, and was able to share her story of how she coped with the same problem. I remember telling her that I was becoming adept enough to talk on the phone while I was breastfeeding and she cried "Good for you! You're multitasking!" She has a great sense of humour, which helps so much.

Breastfeeding my daughter became a marvelous experience. She's healthy and a delightful little thing and we both find breastfeeding a soothing and nurturing time. I'm so happy that I can breastfeed her.

When I had to have surgery recently, and was speaking with the anaesthetist prior to the OR, he was shocked that I was still breastfeeding. "There's no point in breastfeeding after five or six months," he told me. "At this point, you are doing it for yourself. You should quit." I wasn't even surprised to be told this; I was back in hospital.

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