Struggling to Breathe: Exploring Nurses' Experience of Infant Feeding Support

By

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BSN, University of Victoria, 2002
MN, University of Victoria, 2009

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Supervisory Committee

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Abstract

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The successful transition to motherhood can be associated with the experience of infant feeding, and women's views of whether that experience has been positive or negative can shape the mothering experience. However, nurses' engagement with best practice breastfeeding promotion may elicit negative responses from women who are either unsuccessful in their attempts to breastfeed, or do not breastfeed for other reasons. Are nurses adequately prepared or supported to deal with the variety of infant feeding challenges that inevitably arise in perinatal practice settings? For example, Canadian perinatal nurses are expected to conform to WHO-conceived Baby Friendly expectations to disseminate evidence that pertains to the health risks of introducing formula to infants. However, in some circumstances, infant formula is recommended by practitioners in order to provide crucial hydration and/or nourishment, which destabilizes the discourse of risk, and creates confusion for mothers. Questions also arise about the appropriateness of nurses applying WHO guidelines to every woman without first considering intersectional realities which may not align with BF recommendations to breastfeed for six months and beyond. These questions, and others, informed the research question: "What is nurses' experience of infant feeding support?" Eleven perinatal nurses from across Canada were interviewed. The conversations were interpreted using Gadamerian hermeneutic methodology. Participants described a variety of practices and dilemmas that they associate with infant feeding "support," highlighting that complex and contradictory forces are at play for nurses involved in infant feeding support as well as the unintended and negative consequences of following BF best practice guidelines.

Table of Contents

Acknowledgments

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Dedication

For Carol, who is my messenger of wisdom and guidance. You have shown me how to tread water - and helped me to understand.

For my children, who are my messengers of inspiration and hope. You have given me the strength to surface in rough waters.

For Jake, who is my messenger of true partnership. You have swum alongside and kept me afloat.

Struggling to Breathe

How do I find myself here, treading water? What on earth caused me to leave
The sand on the beach, and the view so enticing
Yet here I am, struggling to breathe

I wanted to feel how the seawater moved me. I wanted to see past the mist
I wanted the freedom to kick, splash and practice
To be someone who could assist

The force of the undertow caught me as unaware- I must admit my surprise
The current was strong and it took strength to surface
I doubt anyone hears my cries

I didn't expect to be drawn to the underworld
The allure of the deep still prevails
The insights I sought were concealed, then revealed,
While resisting the urge to inhale

I'm OK-I'm keeping my head above water. I'm fine-I just need to stay calm
I'll try not to splash anyone who comes near me
I will not pull anyone down

That wave barely touched me, well OK, it shocked me (I tell myself that I don't mind)
I don't think my gasp means I cannot tread water
I just need to sense what's behind.

The view of the shore is becoming more distant. That shore looks so different from here…
I wonder if anyone sees me from shoreline
Or whether I've now disappeared

I must have the courage to ask if I've faltered. I must question what I believed
I maintain all trust that my senses will guide me to
Learn, once again, how to breathe.

Chapter 1: The Enigma of the Deep

It was a day like so many others, that day at the beach. We were happy to be together in friendship and comfort, enjoying the delights of the day. A wave of nostalgia accompanies the memories of our laughter, the smell of the sunscreen, and the intimate sounds of gossip. Ah, and that glorious sound of the surge hitting the sandy beach. Boom, boom, boom…the predictability and power of the tide is so alluring in my recollection. But I understand, now, that it was inevitable that I should leave the comfort of the beach. I recognize that it would be necessary for me to leave that pleasing place. How else could I immerse myself and explore the enigma of the deep?

The Origins of Departure

It is August 2014. Fraser Health Authority is featured in the news. The news story describes a document that women were asked to read and sign after giving birth, which indicated that they were aware of the health risks associated with formula (Appendix 3). This practice had been in place for seven years at Fraser Health Authority, but was only in August of 2014 that it came to the attention of the media by women who protested that the document was unethical and that it marginalized vulnerable women who were not breastfeeding. A blog was initiated. Women contributed their ideas to both "sides" of the debate - some defended the document and went on to cite sources such as the *Cochrane Review*[1] as authoritative. Others were outraged that the document belittled mothers by featuring breastfeeding as the responsible choice in spite of evidence to the contrary.

[1] "Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognized as the highest standard in evidence-based health care." (http://community.cochrane.org/cochrane-reviews)

Sidney Harper RN (Project Development Nurse and Baby Friendly advocate for the Fraser Health Authority) responded to the public by contributing her own entries to the blog. She was clear that the intent behind the document was not to offend, but to reinforce the importance of breastfeeding promotion. She stated:

> What I find most interesting is that our culture seems to be comfortable hearing about the benefits of breastfeeding but seems uncomfortable talking about the risks of artificial baby milks or formula. Research has shown that there are higher chances of colds, flu, ear infections, diarrhea and vomiting among other illnesses with formula use. It is easy to turn to formula when breastfeeding challenges present themselves. Mothers who deliver their babies in Fraser Health are offered support and encouragement to increase their confidence and meet their own breastfeeding goals whether in hospital or at home in their community. Breastfeeding is normal and for most babies any breastfeeding is good. If a woman is breastfeeding but is advised by a health care provider that formula is needed, formula is given as we would give a medicine – the right amount of formula for the right period of time can be very useful. (26/08/2014 3:51:09 PM)

Dr. Christa Mullaly (MD FRCSC, Obstetrician-Gynecologist) criticized the document:

> This is an appalling and unscientific document; I take issue with its content, language, and tone. For content, the highest quality evidence, from the randomized trials reported, clearly refutes your fuzzy points (‘may’, ‘might’, ‘could’). The only proven, validated information that you can provide to mothers is that a) formula-fed infants have a very small increase in risk of viral

> gastrointestinal infection in the first year of life, and b) formula is really expensive. For language, vague terms like 'might', 'may', and 'could' are deliberately misleading and suggest greater validity than the science supports. Finally, the tone of this document is unnecessarily demeaning and cajoling. Its clear intention is to shame women who feed their children formula, even in cases in which formula is indicated and necessary for the infant's health. I strongly applaud your decision to pull the document and am highly skeptical that any incarnation of this form could respect women, their infants, and their feeding choices. (28/08/2014 6:13:44 PM)

Dr. Mullaly's response exposes the conflict that surfaces in conversations about infant feeding approaches, wherein breastfeeding is pitted against formula feeding. Fraser Health ultimately pulled the document from circulation with apologies for offending women. Ms Harper stated that, "Infant feeding is an emotionally charged subject in our culture." (Retrieved from: http://news.fraserhealth.ca/News/August-2014/The-choice-is-yours-supporting-moms-to-reach-their.aspx).

I introduce the news story as a way of introducing the intricacies of the hermeneutic interpretation that I undertook in this study in the process of addressing perinatal nurses' experiences of infant feeding support. However, I was fascinated with infant feeding long before I read the news from Fraser Health. The news story, in many ways, was not news to me. My experience as a perinatal nurse over several decades had long given me pause, and I had often reflected on the enigmatic[2] nature of the many

[2] The word 'enigmatic' refers to that which is "mysterious**,** puzzling, hard to understand, mystifying, inexplicable, baffling, perplexing, bewildering, confusing" (www.oxforddictionary.com).

approaches to and interpretations of opinions on literature pertaining to infant feeding support. I wanted to understand more about nurses' participation. The hermeneutic study I undertook involved eleven Canadian perinatal nurses whose experience and interest in infant feeding support supplied the conversations for analysis.

The research conversations that transpired in the course of this study, as well as the academic preparation that I undertook leading up to the research, challenged many taken-for-granted discourses that underpin health promotion initiatives related to infant feeding in the perinatal period. Many elements converged to shape a unified address, in what Heidegger described as the "altogether" gasp of inquiry (Blattner, 2006). The question: "What is the experience of perinatal nurses who offer infant feeding support?" erupted from the dizzying array of discourses that pertain to infant feeding. My research must transcend a personal wish to work something out for myself, though, for as much as I hoped to achieve greater personal understanding by conducting research, I also aim to shape broader meaning. I ask what I can contribute to the larger disciplinary conversation, and what I can do to shape approaches to the phenomenon of infant feeding support (Moules, McCaffrey, Field, & Laing, 2014).

Canadian nursing practice is informed by the World Health Organization (WHO)'s guidelines. In most Canadian maternity settings, nurses enact the authority of the Breastfeeding Committee for Canada (BCC) as the gold standard of best practice related to infant feeding support. I was curious to explore whether varied interpretations of these guidelines existed among my participants prior to starting the research, and how those variations shaped infant feeding approaches.

Other disciplinary perspectives, such as sociology, political science, and women's studies, have also identified concerns about breastfeeding promotion as it is currently promoted worldwide. For example, Knaak (2006), Murphy (1999), Nathoo and Ostry (2010), Paterson, Scala, and Sokolon (2014), Wolf (2011) and others point to unintended negative consequences of breastfeeding promotion as outlined in the foundational World Health Organization (WHO, [2009]) guidelines. I am troubled that nurses' experience of enacting globally-inspired guidelines remains largely unexplored in the nursing literature. The gap is significant, given the profile of nursing in the perinatal sphere. Women's experience in the pre-natal, intra-natal, and post-natal realm most often includes nursing presence, and infant feeding support infiltrates each setting of perinatal nursing practice.

According to Paterson, Scala, and Sokolon (2014), there have been policy debates in Canada on the categories of "maternal health," "women's health," and "reproductive health." I assume a certain distance and ask: "In what ways does the issue of infant feeding occupy a 'position' of health?" Does maternal emotional well-being and/or absence of guilt around infant feeding truly manifest a notion of health? The issue of guilt over infant feeding, as it pertains to government and public agendas, is not easily located in a health context. There is also debate over the role of rights-based frameworks and how service provision fits or does not fit. According to Paterson et al., reproductive rights are increasingly concerned with the many social influences that affect choices in the reproductive realm. However, there are political and public agendas at work that promote WHO-based ideologies surrounding breastfeeding promotion. These ideologies do not attend to specific social influences. Prior to engaging in this research, I was troubled by the lack of attention to individual exigencies in the Baby-Friendly literature and by

documents that permeate maternity settings which depict a "one size fits all" approach (Nathoo & Ostrey, 2010; Sokolon, 2014).

The word "enigmatic" entered my consciousness and promised to capture aspects of the multi-layered and hidden aspects of the topic of infant feeding support. It was shortly after I began to work with the word that I recalled hermeneutic philosopher Hans Georg Gadamer's (1996a) work, *The Enigma of Health.* This coincidence produced a sense of serenity and conjured, once again, Jardine's (2012) reference to "criss-crossing ideas." I knew of Gadamer's work, but I did not knowingly choose the word "enigmatic" in the context of Gadamer. Or did I? I proceed by accessing Gadamer's speculations and the possibilities of situating my topic in the enigmatic context of health:

> So what genuine possibilities stand before us when we are considering the question of health? Without doubt it is part of our nature as living beings that our conscious self-awareness remains largely in the background so that our enjoyment of good health is constantly concealed from us. Yet despite its hidden character health none the less manifests itself in a general feeling of well-being. It shows itself above all where such a feeling of well-being means we are open to new things, ready to embark on new enterprises and, forgetful of ourselves, scarcely notice the demands and strains which are put on us. This is what health is. (p. 112)

I luxuriate in Gadamer's depiction of health and contemplate the buoyant joy of a life that proceeds unthinkingly with living, being, and mothering.

Addressing the Address

How do I begin to explain the origins of inquiry, and my wish to explore an enigmatic area of nursing practice, which involves highly charged emotional investment

as well as controversy? By questioning breastfeeding promotion, as it is currently understood and practiced, I may be perceived as debating the advantages of breastfeeding or undoing the good work of supporting mothers to breastfeed. I have encountered these critiques as I prepared to investigate.

Moules et al (2014) discuss Gadamer's notion of "the address," an idea that pertains to the position of one's inquiry, which is neither the beginning nor the end of inquiry, but rather the place where one is "caught off guard" and "summoned" (p. 71). The occasion of my summons dwells in the heart of perinatal nursing. It is an enigmatic topic that involves many layers of engagement between mothers and nurses, and paradoxical messaging which has the potential to damage women's confidence and emotional well-being. Women's suffering over infant feeding methods addressed me because I saw that, on the surface, the comfort of applying best-practice standardized approaches could guide nurses. However, the same approach also reveals a worrisome consequence for mothers who are unsuccessful at breastfeeding, or do not breastfeed for reasons that are hers to disclose, or not disclose, as she sees fit.

Over many years of nursing practice and graduate work, the "address" builds with relentless persistence. I stop and I listen. I seek meaning in the phenomena that surround the perinatal experience. I struggle to find my breath. Given that nurses are the professionals who most often interact with mothers, I hope to shed light on an area of nursing practice that invites closer scrutiny. I wish to share my address with nurses and hope that my work will inform their care. Mostly, I imagine that by sharing the evolution of inquiry as it unfolded, I will be able to contribute to a multi-disciplinary call for diverse and particular approaches to infant feeding. This will disrupt current approaches.

My exploration promises discovery but, as is the case with all hermeneutic readings, the adventure invites your companionship. I bid you, the reader, to explore alongside with me, to question and interpret, and to participate in the understanding gleaned from nurses' experience of infant feeding support. In our pursuit, there may be times when it feels as though we are swimming underwater and delighting in the discoveries, but also encountering the hidden menaces of the deep. There will be the temptation to seek the safe haven of the water's surface, to re-orientate, and bask in the light. It may not be possible to find the surface easily, for unexpected waves of history and bias come from behind to confound our bliss. Those waves may catch us unaware, and we will once again need to interpret our surroundings and seek the horizon in order to understand where we are and locate ourselves once again. Our visions may change, depending on our situation in the swell.

Conditions of understanding. My interpretation aligns with the *Lebenswelt,* or "lifeworld," so intrinsic to hermeneutic thought. Moules et al. (2014) suggest that "The lifeworld conveys the sense of the unthinking immersion in the world, in the way that we pass through a door without stopping to think about the door-ness of the door, its mechanism, its history, or its symbolism" (p. 21). By attending to specific conditions of understanding, we become open to the nuances of larger conceptualizations of social, discursive, and historical approaches that Moules et al. explore, and which underpin nursing practice - and life - with unthinking persistence. The hermeneutic traditions in this work, therefore, assume the nuances of intersectionality and socially constructed notions of power and hegemony (including scientific privilege and feminism). Nursing scholars Van Herk, Smith, and Andrew (2010) address the advantages associated with an

intersectional theoretical perspective as it pertains to nursing practice, describing intersectionality as the process whereby categories of social identity intersect in the individual and result in differential experiences of privilege and oppression.

Foucauldian notions of discourse align the "discursive" hermeneutic nature of conversations with participants, and flourish within this hermeneutic condition of understanding. Of particular note, Mills (1999) outlines Foucault's notion that unintended consequences can be associated with embracing a particular discourse. According to Foucault, discourse is always socially constructed (Mills, 1999). Mills states: "Therefore, whilst political action can be accounted for theoretically within discourse theory, at the same time it is clear that one's actions may have effects which do not match one's intentions" (p. 27). The unintended consequences associated with current approaches to breastfeeding promotion permeate the inquiry.

The conversations that ensue in the research may disclose worrisome practice or attend to larger societal assumptions of science-based truth claims about breastfeeding. In conversation, things are left unsaid. Far from the metaphorical beach, my imaginings may take on a new dimension. Am I hearing the cries from the shore accurately? Unintended consequences of communication or lack of communication can be uncovered. Scholarship, language, and dialogue propel understanding.

We will encounter the currents of history. The histories of nurses, mothers, my history, and your history escort the inquiry. The gendered nature of my conversations offered the possibility for unique streams of interchange between the participants and me. DeVault (1990) alluded to this possibility when she described the linguistic challenges

that can be associated with the nuances of dialogue between women engaged in the research interview. DeVault and Gross (2012) suggest that:

> Another important idea is that how stories are told is not just an individual matter; people's stories are shaped by the formats available to them and reflect the perspectives and values of their communities. Thus, a narrative may be a place to see human agency in play with social structures, expressive activity that is shaped by its social context. (p. 219)

DeVault and Gross's (2012) words expose the potential to consider unintended social consequences of breastfeeding promotion and the associated scientific health claims that shape breastfeeding promotion literature that nurses access. It would be important to consider what the language in the interview did not specifically reveal and how the "unsaid" operated in this context.

Other conditions may not yet be identified. These influences, and others, contour understanding in conscious and unconscious ways and offer hermeneutic visions of circling, spiraling, fused horizons - all of which contribute to understanding. There are circles of inquiry that include beginnings, insights, and doubts.

It is not my contention that the conversations with nurses represent a definitive story about perinatal nursing practice. Rather, the dialogue might invite ongoing wonder about the specific approaches that surface when nurses enact infant feeding support. When approaching that surface, you may engage with alternate understandings of the enigma of infant feeding support. Fortunately, there are infinite opportunities to take in the vision and catch our breaths. We can always tread water and contemplate the possibilities. I am moved by an image of practicing nurses who work under challenging

circumstances, doing all that they can to "stay afloat." Aquatic metaphors abound and present themselves in what hermeneutic scholar David Jardine (2012) identifies as the unexpected, but persistent, "criss-crossing" of ideas: a coming towards something that is yet to be understood, but which beckons nonetheless.

It is unlikely that budding gills will resolve our adventure. Drowning is also improbable, for we have prepared ourselves well ahead of time. We embark on our immersion with trust and hope to sustain us. The time has come to swim underwater while seeking the light of the surface, to be hit by the wave, pulled down by the undertow. It is time to seek delight in the deep, and the process that leads to understanding.

The Turbulence: Coming to the Question

The Context of Personal Experience

My social identities as a perinatal nurse, nurse educator, mother, and researcher in and of themselves do not sufficiently explain what led to inquiry. My own experiences of mothering, for example, were happy ones, but in spite of the straightforward and rewarding experiences that I personally enjoyed, like all mothers, I lived the challenges associated with giving birth and nurturing an infant. Over time, I wondered and worried about women I cared for in my nursing practice, many of who were struggling with multiple expectations, complicated social histories, and expectations to breastfeed.

Personal history shapes my inquiry. I worked as a perinatal nurse in a number of maternity settings in various locales. In that time, I encountered situations where there appeared to be division among nurses about enacting best practice guidelines, which are evidence-based and prescriptive. Some nurses embraced the guidelines wholeheartedly and others were skeptical. I recall the culture of my perinatal workplaces, wherein

evidence-based approaches were introduced and quickly asserted dominance. But quiet conversations among nurses, carefully orchestrated and enacted only in the presence of a safe chosen few, occasionally contested the direction of best-practice institutional expectations to promote breastfeeding in accordance with prescriptive guidelines. The conversations remained as whispers, for to question the approach was to question the authority of scientific claims and universal truth. It seemed then, as it does now, that nurses struggled to articulate any concerns that defied the seduction of evidence-based approaches to a complex area of perinatal care. The dissimilarity in nurses' approaches addressed me, for although there is much to be valued about promoting ideal practice, in this case divergent methods and attitudes among nurses emerged and affected care, strained relationships between nurses, and challenged institutional initiatives to promote breastfeeding according to best practice recommendations. The consequences are troubling. I have often been saddened by the realization that, for some women, birthing and caring for an infant can be a source of deep unhappiness and set the stage for a mothering experience that is fraught with insecurity and self-recrimination.

My work in the local perinatal mental health program exposed me to the suffering that women experienced when they did not, or could not, breastfeed. That setting enhanced my understanding of perinatal mental health and also informed my advocacy for women's overall emotional well-being in the perinatal period. At the clinic, the psychiatrist and clinical nurse specialist repeatedly shared that women who lived with mood disorders required undue amounts of reassurance that their infants could thrive - and lead healthy lives - without breastfeeding. My exposure to these circumstances were not exactly new to me, but it seemed as though the history of my perinatal nursing career

converged (almost with a sense of resignation) into the realization that this was an area that I had been called to investigate. The topic summoned me. I remember the sigh and the sense that perhaps my life experiences, my nursing experiences, and the nagging sense that something was wrong had prepared me for the inevitable. In his book *The Power of Coincidence (2007,* David Richo explores the experience of synchronicity:

> This synchronicity can be just what it takes to spring us into changes and awakenings that we are ready to experience. Synchronous moments bid to us to pay attention to what comes now or next on our journey. From this point of view, awkward jolts can become graceful transitions, and stops can become steps. We grasp that the people, places, and events of our lives are showing us what we need to know or where we are ready to go. Everyone and everything in our story is part of how our life is coming together and there is nothing left to fear. We then stand at attention to our destiny and join it deliberately, rather than resisting, complaining about, otherwise bemoaning our fate.

What I had noticed, sensed, and, finally confronted, drew me toward inquiry. I acknowledged the address.

Key Issues for Mothers

Bergum (1989) suggests that, "The woman is changed by the experience of bearing a child. She is not a mere vessel, but is an active, growing, changing participant" (p. 154). "Woman" becomes "mother" (1989). Bergum's words depict the profundity of the birthing experience and shape inquiry by emphasizing the importance of successful transition into mothering.

The hermeneutic study (Humphries & McDonald, 2012) that followed my experience in the perinatal mental health program altered me deeply. None of the participants of that study were breastfeeding at the time and they shared their deep shame. They related experiences of feeling judged, misunderstood, and even shunned by nurses when they abandoned breastfeeding. They worried about the consequences of the widely published risks of formula. It happened that, in most cases, my participants had been committed to breastfeeding, but for a number of reasons, these mothers were ultimately unable to breastfeed successfully. The following excerpt from that study reflects the poignancy:

> Yeah, it was nothing positive even going in the direction of formula. You know they (public health nurses) don't go anywhere near that, but some of the things that kept going through my mind were worrying me. And, you know, you try and keep going. You know-breastfed babies are more intelligent than formula fed babies, right? So I'm thinking 'Oh my God'. I forget what the actual stat was, but they're more intelligent. You know if you don't breastfeed, then you're just not giving the right start to your child. You know these things and you want to do that. And I didn't even know if there were going to be learning disabilities and that kind of thing. (Humphries & McDonald, p. 383)

One of the most striking understandings that evolved from that study was the realization that it was the emotional turmoil leading up to the *decision not to breastfeed* that mothers found most tortuous. The study exposed mothers' feelings of social isolation. Many women indicated that their intentions in becoming mothers and mothering were easily

misunderstood by nurses when breastfeeding challenges resulted in the decision to feed the infant formula.

The arrival of a new infant in a woman's life is associated with the vision of seraphic maternal contentment, Madonna-like devotion, and the bliss of motherhood. However, societal assumptions fail to capture the complexity and despondency that may accompany the transition. Knaak (2006) elaborates: "In failing to openly discuss the complete range of experiences associated with breastfeeding, we risk propagating idealized motherhood myths - myths that fail to adequately embrace the often difficult and unpleasant work of infant feeding." (p. 413). In these circumstances, the exquisite vulnerability of women during the perinatal period determines the departure from assumptions surrounding maternal bliss.

The ease with which a woman accommodates the triumphs and challenges of the early perinatal experience is contingent on the social identities that she brings to her birthing. Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit and Brotman (2010) emphasize that women's health research seeks to advance women's health by addressing the many influences, including socio-economic influences that affect women's lives and health. For example, lower breastfeeding rates exist among mothers with lower income and education, teenage mothers, among Indigenous women, and in locales such as Atlantic Canada, where these social conditions are reflected (Gauld, 2010; Knaak, 2006). Mothers' social locations factor into the quest for understanding.

Key Issues for Nurses

Nurses, too, are influenced by their social identities. Nurses share a standard of professional preparation and enjoy employment opportunities. However, intersectional

vectors of age, experience, specialty education, and graduate education distinguish each nurse's social location.

The specifics of the ideologies and guidelines that support nurses' infant feeding approaches will be explored and re-visited at various points in this work, with the understanding that women's health and well-being are inextricably linked with the topic of infant nutrition. Without question, nurses work with complex maternal social situations. For example, there can be unexpected challenges associated with nurses' interactions, such as disclosures of sexual abuse by mothers who are struggling to enact breastfeeding in a context of emotional crisis. Beck (2009) discussed the negative implications of breastfeeding promotion in the context of a history of sexual abuse. Her work offers a transformational alternative in that it emphasized the option for nurses to give women "permission" to give up breastfeeding in order to restore mental health.

Before engaging in the research conversations, I wondered what supports are in place so that nurses can appropriately engage with the complications of infant feeding. For example, when nurses encounter complex social circumstances, what provisions exist other than to promote exclusive breastfeeding practice? Gauld (2010), Knaak (2007), and Sokolon (2014), too, wondered if the impetus to promote breastfeeding supersedes attention to the intersectional elements of mothers' social situations.

What else is at play among nurses when a mother lacks the capacity or the will to continue attempts to breastfeed? I was drawn to examine what may be at play among nurses who play such an important role in infant feeding support, including the context of women's decision making. I wondered how practitioners view formula and what sensibilities may accompany nurses' choice to present formula as a medicinal substance

or indeed as an alternative to breastfeeding. I continue to heed to the call of some mothers' emotional responses to breastfeeding promotion. I am enveloped with the layers of complexity that become associated with infant feeding approaches.

Waves of discomfort about current practice wash over me with relentless persistence. They account for assumptions that I held, and continue to hold, about nurses and their interaction with mothers. For example, among nurses with whom I have practiced, I most often recall a passionate and abiding respect for women's experiences in the perinatal period. With that passion, there can be flashes of inspiration between nurses as well as clashes of understanding. Prior to conducting research, I wondered to what extent my assumptions would be either confirmed or challenged in the interview process.

Mothers and Nurses' Intersection

Infant feeding support can involve tears, triumph, and disappointment, and it is an area of nursing practice where mothers' and nurses' goals have the potential to become enmeshed. Bergum (2007) asks: "What does it mean to be a health care professional in the midst of women's transformative experiences?" (p. 15). The unique histories and social identities of each mother and each nurse ideally collude at the juncture of birthing. Indeed, various social factors that influence the lives and emotional well-being of both mothers and nurses serve as ubiquitous companions in this inquiry. The intersectional lens therefore informs understanding of both mothers and nurses.

The Fraser Health document lurks as an emblematic nudge to my address. Sydney Harper spoke of supporting women's goals, but I wonder how it came to be that nurses considered that they were supporting women's goals in vulnerable post-partum moments, by asking them to sign a document that lists the health risks associated with formula. I

strive to understand and find meaning in the differing perspectives that inform nurses' approach and mothers' responses to nursing practice, including the complex conditions of understanding, including history, social identities, and pervasive societal discourses. For example, in circumstances when infant formula is recommended by practitioners in order to provide crucial hydration and nourishment, the discourse surrounding the risk of formula becomes destabilized. How do nurses navigate the inconsistent messages associated with evidence, informed choice, risk, and interdisciplinary influences that are associated with best practice? To what extent are relationships between nurses and mothers compromised in the context of the inconsistencies? The waves of inquiry gain momentum.

Pervasive Currents

Currents, currency, current thought, water currents. We are cast into a whirlpool of currents. Whirlpools and eddies suggest the circularity associated with hermeneutic thought. There are current (as in "up-to-date") ideas to consider, and there is the currency of science. There are discursive currents to navigate. All of these associations with the word take their place in the interpretation and aid in understanding. Historical political and social initiatives, my history, my biases, the history and biases of the participants, the dialogue that occurs between us, and the "in the moment" insights and truths come together in conjecture and interpretation.

I think of myself as a good swimmer and recall the many experiences I have had in the water. I was taught how to swim and I taught others. I understand the principles of buoyancy. Surely that knowledge will sustain me in my predicament - or perhaps I need

to access *other* experiences and knowledge to survive. I am wondering if, and hoping that, you will swim alongside me.

We encounter the undercurrents of the unexpected, which will pull us in unplanned directions. We may wonder if our peers at the beach miss us or judge us for our folly. Among our peers, we realize there are various levels of comfort in the water. These understandings shape meanings associated with our dilemma. The differences and similarities among us affect us in profound ways. Although the undercurrents of the unexpected will catch us unawares and drag us to the depths, we endeavour to surface once again and find breath. There is discomfort associated with what we explore. The possibilities for interpretation are endless.

Charting the Course of Inquiry

Having offered a broad overview of my study**,** I outline the remaining signposts of the hermeneutic research process, which unfolds in five main sections.

In Chapter Two, I present a literature review and refer to the works that provide discursive underpinnings of my conceptualizations. I draw on the works of French philosopher Michel Foucault (1926-1984) and his ideas about discourse, including the unintended consequences associated with current approaches to breastfeeding promotion. I feature feminist authors who have engaged with the topics of breastfeeding and infant feeding. I also include the perspectives of political science and anthropology and examine the consequences of global breastfeeding promotional initiatives.

The progression of my literary inquiry was not linear. One element fed the other until my inquiry was contoured. As such, I describe the forces that shaped inquiry, knowing all the while that understanding does not evolve entirely by "listing"

components of the literature. Rather the totality of inquiry evolved, took shape, and was realized in a multi-dimensional fashion.

Chapter Three addresses the hermeneutic methodology that underpins my approach to this inquiry. I examine the origins of Gadamerian hermeneutics by accessing the works of hermeneutic philosopher Hans Georg Gadamer (1900-2002) with reference to Gadamer's Heideggarian roots, for Gadamer was a student of the Marten Heidegger (1889-1976). It is through the conduit of Heidegger's works that Gadamer was able to articulate the tenets of philosophical hermeneutics. In doing so, Gadamer charted a possible course for research.

Notwithstanding the academic attention that I give to hermeneutics, it is the unfettered resonance of hermeneutic thought that pervades my attention to the "everyday." The moments of "Ah-ha! This is indeed what is going on here!" propelled me. It is possible to live hermeneutics in metaphor, poetry, literature, and other interpretative ventures that dwell in discursive spaces of understanding. In this work, I do not wish to say: "Now I am displaying hermeneutic thought" as much as I hope to *convey* hermeneutics with discretion and, perhaps, with the deftness of the trickster, Hermes, the Greek god after whom hermeneutics was named. In this way, I am challenged to separate hermeneutics as a distinct conversation. Indeed, hermeneutic thought pervades the inquiry in its entirety, starting with the approach and residing in the interpretations. But in Chapter Three, I offer the foundational possibilities.

The theoretical approach of intersectionality moves alongside my hermeneutic explorations and I expose possibilities for intersectionality to inform understanding. The

presence of intersectionality, like hermeneutics, is embedded throughout the work, but named and articulated in Chapter Three.

Chapter Four presents, for me, the highpoint of my research. The preparation and planning that I undertook culminated, at last, in the conversations with perinatal nurses. The texts therein are rich and provocative. They invite repeated conjecture and demand attention to the discursive, social, and historical conditions of understanding that envelop the conversations. The excerpts that I chose from conversations are the passages that moved me, gave me pause, and challenged my assumptions. The passages stand alone and invite consideration in a milieu of contradiction and questions. They extend the hermeneutic address.

Chapter Five is the view toward the now distant shore. The origins of inquiry have been enacted. The chapter expresses the meaning that arises following my encounters with participants. I trace my personal response to the research, including unexpected insights. The chapter offers a way to navigate towards the shore with renewed insight and enhanced understanding. It features chosen excerpts from the research conversations as well as personal wonderings. The participants' contributions pepper my interpretations and my analysis of the possibilities for enhanced practice. The promise for further speculation, as always, remains.

The profound meanings attached to infant feeding, as it applies to feelings of successful mothering, serves as the beacon. The Fraser Health document, and women's responses to it, shifted the tides and exposed, for a brief moment, what may lurk in the deep. Infant feeding support is indeed an enigmatic aspect of nursing practice. I engage with the enigma.

Who has fathomed the enigma of the deep?

That obscure world where fearful darkness broods?

Who has tamed the restless waves that never sleep?

So constant yet so changing in their moods?

Who can know the secrets of the shifting seas

Where certainty is toppled by the tide

Where confidence is humbled like an upturned tree

And blind confusion is the only guide?

(Taken from "Ocean World"

Words by Anne Conlon

Chapter 2: Accessing the Literature and Wading In

Tentatively, I step into the surf. The water is cold, and the voices from the beach either urge me forward or taunt me. Shall I continue, or should I return to the comfort of the shore?

I am pulled to what exists beyond the haze-and I prepare myself for the currents and undercurrents that lie beneath the surface. I shudder at the thought of immersing myself, although I know immersion is inevitable. I anticipate the breathlessness of discovery.

In Chapter Two, I explore important ideas, literature, and ideologies that have informed my inquiry. I reference the literature, which has, in part, shaped preliminary understandings and prepared me, as the researcher, to interpret the research conversations. I approach the literature by framing it in the context of theoretical and discursive potentials to inform understanding. I share ongoing and emerging questions that arise from the literature and emphasize the dearth of nurses' contributions to date. The possibilities to understand what is at play among nurses are buoyed by interdisciplinary perspectives. Indeed, exposure to interdisciplinary analysis uncovers the need to investigate *nurses' perspectives* about a practice that shapes perinatal nursing care. The literature sets the stage for the research.

Discursive Considerations

Foucault explicates discourse as a reflection of truth that is socially constructed, rather than transcendentally conceived (Mills, 1997). As such, Foucault implies that discourse does not represent what is "real." Rather, discourse reflects the mechanics of how society arrives at a dominant discourse, and it was that process that captured Foucault's interest. A Foucauldian view of power is closely associated and posits that

power is "dispersed through social relations" (Mills, 1997, p. 17) as opposed to representing power that is exerted in some way. In this work, I attend to Mills' conception of Foucauldian discourse as discursive narratives, or "currents," underpinning approaches to infant feeding support.

Discourse, then, surfaces in hermeneutic research dialogue (the "discursive utterances" of conversation [Mills, 1997]) as well as in the commonly held social understandings. Discourses of medical science and evidence-based practice, for example, imply an adherence to scientific method, statistical analysis, and universal approaches to truth. Contrasting discourses may be founded in socially constructed or temporal understandings of truth. Each aspect of discourse, including the discursive nuances that emerge in conversation and other taken-for-granted societal contexts, shaped the conditions of understanding that guided interpretation in this study.

Like hermeneutics, engaging with Foucauldian discourse theory has the potential to expose the unspoken, hidden aspects of human existence (Linge, 2008; Mills, 1997). I explore discourses that uncover webs of complex and contradictory forces that are at play in infant feeding support. Importantly, many of these forces have the potential to empower as well as marginalize, and silence nurses and mothers during the important perinatal period (Beck, 2009; Humphries & McDonald, 2012; Murphy, 1999; Shakespeare, Blake & Garcia, 2004; Wolf, 2011). The many discourses that are attached to the topic of breastfeeding expose various dilemmas.

Foucauldian Terminology

It is salient to explain the terms that Foucault used to describe discursive activity. According to Mills, Foucault envisioned a "discourse" as comprising a number of less

comprehensive discourses, which when seen in combination with each other create a cohesive narrative. Every day "utterances" or statements that lead to recognizable *discourses*, in turn, shape the broader *discourse*. Groups of discourses make up the "episteme," which constitute the knowledge that is associated with a given discourse (albeit a temporal conception of knowledge) and which are subject to "epistemic breaks" when new knowledge replaces previous knowledge.

In describing Foucault's "discourse theory," it is not my intent to apply Foucault's "discourse analysis" method. That is, I am interested in exploring discourses according to their meaning, rather than relegating them to Foucault's definitive discursive structures. Foucauldian understandings, in my work, attend to the "pervasive, complex, and frequently conflicting nature of power relations" (Williams, Kurz, Summers, & Crabb, 2012, p. 343) and open possibilities to understand the discursive influences that surround nurses' practice.

The socially constructed nature of discourse and the inherent risk for unintended consequences offers a vantage point from which to proceed. Nurses' practice realities are shaped by societal discourses of scientific privilege, which health care providers may openly acknowledge, as was depicted in the debacle surrounding the Fraser Health document. Some discourses, however, may be relegated to a more marginalized influence. As Williams et al. (2012) summarize:

> Hence, notions and images of the breastfeeding mother become interpretable not as neutral depictions of reality, but rather as social constructions that are shaped by relations of power that naturalize these images and ideas across a range of settings. (p. 343)

For each discursive possibility, hegemony, power, and exclusion can be assumed. Importantly, some discourses may assume the mantle of "common sense" and fortify their influence. I invite you, the reader, to consider the underlying discourses that shape the literature I describe, starting with the Baby Friendly Hospital Initiative.

Baby Friendly Hospital Initiative

Political and Historical Origins

In the Western world, breastfeeding practice is seen as the preferred method for infant feeding, and currently assumes an uncontested status among health care providers and policy makers (Martin & Redshaw, 2011).

The history of breastfeeding promotion reflects a shift towards exclusive breastfeeding practice, articulated by the joint WHO/ UNICEF's Innocenti Declaration of 1991, wherein infant nutrition was enshrined as a basic human right (Nathoo & Ostry, 2009; Palmer, 2009). Importantly, that document featured breastfeeding as needing protection, promotion, and support (Retrieved from: http://www.infactcanada.ca/innocenti_declaration.htm). The return to breastfeeding promotion in Canada led to the creation of the Breastfeeding Committee for Canada (BCC), the "National Authority for the WHO/UNICEF Baby-Friendly ™ Initiative (BFI)." (Retrieved from http://www.breastfeedingcanada.ca/TheBCC.aspx). The following description positions the Baby Friendly Hospital Initiative (BFHI) in the context of Canadian practice:

> The BCC identified the WHO/UNICEF Baby-Friendly™ Hospital Initiative (BFHI) as a primary strategy for the protection, promotion and support of breastfeeding. The WHO/UNICEF guidelines for the BFHI state that each country

must identify a BFHI Authority to facilitate the assessment and monitoring of the progress of the BFHI within its borders. The Breastfeeding Committee for Canada is identified as the National Authority for the Baby-Friendly™ Initiative (BFI) in Canada which it is working to implement through provincial and territorial action. (Retrieved from: http://breastfeedingcanada.ca/aboutus.aspx)

The protection of breastfeeding practice is a notion that pervades the perinatal nursing world. As a result of the widespread acceptance of Baby Friendly Hospital Initiative (BFHI) guidelines for infant feeding that originate with WHO, women throughout the world are exposed to breastfeeding promotional initiatives. The Baby Friendly documents that I discuss below, therefore, are merely a small portion of the publications that originate from WHO and Breastfeeding Committee for Canada (BCC) many of which are widely distributed in hospital and community maternity settings, and shape nursing practice.

Overview of Baby Friendly Hospital Initiative

I examine the WHO/UNICEF (2009)[3] Baby Friendly Hospital Initiative (Retrieved from http://www.unicef.org/nutirionion/index_24850.html). There are five topics covered in the BFHI (2009).[4] All but the last category is published online. The last section, entitled "External assessment and re-assessment" contains confidential information about facility evaluation, and is not available unless requested by the national authorities that conduct evaluation of BFHI activity (WHO, 2009a).

I introduce the BFHI document as follows:

[3] In the interests of brevity, and because UNICEF is an organization that is officially incorporated into WHO, I hereafter refer to WHO/UNICEF as WHO in the text of this work.

[4] References to BFHI in this work refer to the WHO 2009 revision.

> The Baby-friendly Hospital Initiative (BFHI) is a global effort launched by WHO and UNICEF to implement practices that protect, promote and support breastfeeding. It was launched in 1991 in response to the Innocenti Declaration. The global BFHI materials have been revised, updated and expanded for integrated care. The materials reflect new research and experience, reinforce the International Code of Marketing of Breast-milk Substitutes, support mothers who are not breastfeeding, provide modules on HIV and infant feeding and mother-friendly care, and give more guidance for monitoring and reassessment (WHO, 2009a, p. 72).

The 1991 Innocenti Declaration, therefore, continues to serve as the foundational impetus for enacting the BFHI.

Section One: Background and Implementation

The introductory section of the BFHI document reinforces several foundational approaches found in previous publications and features some additions. However, the general thrust of breastfeeding advocacy remains unchanged. An overarching theme focuses on what steps health authorities must take to achieve "Baby Friendly" status - something that has proven difficult, given the prescriptive nature of the guidelines and the diversity of maternity conditions around the globe. That said, over 20,000 hospitals in 156 countries have been designated as Baby-Friendly since 1991, and the number is steadily growing (WHO, 2009a). BFHI has a presence in Canadian and United States (US) hospitals. The guidelines are seen as principles to guide practice and ostensibly to offer a reference point to which health care providers can be held professionally accountable.

The WHO (2009) BFHI revision makes it clear that the intent is to extend BFHI ideology to as many countries in the world as possible in both the First and Third Worlds.

The "Code of Marketing of Breastmilk Substitutes" (known as the "Code") is a well-known component of the original BFHI (Appendix 1) and has been included in the 2009 BFHI revision. The meaning of the Code is summarized as follows: "One of the main principles of the Code is that health care facilities should not be used for the purpose of promoting breast milk substitutes, feeding bottles or teats" (WHO, 2009, p.49). In compliance with the Code, health care facilities may not give out free formula, may not have formula visible, and may not have any visual representations of anything other than a breastfeeding mother in art or information that is posted. Information about how to safely feed an infant with formula is hidden and distributed only when an "informed choice" is made by the mother to feed the infant with formula. Whether or not the issue of safe preparation is at stake, the Code sends a clear message to women in hospital. The images of breastfeeding only and no visual exposure to formula or artificial nipples tells women that formula is not associated with best practice. For example, nurses are instructed as follows:

> No displays of bottles in ward areas, visible stores or returns area - watch for windowsills that are visible from outside, and bottles stacked in wards. When parents see these products displayed in the hospital they think the hospital supports their use. While the health facility realizes these products are needed at times, it does not want to be seen as endorsing particular brands. (p. 20)

Another foundational feature of the 2009 BFHI is the global criteria for "Ten Steps for Successful Breastfeeding" (Appendix 11), which is the suggested basis for a

hospital's approach to breastfeeding advocacy. An alternative "Ten Steps for Successful Breastfeeding" has also been designed to accommodate settings where there is a high incidence of maternal HIV/AIDS. In that document, considerable emphasis is placed on maintaining confidentiality about the mother's status. There are also a number of statements that suggest that the notion of informed choice underpins infant feeding in the context of HIV/AIDS. If a mother chooses not to breastfeed, it is important to honor the principles of "AFASS," meaning that formula can only be considered if it is acceptable, feasible, affordable, sustainable, and safe. The history of WHO's response to HIV/AIDS, however, is steeped in controversy. (Appendix V1)

Informed consent, as an ideology and a practicality, has implications that are far reaching in the context of HIV/AIDS as well as other circumstances. It is impossible to analyze the implications of the Ten Steps or the Code without considering the rhetoric of informed choice that underpins BFHI literature. According to BCC (2010):

> A written curriculum for prenatal education used by the hospital and/or the community health service and written information for prenatal clients (such as booklets, leaflets, handbooks and text books with general information on pregnancy, parenting, infant feeding and child care) provide accurate, evidence based information. They are free of information on the feeding of human milk substitutes. Women who have made an informed decision not to breastfeed receive written materials on the feeding of human milk substitutes that is current, appropriate and separate from breastfeeding information. All written information is free of promotional material for products or companies that fall within the scope of the WHO Code.

(Retrieved from: http://www.swndha.nshealth.ca/BCC10integratedsteps.pdf)

One of the headings in WHO Section One (2009a) addresses situations in which, according to BFHI imperatives, formula feeding is acceptable, citing some specific and rare health concerns that may apply to the mother and/or infant.

The 2009 version of the BFHI document includes references to being "mother-friendly." The comment refers to supporting women who feed with formula, citing a desire to support the mother/baby dyad in the context of all infant feeding. For example:

> This revised version of the assessment includes specific questions related to the training staff has received on providing support for 'non-breastfeeding mothers' and what actual support these mothers have received. The inclusion of these questions does NOT mean that the BFHI is promoting formula feeding but, rather, that the Initiative wants to help insure that ALL mothers, regardless of feeding method, get the feeding support they need. (p. 24)

Section Two: Strengthening and Sustaining the Baby Friendly Hospital Initiative: A Course for Decision Makers

A course was designed for decision makers in health authorities globally in order to facilitate progress in breastfeeding promotion (WHO, 2009b). The document reads:

> Once higher level administrators and policy-makers have been sensitized to the importance of breastfeeding support in health facilities and the changes necessary to attain it, they will be more likely to encourage and support the continuing education needs of mid-level health workers. (p. 1)

The course outline suggests that the course is generally offered in a ten to twelve hour format. The references include attention to breastfeeding success rates, the advantages of

breastfeeding/disadvantages of "artificial" feeding, the scientific basis of the "Ten Steps to Successful Breastfeeding." The context of HIV/AIDS is emphasized. The Baby Friendly way of being is also associated with cost savings.

Section Three: Breastfeeding Promotion and Support in a Baby Friendly Hospital

This section of the document (WHO, 2009c) outlines a course for health care workers who will be providing direct care to women. The course is designed to be approximately eighteen hours long and emphasizes the following key assumptions:

- Breastfeeding is important for mother and baby.
- Most mothers and babies can breastfeed.
- Mothers and babies who are not breastfeeding need extra care to be healthy.
- Hospital practices can help (or hinder) baby and mother friendly practices.
- Implementing the Baby-friendly Hospital Initiative helps good practices to happen (WHO, 2009c, p.1)

This section also addresses the many risks that are associated with "not" breastfeeding. Role playing examples are meant to provide nurses with expressions and responses that are considered optimal.

The following excerpt captures the tone of the coaching:

> How would you reply to a colleague who says, 'You make mothers feel bad if you tell them that there are dangers if they do not breastfeed'? Health workers do not hesitate to tell women that there is a risk if they smoke during pregnancy or if do not have a trained person at the birth or if they leave their infant in the house alone. There are many risks to a baby that we tell women to try to avoid. Women have a right to

know what is best for baby and may feel angry if you withhold information from them. (Retrieved from: http://www.ncbi.nlm.nih.gov/books/NBK153456/)

Supposedly, by employing principles of informed choice, women will make decisions that are best for themselves and their infants, including the possibility of feeding an infant with formula, if the principles of AFASS are in place.

Section Four: Hospital Self-appraisal and Monitoring

The final section (WHO, 2009d) offers tools to determine whether facilities are ready to be evaluated as a Baby Friendly designated facility. Other facilities who do not work towards the designation, but who value Baby Friendly principles and values have access to the "Gold Standard" of maternity care. Briefly stated, this section reviews the many underpinnings of Baby Friendly care, including adherence to the Code, The Ten Steps, Mother-Friendly activities, acceptable reasons for breast milk substitutes, and other foundational tenets. A series of questionnaires are available to test knowledge about breastfeeding advocacy and mother-friendly environments.

The above discussion offered a brief overview of the BFHI (2009) document with the intention of providing a basic understanding of what is meant when we speak of BF guidelines. Knowledge of BF ideologies, as exemplified in the BFHI, is important because they shape both public health policy and public opinion. Much of the literature on this topic, as reviewed below, builds on these principles of breastfeeding promotion.

Mothers

Feminist Discourse

Mills (1997) addresses Foucault's relationship to feminist thought and acknowledges that Foucault's work did not directly address gender issues. It seems,

however, that Foucault's attention to power generated an interest among feminist scholars. According to Mills, feminist theorists see power in a gendered context, through which "vectors" (p. 71) of race and class appear, aligning with intersectional approaches. Mills emphasizes the utility of incorporating Foucault's perspectives on power into feminist theoretical frameworks, inviting yet another dimension of understanding having to do with infant feeding discourse. The feminist scholarship that I access indeed reflects a web of power dynamics that pervade infant feeding and mothering discourses.

Feminists hold notions about motherhood. DiQuinzio (1999a; 1999b) contends that the term "motherhood" is impossible to conceive, since the word suggests a static and predictable state, as opposed to fluid and diverse mothering situations. On the one hand, DiQuinzio posits that some feminists consider mothering to be oppressive, undermining women's autonomy. On the other hand, some feminists see mothering as an important manifestation of female identity and an impetus for women's political activism. According to DiQuinzio (1999a) "the issue of motherhood often functions as a sort of lightening rod" (p. xi), wherein the many issues that women face become attached to mothering. Therefore, feminist approaches must address mothering, since decisions about when, if, and how mothering occurs is an important issue in all women's lives (DiQuinzio, 1999a; DiQunizio, 1999b).

Apple (1999) traces the evolution of "scientific" motherhood that evolved in the US during the nineteenth and twentieth centuries. She comments on the influences of various educational structures (both formal and informal), cultural icons, and the media - all in the context of shifting "idealizations of motherhood" (p. 90). Apple states that

"Scientific motherhood is the insistence that women require expert scientific and medical advice to raise their children healthfully" (p. 90).

Apple's (1999) account points to a number of disturbing trends. For example, as a result of the increased dependence on medical expertise, it seems that, over the past fifty years, women were placed in the impossible position of being both responsible and not responsible for their children. Women were increasingly encouraged to educate themselves at the feet of the "experts" (such as Dr. Spock and the family physician), but were denied ultimate autonomy over decision-making. For example, strategies that had previously been associated with the learned art of mothering, passed down through women through the generations, were suddenly undermined by burgeoning scientific knowledge. The underlying message throughout this transition remained the same: that it was through motherhood that women were able to discover fulfillment and establish their identity. Interestingly, these ideals coincided with an increased scientification of domestic life in general, wherein increased technology in the home, expectations about scientific approaches to cooking, and other developments served to professionalize homemaking. At the same time, motherhood was being professionalized. Advice from neighbors was no longer considered a viable option for solving problems about child care - a higher scientific authority (usually the physician) was considered to be the expert (Apple, 1997). Apple (1997) concludes that, "The image of the scientific mother changed from the queen of the nursery to the servant of science" (p. 105).

During the time period covered in Apple's analysis, the reverence for science in the context of infant feeding swung from a reliance on medical advice that advocated formula feeding, to a reliance on medical advice that advocated for breastfeeding. There

is irony that, in both cases, medical advice is privileged in spite of the obvious contradictions between the standpoints.

Risk. Feminist scholar Joan Wolf's (2011) work, *Is Breast Best? Taking on the Breastfeeding Experts and the New High Stakes of Motherhood,* constitutes a significant current contribution to the discussion about unintended consequences of breastfeeding promotion. Wolf addresses many issues that had been largely ignored in the literature at the time of her writing. In the context of my interests, Wolf explores such relevant topics as the concept of "total motherhood," wherein women come to believe that they are responsible for eliminating all risks to their children.

Wolf (2011) posits that we live in a world that is shaped by an ideology of "total motherhood" (p. 71). She says:

> Total motherhood stipulates that mothers' primary occupation is to predict and prevent all the less-than-optimal social, emotional, cognitive, and physical outcomes: that mothers are responsible for anticipating and eradicating every imaginable risk to their children, regardless of the degree or severity of the risk or what the trade-offs might be; and that any potential diminution in harm to children trumps all other considerations in risk analysis as long as mothers can achieve the reduction. (p. 71-72)

According to Wolf (2011), the goal of attaining total motherhood is synonymous with breastfeeding.

Wolf also engages in an analysis of breastfeeding promotion. Wolf systematically critiques foundational empiric studies that underpin the science of breast milk superiority. Her analysis is at odds with the myriad of literature that features breast milk as a

substance that prevents infant health issues (Brenner & Beusher, 2011; Groer & Davis, 2006; Mohrbacher & Kendall-Tackett, 2010; WHO, 2009). An evaluation of Wolf's critique of these foundational studies is beyond the scope of this study, but her work aligns with hermeneutic perspectives on the temporality of scientific evidence. For example, a recurring theme of philosophical hermeneutics questions the prominence, authority, and legitimacy of scientific methods as a way of establishing universal truth. The hermeneutic approach does not privilege science as the definitive understanding of the human experience (Gadamer, 1998; Paley, 1998), but instead *includes* science, as well as *other* questions, that are important to human life.

It is worth noting, though, that in spite of the multi-disciplinary approach Wolf (2011) undertook in her work, she did not include nurses as contributors. Her omission confirmed my desire to contribute to the literature by centering a nursing perspective.

Wolf specifically takes aim at American initiatives, such as the National Breastfeeding Awareness Campaign (NABC), and offers a critique of its advertising campaign. Advertisements that were launched between 2002 and 2006 included posters, pamphlets, and billboards and capitalized on the public's confusion about the meaning of risk. In one advertisement, a rubber nipple was placed on a bottle of insulin, suggesting that formula causes diabetes. Another advertisement displayed a pregnant woman on a mechanical bull. The caption read "You'd never take risks when you're pregnant. Why start now?" (Cited in Wolf, 2011, p. 109), suggesting that feeding an infant with formula is tantamount to riding a bull when pregnant. The implications of these depictions are huge. What is the experience of mothers when children become ill or are born disabled, or premature, or die? Are mothers responsible for contravening all risks?

Wolf (2011) goes on to argue that the risks associated with formula use are taken out of context, considering the many day-to-day risks that we all face, including any number of unexpected and uncontrollable environmental risks. Another consideration is that for any woman, no matter what her situation, it is impossible to avoid all risk when making decisions for a child, given the issues of air pollution, traffic fatalities, food safety, and many other realities.

Natural mothering. Feminist philosopher Patricia DiQuinzio (1999a) explores and critiques the notion of idealized and essentialized motherhood, which relates to the notion of naturalistic mothering. She states:

> Essential motherhood construes women's motherhood as natural and inevitable. It requires women's exclusive and selfless attention to and care of children based on women's psychological and emotional capacities for empathy, awareness of the needs of others, and self-sacrifice. According to essential motherhood, because these psychological and emotional capacities are natural in women, women's desires are oriented to mothering and women's psychological development and emotional satisfaction require mothering. (p. xiii)

According to DiQuinzio (1999a) essential motherhood means "mothering is a function of women's essentially female nature, women's biological reproductive capacities and/or human evolutionary development" (p. xiii). The definition is provocative and conjures notions of prescribed and predetermined feminine behaviors surrounding the mothering experience.

Feminist approaches have the potential to provide insight into how women may be viewed in the context of BFHI authority. Feminist approaches to mothering vary, as

discussed above. I wonder, however, if mother-friendly initiatives, as described in BFHI, valorize essentialized motherhood because of its reverence for natural approaches to infant feeding. In fact, BFHI (WHO, 2009) condones the naturalistic position as a taken-for-granted value.

Wolf (2011), too, addresses the rhetoric of "natural" mothering, indicating that influence of nature is compatible with the technical language of science. Supposedly natural approaches, like science, reflect the natural order of life. However, according to Badinter (2011), the romanticism associated with natural behaviors, such as breastfeeding, reinforces an underlying illusion of control, and the conviction that careful planning and "good" decisions can eliminate risk.

Badinter (2011) traces the naturalistic influence of the La Leche League (LLL), a well-known and influential international organization involved in breastfeeding advocacy that mobilizes a base of passionate volunteers. According to Badinter (2011), LLL's guiding principles adhere to conceptions of the "good mother" who attends to what is natural and then naturally puts her child's needs before all else. LLL encourages women to view their breasts as belonging to the baby, who in turn decides when breastfeeding should end. Badinter contends that according to LLL, "The conclusion is irrefutable: a good mother breast-feeds" (p. 72). Marshall, Godfrey, and Renfrew (2007) offer that, "Within medicalized expert discourse, breastfeeding has assumed the status of moral imperative, inseparable from the conception of 'good mothering'" (p. 2147). I am struck with the responsibilities that mothers assume in order to achieve the goal of good mothering. I contemplate that mothers will potentially feel silenced in a milieu of natural approaches, when situations call for alternate approaches to infant feeding.

Lactivism. Political scientist Courtney Jung (2015) has garnered significant media attention in recent months with the release of her book, *Lactivism-How Feminists and Fundamentalists, Hippies and Yuppies, and Physicians and Politicians Made Breastfeeding Big Business and Bad Policy.* She uses the term "lactivism" to capture the frenzy that accompanies devotion to breastfeeding, and references several problematic discourses that influence modern-day mothering. Drawing on a political science perspective, Jung posits that breastfeeding represents a "consensus" issue, which "unites people who otherwise disagree about pretty much everything else" (p. 8). She echoes Wolf's (2011) argument that risk is a motivator for parents, but frames risk in the context of competitive parenting and breastfeeding as a "marker of class" (p.8). Jung's work characterizes the notion of breastfeeding as elitist practice, acknowledging the luxury associated with time and job flexibility that is necessary to achieve successful breastfeeding. According to Jung, other values inspire lactivism, including religious positioning, feminist empowerment, moral imperatives rooted in environmental devotion, and cost saving to society. In particular, Jung exposes the contradictory messaging associated with the act of breastfeeding and the independent value of breast milk. In other words, women are judged for not participating in the physical act of breastfeeding and all the associated benefits of attachment that are said to be critical. However, by valuing breast milk in and of itself, women can at least give their infants the "liquid gold" that will protect them. According to Jung, this perspective is responsible for an industry of breast pump manufacturing and, thereby, reinforces the discourse of risk associated with formula. In other words, as a way of mitigating the risk of formula, mothers should pump their breasts rather than turn to formula.

Discourse of Informed Choice

In the most recent BFHI revision (WHO, 2009), there is specific language that addresses informed consent, especially among women who live with HIV/AIDS. The consequences of implementing the Ten Steps or The Code are very much linked to BFI's conceptions of "informed choice." For example, the Breastfeeding Committee for Canada (BCC) emphasizes that distributed literature about infant feeding must be evidence-based, must extol the advantages of breastfeeding, and must be free of information about formula. (Retrieved from: http://www.swndha.nshealth.ca/BCC10integratedsteps.pdf). However, it is difficult to fathom how a woman can truly make an informed decision when only one alternative for infant feeding is presented.

Nathoo and Ostry (2009) interrogate the notion of "choice" and emphasize the need to attend to the social influences that punctuate a woman's situation, saying:

> Yet, as we have seen, breastfeeding is clearly more than a matter of individual choice. Breastfeeding is shaped by a woman's socio-cultural context, yet an emphasis on individual choice has resulted in steering us away from examining the social forces that determine that 'choice.' (p. 210)

These authors remind us that merely exposing a mother to the advantages of breastfeeding does not address deeper realities of her life, including the "socio-cultural" factors that may feature most prominently when making her choice. It is simplistic to suggest that the breastfeeding/formula feeding binary represents an uncomplicated choice (Maher, 1992). Cultural, historical, economic, societal, and other influences, including nurses' perspectives, shape mothers' choice.

Jung (2015) discusses the BF approach to keeping formula hidden in hospital settings. She quotes from a feminist website which states:

> So a mother asks for a bottle, and the recommended response is to first encourage her to breastfeed, then educate her on why breastfeeding is a better choice and then if she 'still insists' distribute enough formula for one feeding. And then repeat that every time the infant needs another bottle. That's not supporting the choice to breastfeed, that's shaming them. (p.107)

Jung suggests that women's right to choose is better reflected in the statement, "You have the right to do what we tell you to do" (p.108). She cautions that, when breastfeeding becomes a moral crusade, it has the effect of limiting rather than protecting women's choice.

Maternal Attachment/Bonding Theory

"Bonding" refers to issues of maternal attachment with the infant (McKinney, James, Murray et al., 2009). Bonding theory appears to be generally uncontested among nurses. Fundamental nursing texts, for example, cite the theory of authors, such as Klaus and Kennel and their 1976 work in maternal/child bonding, to illustrate the importance of including maternal attachment as a routine tool in nursing assessments (Humphries, 2013). The value of using bonding theory as a framework for assessment has many advantages, since it offers nurses a concrete theoretical backdrop from which to proceed. For example, there are real risks associated with post-partum depression, and a mother's disinterest in her infant may alert health care providers to consider that there is an emerging emotional crisis (Beck, 2001). However, there are also risks associated with interpreting theoretical guidelines in a narrow and rigid way. For example, BF

approaches connect breastfeeding with bonding, and imply that breastfeeding confirms appropriate maternal interest in the newborn.

Else-Quest, Hyde, and Clark (2003) studied the association between breastfeeding and maternal emotional attachment to the infant. Else-Quest et al. state: "The bonding hypothesis suggests that the development of the maternal bond may go astray if certain important experiences during the first few hours or days post-partum fail to occur" (p. 497). Breastfeeding and maternal bonding are seen to be closely related, since mothers who breastfeed successfully often indicate an enjoyable experience with their infants. However, Else-Quest et al.'s research findings do not pathologize bottle-feeding behavior in the context of maternal attachment. Instead, they suggest that bottle-feeding can easily translate into bonding behaviors.

Guidelines originating from the World Health Organization (Breastfeeding Committee for Canada, 2011) promote skin-to-skin contact (namely the naked baby is place against the mother's naked chest within a half-hour of birth). The guideline is strictly observed in maternity settings in compliance with BF imperatives. The recommendations of BFHI address and endorse bonding theory, in part, because the technique is believed to induce successful breastfeeding by enabling the infant to find the mother's nipple and begin suckling.

There is an important caveat to the discussion of maternal bonding. If there are breastfeeding difficulties, a mother's attachment to the infant can be impeded, because of the frustration associated with an inability to feed or the experience of painful breastfeeding (Humphries & McDonald, 2012). The following statement (Retrieved from: .http://jezebel.com/5968243/fuck-you-breastfeeding) exemplifies the possibility:

> It was all so miserable and I associated that misery with my new baby, whom I secretly resented. Of course, I could never tell anyone about how I truly felt, how anguished I was, because that would make me seem selfish and terrible and evil and ungrateful for having a healthy baby, whose health I would be threatening if I didn't exclusively breastfeed her. For some reason, we assume that there must be something *wrong* with a woman if she isn't bonding with this *thing* that's quite literally been torturing her.

However, as Else-Quest et al. suggest, there is reason to view skin-to-skin contact after birth as possibly pleasant, but as not necessary for attachment and "good mothering."

Discourses of Maternal/Child Nursing

In order to attach meaning to perinatal nursing, it is helpful to examine influences that shape nursing care. Hammarstrand and Loewen (2013) offer their definition of maternal child nursing saying:

> Maternal and child health nursing focuses on providing evidence-based, case-managed care to the client within the context of the family. This care involves the implementation of an interdisciplinary plan in a collaborative manner to ensure continuity of care that is cost-effective, quality oriented, and outcome focused. (p. 9)

In their statement, these authors introduce several key discourses, such as evidence-based care, interdisciplinary input, and outcome focused actions. Each can be critiqued for the unintended consequences that could result in the context of infant feeding best practice approaches. Therefore, while the statement is innocuous on one level, I posit that

there are many embedded assumptions that are at odds with many of the realities and complexities of maternity practice.

It has been puzzling to discover that there is a scarcity of nursing literature that reflects my hermeneutic address. To be sure, there is a plethora of nursing literature that offers support for improving breastfeeding success rates, and it is easy to locate nursing literature that attends to the mechanistic difficulties associated with breastfeeding support. It is only works that originate from disciplinary sources other than nursing (for example, Badinter, 2011; Gauld, 2009; Kelleher, 2006; Kendall-Tackett, 2007a; Kendall-Tackett, 2007b; Kendall-Tackett, 1998; Murphy, 1999; Shakespeare, Garcia, & Blake, 2007; Wolf, 2011) that question current approaches. With the exception of a few works (Beck, 2009; Humphries, 2011; Humphries & McDonald, 2012, Humphries, 2012; Nelson, 2006), it is difficult to locate nursing scholars who directly challenge breastfeeding advocacy as it is currently idealized and often practiced.

Nursing Scholarship

Nelson (2006) acknowledged the need for a "situation-specific" framework for breastfeeding promotion and attempted to create guidelines to assist nurses with infant feeding. In my opinion, however, Nelson's suggestions acknowledge the complexity of infant feeding support, but do not offer any concrete recommendations for nurses. For example, Nelson (2006) cites the need to enlist evidence-based practice, clinical judgments, and interprofessional communication. I identify these elements as requiring a deeper exploration, since those terms are open to interpretation. Indeed, all of the elements suggested by Nelson identify layers of professional nursing practice that require enhanced exploration.

Canadian Baby Friendly approaches are rooted in the interdisciplinary fields of nutrition, pharmacy, medicine (including obstetricians and pediatricians), epidemiology, nursing, and others, such as the La Leche League, which came together as the Canadian Expert Working Group on Breastfeeding in 1993 (Nathoo & Ostrey, 2009). From the perspective of disciplinary nursing knowledge, it is important to consider the implications of multi-disciplinary input into infant feeding approaches. For example, Petrovskaya (2014) suggests that interdisciplinary (or "interprofessional") nursing grapples with the wish for nursing to "enhance its status and privilege in society, expand its territory and create and strengthen professional identity of its members" (p. 268). As such, there is tension between addressing Keogh's (1996) plea for nursing to establish knowledge, autonomous practice, and research standards that are unique to nursing, and the impetus to engage in the collaborative aspirations of interprofessional practice. In the context of this tension, I wonder to what extent nurses should be accountable to prescribed infant feeding guidelines that are based on inter-disciplinary sources of knowledge, but which have the potential to obfuscate the broader human issues that arise in the context of infant feeding support that is provided by nurses. That said, there are potential advantages to accessing interprofessional input in order to access broad sources of expertise and knowledge. It is a complex question.

Nursing theorist Jacqueline Fawcett (1980) recognized that research and professionalism must be carefully negotiated. She cautioned that historic nursing conceptions involving "art" as well as "science" would require nurturing if professional nursing was to achieve enhanced disciplinary and professional stature. She stated, with some irony, that:

> The courage and motivation to apply findings requires that nurses overcome many constraints, including agency politics, policies, and procedures: ritualistic practices and the vested interests of other health professionals. The courage not to apply findings requires understanding of the cumulative nature of science and the time required to validate knowledge. (p. 315)

As far back as 1980, Fawcett anticipated the kinds of concerns that have materialized in breastfeeding best practice guidelines. She warned against the tendency for nurses to embrace evidence without critical appraisal of its often-temporal nature. (As I read her words, I wonder where both the "art" and "science" of nursing practice currently sit in the context of breastfeeding support.) Fawcett wisely addressed the challenges of institutionally vested attitudes and behaviors - all of which have stature in the context of the breastfeeding debacle. I am nudged to question the influences of other disciplinary perspectives towards the nursing profession, which is so critically involved in enacting infant feeding support.

Discourses of Power

Foucault envisioned power as circulating through a society, but not as being "owned" by a particular group (Mills, 1997). Foucault's vision of power embraces the potential that competing variables within a given discourse rank equally, "with none of the terms of the equation being dominant" (Mills, 1997, p. 32) and for all power to predictably meet resistance. Thus, Foucault predicted the inevitable disruption of dominant discourses. Foucault's view invites us to revisit taken-for-granted notions in the context of infant feeding support by considering the possibilities of resistance and/or struggle against the power relations that operate.

Nurses' oppression. Dong and Temple (2011) consider the hierarchical nature of health environments and the patriarchal ideologies and structures associated with medicine to be significant influences. Their work exposes dynamics in the workplace and the sources of pressure on and between nurses. Dong and Temple elaborate:

> For oppression to occur, it requires a set of norms that a) are determined by a dominant group and b) that those outside the dominant group are inferior. In essence, these are the antecedents of oppression. Finally the consequences of oppression are harm, constrained freedom, and an inability to explore and realize one's personal potential and group behaviors such as lateral violence. (p. 172)

There is tremendous potential for nurses to engage with each other in order to provide the best infant feeding support possible. However, Dong and Temple's (2011) words alert us to possibilities that interactions between nurses in maternity settings and in the context of infant feeding support may not be ideal. Among other possibilities, I refer to the tension that can exist among nurses who approach infant feeding support with various levels of commitment to BF ideals. For example, some nurses may practice in a way that does not reflect BF expectations, but rather their own inclinations towards clinical decision making in a particular circumstance. Similarly, other nurses may interpret the guidelines literally and their practice will look different as a result. The different approaches surely have the potential to divide nurses and contribute to dysfunctional professional interactions, since many different nurses will care for a woman in the course of her perinatal experience. If one nurse is approaching infant feeding support differently from the other, the care becomes more complex. Clearly, the

dynamics between nurses has the potential to directly affect their infant feeding approaches. I was eager to talk to nurses about their experiences in this regard.

Nurses and Evidence-based Discourse

Broadly speaking, nursing literature has, for some time now, addressed the complexities surrounding evidence-based practice (EBP). Evidence-based practice in nursing care is recognized as offering nurses increased interprofessional status (Nelson 2006; Keogh, 1996). However, there is a plethora of literature that expresses concerns about the influence of evidence-based discourse on nursing practice. For example, Frisch (2014) cautions that "the EBP movement neither defines what evidence is nor does it readily examine the limits of the evidence one has" (p. 347). In the context of breastfeeding promotion, Frisch's words suggest an approach to evidence that extends past empirical substantiation, inviting me to consider, among other possibilities, how social oppression or privilege can shape interactions between women and nurses and influence breastfeeding support.

Kirkham, Baumbusch, Shultz, and Anderson (2007) urge nurses to expand notions of evidence in order to preserve nursing autonomy, recognizing that rigid interpretations of evidence can detract from transformative nursing practice. Kirkham et al. suggest that traditional understandings of evidence may not consider health disparities or the complexities of human life. They draw attention to the impossibility for evidence-based discourse to "focus on individualistic models of health with biomedical solutions" (p. 27). Using a post-colonialist feminist perspective, these authors challenge traditional approaches to science, exposing the potential that the evidence or knowledge is based in racialized, gendered, ageist, classist, and homophobic biases. Importantly, Kirkham et al.

(2007) acknowledge the difficulties associated with standardized approaches to care that accompany evidence-based practice and foreground how scientific privilege is integrated into Baby Friendly initiatives. Their work, therefore, succinctly addresses the issues that are associated with offering infant feeding support.

Paley (2005) explores notions of nursing "expertise," risk management, and patient participation in the context of EBP and acknowledges the potential for nurses' professional autonomy to be undermined. The richness of literature that surrounds EBP has allowed me to explore infant feeding support while understanding that EBP constitutes an important contextual factor.

Thorne and Sawatsky (2014) expose the paradoxical desire for nurses to honor diverse evidentiary claims:

> Although such definitions may seem reasonable by virtue of being inclusive of the diverse ways of knowing within the discipline, we suggest that they entirely misrepresent common understandings of the evidence concept outside of nursing's disciplinary context. Furthermore they contribute to normalizing inherently illogical and problematic ways of substantiating nursing knowledge claims.

Thorne and Sawatsky (2014) thus express a critical tension in nursing practice. In our desire to embrace interdisciplinary ways of knowing, such as evidentiary claims that underpin the disciplinary approaches of others, do we compromise nursing knowledge claims? What meaning can be gleaned by attending to the concerns related to EBP? Clearly, among nursing scholars, there is substantial concern about the unintended

consequences for nursing practice associated with adherence to interprofessional evidence, such as the evidentiary claims of risk associated with formula.

Brenner and Beusher (2011) assume a perspective that may be more readily recognizable to practicing nurses. These physicians advocate for compliance to evidence and reinforce notions of scientific privilege that emanate from medical disciplinary sources. They refer to breastfeeding as a "clinical imperative." The Canadian Pediatric Association, too, endorses BF approaches and builds the case for protecting, promoting, and supporting exclusive breastfeeding (Retrieved from: http://www.cps.ca/documents/position/baby-friendly-initiative-breastfeeding).

It seems there is more to understand about how nurses navigate the call to observe EBP in their interactions with women and infant feeding support.

Egalitarian Discourse in Health Care Provision

I return to my discussion of the Code and the Ten Steps (Appendix 1 & Appendix II), which offer a concise window into the perspectives that are to create equal and consistent care for women globally. On many levels, that aim is admirable since one of the initial objectives associated with BF initiatives was to address the global disparities in maternal health and child care (Nathoo & Ostrey, 2009). I wonder, though, if egalitarianism in health care is an achievable goal. Tang and Brown (2008) question the ideal of egalitarian approaches to health, arguing that diversity has the potential to be undermined in favor of ideologies that promote a "one size fits all" approach to human situations. This is relevant when considering the global approach to infant feeding that is espoused by Baby Friendly initiatives.

The advent of social media, coupled with the online information explosion on birthing, has the potential to expose women in the Western World to the latest trends and to peer pressure. The literature that nurses access around perinatal care is peer reviewed and considered to be evidence-based. If the rhetoric that is found in these scholarly sources has one message and one message only ("breast is best"), it is important to consider the discourses that are silenced when infant feeding is not "best." Women who feed their infants with formula do feel silenced and misunderstood in relation to mothering (Humphries & McDonald, 2012, Murphy, 1999; Shakespeare, Blake & Garcia, 2004) and the discourse of individual choice has the potential to be considered irrelevant.

Tang & Browne (2008) identify an interesting dilemma associated with approaches to egalitarian discourses as they relate to Indigenous peoples and Canadian health care. The authors describe a policy-driven tendency for systems and practitioners to not acknowledge the special needs of Indigenous peoples in the interests of appearing racially neutral. It is a defensible perspective but the needs and the interests of Aboriginal people, and all marginalized groups, are very distinct. I am drawn to consider the parallel between the ethics of employing egalitarian principles of health care provision and the impetus to embrace sweeping global recommendations for infant feeding. In neither case is diversity privileged; instead diversity is undermined in favour of ideologies that promote a "one size fits all" approach to human situations.

Dialogue with practicing nurses has the potential to inform understanding about the implications of applying universal guidelines to individual situations. The implications of a sweeping approach to infant feeding support bears further exploration.

Anthropological Swells

An important question to consider in the context of my exploration of breastfeeding promotion is "Whose needs are being served?" Maher (1992a) draws attention to possibilities and says:

> In most societies, there are strict controls, mediated by the political and symbolic system, on women's sexuality, reproductive capacities, and the form and content of their social relationships. We need to ask in what way, if any, these controls affect the practice of breastfeeding. (p. 5)

According to Maher (1992b), international efforts to address reproductive issues began in the West and extended to developing countries without considering cultural differences or the varied gendered relations that determine women's work, political strategies that promote procreation, and other influences. Maher states: "Breastfeeding is treated in a social vacuum, as a 'biologically imperative' function of the 'biological dyad' formed by mother and child" (p.151). It seems that the domination of the medical model fuels Baby Friendly approaches, which in turn promote the science of breastfeeding superiority as bio-medical truth. Importantly, those assumptions of truth are often poorly applied to situations in either the Global North or the Global South (Maher, 1992b). Maher also drew attention to infant feeding as a behavior that has historically reflected specific cultural and socio-economic realities and gender inequities.

Historical Support for Inquiry

White (1999) exposed the negligence of WHO to properly act on HIV/AIDS knowledge in its breastfeeding promotion. White relates that, in 1997, La Leche League International also challenged the idea that HIV could be transmitted in breast milk, the

history of which Jung (2015) also traces. According to Jung, by 1996, White's previous commitment to "lactivism" shifted. White (1999) described breastfeeding promotional initiatives in Africa, which were led by WHO in the 1990's when risks of Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) transmission through breast milk were well known in international scientific communities. Although it was obvious that HIV could be transmitted via breast milk, bodies such as the La Leche League, UNICEF, WHO, and the World Alliance for Breastfeeding Action were reluctant to address the risks. White (1999) shared her disillusionment with these international bodies whose influence over infant feeding remained significant. In the context of that situation, White (1999) speculated that WHO's failure to address the risks associated with HIV/AIDS and breastfeeding reflected the machinations of bureaucracy, wherein careers, programs, egos, and communication issues prevailed over known risks associated with breastfeeding in the presence of HIV/AIDS. In short, White suggested that many high levels WHO careers were invested in breastfeeding promotion and any warnings about the risks of HIV transmission would jeopardize the funding and careers of many.

Fawcett (1980) addressed the challenges associated with such institutionally vested attitudes and behaviors - all of which exist in the context of the breastfeeding debacle. I am led to consider new insights, since Fawcett's statement about "vested attitudes" resonates with White's (1999) observation that careers and egos had become conflated with the ideologies of breastfeeding promotion. It is possible that similar interests are being served in the Western milieu, where breastfeeding promotion, as it is currently conceived, is tied to the vested interests of political and organizational

bureaucracies such as the Breastfeeding Committee for Canada and health authorities that are committed to enacting Baby Friendly initiatives. I wondered if nurses' careers and identities were closely aligned with institutionally sanctioned approaches to infant feeding support? If so, what meaning resides in day-to-day nursing practice?

Epidemiology and Politics

Nathoo and Ostry (2009) integrate epidemiological and social work perspectives in *The One Best Way? Breastfeeding History, Politics and Policy in Canada.* Their analysis is extensive, and they present an ethical analysis of the breastfeeding discussion, including the observation that breastfeeding is really not a choice for many Canadian women because of socio-economic realities that shape their choices.

Palmer (2009) explores many of the issues that Nathoo and Ostry address in her book *The Politics of Breastfeeding: When Breasts are Bad for Business*. However, in this publication, breastfeeding is presented as a respite from "risky products" such as bottles and artificial milk. Palmer's work is important to my inquiry as it reflects mainstream approaches to breastfeeding promotion, depicting formula companies in the light of their corporate interests and generally approaching infant feeding through the lens of the political and economic forces that created WHO approaches such as The Code (Appendix 11).

Social Justice Perspectives

Reproductive Justice does not specifically address issues associated with infant feeding, but approaches nutrition and reproductive choice as a human rights issue. By including infant feeding in the context of reproductive choice, there are opportunities to view infant feeding support using an alternate paradigm.

The Reproductive Justice movement emerged to address reproductive rights among women of color in the United States (US) in 1994, following the International Conference on Population and Development in Cairo, Egypt. Loretta Ross, a rape victim who experienced social stigma and chose to raise a child born of incest, spearheads the movement (Retrieved from: http://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf). The movement draws our attention to a woman's right to manage her reproductive capacity, including her right to adequate information, resources, services, and personal safety while pregnant, and the right to parent her child.

Although the movement does not appear to address infant feeding issues directly, it is nonetheless relevant. The conditions that are described in Reproductive Justice materials imply that breastfeeding is another reproductive issue that requires attention. This not only pertains to Black women, but all women, given the intersectional realities and complexities of their lives. Ross emphasizes the framework and intersectional principles on which the movement is based (Retrieved from : http://www.protectchoice.org/section.php?id=28). For her, the Reproductive Justice movement promotes a perspective that honors *what is best for the woman, her family, her community,* and most importantly, approaches it from the perspective of human rights. Within this framework, there appears to be an argument for addressing infant feeding choice as a human right.

Bubbling to the Surface: Nagging Conjecture

While the literature discussed above serves as the underpinning for future pondering, there are a number of queries pertaining to perinatal nursing practice that

remain unaddressed in the literature. I am plagued by unanswered questions, but comforted by the prospect of conversations with perinatal nurses. The promise of enhanced understanding looms more closely.

Unintended Messaging of BF Initiatives

I question the integrity of disseminating information on the efficacy of pro-breastfeeding research and, in particular, the lack of attention to the nuances of nursing practice, which must always consider individual needs. As Thorne and Sawatsky (2014) suggest:

> Unless nursing is prepared to abandon its unique contribution to the particular, it will continue to need strength in disciplinary theorizing and philosophizing to steer its way through the landmines of an evidence-based practice agenda that inevitably privileges the general. (p. 17)

Is "the general" privileged when nurses adhere to standardized BF protocols? In some instances, it seems, women's ambiguous or negative feelings towards breastfeeding are insignificant and should not influence nurses' unwavering advocacy for breastfeeding promotion (WHO, 2009c). The statement about the right to "information" does not address the possibility that "information" means different things to different people, including the need to situate information contextually and without inciting fear.

The above example included in the BFHI document featured a sample conversation between a woman and BF advocate. There is no question that consistent information is important in the milieu of maternity care, since too many opinions about infant feeding and infant care can be overwhelming for new mothers. Although the example illustrated a valiant attempt to assist mothers using a consistent approach, the

whole exercise of offering these scripts speaks to the inadequacy of an interprofessional approach that may involve care providers who do not have the same level of responsibility as nurses. For example, no amount of coaching can prepare any nurse for the complicated and unique situations that he/she will encounter. It is also important to consider nurses' clinical judgment as opposed to the prescriptive "right" and "wrong" ways to respond to the concerns that women bring forward. As Benner, Hughes, and Sutphen (2008) state:

> Clinicians must develop the character and relational skills that enable them to perceive and understand their patient's needs and concerns. This requires accurate interpretation of patient data that is relevant to the specific patient and situation. (p. 6)

With reference to "mother-friendly" additions to the BFHI (2009), there is no specific suggestion as to how BFHI *supports* alternate feeding methods in the context of breastfeeding advocacy and the widespread emphasis on risks that are said to be associated with formula. For example, mothers require accommodation and understanding when sensibilities and circumstances impede successful breastfeeding practice (Badinter, 2011; Beck, 2006; DiQuinzio, 1999; Humphries & McDonald, 2012; Maher, 1992; Shakespeare et al., 2007). The addition of "mother-friendly" language in the BFHI 2009 revision promised recognition of mothers' needs; however, it endorsed a return to the naturalistic ideal of mothering, where all things having to do with giving birth and caring for a child are seen to reflect the scientific natural order. As such birthing and breastfeeding are reinscribed as natural and therefore valid mothering behavior as

described by Apple (1997), Badinter (2011), BFHI (2009), Jung (2015), Weiner, (1997), and Wolf (2011).

It is possible that The Code is at odds with other portions of the document, since BFHI acknowledges that formula is a lifesaving substance in certain clinical situations. For example, the suggestion that formula remains hidden in perinatal units, while supposedly aimed at discouraging marketing opportunities for formula companies, presumes influence where influence may not exist. Who is to say what parents might think if they were to see evidence of formula in hospital settings? The proposal is paternalistic, suggesting that visual representation of formula, bottles, or artificial nipples will result in mothers being "tempted" to succumb to the "dangers" of not breastfeeding. Under BFHI guidelines, formula is deemed acceptable in certain contexts, such as when the mother is taking medication that is unsafe in the context of lactation or if infants are hypoglycemic. There are ethics to consider for women who do not want to breastfeed for reasons that they may be unwilling to share (Beck, 2010; Humphries & McDonald, 2012).

In the past, when formula was promoted by medical practitioners, there were a great many "medical" reasons for not "allowing" women to breastfeed. Currently, we see a great number of risks associated with not breastfeeding. As a consequence, mixed messages abound regarding the role of formula, the dangers of formula, and the risks associated with formula use. These messages fuel my ongoing curiosity about nurses' perspectives on these ideas.

Neo-liberal discourse. The term of neo-liberalism is understood in this discussion as a political and economic strategy that incorporates both liberal tenets and corporate capitalist interests. There are competing demands on nurses to enact

institutionally-driven cost saving measures, while simultaneously achieving professional standards. Attending to both directives reflects an ongoing tension in health care delivery.

Holstein and Gubrium (2011) remind us of Foucault's attention to systems of power and knowledge that comprise discourse. They argue that,

> Foucault is particularly concerned with social locations or institutional sites - the asylum, the hospital, and the prison, for example - that specify the practical operation of discourses, linking the discourse of particular subjectivities with the construction of lived experience. (p. 344)

Foucault's discussion of institutional discourse is relevant. For example, well-baby nurseries have been dissembled in favor of "rooming-in" policies (meaning that mothers and babies cannot be separated during the hospital stay). One rationale behind this shift is that mothers will be better able to recognize their infant's cues, learn to respond to the baby's needs more effectively, and enact more effective breastfeeding practice - all of which will contribute to the all-important bonding between the mother and the babe. At the same time, the rooming-in arrangement is also the product of the neo-liberal strategy of corporate cost-savings in hospitals. This cost savings includes the hope that breastfeeding can be established quickly and women can be discharged. However, this initiative is problematic from a breastfeeding promotion perspective because an early discharge occurs before many suckling difficulties are identified because the mother's lactation has not evolved to the extent that challenges are obvious. This arrangement also effectively eliminates the need for nursing staff to cover a "well-baby" nursery, allocating many of the responsibilities that were previously part of nursing practice onto the new parents. Further, decreased rest for the mother may increase the risk

of post-partum difficulties, but such considerations are secondary to the cost-effectiveness of "rooming in" policies. Before beginning the research, I wanted to know more about nurses' responses to institutional decisions and how environmental realities can shape nursing practice.

There is an interesting paradox embedded in the BFHI's approach to cost-savings and entrepreneurialism. Among other considerations, BFHI promotes the idea that health facilities will achieve short-term savings by reducing formula expenditure, encouraging all women to breastfeed, and presenting breastfeeding as the normal practice. Ironically, though, formula expenditures now occur as a result of Code ideology, which prohibits any entrepreneurial activity on the part of the formula companies. Historically, formula companies donated formula to hospitals as a marketing strategy, thereby partially assisting health facilities with some of the costs associated with providing a necessary resource. The Code dictates that corporate strategies of cost saving must be sacrificed in favor of supporting a philosophical ideology that views marketing formula as exploitative. These observations provide a curious juxtaposition of ideologies, considering the reference to cost savings, the strength of the Code, and the treatment of formula in maternity settings. I wondered what nurses might say about the how the Code shapes nursing practice and whose needs are being served by its implementation.

Entrepreneurialism and breastfeeding. Other manifestations of entrepreneurialism appear in the context of BFHI values. For example, private pre-natal teaching, post-partum support groups, and private lactation consulting services exist and thrive as a result of the promotion of breastfeeding as normal and natural. Such entrepreneurial businesses profit from a BFHI inspired breastfeeding industry (Jung,

2015). Women who need post-partum support or assistance with breastfeeding difficulties are able to access private "for profit" resources, but only if they have the necessary financial resources available, or if the resources are available in remote settings. Clearly there is a two-tiered approach to breastfeeding support that makes adherence to BF ideals impossible for many. In the case of mothers' breastfeeding challenges, successful breastfeeding is equated with privilege.

The correlation between breastfeeding and optimum infant health is related to budgetary agendas as well. Assuming that one accepts the efficacy of the biophysical benefits that are touted in oft cited BFHI cited research, it is possible to link the health benefits of breastfeeding to long-term cost savings among taxpayers and health care consumers. Jung (2015) argues that public health initiatives hold women responsible for spending health care dollars if they do not breastfeed. If health care systems can reduce expenditures related to diabetes, asthma, celiac disease, cancer, and many other chronic illnesses that BFHI suggests are related to formula feeding (WHO, 2009c), breastfeeding promotion can be rationalized. However, much of the evidence-based research that points to the reduction of risks related to the above ailments (as a result of breastfeeding practice) indicates statistical prevalence only with no established causal relationships (Jung, 2015; Knaak, 2002; Sokolon, 2014; Wolf, 2010; Williams et al., 2012). Such objections are not found in the BF literature. There are also lingering questions about the extent to which perinatal nursing practice is concerned with budgetary matters and how those concerns may influence care.

As I planned my research, I wanted to explore what possibilities that currently exist for nurses to enact competent evidence-based practice, while offering emotionally

sensitive support for every woman. I was eager to interpret the dialogue that had the potential to shed light on these questions.

Scholars working in Political Science (Jung, 2015; Nathoo & Ostry, 2000), Women's Studies (Apple, 1999; Badinter, 2011; DiQuinzio, 1999/1999a/1999b; Jung, 2015; Lewis, 1997;Wolf, 2011), Sociology (Gauld, 2010; Kelleher, 2006); Murphy, 1999), Anthropology (Maher, 1992), Psychology (Else-Quest et al., 2003; Kendall-Tackett, 1998/2007a/2007b; Marshal, Godfrey & Renfrew, 2007), and Medicine (Brenner & Buescher, 2011) offer discipline-specific critical analyses of breastfeeding promotion which provide important contextual information. But where are nurses' voices in the commentaries? Where is nursing disciplinary knowledge reflected in the discussions and critiques of current infant feeding approaches? Giving voice to nurses' experience is a prospect that bubbles to the surface.

In the upcoming chapter, I outline the possibilities of enhancing understanding by describing hermeneutic methodology and the theoretical influences that shaped preparation for researching this contested topic.

I breathe deeply while I can.

Chapter 3: Hermeneutic Floating

Perfect beauty, matchless elegance

Mine by right, my inheritance

My absolute and faultless symmetry knows no rival, no affinity

Beauty, perfect beauty

Floating free from drudgery, I reflect this great mystery

Why am I blessed with such prosperity, perfect form and immortality?

Beauty, perfect beauty.

(Taken from Ocean World: "Love Song of the Diatom" Words by Anne Conlon)

The diatom (plankton) floats in the vastness of the ocean. Its miniscule character is constant, vulnerable, and yet intimately connected with sea life. The sea, as we know it, could not exist without the humble plankton, nor could plankton exist without the vast eco-system surrounding it. The smallest part contributes to the greater whole, as plankton floats and whirls in the waves, currents and undercurrents with circular splendor. Plankton is drawn to dwell with inevitable and infinite transformations that occur in the deep. We marvel at its fragility and temporality, and our understanding of sea life evolves. I delight in the metaphoric significance of planktons' manifestation of the "part and the whole." The unheralded communion between plankton's existence *(Dasein*) and the principles of hermeneutic thought erupt and resonate.

I reflect on my time with hermeneutic scholar (and Hans Georg Gadamer's biographer) Dr. Jean Grondin, at a three-day seminar that occurred in Halifax in May 2015. Dr. Grondin alluded to hermeneutics as praxis and suggested that we are "doing"

hermeneutics in our everyday professional practices as well as our research. We make meaning of metaphor, art, conversations, and dialogues. The art of interpretation underpins our practice as well as the research that we undertake in association with our practice. We live hermeneutics (J. Grondin, personal communication, May 20, 2015). I contemplate the privilege of contributing to professional practice while floating in the perfect beauty of hermeneutic thought.

In this chapter I explore the philosophical underpinnings of hermeneutic methodology and explore the influence of the theoretical lens of intersectionality and its potential to inform understanding. I discuss the way in which hermeneutics was "lived" in my study by describing key aspects of the research design. Finally, I introduce the eleven participants whose conversations are featured in Chapter Four.

Philosophical Hermeneutics and Hermeneutic Research: Exploring the Approach

My interest in hermeneutics includes its historical legacy and the iteration of phenomenological hermeneutics as understood by Martin Heidegger (1889-1976), whose ontological influence on his pupil Hans-Georg Gadamer (1900-2002) was pervasive. In this exploration, I reference "philosophical hermeneutics" as pertaining to the unique work of Gadamer. Among all of Gadamer's scholastic contributions, he is most known for *Truth and Method* (1975/2004). Linge (2008) summarized the thrust of the work, saying:

> The task of philosophical hermeneutics, therefore, is ontological rather than methodological. It seeks to throw light on the fundamental conditions that underlie the phenomenon of understanding in all its modes, scientific and non-

> scientific alike and that constitute understanding as an event over which the interpreting subject does not ultimately preside. (p. xi)

To achieve understanding, then, is a multi-faceted affair. In hermeneutics, there is more to conversation than literal translation of words into meaning within the context of a language. There are identities and histories to consider, popular influences of online resources which are scholastically credible, or not, and traditional scholarly influences that are poised to contribute. Works of art may shift our grounding, and invite us to abandon the pursuit of groundedness. Understanding is thus informed by underlying influences that contribute to interpretation in inevitable ways. As such, there are possibilities for theoretical perspectives to inform interpretation and understanding.

The process of exploring relationships between philosophical hermeneutic tenets and other theoretical perspectives offers the possibility for ideas to become enmeshed in one another. The prospect of isolating ideas as a means of offering insight seems, at times, to be unworkable. As a reader you will encounter, first, the introduction of ideas, followed by circuitous references to those ideas, including repetition. I invite you to entertain the hermeneutic circle of understanding as it unfolds, wherein the parts contribute to the whole, and the whole of understanding is contingent on interpretation. I invite you to participate in the art of understanding.

Establishing Congruency

Articulating the congruency between philosophical hermeneutics and the research approach has the potential to add depth to and aid in the overall interpretation that is central to hermeneutic thought. The central tenets of philosophical hermeneutics that have the potential to inform a research approach, which is not based in

methodological origins. As stated, hermeneutics as a research approach is ontologically based. Delicate distinction foregrounds my discussion, since I do not attempt to offer a systematic hermeneutic methodology, that is, a step-by step approach to hermeneutic research. To do so may reflect the potential for human alienation associated with an objective human science, which is what Gadamer attempted to overcome in his *opus magnum, Truth and Method* (Kvale, 2009).

A recurring theme of philosophical hermeneutics involves the concern around the prominence, authority, and legitimacy of method as a way of establishing universal truth. In hermeneutics, science is significant insofar as it represents concerns that may be, in certain circumstances, of interest to hermeneutics. A hermeneutic research approach accommodates the exquisite distinctions surrounding science and the *other* questions that are important to human life. Gadamer (1975/2004) therefore cautioned that the methodologies developed by the natural sciences distanced people from their experience of the world, and have the potential to occur outside of the whole of experience. Koch (1995) labels methodological requirements for rigor, validity, and reliability as the persistent "hegemonic legacy of empirical-analytical research" (p. 178). The vestiges of empirical-analytical approaches align with scientific method, exposing the need for alternatives that reflect hermeneutic thought more congruently.

Importantly, though, Gadamer did not discount scientific inquiry altogether, nor advocate that the practice of philosophical hermeneutics be confined to the humanities. As Johnson (2000) suggests:

> Indeed, Gadamer holds that philosophical hermeneutics includes all forms of human understanding. The problem that hermeneutics addresses is universal. The natural sciences also need to ask hermeneutical questions (p. 57).

However, science is not seen to represent a holistic understanding of human experience in and of itself (Paley, 1998). A hermeneutic research approach must therefore accommodate the exquisite distinctions surrounding science and the *other* questions that are important to human life. The hermeneutic research question emerges from this insight. What is the researcher trying to explore? Gadamer (1966) articulated:

> The genuine researcher is motivated by a desire for knowledge and by nothing else. And yet, over against the whole of our civilization that is founded on modern science, we must ask repeatedly if something has not been omitted (p. 10).

The hermeneutic research question comes into view in a milieu of wonder, and initiates the trail of congruence that must expose the research process. In the absence of statistical or theoretically derived assumptions of truth, in hermeneutic research, the researcher is therefore called to articulate decisions to ask the "other" questions that have the potential to deepen understanding of human situations.

The Lens of History: The Evolution of Hermeneutics

The word "hermeneutics" is a word that has elicited a number of interpretations over the years, taking its initial roots from references to "Hermes" the Greek god and "messenger" who was charged with taking messages from Zeus to the humans, and who was known to interpret the messages in ways that he deemed most effective (van Manen, 1997). Sherratt (2006) suggests that the term is derived from the Greek "hermeneutikos", which translates "to interpret". Over time hermeneutics also became associated with

translating Biblical texts into languages that could be understood by the evolving Christian sects in Europe, as well as translating legal texts from one language to another (Sherratt, 2006).

The works of Frederich Schleirmacher (1768-1834) and William Dilthey (1883-1911) aspired to establish a scientific-like methodology that would assure interpretation of the *Geisteswissenshaften* (the humanities). Heidegger and Gadamer, however, rejected the prospect of achieving universal interpretative certainty by applying scientific method to metaphysical questions (Grondin, 2003). Husserl, Heidegger and Gadamer were each committed to an alternate philosophical pursuit that valued *temporal* interpretative meaning.

In general terms, hermeneutic activity applies to situations where interpretive effort is required to achieve meaning, addressing alien as well as familiar phenomena that we seek to better understand (Linge, 2008). The term "hermeneutics" gained prominence in the seventeenth century, during a time in which Biblical interpretation and translation was taken up as a scholarly endeavor. Schleirmacher's work, however, extended hermeneutics beyond the realm of Biblical translation, seeing hermeneutics as a possibility to "illuminate all human understanding and not just offer principles and rules for interpreting particular texts" (Crotty, 1998, p. 92-93). As such, Schleimacher is associated with founding modern hermeneutics. This statement is profound in its implications, since Schleiermacher introduced the "psychological" component to interpretation, by attending to not only the grammatical mechanics of interpreting text, but also setting the text within a literary setting, wherein the hermeneutic interpreter "is able to divine and elucidate not only the intentions of the author, but even the author's

assumptions" (Crotty, 1998, p. 93). The possibilities for the readers to interpret the texts for themselves are thus revealed. According to Sherratt (2006) hermeneutics, as a discipline, is deeply rooted with the Ancients, but today is associated with contesting the technical explanations of science by promoting "agendas of meaning and purpose" (p. 18).

Husserl (considered to be the "father of phenomenology") was Heidegger's colleague. Husserl's stature as a leading phenomenologist is often associated with his phrase "Back to the things themselves!" His statement was a plea to reverse what Husserl saw as a dangerous philosophical preoccupation in the 19th and 20th century with scientific method, which was fast becoming a canon for creating universal truth. The "things themselves" referred to what was relevant to the lived experience, including the everyday phenomena associated with human existence (Crotty, 1998; Grondin, 2003). Husserl's plea was taken up by Heidegger and Gadamer, but with the perspective of the unique and deeply philosophical underpinnings that were known to them, relating to notions of temporality and Heiddeger's conception of *Dasein* (existence). Gadamer, in particular, saw the desire for scientific certainty to be a flight from temporality, incorporating the impossibility for outdistancing the limitations and mortality of *Dasein* (Grondin, 2003). The phenomenologists perceived the importance of the humanistic interests, which had been so exalted before the Enlightenment period, and so celebrated for centuries through the study of *Geisteswissenshaften*. However, philosophers at that time appeared to be consumed by application of the scientific method, and interest in the natural sciences as holding the possibility for universal truth (Grondin, 2003; Johnson, 2000; Sherratt, 2006).

Husserl focused on "the study of lived experience or the life world" (Laverty, 2003, p. 22). The term "life world" refers to the common sense, taken for granted aspects of life, which are not prone to pre-reflection or conceptualization (Laverty, 2003). Husserl believed in "bracketing out" preconceived understandings of the phenomena in order to see it clearly-a perspective that Heidegger and Gadamer each rejected as being impossible (Linge, 2008), and which constitutes one of the key developments of Gadamerian philosophical hermeneutics. This principle is fundamental to Gadamerian thought. The distinction represents one of the key differences between phenomenological and Gadamerian hermeneutical approaches to research.

Heidegger and Gadamer

Without question, Gadamer's work built on Heideggarian thought, but Gadamer furthered philosophical hermeneutics beyond Heidegger's conceptions. Gadamer contributed epistemological perspective to Heidegger's highly ontological works, and "moved to extend Heidegger's work into practical application" (Laverty, 2003, p. 25). Like Heidegger, Gadamer espouses language as the medium from which understanding occurs. Heidegger moved hermeneutic phenomenology into an ontological realm of *Being*, which unveils a complex underpinning to the human situation, conceptualizing movement in and out of the "hermeneutic circle of understanding" as a way of explicating the profound nature of *Being* that separated Heidegger's work from previous philosophic conjecture (Blattner, 2006; Caputo, 1987; Crotty, 2010; Laverty, 2003).

The personal histories of Heidegger and Gadamer, world history and tradition played significant roles in these philosophers' evolving thought. Their scholarship evolved under the veil of the first and second World Wars in Germany. Their academic

careers were dependent on the uneven politics of Germany and the competitive environments of the universities wherein they were employed. They endured untold hardships, and each suffered social and academic marginalization as a result of their political views, or in Gadamer's case, his desire to keep his political views neutral in the context of the repressive environment that evolved in Germany towards the end of World War II (Grondin, 2003).

Heidegger was plagued with elusive understanding about "groundedness" and Gadamer held a life-long fascination with explicating understanding about the position of grounding in the context of hermeneutic experience (Grondin, 2003). Briefly stated, these two philosophers dismissed theoretical grounding for its role in attempting to elicit universal truth claims, but struggled with the realities of expressing philosophical ideas *without* procuring perceptions of "groundedness," Interestingly, over time, Heidegger suspected that hermeneutics had evolved into another iteration of metaphysical inquiry, which seeks to find universal grounding for human problems.

Gadamer, however, continued to take up hermeneutics throughout his own life, as well as after Heidegger's death, and Gadamer's philosophical hermeneutics came to be considered to be one of the most significant philosophical contributions of the 20th century (Malpas, 2013). Insights about Heidegger and Gadamer contribute to my personal appreciation for the magnitude of their achievements, and the influences that shaped the philosophy in which they were immersed. Knowing something of their personal history reinforces a key aspect of their philosophy: the finitude of their humanity and the parts and the whole of their hermeneutic thought, including their human responses to the life-world of 20th century Germany. There is much to consider about

how their lived experiences influenced their thought since, according to philosophical hermeneutics, when interpreting the meaning of dialogue, the temporality of *Dasein* must shape all understanding, including the lived experience. The legacies of Heidegger and Gadamer, and the interpretation of their works are therefore not estranged from their histories.

Philosophical hermeneutics reflects Gadamer's skepticism of the potentially objectified experience of history (Grondin, 2003; Johnson, 2000; Linge, 2008; Sherratt, 2006). Instead, the hermeneutic notion of historical "tradition" acknowledges the influence of history in our current milieu without objectifying history as a theoretical abstraction. Gadamer strove to honor our historical nature by integrating the past (including language and works of art) into our world as a mediating influence (Johnson, 2000). In other words, language and the arts (among other historical traditions) have mediated understanding throughout the ages by procuring history into the present. Gadamer thereby emphasized the communion of historical traditions in the historically constituted self, whose *being* exists in time (Sherratt, 2006).

Gadamer recognized that the practice of hermeneutics had historically developed a methodology of interpretation (manifested, for example, in translation of texts). Gadamer was also concerned with Schleiermacher's attempt to establish a methodology for the humanities (*Geisteswissenshaften*). Understanding the centrality of *Geisteswissenshaften* is a way of underpinning a discussion of hermeneutics, since it attends to the kinds of questions and problems that engage hermeneutic thought. *Geisteswissenshaften* is the "human world characterized by *Geist*-mind, thoughts, consciousness, values, feelings, emotions, actions, and purpose, which find their

objectification in languages, beliefs, arts, and institutions" (Van Manen, 1997, p. 3). The focus on humanities contrasts with *Naturwissenschaften,* which involve the natural or physical sciences (Van Manen, 1997). Gadamer's attention to *Geisteswissenshaften* in *Truth and Method* exposed hermeneutics as a philosophy, and transported hermeneutics from its methodological history associated with transcribing biblical passages, legal texts and literature, to philosophical hermeneutics (Johnson, 2000).

There are distinctions between phenomenological traditions that originate from Husserlian (transcendental) and Heideggarian (existential/hermeneutic) approaches. As mentioned, Husserl's phenomenology involves the practice of "bracketing out" the lived experience of the interpreter, which is the attempt to remove the bias in order to procure objectivity. Heidegger and Gadamer moved away from that objective, instead opting to embrace the prejudice and bias of the interpreter, since they believed bracketing out was impossible (Grondin, 2003; Johnson, 2000; Kvale, 2009). Husserlian phenomenology aims to *describe* the lived experience, whereas hermeneutics *interprets* (Koch, 1995). Hermeneutic inquiry relies on the writer/interpreter/researcher to engage in judgment that will include her history, bias, and lived experience (Johnson, 2000), as opposed to "thematizing" comments based on the number of times they occur in a research interview, or counting the number of times an idea is repeated among participants (Kvale, 2009). Themes may naturally emerge, but in hermeneutic interpretation, it is more a case of discovering or uncovering themes than it is about consciously examining data to establish themes.

What is At Play?

The relevance of hermeneutic inquiry to my own area of interest evolves unsurprisingly, in light of questions that surround the privilege of scientific research that are foundational to current infant feeding approaches. I am enveloped with the sense that there is more to consider, and other questions that need to be asked in order to serve the needs of mothers. Questions, other than what surrounds scientific efficacy of evidence arise. Some questions are situated in ethical foundations, where we ask questions about the reality of women's choice in health care decisions, and the extent to which nurses who care for women are able to balance competing discourses of science and the ethics of individualized approaches to care. Socially constructed perspectives inform the *other* questions, including issues surrounding reproductive justice, mothers' and nurses' social identities, institutional pressures and political agendas, the legalities of delivering care, and the role of best practice guidelines in nursing practice.

The experience of nurses who intimately engage with mothers in the maternity setting has the potential to enhance our sense of what Gadamer emphasized in his discussion of play. What is at play in nursing practice? Gadamer (1975/2004) discusses the hermeneutic identity:

> The work issues a challenge, which expects to be met. It requires an answer-an answer that can only be given by someone who accepted the challenge. And that answer must be his own, and given actively. The participant belongs to the play. (p. 26).

Gadamer closely identifies hermeneutics with the interplay that occurs in dialogue, likening the process to a "playful" exchange, with the word "playful" understood as

depicting exchange, dialogue and reflexive conversation. Gadamer (1962) acknowledged that the tie between linguistics and thought is viewed as both a limitation (that is, language does not always express thought) and as a possibility for meaning. He stressed the advantage of playfulness through dialogue as a possibility to minimize the limitations of language. It seems that Gadamer is drawing attention to the hidden and reflexive opportunities that exist in conversation and the repartee that has the potential to exist between participants. Gadamer suggests: "The common agreement that takes place in speaking with others is itself a game. Whenever two persons speak with each other they speak the same language" (p. 56). Questions and answers build on previous questions and answers, suggesting a "back and forth" dynamic, all of which manifest in the hermeneutic circle of understanding.

Conversing with nurses has the potential to create a space in which questions and insight about the lived experience of practicing perinatal nurses arise. Husserl's plea to remain focused on "the things themselves" (the lived experience as opposed to theoretical abstraction) is implied, supporting Heidegger's proposition that our lives are intelligible only through the interpretation of the everyday (Dreyfus, 1992).

McBride-Henry, White and Benn (2009) advance Heideggarian philosophical understandings about the maternal/child infant feeding relationship by highlighting "inherited understandings" (p. 33) about the breast. These authors approach the possibility that breasts are objectified in alignment with a dualistic mind/body tradition, making it difficult for women to "articulate and reconcile their embodied breastfeeding experiences" (p. 33). Heideggerian perspectives offer a framework from which to explore "how humans perceive objects that appear in their world" (p. 34), and as such, the

attention to the breasts, and the many socially constructed and historic associations that are associated with women's breasts, are a relevant focus. For example, women's inherited understanding of their objectified breasts (in the context of new motherhood) is taken up in ways that can undermine their success with breastfeeding, as McBride-Henry et al.'s qualitative study reveals. The authors urge for a more inclusive approach to the language of breastfeeding, in order to achieve a more *embodied* experience.

A decision-making trail must expose the research process in order to establish trustworthiness (Whitehead, 2002). In the absence of statistical or theoretically derived assumptions of truth, in hermeneutic research, the researcher is therefore called to articulate decisions to ask the questions that have the potential to deepen understanding of human situations. This idea stands in contrast to a methodical series of steps that can be accounted for in a validated and pre-ordained way. In my study, for example, hermeneutic understanding evolves in a metaphoric milieu of the unexpected circling, surfacing, and immersion in the depths. Blattner (2006) refers to it as the "altogether" gasp of recognition-the fusion of horizons - that accompanies understanding and meaning. There is familiarity with that notion, and it is possible to reflect on what happens when we interpret insight in the course of everyday navigations. The notion is also elusive, since an altogether gasp can be hard won. There are unique possibilities-and challenges-that accompany the statement "I understand."

Pursuing Meaning

According to Carter and Little (2007) there is potential for an "axiological clash" in qualitative research, and a need to establish congruence when considering epistemology, method, and methodology within a research framework. These authors

draw our attention to the profile of "axiology" (or the underlying value) that guides epistemological preference. The variety of world views that influence research, including very basic values and beliefs about the existence of an independent reality, the valuing of subjectivity or objectivity in acquiring knowledge, and other deeply held views, have the potential to influence a given research idea. What values are important to the researcher? What epistemological positioning occurs as a result of those values? What methodology and methods, then, are coherent with that positioning? According to Carter and Little, axiology underpins methodology (the epistemological premise of how the research should proceed) and determines what methods will be most useful in research.

As I consider the possibilities for choosing a research approach, I examine the values that I hold, and find resonance with a perspective that explores nursing experience, which, like other human experiences, interweaves "in ambiguous ways that are not mathematizable into univocal terms that could be simply counted and recounted" (Jardine, 1992, p. 56). Nursing research will ideally enhance nursing disciplinary knowledge and practice. Therefore, the aim to *understand* appears congruent with kinds of dilemmas that arise in nursing-dilemmas that are mired in complexity, and shaped by opportunities to understand intimate human interactions.

I offer chosen ontological tenets of philosophical hermeneutics in order to promote insight about a research approach, paying special attention to hermeneutic dialogue and the interpretation that flows forth as a result of conversations. Indeed the hermeneutic dialogue dwells in the core of the hermeneutic experience.

An Interpretable World

Hermeneutic understanding transpires by contemplating the influences that enter the experience of the interpreter who exists in a world that is interpretable (Moules et al., 2014). I discuss the possibilities for hermeneutic interpretation below.

Sherratt (2006) describes Gadamer's conceptual *forestructure of understanding* as a way of beginning the process of understanding. *Forestructure* pertains to the projected meanings, or pre-conceptions, that exist as a result of history. Gadamer posits that it is through those pre-conceptions (our biases and prejudices) that understanding can transpire, since those conditions allow access into the hermeneutic circle. Once in the circle, pre-understandings are revised, maintaining flux until the fused horizon of understanding is reached by fusing present prejudices with past historical meaning. According to Gadamer, our history, including prejudice and bias, and the traditions associated with our history (such as language) becomes intrinsically woven into the final understanding (Sherratt, 2006).

Nursing scholars Fleming, Gaidys and Robb (2002) address the challenge of undertaking hermeneutic nursing research, while acknowledging the difficulty with aligning the non-structured essence of hermeneutic understanding with the need to conform to the structure of research. Their work reflects the challenge that can be associated with hermeneutic research. These authors summarize: "Gadamer's philosophical hermeneutic denies that the ability of understanding needs an awareness of rules" (p. 115). They also say: "Nevertheless it is Gadamer's opinion that in order to reach understanding, methodical direction through a systematic approach is needed" (p. 115). The signposts toward understanding are, therefore, not easily articulated, since

those two statements have the potential to appear contradictory. Is creating a research "approach" a rule-based theoretical abstraction that is incongruent with philosophical hermeneutics? I examine the possibilities.

Fleming et al.'s (2002) identify five stages to guide hermeneutic research, which include deciding on a research question, identification of pre-understandings, gaining understanding through dialogue with participants, gaining understanding through dialogue with texts, and establishing trustworthiness. Importantly, these authors' suggestions, while helpful, do not represent a simplistic and linear approach to conducting hermeneutic research. Instead a hermeneutic research approach *emerges* from the philosophical tenets. The stages that Fleming et al. describe, like other hermeneutic wonderings, may have most meaning in retrospect, as if to say "Yes, this is what occurred for me on my journey towards understanding. This is how understanding transpired". Truth before method.

In order to provoke our pre-understandings, as researchers, we may attend to everyday kinds of behaviors, engaging in conversations with colleagues, other researchers, texts and other resources (Fleming, Gaidys & Robb, 2002). A sense of everyday meaning pervades. In other words, Gadamer insisted that it is neither possible nor desirable to separate bias since inquiry reflects human inclinations in the everyday encounters of making meaning. It is possible then, to imagine that entry into the hermeneutic circle begins with the history, prejudice, and biases that accompany the everyday experience.

In hermeneutic inquiry, the traditional research constructs are replaced with expressions of "trustworthiness" and "believability" (Fleming et al., 2002). For example,

hermeneutic interpretation is not contingent on the number of similar responses in a given study, or the wish to compile statistics to verify a claim. Gadamer decried the primacy of modern statistical analysis and reinforced the importance of the *other* questions that surround statistical analysis, but which often remain unasked (Johnson, 2000). The trustworthiness of the research therefore will depend on the ability of the writer/interpreter to articulate why the statement has meaning, and what rumination occurred on the part of the interpreter (Fleming, et al., 2002). The statistical claims associated with evidence surrounding the risks of formula are of interest here, since many of the currently published claims are based in statistical prevalence only, non-replicated studies, and not associated with established causal relationships (Sokolon, 2014; Wolf, 2010).

Koch (1996) addresses implications for reporting hermeneutic research, saying: "The responsibility lies with the writer to show the way in which a study attempts to address the issue of rigor. It is for the reader to decide if the study is believable "(p. 178). The researcher can demonstrate trustworthiness in hermeneutic research by using clear documentation about the analysis, the use of direct quotations, and by exposing biases. When the researcher exposes the trail of interpretation that is occurring for her, she gives the readers the opportunity to better understand the meaning that evolved-meaning that often occurs in the absence of statistical validation. Importantly, that spirit of transparency may incite readers to begin the process of interpretation for themselves. Hermeneutics upholds wisdom in the classical sense, for Aristotle extended the notion of phronesis (practical wisdom) and emphasized the art of appreciating the singular situation without contamination from principles and certainty (Caputo, 2014).

Interpreter as research instrument and judge. Gadamer maintains that hermeneutic interpretation involves a perspective of judgment, hearkening legal interpretations that were historically associated with hermeneutics (Johnson, 2000). In hermeneutics, it is not a case of applying universal knowledge in a judgment-free context. Instead we understand universality to occur linguistically, that is, language constitutes the universal medium through which understanding is possible. The interpreter may "judge" or "sense" the comment as significant.

Grondin (2015) explored the centrality of sense (derived from the Latin word "sensus") to hermeneutic approaches. According to Grondin, the notion of sense incorporates the capacity to sense, using all five human senses, but also includes the sixth sense, which may manifest in the capacity to apprehend, and be open. Grondin likens "sensing" to rational thought, but warns that pure rationality, without the commitment to remain open to possibilities, reduces us to the smallest denominator of mental capacity. Grondin also discussed the notion of common sense (derived from the Latin word "sensus communus"). Conventional wisdom, sensibility, a sense of the way things are going, what is sensible, and a non-universal form of intelligence that is shared by a community - all these contribute to hermeneutic conceptions of common sense, and open us to insightful interpretation (J. Grondin, personal communication, May 20, 2015).

Bringing to Language Something New (Moules et al., 2014)

Grondin (2003) asks "Can the interpretative - the hermeneutic - really be overcome?" (p. 12). His question is thought provoking, for it implies that interpretation occupies a very basic aspect of human approaches to truth. In Heideggarian terms, it seems that in the fullness of *Dasein*, we are unable to avoid interpreting the facticity into

which we are "thrown" in the world-that-is-already-there. In other words, the everyday realities of our circumstances will always provide the backdrop for our inevitable interpretations, which resonate with both familiarity and newness (Moules et al, 2014).

Jardine (1992) succinctly expresses the heart of interpretive work. He says: "Bringing out these living interweavings in their full, ambiguous, multivocal character is the task of interpretation" (p. 51). Jardine posits that the event of understanding cannot occur without the activity of questioning. The surprise of an interaction often precedes the inquiry of interest, wherein there can be "an eruption of the new in the midst of the already familiar" (p. 51-52). Jardine's reference to "surprise" accurately reflects the dynamic that occurs when a glimmer of insight or wonder surfaces in conversation, and fuels further curiosity. In every encounter with a research participant, then, there is an invitation to carefully consider the statements, while envisioning the parts and the whole. Heidegger (1927/2010) stated: "In the everyday 'just passing through life' that takes care, *Dasein* never understands itself as running along in a continuously enduring succession of sheer 'nows'" (p. 390). In that statement, Heidegger emphasized that Dasein (our "existence") accepts all temporal interpretations, but embraces them in the fullness of that existence. It seems, then, there is more to understand than the "succession of nows" such as the listing of events or the cataloguing of statistics. Instead, the promise for hermeneutic interpretation is to rest and pause, and allow meaning to come into view. The notion of *aletheia,* or the event of revealing and concealing (Moules et al., 2014) presents rhythmic companionship to the meaning that may surface, disappear, and become replaced by something new.

Jardine (1992) also embraces the possibility for ambiguous understanding in hermeneutic interpretation, and in that possibility, another avenue for recognition unfolds. Indeed, in the course of our everyday conversations, there is potential for ambiguity and contradiction. From a hermeneutic perspective, the meaning that follows will be contingent on the overall reflection of *Dasein*, wherein the attention to the "now" will always occur in a larger and fuller notion of human life, and contribute to the potential for unity of meaning (Sherratt, 2006). To be sure, *Dasein's* presence envelops the hermeneutic interview, wherein the researcher is charged with the need to be sensitive and intuitive to the dialogue that unfolds, knowing that the text of the conversation captures a historical moment. Kvale (2009) outlines specific interviewing goals that include interviewer skills such as careful listening, the importance of non-verbal clues, sensitivity to ethical transgressions, relevant questioning, and others. All of these dynamics transpire and evolve spontaneously in response to the initial research question, and the many questions that follow in the context of hermeneutic interrogation.

The part and the whole. The ancient Greek philosophers influenced modern hermeneutics by envisioning texts as "wholes", and not just a compilation of "parts", giving rise to the enduring theme that is inherent to hermeneutics and the hermeneutic circle of understanding (Crotty, 1998). Gadamer (1975/2004) explained:

> Let us consider how hermeneutics goes about its work. What consequences for understanding follow from the fact that belonging to a tradition is a condition of hermeneutics? We recall the hermeneutic rule that we must understand the whole in terms of the detail and the detail in terms of the whole. This principle stems from ancient rhetoric, and modern hermeneutics has transferred it to the art of

> understanding. It is a circular relationship in both cases. The anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts that are determined by the whole themselves also determine this whole. (p. 291)

Heidegger (1927/2010) offers his vision regarding the "part" and the "whole" of hermeneutic understanding.

> Apart from the fact that the moon is never wholly to be grasped even when it is full, the not-yet by no means signifies a not-yet-being-together of parts belonging together, but rather pertains only to the way we grasp it perceptually. (p. 234)

In that statement, Heidegger offers a world of meaning about what may be known, and yet concealed, since we know that there is more of the moon than we can see. For example, even when the moon is "full", there is an entire dimension that is hidden from our human sight. The metaphor of the moon also speaks to the propensity we have, as humans, to view what we *see* as what *is*, without remembering that there is much that lies beyond our perceptions, or what is easily visible to us.

The implications for understanding (relating to Heidegger's metaphor) are evocative. When engaging in dialogue, or when interpreting text, there is always a possibility that there is more at play than what may be literally spoken, but the ability to fully comprehend the meaning will be dependent on the ability of the interpreter to take into consideration the fullness of the experience (the knowing of the moon's completeness). Conditions of understanding - for example, the specific nature of dialogue between two individuals as well as the broader engagement with the influence of

dominant discourse - will present as intrinsic to the interpretive process. The dialogical skill of the interpreter at the time of the interview, as well as engagement with the text following, will determine the depth for revealing the fullness of experience.

The relationship between the interpreter and the texts that are being interpreted come into focus as the center of interpretation. Fleming, Gaidys and Robb (2002) suggest that one way of approaching interpretation of the text is to gain an overall understanding of the whole of the text (the overall insight gained) before addressing the contribution of the parts (the individual statements and unexpected ideas). They suggest that when interpreting text, "each sentence or section is then related to meaning of the whole text and with it the sense of the text as a whole is expanded" (p. 118). The interpreter might therefore ask herself "What is the meaning of this statement as it applies to the whole of the understanding that I am gleaning?" The understanding that ensues will truly be reflective of the way we *understand* - not as a construction of methodical and systematic checks and balances, but with the fullness of the interpreter's life experience as it fuses with the life experience of the participant.

Gadamer (1975/2004) referred to Heidegger's concept of the hermeneutic circle of understanding, and suggested: "The description as such will be obvious to every interpreter who knows what he is about" (p. 269). Gadamer thus alludes to the importance of self-understanding on the part of the interpreter, which includes the notion of "pre-understanding" and bias. If the interpreter is aware of her own biases when engaging in the hermeneutic interview, the prospect of fulfilling the circular propulsion towards meaning has a better chance of succeeding. Knowing what one is "about" as an

interviewer and interpreter is therefore central to the process of understanding what is at play.

The fused horizon of understanding. Turning attention towards the hermeneutic underpinning of "understanding" also benefits from imagery. According to Laverty (2003) the horizon of understanding is explained as a "dialectical interaction" between the interpreter/researcher and the author/text. As Gadamer (1975/2004) suggests, though, there is more to contemplate, since hermeneutic understanding does not manifest through theoretical abstraction, but is a practical notion that manifests by "doing". In this possibility, I glimpse the fusion between ontological and epistemological understanding. That is, the understanding of what *is* remains achievable by engaging in the act of interpretation. In hermeneutic interrogation there must be a commitment to question and explore meaning *in order* to establish what *is,* rather than beginning interrogation with the premise of truth and then attempting to substantiate it.

The metaphorical fusion of the horizons that occurs between the participant and researcher is a powerful image to evoke the glimpse of understanding and meaning. The steps that the researcher takes towards the horizon of understanding ensure an ever-changing landscape as she proceeds. However, the horizon, although in sight, is ultimately unreachable. That image may conjure a sense of discouragement compared with the hope of certainty that accompanies instrumental research methods. However, in viewing the elusive horizon, there is also a possibility for *resting* with the inevitability - a sense of recognition for the place where we are, at the time when meaning unfolds. The resting and pausing is consistent with suggestions that research is complete at the time that understanding is achieved (Kvale, 2009).

I develop previous references that addressed the "parts and the whole" as well as the "fused horizon of understanding", as they merge into the circuitous imagery of the hermeneutic circle. In reference to the image of the hermeneutic circle, Gadamer (1975/2004) explained: "What Heidegger is working out here is not primarily a prescription for the practice of understanding, but a description of the way interpretive understanding is achieved" (p. 269). Gadamer's words disclose that understanding and interpretation occur without any attempt to construct. Instead they occur with the insight of *discovery*.

The possibility for discovering understanding is deceptively challenging, since any anticipation of meaning (the first step of entering the hermeneutic circle) must encompass support for the whole understanding. As mentioned, the ability to reconcile understanding can occur only when there is a commitment to explore the "part" of understanding that is inconsistent with the whole, perhaps shaping Gadamer's (1975/2004) reference to the "first, last, and constant task"(p. 269) to achieve understanding. What is the meaning of a statement in the context of the lived experience? How does it (or does it) enhance understanding of the evolving whole? Does understanding shift as a result of the insight? These questions suggest the circuitous progression of understanding that occurs in hermeneutic circling. I envision that as the researcher travels around the circle, she may find herself at the "place" on the circle where she started, but occupying a new dimension of understanding.

While traversing the hermeneutic circle, the researcher is also caught in the fusion of the moment when the dialogical interaction occurs, conjoining the history of the researcher with that of the participant. Whitehead (2004) suggests that the process of

entering into the hermeneutic circle is engaging "in a process of moving from the part to the whole, allowing emerging data to remain open to divergent interpretations, and recognizing the temporality of truth and the horizons of the interpreter and the text" (p. 515). The interpretation that follows will therefore build on possibilities of temporality and divergence, combined with the anticipation of understanding. This concept has profound implications for the hermeneutic research experience, since any interpretation marks a historic moment, and is subject to ongoing interpretation over time.

The Historical Traditions of Language and Art

An important hermeneutic foundation involves attention to Gadamer's "dialogical" approach. Gadamer was known to access the tradition of Platonic dialogue, as well as Heidegger's Aristotilean conception of "phronesis" or practical wisdom, which in turn influenced his approach to dialogue (Malpas, 2013).

Gadamer's perspective was steeped in discursive dialogic, and "conversational" character of his writing (Malpas, 2013). Gadamer (1966) characterized the problematic allure of self-consciousness as a static abstraction that removes us from our authentic selves and impedes our communication with others. Our use of language, and its relation to communication therefore assumes an essential profile in the hermeneutic interview. Gadamer highlights the promise to achieve understanding by participating in everyday conversational dynamics that constitute our *Being.* DeVault and Gross's (2012) work with feminist approaches to conducting research align with Gadamerian notions, by drawing attention to the everyday dynamic of communication, the focus of which, as DeVault and Gross explore, invites unique understanding associated with women conversing with women. They say: "Feminist scholars operate reflexively and

relationally, so we begin by considering our own intellectual biographies and contexts and our relations with each other." (p. 207)

Gadamer proposed that we are, at all times, thinking "in a language, "although languages may differ among us. It is this linguisticality that constitutes hermeneutical universality - the notion that rationality is connected with language, or as Sherratt (2006, p. 80) describes: "Language speaks us." In other words, it is within language that humans live. Linguisticality constitutes reality.

Gadamer referred to the "angle" of the interpreter, whose linguistic sensibilities and assumptions - conditions of understanding - will reflect her lived experience and perspective during a particular dynamic. It seems that interpretation occurs in the interpreter's "own language," which is an important distinction when comparing alternate possibilities, such as *reflecting* or *describing* the language of the author/participant. Instead, the interpreter's use of language reflects her *self*, bring into line Gadamerian notions that language constitutes thought. The flash of insight (the fusion of the horizons of understanding) may occur later, as a result of engagement with the text. Such a possibility therefore charges the researcher/interpreter to incorporate thoughtfulness, ethical awareness, and transparency into the interpretation at all stages of the research.

Dialogue between the researcher and the participant is valuable for the promise it holds as text for interpretation, and the imaginings and wonderings that are revealed, as opposed to any truth claim that transcends time. There is also interest for what may be left "unsaid" in the projected interpretation. Linge (2008) examines the possibilities around the unsaid by elaborating:

> In every moment of dialogue, the speaker holds together what is said and addressed to the other person with the 'infinity of the unsaid'. It is this infinity of the unsaid - this relation to the whole of being that is disclosed in what is said - into which the one who understands is drawn. (p. xxxii)

If it is possible to extrapolate a concise understanding of Gadamer's relationship to the hermeneutic conversation, the following statement serves as a lasting and thoughtful message. He said: "By hermeneutics I understand the ability to listen to the other in the belief that he could be right" (cited in Grondin, p. 249). In that statement, Gadamer exposes hermeneutic dialogue as a medium for reconciliation. The hermeneutic interaction attempts to build common solidarity and fuse understanding, knowing that reaching the horizon is never possible, but always maintaining a vision of the fusion.

Aesthetics and art. In his essay *Aesthetics and Hermeneutics***,** Gadamer (1964) described the power of art, and summarized his reverence for the influence and congruence of art with hermeneutics. He said:

> For of all the things that confront us in nature and history, it is the work of art that speaks to us most directly. It possesses a mysterious intimacy that grips our entire being, as if there were no distance at all and every encounter with it were an encounter with ourselves. (p. 95)

As participants in hermeneutic research, we also have the potential to be "gripped" with the altogether experience that can accompany the experience of art. Hermeneutics, like art, embodies interpretation as the foundational perspective towards creating understanding. A researcher/interpreter's references to art, as well as her original artistic creativity therefore have the potential to enhance hermeneutic inquiry and ongoing

interpretation by uncovering understanding in original ways, and reveal what may have been concealed in alternate interpretations.

According to Grondin (2015), the practice of hermeneutics itself was originally considered to be an art. “Hermeneutike” is a Greek word. “Ike” refers to knowledge or “techne” and translates to Latin as “ars” or “art.” Although art can be taught to a certain extent, experience cannot be taught, and must be gathered. Hermeneutics is the knowledge and art that interprets experience, and bridges gaps in knowledge with history and language. The ability to use sensibility (the capacity to employ sense) and consider more than objective knowledge - to listen and understand - is the art that underpins the process used by hermeneutics (J. Grondin, personal communication, May 20, 2015).

The temporal nature of my present insights unfolds in the fullness of *Dasein*, and tempers the meaning of my existence. As Grondin (2003) summarizes: “The virtue of hermeneutic modesty sharpens our watchfulness concerning the arrogance of thinking we can overcome this finitude” (p. 285). It is indeed our finitude that makes the understanding precious.

Informing Understanding

The fusion of horizons in hermeneutic understanding takes place contextually, involving history, the text, and conversation (Moules et al., 2014). By introducing the theoretical perspectives of intersectionality it is possible to integrate the contextual realities of human life. Intersectionality informs us historically, accompanies the dialogue, and engages our interpretation with the texts, by drawing our attention to socially constructed identities of nurses and mothers. Paterson, Scala, and Sokolon (2014) summarize:

> By adopting an intersectional lens, feminist research strives to uncover the interlocking processes and practices that produce and reproduce existing social hierarchies that disadvantage women in general and some women in particular. (p.7)

Intersectionality addresses issues of social justice, power, and domination. According to Van Herk, Smith, and Andrews (2010), the intersectional lens "arises from postcolonial feminism and other critical theories and attends to, and uncovers, the different voices and socio-historical locations that have often been ignored or oppressed" (p. 30). As such, intersectionality resonates with hermeneutic inquiry, wherein there is an attempt to bring forth the multivocal quality of interpretation (Jardine, 1992), integrate embedded historicity, and seek what may be concealed (Johnson, 2000, Moules et al., 2014).

An intersectional lens is helpful when approaching individuals whose identities fall into more than one circumstance of oppression, in order to see individuals in the fullness of their existence, hear their voices, and ensure that the completeness of their situations is not overlooked (Van Herk, Smith & Andrew, 2010). There are opportunities to consider the influence of power, for example, for both nurses and mothers, and the ideologies and structures that may constitute the social identities for each. Both intersectionality and hermeneutics attempt to understand the individual in the fullness of their lives, perhaps revealing what is concealed (*aletheia)* and augmenting the meaning that transpires from the revelations. The challenges facing mothers constitute the complexities of caring for women in maternity settings, since many unique influences will affect mothers' confidence in the early perinatal period.

Importantly, intersectionality explores socially constructed identities, the way that people view themselves, and how those views affect their interactions with others and the world (Van Herk, Smith & Andrews, 2010). Any identity, in isolation, has potential to uncover meaning, but when multiple identities of oppression and privilege (and the many factors that comprise those perceptions) are identified in an individual, there is potential for a more complete understanding of what may be at play.

The intersectional lens does not dissect the multiple identities and address them in isolation. Rather, there is an incentive to use the vector of intersectionality to make meaning of differential experiences of privilege and oppression (Hankivsky, Reid, Cromier et al., 2010; Van Herk, Smith & Andrews, 2010). Intersectionality "strives to understand what is created and experienced at the intersection of two or more axes of oppression" (Hankivsky et al., 2010, p. 3). Like hermeneutics, the vector of intersectionality uncovers an altogether fusion of understanding, which considers the parts in context of the whole.

Hankivsky et al. (2004) ask critical questions about the dilemmas associated with conducting "intersectional research." In this study, intersectionality, as a theoretical lens, serves to inform hermeneutic understanding, rather than offering a methodology from which to proceed. However, there are key cautions associated with the intersectional lens, especially when considering issues of "essentialism, false universalism, or obliviousness to historical and contemporary patterns of inequality" (p. 4). These authors also caution the researcher not "see what they want to see" in their research (p.4). (Appendix 4)

The cautions serve to remind this researcher about the privilege of conducting research that explores a delicate aspect of nursing practice, and the humility that must accompany the interpretation.

Nurses, Infant Feeding Support, and Intersectionality

Nurses also come to the practice area with the potential for all the social entanglements and diverse identities that are of concern when adopting an intersectional lens. All of these possibilities contribute to nursing approaches, engagement with others, and affects the attitudes that nurses hold regarding many aspects of nursing practice, including infant feeding support. The interpretation of dialogue develops by incorporating age, experience, level of education in nursing, ethnicity, and other factors that shape participants' identities. The intersectional lens may therefore expose the challenges associated with prescriptive global guidelines (WHO, 2009) for infant feeding that do not address the complexity of individual circumstance.

Within the research dialogue, there is potential for the researcher to exude inappropriate power, or to be seen as powerful because of education disparities between the researcher and the participant (Cannella & Lincoln, 2011). An intersectional approach also alerts us to the possibility that nurses have the potential to appear as an oppressive influence, given the association of power and influence that are commensurate with education and position (Hankivsky et al., 2010). How does knowledge of mothers' social entanglements influence nurses' approach to infant feeding support? What institutional oppressions challenge nurses when they do (or do not) advocate for alternate feeding choices? The intersectional lens hovers predictably as the tide, and reminds us of individual exigency with rhythmic persistence.

Nurses face the challenge of complying with best-practice guidelines while simultaneously navigating women's entangled identities. The realities of women's lives invite a closer look at the implications of applying global recommendations and question whether Baby Friendly recommendations are meaningful only for mothers who belong to an elite class (Jung, 2015). The ability to participate in essentialized maternal activities including educational, moral, or financial devotion to children (including the expectation to breastfeed) is unreachable for many women, and contribute to their social isolation (Humphries & McDonald, 2012)

The lens of intersectionality guides understanding as I consider the homogenous yet often differing perspectives that are shaped by participants' histories. Throughout the conversations and during the interpretation, I remained interested in how participants' thinking and practice takes into account the complex differences of female experience and the influence of social location in women's lives.

For example, nurses confront discriminatory influences as they attempt to navigate the sometimes-contradictory expectations of institutions and peers to enact infant feeding support. Before commencing the research, I was curious about the way that nurses perceive their autonomy and/or oppression in the context of guidelines, expectations from patients, peer pressure to conform to institutional expectations, physician's orders, and other examples of socially located realities that shape nurses' identities. I anticipated the opportunity to hear nurses' voices regarding possibilities for integrating infant feeding challenges into best practice guidelines. I was also interested in interpreting nurses' dialogue in the context of age, experience, level of education in nursing, ethnicity, and other factors that shape ever-evolving social identities.

I also wondered what might accompany nurses' sense of their own privilege or oppression. Intersectionality seeks to view experience in the context of converging and divergent sources of oppression, all of which offers insight into possible avenues for infant feeding support.

The Research Design

Recruitment strategies for my study included snowball sampling (where "word of mouth" information about a study occurs), attendance at a perinatal health conference (where I presented a recruitment poster that described the upcoming research), and an advertisement in the *Canadian Nurse* journal. (Appendix V). The snowball sampling and the advertisement in the nursing journal were the two most successful avenues of recruitment. I also approached several nurses and was approached by nurses in my local community who were interested in participating. Ultimately, I chose some participants based on their backgrounds with infant feeding support, hoping to gain insight by speaking with nurses who approached practice from a variety of perspectives and experiences. During my recruitment I did not aspire to attract a "tick box" of nursing roles, but I wanted to give voice to both perinatal nurses who served in a particular setting as well as the participants who I knew nothing about before engaging with them in dialogue. I started the conversations without a clear idea of how many participants I would need to achieve understanding. In the end, I conversed with eleven nurses, all of whom were assigned pseudonyms. Any identifying information was omitted or altered.

The conversations took place in a face-to-face format, on Skype, or via telephone. They were audio recorded. Each interview lasted at least one hour and on one occasion the interview proceeded for close to two hours. Although my consent included the

possibility to interview a participant more than once, in the case of my particular experiences with participants, I sensed that one conversation provided a rich opportunity for analysis. The conversations were so rich that the comments seemed to stand independently as "part of the whole," and with the potential for fecundity.

At the beginning of each conversation, I asked participants the question: "What is your experience of infant feeding support?" The question was broad, but all participants engaged with the question in ways that were unique and rich. I chose that question because I thought it would allow for participants to share what was at play in nursing practice.

In addition to the research question, I prepared a list of several additional questions in case the conversations become stilted, or if the participant needed prompting to expand on ideas. Examples of additional questions included: "What meaning surrounds 'risks' associated with formula use?" and "How do you understand the relationship between infant feeding and women's perceptions of good mothering?" In most cases, the additional questions were not necessary, since the conversations were fluid and rich, and evolved without them and sometimes the dialogue evolved in new and unexpected directions. Topics that I had not considered ahead of time emerged. As the interviews progressed, another question evolved: "How do you understand the relationship between breastfeeding support and good nursing?"

Although there were several others who responded to my recruitment request, I recall feeling, even after the first two interviews that the content of our conversations had been so complex and rich, that I could have stopped there! Nonetheless, I luxuriated with several more exchanges. My conversations do not represent a comprehensive or

exhaustive account of infant feeding support among nurses. Instead, the research process, and my decision to stop at eleven participants depicts a desire to make meaning with what was "in front of me." After eleven interviews were completed, I indeed felt that I needed to pause. I sensed there was indeed something to say - that it was time to delve into the texts and interpret the meaning of the conversations with more depth.

DeVault and Gross (2012) describe the historical tradition of feminist interviewing, wherein the research interview offered an opportunity for women's voices to be heard, and for hidden aspects of women's experience to be exposed. The consequences were often liberating. These authors elaborate:

> But another essential aspect of feminist interview research interrogates the challenges of communication and the inherent contradictions in the desire to give voice to others. This strand of thinking has produced a variety of feminist studies that use interview data in complex and nuanced ways, often to explore language and discourse itself. (p. 207)

I hoped that conversations with participants would indeed proceed in a multi-dimensional fashion, and that the dialogue would reflect ideas about language and discourse since these elements are embedded in my research approach. DeVault and Gross (2012) acknowledge the importance of careful listening in the interview setting, and outline the effects of power relations that can exist when women speak with each other. They caution:

> Furthermore, although it may seem plausible to assume that our status as women or feminists prevents us from reproducing power relations during and after an interview, such an assumption is problematic. As researchers, we must be

> cognizant of the fact that feminists may be divided by relations of power and privilege. Listening may require that we acknowledge the ignorance our own privileges may have produced before we can hear what others wish to tell us. (p. 217)

I resolved to consider the implications of my privilege as part of my lived experience. To be sure, the prospect of incorporating all of these insights was daunting, but without question, the caution speaks to the sophistication and challenge associated with qualitative interviewing.

Both a professional transcriber and I transcribed the interviews. I reviewed the texts of those conversations by comparing the written texts with the audiotapes in order to appreciate the nuances of the silences, the pauses, and the tone of voice that informed the interpretation. I also engaged with the written texts on many occasions throughout the analysis. Subsequent encounters with the text produced new insights and new discoveries.

There were limitations to my sample. In my recruitment materials, I encouraged participation from nurses of diverse social identities as a way of attracting ideas that would potentially shape a meaningful analysis for me (Appendix V). Some homogeneity existed among the participants since all were nurses, and shared, at least, commonalities in undergraduate education. My respondents were diverse in age, experience, and in education to some extent, since some had graduate education and some did not. There were a variety of educational backgrounds, including Nurse Practitioner, Lactation Consultant, Public Health roles, and specialty trained nurses in Obstetrics, Neonatal Intensive Care (NICU), and Pediatrics. The most basic level of education was a newly acquired Bachelor of Science in Nursing (BSN) after many years of practice with a

nursing diploma and specialty training. As such, all my participants represented a relatively privileged group of women. All were articulate and thoughtful. All were mothers themselves, although I had no way of knowing that when I responded to their expressions of interest for participation. No men came forward, nor did any of my participants identify as an ethnic minority. No participant disclosed a sexual identity other than heterosexual. All were fortunate to be employed in the area of nursing that satisfied professional goals.

Confronting Fear

Hermeneutic scholar Jean Grondin suggests that fear can be a significant guide in hermeneutic exploration. But first, he advises, we must ask ourselves what it is that we are afraid of (J. Grondin, personal communication, May 20, 2015).

My interest in exploring unintended consequences of breastfeeding promotion did not always meet with enthusiasm. Recently, for example, when attending a women's health nursing conference, I encountered session after session where the benefits of bestpractice guidelines were reinforced, and strategies to credential more Baby Friendly settings emerged with uncontested fervour. When invited, I tentatively explained my area of interest to nursing peers, and was most often met with quizzical looks and, in some cases, deafening, disapproving silence. The tentative nature of my explanations therefore pervades the history of my inquiry.

When examining the origin of my tentativeness, I re-examined aspects of my hermeneutic approach. In so doing, I uncovered a number of tangible fears that I held about conducting the research. For one, I wondered what repercussions might evolve for me personally as a result of contesting what nurses in nursing literature have rarely

contested. I also wondered how I might respond in the interview situation if a participant espoused what I consider to be problematic practice. What would I say, and how would I proceed? I was also troubled that I would alienate peers, and disrupt the camaraderie and sense of united purpose that I value so highly in nursing practice. To open the conversation, and enable living dialogue among nurses, with the potential for turmoil, was daunting. I acknowledge the passion and fervour that accompanies breastfeeding promotional approaches, but I sensed that I could be viewed as someone who presents a barrier to breastfeeding promotional strategies as they are currently conceived and practiced. I suspected that I was at risk for being seen as swimming against the currents of scientific and evidence-based approaches. I recognised the potential to interrupt taken-for-granted organizational hierarchy by questioning global public health initiatives. The process of wading in was lengthy, and tentatively executed.

Attending to the Whole

Below, I offer an overview of the conversations - what I take from the experience as a whole. I introduce my participants.

Like me, Gloria is a former Labour/Delivery (LDR) nurse with a broad history of nursing practice in urban and rural settings. She has recently undertaken graduate education, and she is also a new mother.

Helena works as a Public Health Nurse. Her history includes nursing practice in a busy urban Labour/Delivery (LDR) unit. In particular, it was clear that Helena was dedicated to supporting women who are socially marginalized or suffering in any way, and she shared examples of challenging situations that are associated with meeting the complex needs of mothers.

Ingrid's background as a pediatric nurse offered a very different approach to infant feeding support from what I had been previously exposed to. Ingrid emphasized the interactions with families that occur, as well as the lived experience of not only mothers, but families, in the context of an ill infant.

Jemma is a busy young mother, nurse, and La Leche League leader whose infectious enthusiasm for breastfeeding promotion reflected the passion that she has for supporting women. She shared her commitment to enact Baby Friendly approaches, and awakened me to the challenges associated with lay support of breastfeeding that occurs in the context of La Leche League activities.

Kathleen is a lactation consultant who works with women and nurses to promote breastfeeding. She sees breastfeeding as an opportunity to empower mothers - to do something that is within mothers' power, in order to facilitate a confident approach to mothering.

Lorraine is a nurse practitioner working in the perinatal field with a rich background assisting women with infant feeding, and a sustaining interest in promoting breastfeeding. In our conversation, she promoted women's "right to breastfeed."

Marlese works in the NICU (Neonatal Intensive Care Unit) of small city hospital in central Canada. In particular, she was empathetic to mothers who are very determined to breastfeed in a NICU setting, but find themselves unable to achieve success. Marlese also discussed the inter-disciplinary conflicts between NICU nurses and lactation consultants and midwives.

Noreen practices as a public health nurse in a mid-size city, although her background includes practice in a large center in NICU, post-partum, and ante-partum. Noreen views any amount of breastfeeding as a "victory."

Olivia works as a postpartum nurse in Fraser Health and was therefore able to comment on the influence of the document described in Chapter One. The conversation between Olivia and me involved focused listening, and thoughtful imaginings. Olivia expressed a sense of satisfaction about the opportunity to participate in the interview, and said she felt she had grown as a result. I felt the same way.

Pamela's outlook reflected her rich background as a British trained midwife, and many years as a practicing perinatal nurse in Canada. Her willingness to reflect, consider, and share reflected the deep commitment to respecting women's birthing experiences. Pamela described her desire to uphold women's successful transitions to motherhood.

Rita's exploration of her experience with infant feeding depicted an astute account of her evolution as a nurse in postpartum and LDR settings. Rita was forthcoming about development that she discerned in herself, based on experience in life, nursing practice, and mothering.

Entering the Circle

The hermeneutic circle opens and summons. Just as the unassuming plankton float freely, and permeate the vastness of ocean life, so too, the tenets of philosophical hermeneutic whirl individually and independently, while facilitating fusion with the larger spiral of understanding - the whole - that shapes the research approach.

In Chapter Four, I invite the reader to engage with both the “whole” and the “parts” since conversations with each participant entice the separation and fusion of these ideas. The enigma beckons. Immersion is inevitable.

Chapter Four: Taking the Plunge

The undertows caught me. I didn't plan to be carried so far from the shore. There was panic, at times, as I struggled to reach the surface, so strong was the undercurrent. I was consumed by the need to take a breath - but oh, what I glimpsed beneath the surface! I found myself plunging in again and again, succumbing to the allure of immersion.

It was finally time for me to talk to nurses. I remember my delight at the ease with which my recruitment occurred for this study. The response to my recruitment was immediate and enthusiastic. The number of nurses that wanted to talk about their experience with infant feeding support heartened me.

I was overwhelmed, inspired, and humbled by the commitment of my participants. The experience of conversing with nurses was different than what I assumed it would be - occasionally conversations unfolded with surprising elements. I anticipated - and hoped - that there would be surprises, but experienced the paradox of being surprised nonetheless. Such is the nature of surprise, I suppose, but the revelations on occasion provoked a gasp. In keeping with the hermeneutic value of the individual case (Jardine 1998), it is not the number of surprises that have come to call in the context of my inquiry. I am most affected by the occasion of the gasp, and the struggle to regain composure that accompanies exposure to a comment that may be made in haste, as an afterthought, or in the context of an idea that "slipped out" unintentionally.

The Ripple Effect

Hermeneutic scholar David Jardine (1992) referred to the "fecundity of the individual case," alluding to meaning and understanding that has the potential to reverberate exponentially as a result of a singular hermeneutic interpretation. For

example, a comment in a research interview may resonate with meaning and offer a basis for interpretation. The concept of "fecundity" was one of the first hermeneutic ideas I encountered and it offered me significant guidance over time. I envision dropping a stone into a still body of water and watching, transfixed, as the circuitous ripples evolve from that singular interruption. I delight in the possibilities, for the reverberations of a single statement, or thought, liberates hermeneutics to consider the fecundity, or richness, of the individual situation. The participant statements that stood out for me are highlighted below - not because many repeated them, but because they shifted me and gave me pause.

From time to time, comments from the participants startled me. At times, I was aware in the moment that I had heard something provocative. At other times, I was overcome later, when interacting with the text. The comments frequently conveyed a sense of hermeneutic "revealing and concealing" (*aletheia*) as they apply to the experience of insight that occurs "when something opens that was once closed, when something reveals itself or is revealed" (Moules et al, 2015, p. 3). Indeed, stimulating statements, like sea waves, recoiled and charged throughout the interviews. Their persistence was both unsettling and predictable.

I depict my personal responses using italics. At times my reaction is informed by literature, which is incorporated in the response. At other times, in order to suggest a more distanced analysis, I expose the scrutiny by using plain text in the style of a more traditional scholarly approach. In all cases, I attempt to engage the reader with the direction of my thinking while envisioning the elusive fused horizon of understanding.

Supporting the Breastfeeding Bandwagon

Gloria (an LDR nurse and new mother) used the phrase "breastfeeding bandwagon" to refer to common expectations among nurses with regards to infant feeding support, including responsibilities to enact Baby Friendly (BF) approaches. Her comment insinuates nurses' overall acceptance of infant feeding best practice. In my conversations, I uncovered many differing opinions and speculations about how those approaches are enacted.

Jemma (a post-partum nurse in a small Canadian city) expressed strong beliefs about the importance of breastfeeding as a panacea to good health and a healthy society. As a young and energetic mother, she continues to breastfeed both of her children, who at the time of the interview were aged three years old, and seventeen months old.

> Well, my entire outlook on healthy living is kind of informed by breastfeeding. And the chronic illnesses and things like that, I see the link to a lot of problems in society and a lot of problems with our long-term health, and how it relates to early infant feeding.

Jemma was suspicious of the formula companies that market formula as an equitable alternative to breastmilk. She elaborated:

> But of all the evidence I read, and maybe I have a strong confirmation bias, but everything I read about breastfeeding is really significant to me, and the harms don't seem to be minor. That's the whole marketing of formula, right? To make everybody feel like breastfeeding and formula are equal. So, yeah, I look to the evidence, and I think there's a lot of strong evidence of the risks and benefits, mostly the risks. So I guess, when I'm at work, it's very rare that a baby will be

> supplemented. I will just work really hard with them to get breastfeeding going. I don't necessarily know what happens after I leave, but there's been lots of times where I'm holding the breast, and I'm holding the baby and I'm right in there with them and just doing as much as we possibly can to keep the baby nursing.

Noreen, a public health nurse with a NICU background, commented on the status quo of breastfeeding promotion as she sees it:

> Certainly, I think as you say we are becoming more Baby Friendly and there's been certainly a lot more of a cultural shift back towards breastfeeding as being natural, and the normal feeding for human babies. I think in the course of that a lot of our language has been guilt-providing for moms. But that is also their choice to take that on. But we certainly see a lot of moms with postpartum depression and infant feeding is a big thing around that.

Noreen introduces many important nuances associated with breastfeeding, which will be explored below. She alludes to a cultural shift that resurrected breastfeeding practice and implies that producing a product (breastmilk) is natural and that breastmilk is normal for human babies. She also assumes that guilt is a controllable emotion. She alludes to the connection between infant feeding and postpartum depression.

My history intercedes as I consider the pathos of women who suffer with feelings of being misunderstood, wracked with guilt and desperate for absolution from nurses after making a painful decision to put an end to their unsuccessful efforts to breastfeed. It cannot be just be as simple as being a "choice to take that on." Yet this is a pervasive attitude that I have encountered in the literature and among peers. The examples of Knaak (2006) and Williams et al. (2012) provoke a sense that addressing inconsistencies

and problematic approaches to infant feeding can occur only within the parameters of Baby-Friendly rhetoric. These authors, and many others, identify such problems as undue emotional upheaval when breastfeeding is not achieved-of that there is little argument. However, it seems that, although current approaches can be critiqued, in the end, Baby-Friendly initiatives are seen as a panacea that can address many, if not all, the issues related to breastfeeding, guilt, and mothering. I remain troubled that the deeper issues associated with mothers' emotions is circumvented by engaging with familiar BF evidence-based strategies. It seems that the profile of Baby-Friendly is so entrenched in the discussion that departure from its authority is unthinkable.

Using Foucauldian discourse analysis and feminist theory, psychologists Williams, Kurz, Summers, and Crabb (2012) analyzed breastfeeding promotional materials in an attempt to address guilt among non-breastfeeding mothers. Their analysis identified inconsistent messaging in information, specifically related in references where it was implied that women have control over their emotions and their guilt, and can choose or not choose to indulge in guilt. These authors argued that this level of control and choice is impossible and suggested that mounting a medical argumenta in favor of breastfeeding would inevitably produce guilt. Importantly, the authors point to impossibility of *attending to* mothers' guilt - guilt that the authors attach to socially constructed discourses of good mothering, risk, and the virtues of the natural that are seen as inevitable.

Jung (2015) suggests that attention to breast *milk* has eclipsed previous assumptions about breast*feeding.* Jung's (2015) perspective on the "product" aspect of the breastfeeding discussion is relevant here and throughout much of my analysis, since

breastfeeding is often itself the subject of a dualistic assumptions. Are we referring to breastfeeding as a bonding and mothering activity, or are we discussing the benefits of breast milk and the associated science that asserts its superiority? Jung suggests that, "the main arguments in favor of breastfeeding have shifted from the delivery system (the mother) to the product (human milk)" (p.148). Her comment is evocative since in conversations with participants, the difference was rarely highlighted. More often, references to the health benefits of breast milk were conflated with other advantages of breastfeeding as an activity. I am aware of my own hermeneutic circling and increased level of understanding as a result of this insight.

Noreen continued her discussion about the advantages of breastfeeding:

> And how you relay that message without creating shame or inadequacy on top of everything else is a difficult one. I've seen lots of women who intentionally breastfeed, particularly as a buffer for postpartum depression because they know it will potentiate the oxytocin levels and lessen the effects of postpartum depression or at least delay it. So that information is getting out there. If they're prone to depression or any kind of anxiety, this (breastfeeding) may be of help to them in some way. So the other thing is not only is it about breastfeeding but I think going also to extend that to skin to skin and just behaviors that support bonding and attachment. And breastfeeding is the best way to do that.

Clearly the advantages of breastfeeding can be seen as multifocal: the advantage of the product, the advantage of the activity, and the advantage of breastfeeding in the context of postpartum depression, based on theorizing about biomedical bodily responses. Kendall-Tackett (2007) accessed selected physiological and scientific data in order to

make the claim that breastfeeding is a protection against postpartum depression. Psychoneuroimmunology [PNI] theory attends to the connection between maternal inflammatory responses in the partal period and stress. Kendall Tackett emphasized the advantages of breastfeeding, which releases oxytocin, as a calming influence in the context of post-partum depression. Her findings were interesting from a theoretical perspective, but they are not based on conclusive methods-they only reflect the ability to construct possible connections between physiological body processes and the effect that they may have on mothers' emotions and tendencies towards nurturing.

Rita is an experienced LDR and postpartum nurse. She commented on the challenges that exist for younger or inexperienced perinatal nurses and the advantages for clinging to guidelines (and becoming immersed in breastfeeding advocacy) in the context of the complicated work of infant feeding support. She stated:

> Baby Friendly is a movement that is trying to provide consistent guidance to everybody that's involved with infant feeding. It applies not only nurses, but everybody else- so it can be one approach, one body of knowledge that's accepted, and that we can all have some common understandings. And I think that for new nurses who are just starting their careers these are very important guidelines to have a starting point. But as I've thought about evidence-informed practice, I do think about the other side of evidence as the side that makes us inflexible and it doesn't make us look at what is going on for that human there. I think the younger nurses just starting probably need the guidelines the most. They don't have the confidence, but one would hope that people don't get too locked into that.

Jemma, however, expressed great support for the Baby Friendly guidelines as they developed and wished that more hospitals would move in that direction. Her enthusiasm may validate Rita's suppositions about the need for younger and/or inexperienced perinatal nurses to have some kind of structure to guide practice. Jemma elaborated:

> I support them. And I would like to see that happening at my hospital and it doesn't at all. Our (breastfeeding) rates reflect low initiation, pretty high supplementing rates, and then we still accept free formula. So we're a ways off. I feel like it (Baby Friendly) is a good way. I like the Ten Steps and I feel like it would be really helpful.

I share some personal musings about The Code. (Appendix 1) This well-known portion of BF guidelines endorses a maternal/child culture wherein information about formula is distributed only upon request and where formula is hidden from view in order to normalize breastfeeding and dissuade formula companies from profiting by exposing their products in plain view (WHO, 2009). The Code frames formula as "alternative" to the normative practice of breastfeeding, but I wonder if within that framework, The Code implies that exposure to formula will tempt women to succumb to the convenience of formula. The unintended consequence, then, of enacting The Code and the Ten Steps has the potential to undermine respectful and collaborative care. Women who choose formula (or who may be entertaining thoughts of choosing it) may feel intimidated by prescriptive efforts to hide formula and question its safety. I wonder whether these guidelines, which arguably aim to achieve a consistent and egalitarian approach to infant feeding for all women, are, at their roots, patronizing in the message in that the message is that the hospital "knows best."

Noreen clearly had in depth knowledge about breastfeeding given her extensive background in NICU, her public health background, and her training as a lactation consultant. In particular she commented on feeding options for neonates which included scientific arguments that favor breastmilk based on evidence that premature infants do not tolerate formula as well as they tolerate breastmilk. Noreen's support for the "breastfeeding bandwagon" also privileged the infant's right to breastfeed. She shared a story:

> I was up in the recovery room the other day with a mom and she told me, 'I'm not breastfeeding. I'm just going to formula feed. That's what I did with my other two kids.' But our policy is skin to skin with babies in the recovery room, so I said, 'Okay, I'll just put the baby on your chest and we'll put him in between the breasts.' Well, we're talking about this and this baby latched on, all by himself. Flipped himself over there and she said 'I'm not breastfeeding'. And I said, 'your baby doesn't know that. And so, I said, what do you want to do? And the dad was absolutely ecstatic. And he said, 'Just let him breastfeed.' And she said, 'Well, okay he can breastfeed,' so she breastfed for a few days and she said, 'No, that's it, I'm done.' That was all right. I thought that was a victory for that baby and he had a choice. He knew instinctively what he needed to do and he did it regardless, of what his mother wanted to do.

Baby was happy. Father was happy. The natural instinct of infant suckling is celebrated. I am pondering, though, what the experience of the mother may have been in this situation. The mother clearly stated her preference for formula feeding and it was dismissed without any concern that there may have been more underlying that decision

than the mother articulated. It seemed that the infant's rights to breastfeed were pitted against the mother's right to choose.

Noreen shared her support for mothers who pump breastmilk when they have an infant in the NICU:

> They (the women) pumped and gave breast milk to this baby for however many weeks because they knew that it was for the infant's sake that they were doing it not for their sakes. So that's kind of the other thing that I try and talk to moms about as well is what about the infant's choice? Not just the mother's choice.

The infant's nutritional needs assume a very high profile, especially in the NICU. Discourses that support "total" (Wolf, 2011) and "essential" (DiQuinzio, 1990a) notions of motherhood resonate, wherein the needs of the mother can be unwittingly pitted against the needs of the infant. I consider the desperation that some women feel about pumping and the demoralizing effect that it may have on their mothering (Humphries & McDonald, 2012). I wonder if comments surrounding the 'infants' rights to choose' find its origins in the WHO declaration, wherein the rights to infant nutrition are enshrined, thus reinforcing notions of total and essential motherhood.

Celebrating breastfeeding. As a lactation consultant, Kathleen is passionate about breastfeeding practice and breastfeeding support. She spoke about breastfeeding as an opportunity to empower women. She described situations where the young women that she dealt with became less concerned about their body image through the act of breastfeeding. According to Kathleen, breastfeeding opened up a different kind of reality for them. Their love for their babies overwhelmed them, and they were released from their concerns around their body image through the act of breastfeeding, and women

wanted to be with their infants. She applauded the support that support that women give to each other and how breastfeeding mothers seek each other out and spend time together while breastfeeding. Kathleen exuded positivity about approaches to breastfeeding practice: "I see these young girls out together running with their babies in the strollers. And they're all together and breastfeeding together. It's wonderful."

The isolation of the mothering experience, according to Kathleen, can actually be lessened because of breastfeeding. I asked Kathleen if she could tell me more about the idea that breastfeeding gives women "strength." She talked about the joy of accomplishment that accompanies a successful experience overcoming breastfeeding challenges:

> I'm working with a woman right now who has a baby with trisomy, and her husband is leaving her because he doesn't want a baby with trisomy. And she has a two year old. Breastfeeding is something she can accomplish. It's important for her to do this to build her strength.

In contrast to those who argue that breastfeeding can lead to feelings of disempowerment (Williams et al., 2012), Kathleen spoke about the advantages. In particular, she addressed what she saw as an unfortunate tendency for mothers to control the amounts of milk the infant received, the impulse to attend to their own personal schedules, and feed the infant according to pre-determined times and length of times. Instead, Kathleen advises women to "give in" to the needs of the infant, and their own womanly *needs* to feed the infant as a way of relaxing into the rhythm of mothering. In other words Kathleen suggested that the mother's needs would be better served by "giving in" to the demands of breastfeeding.

This is a different way of framing things-Kathleen is not creating a situation wherein babies' 'rights' and mothers' 'rights' collide. Instead, Kathleen discusses the advantages of surrendering from the perspective of the mother's needs and what makes things easiest for the mother. The social, discursive, and historic conditions of hermeneutic understanding erupt as I recognize societal discourse pertaining to natural motherhood and women's biology as a determinant of behavior, all of which counters the work of feminist authors such as Apple (1999a), Badinter (2011), DiQuinzio (1999), Wolf (2011) and others. I contemplate the meaning of mothers' surrender in the context of many mothers' lived experience where lack of partner support, the need to care for other children, or the need to return to work may dictate choices about infant feeding. Some women do not have the choice to ignore the clock and relax into breastfeeding. The intersectional lens, with its attention to women's social locations, persists. There is much to be considered in regard to women's opportunities, or lack thereof, and how they are relevant to infant feeding! Are nurses concerned enough about investigating women's situations?

Kathleen's words, and her presence, in the life of a woman of privilege would undoubtedly be soothing and therapeutic. I am reminded of the need for breastfeeding support, even for women who are able to live out BF recommendations of exclusive breastfeeding for six months and beyond.

Kathleen's approach to infant feeding support was decidedly aligned with current Baby Friendly approaches, but her comments touched more on the social implications involving emotional empowerment for women, and the importance of supporting mothers to mother in the best way that they could.

As a long-time public health and NICU nurse, Noreen's perspectives were consistent with Kathleen's vision for exclusive and joyful breastfeeding. She described her passion for health promotion and how it related to the celebration of breastfeeding:

> We have a lot of health promotion, which is actually getting people to stop things. Like quit smoking or obesity. But there's very little in promoting something so basic as breast milk and it's so universal, and why wouldn't I do that? I didn't want to focus my nursing career on downstream activities where we're just trying to catch up. I wanted to be at the front of things and try to promote something that would hopefully mean that families wouldn't have to deal with some of those health consequences down the road. I said 'Why are we having this incongruity with infant feeding? Like it makes sense to me to breastfeed. Why doesn't it make sense to every other mom?' There's a basic understanding: Well, I've got breasts, I have milk, and I have a baby, end of story.

Noreen acknowledges that simply educating people about the advantages associated with breastfeeding is not always enough to achieve this goal. Has there been any attention paid to the intersectional forces that may shape a woman's decision? Importantly, what is the influence of Noreen's social location as a woman occupying a position of relative privilege? To what extent are nurses examining their own social positions, and how they shape practice- or are nurses educated to do so? It seems that her health promotion orientation is about influencing behaviors, but what are the parameters of health promotion ideology in the context of intersectional considerations? This is clearly a huge topic. I am merely blowing bubbles on the surface of the ocean. But

perhaps those bubbles will serve as a notice that someone may be struggling to catch her breath.

Noreen approaches breastfeeding in the context of women's biology, and in terms of doing what "makes sense." She reinforces the notion that breastfeeding, and in particular, giving the infant breast milk, will prevent future health problems for families. She says there is "very little" in health promotion literature about promoting breast milk, hearkening to Jung's (2015) observations about the shift in purpose from the activity (breastfeeding) to the 'product' (breast milk). I am curious about Noreen's perception that there is 'very little' promotion of breast milk, as an advantageous substance in and of itself. Her conjecture exposes the lack of clarity about the advantages of breastfeeding. For example, sometimes the discourse assumes that breastfeeding, as an activity is one that promotes successful bonding. However, at other times the focus shifts to the advantages of what the breasts produce, without actually distinguishing the two ideas. 'Lactivism' (Jung, 215) suggests there is that there is a kind of hysteria associated with valuing breast milk. I wonder how much promotion of breast milk as a product would be 'enough,' and what the ideal presentation of evidence could look like in the eyes of many nurses.

What else may be at play in the health promotion goal of educating mothers about the risks of formula? Indeed, Knaak (2006) suggests: "The educational and promotional literature has become biased, making it more of a tool for persuasion than a tool for education" (p. 412). Using an intersectional lens, the attention to risk ignores the diverse situations associated with the social, economic, emotional, and logistical elements of breastfeeding commitment. Women who struggle with alcohol or substance addiction, for

example, may be conflicted about the benefits of breastfeeding, knowing that those agents are passed to the infant in breast milk (Bowen, 2011). Women who live with bi-polar disorder or other mood disorders may require psychotropic medications and prefer not to pass these through breastmilk (Altshuler & Kiriakos, 2006; Ross, Gunasekera, Rowland, & Steiner, 2005).

As stated, Brenner and Buescher (2011) posit that breastfeeding is a "clinical imperative," citing the biomedical processes that establish breast milk as the superior form of infant feeding. From a health promotion perspective, then, the unintended consequence of BF breastfeeding promotion is the creation of a culture of fear around formula (Wolf, 2011), since the risks associated with not breastfeeding and resorting to formula are well documented (Mohrbacher & Kendall-Tackett, 2010).

Taking into account the complexity that accompanies evidence, I question the larger issues that may shape nurses' relationship to evidence and the extent to which nurses are prepared to enact Fawcett's (1980) plea to "understand the cumulative nature of science and the time required to validate knowledge" (p. 315). For example, the WHO's (2009) BFHI is riddled with the language of risk, beginning with the statement that breastfeeding is something to be protected (WHO, 2009a, p. 79). In other words, claims about heightened intelligence and a decreased risk of Sudden Infant Death Syndrome (SIDS), two stated risks associated with not breastfeeding, are dependent on studies that correlate variables but do not provide scientific explanation.

As a nurse practitioner, Lorraine has a rich background assisting women with infant feeding and has a sustained interest in promoting breastfeeding. She, too,

highlighted the health promotion perspective on breastfeeding and introduced the notion of informed choice:

> I listened to a presentation (by a lactation consultant) that was about infant feeding choices. And she said she likens it to smoking. That if you choose to bottle-feed your child and you can breastfeed, you're actually doing more harm than good. She was a bit of a fanatic in that regard. (*Identifies another as a fanatic*) But she said, we can't pretend to women that there isn't a difference. We can't pretend that it's not better to breastfeed. And we can't pretend that there aren't adverse effects of using formula. So just like we counsel women about the effects of smoking in pregnancy, and that maybe risk reduction is better than nothing, at the end of the avoidance is best. That's what we should be doing with breastfeeding and bottle-feeding talks. As nurses, it's our role to say this is the evidence, this is what we can do to support you, and if at the end you make a different choice, that's your business. But these are things you need to know before making that choice.

The discursive influence of science in shaping the debate over breast milk vs formula is exposed once again. I am disturbed that smoking is linked with formula, but this is a connection I have heard repeatedly and read about in breastfeeding promotion material. In these situations, the discourse of formula risk is highlighted and conflated with smoking as if to suggest that evidentiary claims are equal in scope and validity. When I first considered the complexities of infant feeding support, I wondered what professional turmoil I would encounter. I also considered the possibility that nurses have

come to ignore foundational nursing approaches that seek to establish relationships with patients and recognize their unique needs (Fawcett, 1980; Scaia & McPherson, 2014).

If nurses lack the background to critically appraise research or the discourses that surround breastfeeding advocacy, their autonomous practice may be undermined. Wolf (2011) suggests that, "When researchers consistently eliminate the explanatory power of potentially significant variables, including behavior, through inadequate controls, faulty conclusions become operating assumptions" (p. 37). Wolf's words bear consideration in terms of the widely accepted truth claims about breast milk superiority that shape infant feeding discourses. She clarifies that, "Except in the case of GI infections, the biological mechanisms that might offer protection have not been demonstrated and cannot be reliably assumed" (p. 43). Wolf also points to the curious situation where breast milk superiority is not challenged in spite of what she identifies as "critical flaws in the scientific evidence (which has) inspired dubious public health claims" (p. 106). Wolf goes on to cite and critique many of the foundational research studies that shape current evidence-based discourses about infant feeding. Yet, this research is disseminated, and nurses are encouraged to cite the findings with confidence.

I am led to consider the implications of current approaches to health promotion, including the tendency to valorize education as a panacea for controlling behavior. In the context of breastfeeding promotion, as a health promotion initiative, the unintended consequences can be far-reaching and troubling. Are nurses concerned with the gaps between providing information and observing social realities?

My conversation with Noreen evolved into a candid discussion about women's choice, which drew on her extensive experience in NICU as and her passion for public

health and health promotion:

> When you look at cultures where there's extremely limited outside influence, really, and I was thinking about that-they don't have a choice, really, because they have no idea what are some of the other options. So they're just doing what culturally they've been doing for years. *(Historic references to the "natural" view of mothering)* And I thought, just kind of thinking about choice, sometimes we give them too many options.

The notion of 'choice' surfaces as an equalizing perspective when addressing breastfeeding dilemmas. I wonder to what extent nurses have engaged the evolution of the idea of choice or the potential for obstacles that inhibit "informed choice" in the context of infant feeding decisions. I reflect on the tortuous journeys that accompanied mothers' departure from breastfeeding and their adoption of formula. Women's "choices" can be laden with feelings of self-recrimination, guilt, doubt, and feelings of being misunderstood by their nurses, who embrace the evidence-based claims of breastfeeding promotion with confidence (Humphries & McDonald, 2012). I wonder, afresh, about the meaning of nurses' infant feeding "support" in the context of informed choice.

Questions about power relations come to mind. Nurses have worked to escape the patriarchal and militaristic chain of command within the medical system. Yet here it seems that there is support for another iteration of patriarchal relations. If nurses "give" women "too many options" and too many choices, they reinscribe the very thing to which they say they have been victims-the powerlessness associated with social hierarchies.

Noreen discussed more about the way her practice has evolved in regard to the notion of choice:

> And with too much education and certainly when we're pushing one thing versus the other, we're trying to sway them-whether we give them the risks of formula feeding vs the benefits of breastfeeding, we're certainly trying to sway them one way versus another. *(Social implications of power relationships)* So do they have choice? Definitely with Baby Friendly and definitely as a lactation consultant, I'm going to do my darndest to limit that choice so that they're breastfeeding or ideally giving breast milk whether it's their own or donor milk. (*Discourse of scientific privilege regarding breast milk superiority)* So I am trying to impact their choice. And I think we do try as health care professionals, we try and steer people's choices, most definitely. And, is that wrong?

Noreen questions whether it is "wrong" to limit choices using the mantle of health promotion. I am catapulted into considering the influence of standardized care.

I seek understanding of what appears to fly in the face of individualized nursing approaches and value of an intersectional lens to disrupt the unvarying approach. I see no opportunity, in Noreen's description, for the nurse to consider mother's social situation. I glimpse elitist assumptions that breastfeeding challenges can always be supported. This is what it looks like to disregard the intersectional lens.

Helena's public health background includes encounters with many people of various backgrounds. She spoke of the regret she felt that she did not "try harder" with a young woman who had limited resources to get the support with breastfeeding that she needed. Her remorse was palpable:

> And you know what it was in the end? She didn't have transportation. She didn't have money for transportation to come to the hospital to visit her baby and pump.

> So when I look at it from the perspective of the social determinants of health, here's a sixteen year old with a sick baby, without any money, lives with her mom, her mom doesn't have any money, and she can't get to the hospital. It was a real roadblock. And then I think, how come I missed that? How come?

Marlese discussed her frustration with women's inability to be close to their infants in NICU and how this situation ultimately affects breastfeeding success. She described an arrangement where mothers can stay in the Nurses Residence, which is close by, but not close enough for mothers to reach their infants before they are too tired to try feeding at the breast:

> I mean, staying at the residence is a lot cheaper than a hotel, but it's expensive if parents have to pay. And it's not that close to the NICU. It's all the way on the other side of the hospital. By the time they walk back and forth, that's probably a good twenty minutes right there.

I glimpse Helena's unspoken attendance to mothers' social location. I sense Marlese's sensitivity to the financial realities of coping with a premature infant in NICU. This is what it looks like to consider an intersectional lens.

Gloria's perspective reflected her experience both as a new mother and her many years working in a variety of maternity settings, in both LDR and postpartum, and as a pre-natal educator. She discussed nursing care in the perinatal period, emphasizing the influential role of pre-natal and then perinatal educators who all promote BF initiatives. She also noted that women sometimes blame nurses if problems arise. As Gloria said: "It all comes back to the nurse." Her statement serves as a catalyst to explore further what is at play among nurses, including their perceptions of influence, and power, their social

locations, and their overall awareness of mothers' social locations. The influence of intersectionality continues.

It All Comes Back to the Nurse: Exploring Nurses' Social Locations

Gloria indicated that that nurses can feel guilt and remorse when reflecting on their practice. She commented on peer dynamics:

> I don't think that as nurses, well, for myself anyway, that we're always confident enough to even challenge our colleagues on why their views on breastfeeding are so strong. I think we often will hear a colleague say, 'Well, breastfeeding is best'. But maybe we have some information that is different, based on our experiences. Most of us don't really challenge those that are really pushing their beliefs. You know, I often wonder if not being a challenger myself, if I'm really not just doing a disservice to the families that I actually serve. I'm actually doing a disservice.

Dong and Temple (2011) state that, "Silencing came from the belief that 'good nurses' do not challenge the status quo and will therefore silence themselves to avoid conflict. Lateral violence came in the form of nurses' lack of support for and aggression towards each other." (p. 171). Keogh (1997) discusses nursing autonomy and professionalism, including the issue of peer influence. Other classic articles by Fawcett (1980), Kirkham, Baumbusch, Schultz and Anderson (2009), and Thorne and Sawatsky (2014) allow me to return to the philosophical aspects of nursing knowledge in order to enhance analysis. Gloria's words reminded me of these dynamics.

Rita also reflected on her history working as a hospital perinatal nurse and her evolving views on her own nursing practice:

> I think that's the nature of nursing-you make mistakes and you have to live with it and you go forward and it's not the end of the world-we're not talking about somebody dying here. But it is a little tricky, and sometimes it is difficult to actually say to yourself as a nurse, when you have all this responsibility, 'I may have hurt somebody because of my actions.' And own that. And maybe some of us find that too painful and so we don't actually reflect on our practice or open up the possibilities because the reality is that you've hurt somebody. And as a nurse, you really try not to do that. I'm just questioning: What is the resistance around being more balanced, being more circumspect? Why do we buy this particular line, so hook, line and sinker? Why did we all get on this wagon? I admire the nurses that I didn't admire at one time. I look at them and think, what is it about you that you stayed so woman-centered? Or stayed big picture? What about you allowed you to do that? I'm curious because I think my generation was very engaged (with BF approaches).

Rita's words nudge me to consider the social realities that pervade nursing culture. Her comments open the possibility that it can be threatening for nurses to acknowledge their power to "hurt" someone in the context of practice. Knowledge of the "hurt" may not surface immediately, but only through reflection. This may make reflection difficult. This may also influence our relationships with each other, for Rita's comments also suggest that nurses are constantly looking at each other's practice, through either a critical lens or a more appreciative lens that comes with age and

experience. Evolving perceptions of practice, power, and our sense of competence may shape our social identities as nurses.

Noreen alluded to the influence of a university education on perinatal nursing practice, but did not fully explore the idea:

> There's a very large generational divide when it comes to infant feeding and I think some of that has to do with old practices and old dogs not learning new tricks, or refusing to because they think this is the same thing we were doing ten years ago, twenty years ago, it just has a different name. And that ideology of 'what worked back then still works now.' And some of the older nurses I worked with are not university educated. Not that that means anything, but……
>
> Researcher: It's a good question to ask. Do you think it means something?
>
> Noreen: I think for some it does.

I waited for Noreen to return to the conversation about nursing education and how it influences practice, but the dialogue went in other directions.

Olivia and I touched on some of the differences among nurses and how this might shape their attitudes and practices:

> Researcher: Among the nurses you work with, you mentioned that age is one thing you noticed as affecting attitudes. Is there anything else that you notice with nurses? Other identities? Socio-economic background? Cultural background?
>
> Olivia: I don't think culturally I've noticed anything in nursing practice. But I think I have in terms of education. There's a huge range of what the education is on our unit with regards to the nurses. I feel that fewer of the older nurses have degrees, so they're not really aware of research. Research scares them. They have

no clue how to, where to go to look at research. They really shy away from research. And then you have the newer grads that are all coming out with degrees and they're all about the research. And then you have the middle ground, where some have degrees, some don't and are the ones who are very interested in breastfeeding and will take further courses to further their education. So at our hospital we have a basic course that the manager requires-she pays for her staff to go. Her staff will do the course…there is obviously a difference in practice when they have the course. They come back like changed people…so I feel like there's a huge variation in education about breastfeeding and that does affect the practice. That's the biggest thing that is affecting practice.

I explored more about perceptions of nurses' social identity based on education level. I was also interested in pursuing notions of clinical wisdom that are based in a depth of nursing knowledge,

Researcher: Do you work with anyone who has a Master's degree?

Olivia: Yes, one of our new nurses, she came on with me, she's almost finished her Master's.

Researcher: Do you see any kind of influence there? With the graduate education, do you see anything in terms of how some of these issues are approached?

Olivia: It's hard to say, because she's just one nurse. She is also Indo Canadian, so she has an understanding of where some of the 'East Indian' moms are coming from. She's very supportive of breastfeeding but also recognizes their right to choose. So I wouldn't say she's one way or the other. She's very much 'The mom leads the way.' And she seems very at peace with that decision. She never talks

> about it. Whereas other nurses will be, 'I'm so frustrated with this mom because she won't breastfeed. She keeps giving it bottles, but she said she wants to breastfeed. Then why is she giving bottles?' So some nurses will go on and on about it, whereas this nurse, with her Master's, she's very professional. She just goes about….the mom leads the way…she just goes about her work. Yeah, she's quite the example, actually.

Olivia recognizes, in this nurse, something exemplary.

As I examine the text, I think about my own history, which includes twenty-five years as a practicing diploma trained nurse before I received Baccalaureate education. In the technological world in which we live, nurses are increasingly associated with technical and task-oriented responsibilities which are, ironically, more reflective of the apprenticeship models. I think about the learning that occurred for me, and the confidence that I gained as a result of first, my Baccalaureate education, and then, my graduate education. I wonder whether nurses will be able to think more clearly and understand the dynamics of nursing culture more fully as a result of education. Can education shape nursing care in positive ways, especially through the integration of technology? Or, does this reflect the elitist attitudes of privileged and educated white women? DeVault and Gross (2012) remind me of the need to listen with the highest degree of openness that I am capable of. The influence of my social location and the social locations of my participants gains momentum.

Marlese discussed the different approaches to practice based on nurses' age in the NICU unit where she works:

> Because we have some ladies that have worked there thirty, forty years, and then there's a lot of us that haven't worked there quite as long. We want to change the ways that sometimes we're feeding our babies and there's a bit of resistance there with some nurses too because they've always done it a certain way. And they feel like it's worked. But research says the different practices are better. So think there are a lot of challenges that go on within our hospital with infant feeding in that regard.

Noreen went on to discuss more about infant feeding debates in her workplace:

> I know that breastfeeding versus formula feeding in our NICU was a huge divide. It was one of those things that were an easy target for bullying of some nurses. And it was actually horrific in our nursery because I think infant feeding is one of those things that's an easy target. Certainly, those nurses who've been there for twenty-five years are more supportive of breastfeeding. But they are also starting to tire. And they want to take the road more travelled. And if the easiest thing to do is to bottle feed and not get this mom down there to breastfeed and to support that family or whatever the mom wants, they're going to take the easiest path. And then there are the young girls who know better and have children of their own and are trying desperately (to promote breastfeeding). The younger nurses that are in the NICU also want natural childbirth. They don't want interventions. They want home births; they want a midwife. They're more open to all the other things that go on in in maternity. So because they're taking a stand with some of those things-and unfortunately a couple of girls that I work with who chose to have home births did not disclose that. They were afraid of being harassed or

> ridiculed for choosing a homebirth. So that went hand in hand. I've had multiple arguments with staff members that turn into an impasse and you sure as heck better know your stuff with some of them because they will take every piece of information out there and throw it in your face. There is a group of four nurses who are bullies in our nursery, and that (the breastfeeding/bottle feeding debate) was one of their tactics. And they would intentionally bottle feed-intentionally bottle feed a breastfeeding baby behind a parent's back to make a statement that they were in control. It's deplorable, actually, some of the stuff that they did using infant feeding as a tool to do that.

Issues in disciplinary nursing are relevant. For example, Kikuchi (2006; 2009) as well as Thorne, Henderson, McPherson and Pesut (2004) explored the risks associated with assigning "binaries" to nursing issues. The "breast/bottle" conversation is relevant to discussions of binaries. Newman, Smith, Dexheimer Pharris, and Jones (2008) conceptualized nursing approaches by seeing the whole while attending to the part-a notion that aligns well with a hermeneutic approach to nursing care. Gadow (2000), McBride-Henry, White, & Benn (2009), and McDonald and McIntyre (2001) addressed the "marginalized" body. In each case, ideal nursing care is conceptualized as a "whole" approach-not one that reduces the person to body parts or polarizes and judges dilemmas. The insistence on propagating the breast/bottle binary and on dissociating breasts from the woman does not reflect an ideal nursing approach.

Noreen's words about the use of breastfeeding and bottle-feeding as a way to exert control are chilling. Her description is highly significant in that it exposes the potential for nurses to exercise power inappropriately. The interpersonal dynamics

among these nurses and their tendency to scrutinize each other's practice is both ethically and legally bad practice. Sadly, Noreen's words resonate with my own experience. I remember discovering that a colleague had fed an infant formula without telling the parent. At the time, I felt powerless and incapable of addressing the issue. I regret that I did not stand up for what was ethically appropriate, and I ask myself now why that was so. I remember that there was a distinct tension on the unit surrounding the practices of the "old guard" were being replaced with the evidence-based discourse of the newer and more recently educated nurses. I was tentative about challenging the divide and exposing a member of the staff who had been wonderfully supportive of me. And yet she was the one who had secretly fed the infant. I see with greater clarity the meaning of Gloria's words about "doing a disservice" by not speaking up. I think, in retrospect, that it was situations such as these that served as the catalyst for my inquiry. The oppressive cycle is significant.

Perhaps I am now trying to "speak up" and "open up" a picture of nursing Practice that I view as fractured. I ask: "Was this the beginning of my hermeneutic 'address?'"

The women who participated in my hermeneutic study (Humphries & McDonald, 2012) shared their powerlessness as they tried to navigate nurses' approaches to infant feeding support. In some cases, nurses' utterances were interpreted as coercion. An image of "nurses over mothers" emerges. Ideally, nurses consider mothers' vulnerabilities, rather than adopt coercive or judgmental approaches. But somehow the context of infant feeding support seems to divert nurses from established approaches to patient care. That said, mothers' social privilege my unwittingly uphold elitist notions of mothering, since

social privilege is an advantage when attempting to satisfy many BF goals. For example, some mothers will be able to access the support needed to achieve successful breastfeeding. Some mothers will judge other mothers for not breastfeeding. Admittedly, engaging with women's different social backgrounds and needs does complicate nursing practice, but sensitivity and wisdom as guiding principles, are key.

Settling Them Down

Coming from a pediatric background, Ingrid expressed her support for parents to feed their infants formula in times of crisis. Ingrid suggested that the unified approach among perinatal nurses, which promotes breastfeeding superiority, could create difficulties for mothers and families in the pediatrics unit where she practices. She indicated that she often needs to "settle the parents down" when they are confronted with the urgent need to nourish their infants with formula:

> The babies that are admitted to our unit are not thriving. So they've come with hyperbilirubinemia and dehydration. And they're not thriving because they're not feeding well. So there's a whole vicious cycle that has taken place at home. And they are all almost always breastfed babies. So there's a whole dynamic that has taken place with those mothers. And that has to do with their cultural background, or it has to do with the pressure they're receiving from their families, from their husbands' families, from the nurses that taught them breastfeeding in Mother/Baby.

Ingrid introduces cultural background as a factor in sensitive nursing practice early in the conversation. Depending on the geographic location of the practice, nurses encounter clients from various international, Indigenous, racial, and ethnic backgrounds.

Ingrid works in a multicultural mid-size city. The meaning of motherhood and family differ between cultures, according to Ingrid, and this shapes her nursing practice in important ways

Ingrid discussed her experience of working with Indigenous babies and families:

Ingrid: Culturally, I just realized, we have a lot of First Nations babies and families. And there is not an issue with breastfeeding there at all. They don't seem to worry about bottle-feeding. Using formula is not a problem at all. And in fact a lot of moms opt for it.

Researcher: Right, and there are a lot of efforts towards getting those attitudes changed so that more First Nations people are breastfeeding. Because their breastfeeding rates are lower than….

Ingrid: Very much so. And in fact, it's funny, I didn't even realize that until we were talking. When I walk in a room and I know there is a First Nations Mom in there, I just assume they're going to be bottle-feeding. It's just because of my experience.

Researcher: Interesting.

Ingrid: It's just because of our cultural difference. As a culture, we, as in the Caucasian "we," the Canadian "we," whatever, seem to be obsessed with the breastfeeding, but they're not.

Hankivsky et al. (2010) offer a number of cautions when adopting an intersectional approach in research (Appendix 1V). In particular, I acknowledge the tendency to essentialize First Nations mothers, as if all social and structural factors that apply to some will apply to all. Unlike Ingrid, for example, in my own experience of

working with First Nations mothers, I did not encounter a universal preference for breast or formula. In Ingrid's practice, however, the infant would be older, suggesting, perhaps, that many mothers try to breastfeed but give up after discharge, or that other social and structural possibilities, such as those that Gauld (2010) outlines below, are at play.

It is well documented that Indigenous women throughout the world suffer the effects of colonization and experience socio-economic marginalization (Gauld, 2010). I am curious about breastfeeding activities, attitudes, and pressures among First Nations women in Canada.

There are a limited number of studies that explore this topic. According to Gauld (2010), the well-known statistics about lower breastfeeding success rates among Indigenous women in Canada are not taken into account in Baby Friendly initiatives that purport to service all women. The participants in Gauld's study identified such factors as colonization, oppression, and guilt as factors that influenced infant feeding practices. They also mentioned other variables, such as a loss of autonomy, lack of investment in (Western) notions of maternal attachment theory, and interpersonal influences such as jealousy from the male partner. These influences, coupled with lack of support from extended family and discomfort with breastfeeding in public, related to the sexualisation of the breast. Gauld summarizes her findings as follows:

> In this study, the mother's actions and key informant statements sought to establish Aboriginal women as good breastfeeding mothers. I argue that policy, which promotes formula from a risk perspective, contributes to this moralization of infant feeding, and therefore formula should be presented neutrally. With mounting public health efforts to increase breastfeeding rates I argue that it is

> vital for breastfeeding policy to adopt an intersectional lens in order to ensure that the social and structural factors influencing women are considered. (p.i)

The social and structural factors that Gauld describes align with hermeneutic conditions of understanding, including social, discursive and historic approaches. There is embedded wisdom in considering them at every juncture.

Olivia noted that some mothers simply take the path of least resistance while in hospital. Although she was not specifically referring to Indigenous women, Olivia's comments implied that women's infant feeding decisions often reflect power relations, including feelings of intimidation, associated with the dynamic between mothers and nurses. Olivia mused:

> A lot of nurses I work with really do fret about what's going to happen when the women get home, around the infant feeding, too. There is a bit of a perception too that there are a lot of women who follow the rules with breastfeeding as long as they're in the hospital, and then as soon as they get home they switch over to formula. And I don't know whether that's function of circumstances or whether that's a function of the fact that we have a reputation for coercing women, or what that is. I've hear that quite a bit out there in the community, that a lot of women feel like they're going to go along with the gag while they're in the hospital, just to avoid the issue.

What meaning is associated with a woman's perception that she has to "go along with the gag?" I am reminded of some women's plea to be given "permission" not to breastfeed (Humphries & McDonald, 2012). I also wonder about the consequences not only of promoting breastfeeding, but also valorizing breastfeeding success "rates." What

does "success" mean in this context? How does the focus on "success" contribute to notions of conformity and failure? In the latter case, a woman and her care providers will want to "fix" this failing, either on an individual basis or at a broad societal and/or cultural level.

Gauld (2009) describes how public health agencies are attempting to improve breastfeeding success rates among Indigenous women. What sub-text is at work here? Do such initiatives suggest that Indigenous women are inadequate mothers? Or, do they imply that caregivers are not providing Indigenous women the right support? These questions are critical because they indicate the need to look at nursing practice, which is at the forefront of breastfeeding support. What is the sub-text associated with framing women's mothering behaviors in the context of breastfeeding "success rates"? Does that perspective imply that lack of breastfeeding represents lack of success or failure on the part of the woman? Does it imply failure on the part of the caregivers involved with breastfeeding support? The implications of these questions are critical, because they expose the need to expose the situation of nurses, who are at the forefront of breastfeeding support.

In Noreen's maternity setting, mothers tend to be Caucasian or First Nations, with a growing number who are Saudi:

> Researcher: Tell me about the Saudi practices. What's different about caring for them?
>
> Noreen: If they read the Koran, they're supposed to breastfeed for two years, so some of them are strong Muslim faith, and some of them are a little bit westernized. A lot of them want to have children here so that they have Canadian

children so they can come back and forth even though the majority that I've met intends to go back to Saudi. They use a lot of herbal teas and things for whether it is for the infant or whether it be for the mom, whether it's the dad or the grandfathers, they're definitely not as involved with the infant care as the mom is. So they will quite often leave the room while you're dealing with them. It's usually the dads who do a lot of the translating because they're the ones that are in school. And then usually their partners are taking English classes, so they don't speak as well. So quite often the dads will do translating, so you're missing a lot in translation and they really don't want to translate a whole lot. They're certainly caring for their partners and for their children, but they're not involved. They do very little. And usually the mom will have an assortment of friends around her. And it's kind of odd-because in public health, I don't know if they just all rent the same kind of apartments or townhouses, but it's odd that I do quite a few visits to the same townhouse, but with different families. So whether they're renting it or whether those are the ones where people have the babies and generally they have their friends or their sisters that are the main support for them. And they're very pro-breast feeders. They all breast feed. They don't formula feed unless there's some reason to formula feed like low blood sugars or something. But generally they're supported by other women in the community. And that's part of their culture, is that they really don't do anything for about a month and then it's the sisters or the friends that do things for them.

I am struck with the richness of perinatal nursing practice, wherein nurses have the opportunity to engage with different cultures and social identities, and gain exposure

to some of the global realities of mothers' lives. The descriptions support the mother in her totality, and transcend reductionist notions of infant feeding support as the "only support" needed.

I recall many different cultural practices surrounding birth and infant feeding I experienced when caring for women of Chinese descent. But even there, I do not wish to essentialize, since customs vary from region to region in China. To consider intersectionality in nursing practice must disrupt any tendency to generalize, assume, universalize, or succumb to oblivion about "historical and contemporary patterns of inequality" (Hankvisky et al., 2010, p. 4). It can be challenging for nurses not to "succumb."

Olivia and I discussed some of the unique aspects of caring for Chinese women:

Olivia: I would say, among the Chinese families, there's a belief about colostrum, not so much that it's bad, but that it's not sufficient for the baby that it's of no value to the baby. So the grandmothers are teaching the daughters and the daughter-in-law that this milk is no good, that you give formula and then when your milk comes in, you put the baby to the breast. So I feel that there's a battle at work, where we are battling with that. And we're telling them, well, actually we know that these ingredients are in colostrum, this is what colostrum does to help your baby and we would encourage you to give that to your baby. And most of the moms are willing and do want to, but I feel like there's an influence from the grandmother. We don't understand the language and we don't understand the culture. So I think the grandmother has such a huge role-and I wish we could educate the grandmothers and try to understand where they're coming from as to

> why they try to prevent the baby from having this colostrum. And sometimes I think it's just simply that the mom is just tired and the grandmother wants to give her a rest so she wants to bottle feed that baby. Sometimes I think it's that.

Noreen also articulated that supports for mothers, and especially poor mothers, are critical, saying,

> When you look at families and how they cope postpartum, you hit the nail on the head about the issue of isolation. And I think families, or moms, that don't have a tangible, physical support in the home. Like whether (and by that I mean good support) not just someone who's sitting there and talking to them, but actual physical support where this mom can kind of cocoon for a while and regroup and heal. Our culture doesn't support that. Not at all. These moms are out shopping two days after they've had a baby, or there down at welfare trying to battle custody for their other kids, or whatever the scenario is. So it's very complex with our cultural values. And the lack of support-tangible support…that makes all those issues much more significant.

Noreen went on to state:

> Interestingly enough, I had a mom in a prenatal class-it was a very high risk prenatal class with mostly street people. And the mom's desire was to breastfeed. And she knew she could. But the reasons she didn't is because she felt that she had to use the baby money that came in to buy formula because it was less money for her partner to buy drugs. And so she felt guilty, kind of a reverse guilt, because she really wanted to breastfeed, but she felt that she had to keep that money away from her partner. And I thought, wow, that was a real profound

> moment for me. I thought, good grief. And I know that with some of these moms as well, it's just so complex, why they choose to do what they're doing. And yet it can be very encouraging when you have these fifteen year olds who are saying, no, I want to breastfeed, I know it's the best thing for my baby and I'm going to do it. And are determined. That's the message they're hearing even though we're like well, sure it's best, but it's also normal. We want to normalize it. And they're starting to grasp that as, it's my baby, it's my breast, I have food for this kid. I grew it inside me. So they're kind of taking it back to the very basics of human nature. And that is really cool to see, that they're not complicating it with all the cultural stuff that we're throwing at them. On both sides.

Notions of culture and natural mothering are integrated in Noreen's narrative. I wonder if discourses of natural mothering serve as a "port in the storm" when the complexity of women's lives are revealed.

Ingrid identified other factors at work in mothers' lives that inform their decisions about infant feeding:

> They bring a lot of those voices with them and we spend quite a bit of time with these parents, settling them down around the feeding issues, and just kind of figuring out a way that the baby can get fed. Basically our attitude on pediatrics, across the board, is just get the baby fed. Whatever works best for the baby and the mom, as a dyad, that's what we do. So that's very much our party line. And what I've noticed is that a lot of women will come in and say things like 'I'm just not good at this. I'm just not good at breastfeeding. I must be doing something wrong. He doesn't like me. He doesn't like my breast milk. It's like she's allergic

to me.' There's a lot of guilt and shame and values stuff going on- the overriding nursing diagnosis with these situations is maternal anxiety related to breastfeeding.

In instances when a switch to formula is needed, Ingrid indicated that it was often necessary to involve other family members:

> The people who I'm going to sell the concept that formula is okay are going to be the father and the grandma of the baby, that's the mom's mom. Those are the two people I'm going to want to sell to, and once that's good, then usually the mom is good too. If she's veering on the edge of 'yeah I want to do this' and they're on board, bam, you've got a sale. It's awful to think it's almost a sale thing. But that's what it is. It's a soft sell.

But I must ask: What messages are we conveying as nurses when we must speak of selling an idea? We undo others' work and contest its validity. How is it possible, under these circumstances, for nurses to establish trust?

While Ingrid was clear that she felt comfortable recommending formula, I asked several participants about their comfort levels in this regard. Kathleen, for example, related that in her role as a lactation consultant, she uses her intuition to help her communicate with the mother when the topic of formula is broached. I asked Kathleen if it was possible to bond with an infant if not breastfeeding, and she replied "absolutely." She emphasized that the mother was the most important and that it was critical to support her so she felt good about what she was doing. Kathleen did not directly answer the question as to whether she ever recommended formula, but stressed the need to support women's choices. In response to the same question, Jemma's affirmed the

incontestability of scientific evidence about the benefits of breastfeeding. In response to whether she had ever recommended formula, she said:

> I was really, really close, but I actually didn't. I kind of did, but didn't. It's so difficult for me to do that. I just feel like every baby should be breastfed and needs to be with their mom and have that skin to skin. Over the last three years I've been sorting through my biases and trying to always be able to understand other people's situations and that not everybody is breastfed.

As I write, I realize that the responses to this question were, in each case, "implied." It is difficult for nurses to categorically state (or "admit?") that they recommend formula under certain circumstances. Are references to "women's choice" a way of defending clinical judgment? Will admitting to recommending formula somehow implicate a nurse or make a nurse culpable to charges of negligence? Aside from using formula in cases of "medical necessity," there are currently no guidelines in place for nurses to recommend formula.

Marlese's commentary reflected her experience as a NICU nurse in a small community. She indicated that she had felt very badly for the mothers who really wanted to breastfeed but couldn't. She explained:

> We suggest it (formula) at times. I guess you don't ever want to pressure moms, but it kind of comes down to a point where you're like 'your baby needs to feed.' And I think in our situation, we rarely use ETPN (*Early Total Parenteral Nutrition*) and stuff like that in our hospital, so it wouldn't be a matter of protocol or anything like that. But when the mom is struggling with the decision about how to feed her baby, it's tough, getting to the point where you have to say to a mom,

> you might have to consider formula because you don't have enough milk. And it's tough for me to say it, because you know how important it is for these moms to breastfeed. But I do suggest it. Lots of times I'll say 'when you're at home, if you have no milk supply, how are you going to feed your baby?' I approach it in that manner a little bit, because they need to think beyond the point of okay, my baby's hungry and really need to think of some options about how you are going to feed it. And, at the same time, we're going to try to help you get to where you can breastfeed.

Vulnerability is palpable. Nursing support is a life-line.

Helena shared her experience working with a mother in her role as a public health nurse. In this case, it was clear that Helena wanted to encourage bottle feeding, but her sense of obligation to support the woman's goals took precedence. She also shared the moral distress she experienced when a mother was trying inordinately hard to breastfeed successfully in spite of cracked nipples and pain:

> There was one client that I had that was determined to breastfeed. She had tons of milk and she could pump like crazy, but she really wanted to breastfeed. She believed the evidence, too. She did. And she did not want to let it go. And she had amazingly deep cracks in her nipples and she was so determined to carry on. And she did carry on. And she saw GP experts and breastfeeding experts and lactation consultants. So if women believe the evidence, they really go to extraordinary lengths. So where does that leave women when they quit? What does that mean to them? I really felt for this woman and I felt like 'Don't you just want to give it up?' I wanted her to give it up. Sometimes women go to such extraordinary

lengths that I feel frustrated. And sometimes I think I wanted to give before they want to give up!

The existence of BFI guidelines may offer structure when confronting the complexities of infant feeding choices. Nursing's historical relationship to direct patient care can be compromised when the outcome-focused interdisciplinary sources of information (such as BFHI [WHO, 2009]) take precedence over the nurse/patient relationship (Scaia & McPherson, 2014). For example, women may struggle with breastfeeding and experience a depleted emotional capacity to continue. What guidance exists for nurses, other than to resort to BF breastfeeding promotional strategies, including discussions of all the risks and dangers associated with formula? A chasm of misunderstanding emerges, since women's vulnerability in the perinatal period, their perceptions that they are being coerced (Beck, 2009; Shakespeare et al., 2006), and their feelings of failure (Martin & Redshaw, 2011) intersect. I wonder how the dynamics between mothers and nurses are affected by the dominant discourse of breastfeeding superiority (Humphries, 2011). I wonder how easily nurses are able to reconcile recommending formula in a culture of "breast is best."

Pushing breastfeeding. In contrast to the Marlese and Helena's narratives about wanting to recommend formula in some situations, Gloria shared concerns about the unquestioning way that nurses take up best practice guidelines and "push" breastfeeding practice.

Gloria: The other thing that we do that's really problematic is we really push right away, right at birth, to go 'skin to skin.' The baby must go to the chest-that's the

way we do it. We don't ask 'do you want your baby on your chest?' We just make this assumption that all women think that this baby needs to go to the breast.

Researcher: Well, it's in the guidelines.

Gloria: And we're actually damaging-for some women we're actually creating a very traumatic or a very negative experience for them. It always makes me laugh that we have such strong values and we instill this (valuing of) breastfeeding. We push it, we push it. As nurses, we're supposed to be open to individuality. We're supposed to be unbiased.

My history as an LDR nurse floods back. I remember the situations when labor was progressing rapidly. I hoped that someone else (the physician, midwife, or prenatal teacher) had discussed skin-to-skin practice with the mother and prepared her. Under any circumstances, it is difficult to prepare women fully for the moments after birth because there are so many unknowns. It is an individual and personal experience. Some women embrace the infant, but other mothers appear unprepared and dismayed. There is no "one reaction" to skin-to-skin practice. I wonder if we pay enough attention to women's responses. But the evidence that supports this practice is authoritative. Breastfeeding is enabled, baby's thermodynamics are regulated, mother's oxytocin production is enhanced, and the newborn's nasopharynx can be colonized with "friendly" family bacteria belonging to the mother. Is it possible to reconcile negative emotional responses with scientific privilege?

Challenging the evidence. Gloria expressed concerns about nurses' ability to critically assess the evidence that underpins breastfeeding promotion initiatives:

> I don't believe that all of the research is strong research. I don't because that all becomes very much a personal perspective and there are so many variables. A researcher can definitely get the answers to the questions they want. So I think you really have to look at it. And do we do that? Probably not. We're not screening the evidence as we should. And that could be because of our lack of skills as nurses and our (in)ability to do research.

Kirkham, Baumbusch, Shulz, and Anderson (2007) describe the commonly held assumptions about evidence-based practice:

> *'Evidence-based practice is currently the primary approach to knowledge uptake for professional practice and is believed to support efficiency and ensure that practice decisions result in the provision of effective treatment' (p. 26).*

Which voice gains ascendancy? It may be difficult for nurses to challenge the authority of medical evidence. It is based in statistical and/or scientific "truths" that are framed in elite biomedical language that is largely inaccessible to nurses, or which emanate from medical disciplinary sources who offer specific direction to nursing care. Yet, there is mounting evidence that challenges the status quo. For example, there is no causal relationship that has been established between breast milk and infant intelligence, although statistical significance suggests that breastfed babies have increased intelligence as compared to babies who are artificially fed and enjoy a lowered risk of Sudden Infant Death Syndrome (SIDS) (Retrieved from: http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/nutrition/reasons-raisons-eng.php). However what are the ethics of publishing this information as evidence without including other evidence that refutes such claims such as the research of Der, Batty and Deary (2006)

whose British longitudinal study concluded that genetics, rather than infant feeding method, determined infant intelligence. It appears that in publishing selected research initiatives, the interests of BFI are served. Mothers, however, find themselves in an impossible position since not choosing to breastfeed will ostensibly compromise their infant's intelligence.

Evolutions

Participants reflected on transitions they had experienced as nurses or assumptions about age and experience they had encountered among their peers.

Pigheadedness and swallowing the company line. Rita discussed at length the changes she had undergone, tracing these developments from when she was a young nurse to the present. She stated:

> I remember having fights with some of the nurses who challenged me a little bit and I look back on some of my practice being quite pigheaded about some of what I was doing. This comes largely out of growing up as a nurse-but I look back on some of the things that I did as a newer nurse where I accepted the dogma and I feel badly about it. But I'm grateful that I'm more informed now. I'm grateful that I'm more mature, that I see the woman in front of me differently. And I don't think as a young nurse I understood the complexity of women's lives.

Brenner and Buesher (2011) disrupt any intent to honor complexity:

> *Rather than perceiving and presenting it (breastfeeding) as a desirable option for infant feeding, healthcare workers should see breastfeeding as a clinical imperative, no different from control of blood pressure in a hypertensive patient or vaccination of children against common childhood diseases. (p. 1767)*

Dr. Jack Newman, the Canadian pediatrician who is well known for his breastfeeding advocacy, is adamant about the risks associated with formula use. He states:

> This means that we should consider formula a drug, which, if one thinks about it, is exactly what it is. It replaces a normal fluid (breastmilk). It is only very superficially like that fluid it replaces. There are known side effects of formula, in the short term, medium term and long term, some quite serious and irreversible. Formula may occasionally be necessary, but so are drugs. In rare cases, formula can be lifesaving, but so can some other drugs. A drug is, as my pharmacology professor said to us in medical school, a poison or toxin with beneficial side effects. There is much wisdom in that statement. So when a mother decides to feed her baby artificial milk instead of breastfeeding, she is not avoiding the problem of giving toxins to her baby. (Retrieved from: http://www.nbci.ca/index.php?option=com_content&view=article&id=51:toxins-and-infant-feeding&catid=5:information&Itemid=17)

Newman's views speak to the complexity that nurses face as they navigate infant feeding dilemmas on a daily basis and the conflicting ideas that shape their approach to comprehensive care. The dynamics prove to be intricate. I am struck with the turbulence. *Was **this** the beginning of my hermeneutic address?*

> Gloria reflected on how her practice as a prenatal educator had shifted:
>
> Researcher: As a prenatal educator, did you feel quite a bit of pressure to stick with the rules?
>
> Gloria: I did, yeah. And I stuck to them very closely as a new educator. But I don't actually stick by them very closely now. Within the last four years I do say

> to women, have a can of formula in your cupboard, tucked away in the back. But I will also say, don't tell anybody you heard this from me. And I'm taking a risk, obviously, because it can get back to my boss.

Nurses' historic voicelessness and subordination in the medical world are well documented in the nursing literature. But nurses' voices are not "one voice." Here I am sensing that nurses do not agree on the efficacy of evidence nor do they approach many aspects of their care with the same ideological principles. The discourse of risk is highly influential, in all its social, medical, and epidemiological meaning. Risk is a concept that is omnipresent as a determinant for decision-making. It seems impossible to dismiss its presence.

Gloria also discussed how her newly acquired graduate education made a difference: She said:

> There was a time when I kind of swallowed the company line, hook line, and sinker. Now I'm not that person anymore. I'm interested in exploring other paradigms in terms of how we approach infant feeding support. What and who should we put first?

Pamela also reflected on her long and varied career, which ranged from her midwifery experience in Britain to her work as an LDR nurse in Canada. She shared an epiphany that she had many years ago:

> I went through labor and delivery with a young woman who was young enough, when her breasts, you know, were sexual objects rather than feeding objects, but she had decided already, she had made her mind up she wasn't going to breastfeed. And I supported her through the labour and she had a long pushing

phase. She pushed and pushed. I was right there and then, at the end, she managed to have a spontaneous vaginal delivery. She birthed the baby, took the baby, and we put the baby to the breast. She was quite surprised how the baby took to the breast. And a little bit later, she fed the baby again and I was so pumped about this. And I realized that I was emotionally involved in this. I wanted her to breastfeed. Then I met up with her GP the next day and her GP said, well, you know, she's really only breastfeeding to please you. And it was such a moment. I've thought about it a lot since. What was I doing? I was manipulating somebody, I was pushing her along a path to breastfeed thinking that, oh, gosh, she'll take to this. She's going to really like this. So we are directive sometimes!

Assumptions made with the best of intentions.

Change and evolution.

Diffusing rigid approaches.

Olivia and I discussed some of the complications associated with "rooming in," when the mother and baby are not separated after birth. Our dialogue evolved into a discussion about different generations of nurses as it applies to their age, and the various attitudes that jockey for precedence in perinatal nursing practice.

Researcher: I don't know about your place, but in mine, a lot of nurses on the night shift often end up having a baby with them at the desk because they're trying to give the mom a rest.

Olivia: Yeah. It does happen in our unit too. One of the things that I struggle with at the work is that the staff tends-the newer staff are more open to Baby Friendly. The older staff is dead against BF and has a big problem with it. And they also

have a big problem with breastfeeding, a lot of them, I find. So they feel like they didn't breastfeed their children, or they themselves weren't breastfed and they're just fine, so they can't agree with the research. The research doesn't make sense to them. So then that personal opinion does rub off to other moms, when they're telling that to other moms. They're often quicker to, when a mom is struggling with breastfeeding, they're often quicker to say, let's give it some formula when there is no need whatsoever in that situation and the mom is not asking for it. The nurse is recommending it. So I see that happening a lot too and I think that also is detrimental. It's not respecting the mom's choice either, when that mom is choosing to breastfeed. The nurse is encouraging her to use formula just this once, to calm the baby who's screaming, for example. But I think the choice goes both ways, and that lack of support.

Researcher: So it's interesting that you mention the age. And this is not the first time I've heard it. What do you think about the fact that the older nurses are saying, 'I wasn't breastfed and I'm fine'?

Olivia: I can't help but wonder about it. I like to think to myself, it's a really good point. I think the breastfed child-I'm not up on the statistics, but I think that the age group of women in their fifties and sixties, maybe the minority of children were breastfed at that time as babies. So we are having all these adults walking around now who were potentially formula fed. But then we do see a lot of heart disease and diabetes and other health conditions as well. So just because this nurse is healthy doesn't mean to say that statistically there's a less healthy population walking around from her generation. But I do wonder about it. I do

> think, what about, for example, nurses who are my age who have babies at the same time as me, who did bottle-feed their babies and formula feed them? And their babies were never hospitalized. They don't have asthma. They're healthy. And I find myself questioning the research to a point as well. Then, when you think deeply and my training regarding how to evaluate research, it's not fair to just use those examples, right? I think if you look at the big picture. And we don't know how those children are going to grow up. Maybe they're going to develop heart disease when they're older. Who knows? But it's a struggle for me.

Notions of natural mothering, adherence to evidence-based dictums, and a longing to better understand the complexities pervade Olivia's dialogue. Her candor exposes the many competing discourses that confront nurses in every day practice. Knaak (2006), too, attended to the discourses found in breastfeeding educational materials. The author critiqued and identified statistical attention to risk and benefit, the ideological discourses of infant attachment, and other myths that "fail to adequately embrace the often difficult and unpleasant work of infant feeding" (p. 413).

This is not to say that we ignore the currency associated with recommendations for health risk. Drawing on Gadamer, it is pertinent to ensure that science is asking meaningful questions, and presenting health risks with the benefit of the contextual. For example, there are causal relationships associated with folic acid intake during pregnancy in order to prevent infant neural tube defects. More recently we have become aware that the mosquito carries the risk for spreading the Zika virus, leading to microcephaly in the infant. What are the implications of this knowledge? How does this science differ from the science associated with breastfeeding? What is the context of

evidence in infant feeding and how do the voices of other discourses (the neo-liberal voices, the patriarchal voices) complicate the meaning of choice for women? What understandings can we anticipate?

In spite of her critiques, Knaak (2006) concludes that heightened efforts to credential Canadian hospitals and health centers as Baby-Friendly will ensure positive experiences for more women. Knaak envisions the advantages of increased support for breastfeeding as a way to mitigate the discourse of risk. Her conclusion is perplexing since BF ideals profile the discourse of risk – a profile that she had critiqued earlier in the article. For example, the Ten Steps are presented without the risks and benefits of each option. And there is no discussion about mixed feeding possibilities. It appears that once again, infant feeding is presented in the context of a breast/formula dichotomy.

Support for Mothers by Mothers

The participants' personal experiences of mothering arose in each interview. In most cases, the topic arose spontaneously. Participants often waited until we were well into the interviews before they shared their personal experiences, as the dialogue moved from more clinical themes, to personal stories. The disclosures of personal suffering moved me. I wondered, and continue to wonder, to what extent, and in what ways, does the personal experience of mothering shape nursing practice in the context of infant feeding support?

Rita spoke about her high-risk pregnancy and the experience of becoming a mother:

> It was humbling. Hugely humbling. A re-jig of some of my assumptions, because I didn't have an ideal situation. The breastfeeding was a challenging ideal to live

> up to, in that circumstance. I think I lived through a lot of that grief, so I have empathy for it now. And I don't think I would have that same empathy had I not suffered myself. And then the pain, and I look back on it now and it's almost comical to think how crazily important that I just fed with breastmilk. I question some of the stuff that went on in my mind, and where did that come from? The breastfeeding for me became overly important as a way to make up for what I'd failed at.

Lorraine mused on how her experience of mothering influenced her nursing practice:

> I think before I had my own children I would always think it didn't matter-just like a heart surgeon who has never had a bypass-it's irrelevant. But now that I've had children, I think it can enhance or actually make practice more difficult, depending on how your experience went. Because I think the ones who are very supportive had good support themselves, or have had good experiences. And the ones who haven't seem to think nothing will work, why bother? So I think nurses need to do some self-reflection and make sure they're not making value judgments based on their own experiences, as easy as that is to do. It's hard to check yourself at the door, but we should try to do that because I'm very pro-breastfeeding. I breastfed my kids until they were a year and a half each and even then I didn't want to stop but they wanted to. And I have to catch myself sometimes, even with my own patients, have you chosen a way to feed your child? And if they say, breastfeeding didn't work, you almost want to say, 'well, didn't you go to this person? Or did you try this?'

Lorraine is describing the nuances of infant feeding support wherein there is a kind of "impossibility." There is tension between two approaches that are both based in well-meaning, but somewhat oppositional possibilities. Nurses must temper the temptation to undermine mothers' confidence to succeed by openly suggesting formula with the unintended tendency to coerce by ignoring formula as a strategy when mothers are struggling. It's hard for nurses to "get it right."

Marlese indicated that she was surprised when formula was recommended during the perinatal period:

> I know I wasn't producing enough milk. The nurses suggested formula and it crushed me a little bit. I was like 'I don't want to do that'. I never thought I would feel that way. When I would talk to parents sometimes, I would be pro-breastfeeding, but not against formula either. I'm just straight in the middle. Whatever works to feed your baby. And then when I gave birth, I never realized how much I wanted to breastfeed and not give formula. For somebody else, it didn't matter to me, but for me, it wasn't an option. So it's really funny how it affects you that way.

Later in the conversation, Marlese mused:

> But now when I think of it, because of how I felt, it's a little bit harder for me sometimes to suggest that (formula) because when I see a mom that really, really wants to breastfeed - you know it's going to hurt her a little bit.

Kathleen acknowledged that her mother still felt guilty because she had not breastfed her oldest son. She blames herself for all the troubles her son has in life. Helena shared a conversation that she had with her husband prior to our interview:

> My husband and I were talking about this tonight because I told him that I was going to have this interview and we're going to talk about breastfeeding. And he's like 'yeah, well, I didn't breastfeed.' His mother didn't breastfeed him. There's an awareness out there that breastfeeding is good for you. So, what does that mean, if your mom didn't breastfeed you? She didn't do a good job, then? That's almost how he was saying it. That somehow he got short-changed on things.

I would never have anticipated these responses to my research questions, which expose multi-generational expressions of guilt.

In another articulation of multi-generational influences on nursing practice, Pamela shared her interest in infant feeding support as a way of extending her ideas about nurturing and bonding. For Pamela, breastfeeding is only one way to nurture an infant. She knows that, as an adopted child, she was never breastfed and yet her bond with her adoptive mother is strong. For her, bonding through suckling, and the notion of good mothering are interlinked.

> And my mother told me that she chose me because I nestled with her and went to suckle at her. And that's the reason she chose me. And she told me when I was a little girl that she had a choice of another baby or I and she chose me because I did that. So that shows what sort of commitment there was right off the bat, to being a good mother. A good mother. She recognized that nurturing and bringing the baby close, that there was something chemical. And then she took me home and then of course she formula fed me.

Gloria's experience with infant feeding support was rich and diverse. As a prenatal instructor, she was aware of Baby Friendly expectations that formula feeding was not to

be discussed in her classes. As a perinatal nurse who had practiced in a number of settings, she supported women immediately following birth and on the post-partum ward. Her own birthing experience, however, appeared to shift her assumptions. She struggled for weeks with her own lactation issues, saw her infant struggle to thrive, and with significant regret, commenced formula feeding in lieu of breastfeeding.

I am drawn to a recurring inquiry about meanings that arise. What is it about the early perinatal experience that is so profound? What is the meaning of nursing presence and how does it intersect with mothers' experience? I am drawn to the inevitability of bringing nurses' wholeness into practice by drawing on hermeneutic philosophical principles that suggest history, bias, and dialogue shape meaning. Nurses' suffering has the potential be a source of insight and wisdom for patients.

Like Gloria, Helena spoke of her own mothering. She identifies a moral dilemma associated with her son's asthma:

> But with one of my kids I thought, well, it's going to be a lot simpler if I give him a bottle through the day, because then I won't be all "tied up". So that's what I did. He would guzzle the bottle down and then be fussy anyhow. He was really satisfied at the breast, so I don't know why I did that. And now, out of my three kids, he's the one that has asthma.
>
> *Even after all these years, she is remorseful about introducing formula.*

Pamela wondered about her daughter who was given formula immediately after birth by a nurse who did not ask permission to do so. This child now has many challenges with her diet.

She wonders.

Pamela recently observed a nurse who started handling a mother's breasts without asking her permission. She then instructed the woman to get her own hands "out of the way" so the nurse could place the baby on the breast.

What might that mother think later, over time? Pamela's description resurrected something in my own past that I thought I had forgotten. I now remember how roughly the nurse handled my breasts when I fed my infant for the first time. I feel angry after 24 years. A nurse made me angry and I remember it 24 years later.

Ingrid described her experience of sixteen years ago when she breastfeed her child. She recalled the experience as being fraught with self-expectations, fatigue, a hungry infant, and months of perseverance. She regretted carrying on with breastfeeding for as long as she did. She remembers the experience as a curious one, and now sees it as a ludicrous exercise, given all that accompanied the commitment to continue. She felt she did not have a choice - she felt she was required to pump and store her milk when she had to undergo medical procedures that rendered her unavailable to breastfeed. She stated:

> I'm blown away that nobody said, 'Hey you're going in for this test, formula feed your baby for a week.' I was woken up at night so I could pump and everything. It was just like it (*breastfeeding*) was everything. Getting that breast milk for him became - I really understand how, as a parent this could throw you into a complete spiral. And what professionals say to you at this time is so important. Because you just take it in and believe it.

I initiated my inquiry as researcher who is a woman and a mother. My interpretation emerges from dialogue with participants who are also women and mothers, and who care for new mothers (who are women). The disclosures may, on one level,

support bio-medical discourses pertaining to risk and the way that health care providers have taken up the language of risk. The ongoing tension between Apple's (1996a) depiction of the "scientific mother" reverberates with the understanding that these particular women are also nurses, whose education and practice is steeped in reverence for science and evidence. As such, their burdens may be compounded.

Feminist scholars Wolf (2011) and Badinter (2012) argue that a mother's needs can become subsumed under the ideology of "good" mothering, a notion that has become closely associated with breastfeeding practice. Those authors, like Shakespeare, Garcia and Blake (2007), recommend that the terminology be shifted from "Baby-Friendly" to "Mother-Friendly" in order to honor the needs of the mother and the challenges they confront in the early post-partum period.

Wolf's (2011) explores the notion of "total motherhood," which aspires to address and mitigate all risks. What are the implications for nurses who are mothers (or mothers who are nurses)? Nurses must surely "know better" and function at a formidable level! And yet, they are women and mothers. They were new mothers once and just as vulnerable as the many new mothers they have cared for. The complexity of women's circumstances, including the feelings of vulnerability that accompany the early mothering experience, offer a glimpse into the unintended consequences associated with BF approaches, no matter who the mother is. I absorb the disclosures of mothers' and nurses' experiences. I sense the suffering.

Disciplinary Waves

Supporting What the Baby Needs

I am reminded, again, that Baby Friendly initiatives have multi-disciplinary

origins. As discussed in previous chapters, many issues that we encounter in nursing practice are not addressed in Baby Friendly approaches and the experience of being with a woman at the bedside adds intricacy. Nurses adopt divergent approaches, based on the focus of need that is being addressed. For example, nurses hold differing views on whether the mother's needs or the infant's needs take precedence. They also diverge on the question of when it is appropriate to recommend formula as an urgent intervention to protect the infant's well-being.

Carefully and with caution, Marlese shared her concerns about her work in the NICU. She felt that she had been misunderstood when she ensured that an infant was fed. Indeed, within the context of Baby Friendly, there are many strategies that are suggested to "protect" breastfeeding. She summarized:

> Marlese: Sometimes I feel like the maternity nurses don't quite understand the feeding aspect of a NICU baby. There's just definitely a difference. Sometimes, I think we could adjust our practice to what the baby needs.
>
> Researcher: I know in my own experience, this issue has affected relationships. It has divided nurses in the sense that perinatal nurses have a strong idea about what needs to happen, and they feel that the NICU nurses, for example, jump in too quickly with formula, or that NICU nurses are not considerate enough about the nipple confusion concept, etc. I don't know whether what I'm saying is what you are referring to.
>
> Marlese: That's exactly it. That's bang on, pretty much, and some moms will be so determined that they're just going to breastfeed their baby that they will do that. And they have major breakdowns. It's hard to watch because you want to comply

with what they want to do for their baby but, at the same time, you see them breaking down and it's hard not to say 'why don't we try a bottle?' But at the same time, regarding their sanity, it's a very tough scenario in the NICU. I feel like, you want the moms to breastfeed, but sometimes to get the baby out of the NICU, bottles are inevitable. And, our lactation consultants want to get our facility Baby Friendly and they don't want us to use any formula. But I don't think they fully understand the challenges that are faced with moms to do complete breastfeeding…she (the lactation consultant) doesn't really see the challenges of how difficult it is to breastfeed your baby in a NICU, and all the challenges that comes with it. Because she works more out on the floor with the postpartum moms and the full term babies, and they'll latch on and feed a lot better than the babies in NICU.

So many competing "inter" and "intra" professional forces….the postpartum nurses, the NICU nurses, the lactation consultants, the physicians, the midwives… the mothers……and breastfeeding promotional forces that underpin BF approaches. Whose voices dominate this conversation?

Olivia, too, has encountered differences among interdisciplinary relationships involved in perinatal care.

Researcher: Have you encountered conflict about offering formula too quickly?

Olivia: Yes, by a midwife. I had an encounter once where I came onto a day shift, the night nurse had provided formula, the midwife came on, and she was furious and quite angry with me that the mom had been provided with formula……. I've never seen it with a doctor. Never. I feel like the doctors are very happy to give

the baby formula because they're guaranteed that the child is well fed. So I do feel that the doctors are more comfortable with the formula-fed baby.

In my previous study, women said that pumping their breasts made them "feel like a cow" and that it increased their feelings of maternal inadequacy. Many strategies that are used to promote lactation may prove to be beyond women's emotional capacities (Humphries & McDonald, 2012). Feed your baby. Ingrid's words resound. It feels impossible to honor evidence-based BF approaches in some situations. Or, perhaps it is most important to ask "which evidence?"

Marlese indicated that the lactation consultant on the postpartum unit was unsympathetic, at times, to the plight of the NICU nurses and not fully aware of the feeding issues that arise in NICU. Marlese opined that the situation could be improved if both the lactation consultant and the midwives would actually spend time in NICU so they could see the work they do with women around feeding and the challenges they face.

Marlese also described the challenges associated with the ideal of "feeding on demand" in the NICU. For example, a premature infant may begin "cueing" and exhibiting hunger but by the time the mother can be summoned to breastfeed the infant, the infant is too exhausted. Realistically, hospitals would need to provide on-site housing for women with babies in NICU. Marlese said that many of the physicians she works with want the babies fed and do not value attempts to include mothers or breastfeeding attempts. It seems that, in her unit, the nurses are caught right in the middle of the "intra" and "inter" disciplinary influences of midwifery, lactation consultation (nursing), and medicine.

Hermeneutic Circling: Women's Choice

During my conversations with participants, the topic of women's choice recurred. For example, the in-the-moment decisions about putting an infant skin-to-skin after delivery is not always as straightforward as the BF guidelines might have us believe. These guidelines assume "normal" "low risk" and "complication free" deliveries, which do not take into account how unpredictable deliveries can be. A low-risk delivery can quickly and unexpectedly turn into a high risk delivery, for example. A physician might characterize a delivery as "complication free," but it might not be perceived as such by an emotionally traumatized mother. I think about possible lapses in clinical judgment that could result from subscription to these labels. The same could also be true if other BF directives are followed.

My Hermeneutic Rant

I am going around and around the hermeneutic circle where choice and evidence are concerned. I keep coming back to the ethics of disseminating 'evidence' relating to the 'risks' of formula. I wonder if the default approach of respecting women's choice is flawed. Is it not unethical for nurses to be giving infants formula if, in fact, it is as dangerous as the evidence leads us to believe? Many publications (including the Fraser Health document [2014]) warn of the danger of a single exposure to formula and the potential it has to cause damage to the coating of the baby's gut 'and make illness more likely' (Appendix V). While this is statement is associated with the interpretation of evidence associated with this particular document, it is not the only document where this information is published. I am reminded of Dr. Mullaly's words in the Fraser Health blog, the works of Wolf (2011), and Sokolan (2014), who question the "evidence" related

to breastmilk superiority. It was difficult to explore the meaning of "choice" with some participants. Many were not interested in dissecting what I identify as problematic with the notion of "choice." Is this tendency reflective of the environmental realities of task-oriented, busy nursing practice, or disinterest in engaging with theoretical and/or philosophical issues associated with breastfeeding promotion? It seems that many of my participants' support for individual care default to notions of women's choice without considering the incongruities. Nurses hope mothers will make the "right" choice, but if not, it's simply "their choice." I do not encounter ambivalence and contradiction in the way choice is presented to mothers. Informed choice appears to be a concept that is valued by nurses when they distribute and explain Baby Friendly literature, but how well are nurses able to reassure women about alternate choices? Is reassuring women even central to perinatal support? Am I imagining a dilemma that does not exist or is it just not on nurses' radar?

Jemma touched on the fact that women have "choice" and that she would like to "respect" that. She stated that she did not think women actually had informed choice, since she does not believe women have enough information about risks of formula.

What exactly is "informed choice" in the context of this discussion? After all this time, I don't think I really know. How much available bio-medical information would result in real informed choice? How much information is appropriate to communicate to women who are already concerned about so many aspects of mothering? In cases when formula is recommended the nurse is in a position of offering something "dangerous" to the infant, considering that nurses disseminate and sanction the information about risks. I am perplexed by health promotion tactics that scare vulnerable new mothers.

Perhaps the integrity of women's "choice" does not permeate nurses' everyday practice. Perhaps these conversations surface only in scholarly analyses.

Support for Natural Mothering

As I reflect on Helena's conversation, I sense that her experience with infant feeding support is one that embraces the joy of mothering and the joy of the human anatomy that can allow breastfeeding to occur. As such, she experiences and re-experiences the satisfaction of facilitating that process with women.

Kathleen was clear that her own mothering experience factors into her approach. The beauty of honoring the "normal" aspects of mothering was implied. Breastfeeding connected women with the historical, universal experience of mothering in a way that formula feeding could not. Marlese expanded on the notion of natural mothering which she contrasted to images that girls are exposed to in which breasts are constructed as sexual objects:

> I know with some of these moms it's very complex, why they choose to do what they are doing. And yet it can be very encouraging when you have these fifteen year olds who are saying, 'No, I want to breastfeed, I know it's the best thing for my baby and I'm going to do it.' They are determined to do the best thing for their babies. That's the message that they're hearing even though we're like, well, sure, it's best, but it's also normal. We want to normalize it. And they're starting to grasp that as: 'It's my baby, it's my breast, I have food for this kid. I grew it inside me.' So they're kind of taking it back to the very basics of human nature- which is really cool to see, that they're not complicating it with all the other cultural stuff we're throwing at them.

However, Sokolon (2014) cautions about naturalistic understandings of breastfeeding:

> In this sense, 'natural' refers to the biological or physiological functioning of the female reproductive body. Breastfeeding, however, is not understood as natural, in the sense of an innate, effortless, or involuntary biological act; rather, most new mothers require a great deal of guidance and support for successful breastfeeding. (p. 215)

Kathleen, like Jemma, sees breastfeeding as a part of spiritual experiences of mothering, womanhood, and women's biology. For these participants, breastfeeding support comes from a place of personal altruism and a reverence for the natural.

How do we reconcile the discourses associated with the "natural"? There is beauty and efficiency when breastfeeding is uncomplicated. There is beauty and efficiency when joyful mothering exists even in the milieu of complexity. I sense that invoking the 'natural' is associated with a choice, but for some, breastfeeding (as a natural action) is not available. Too many aspects of care are assumed to be a matter of choice! What does support look like for the mother whose choices are pre-determined and not "natural"? Badinter (2011) says: 'Nature has become a decisive argument for imposing laws or dispensing advice. It is now an ethical touchstone, hard to criticize and overwhelming all other considerations' (p. 61). And yet, so much of this discourse is about reifying "nature" and the "natural," we sometimes forget that "Mother Nature" is not always kind.

Good Mothering/Good Nursing

Marshall, Godfrey, and Renfrew (2007) state that, "Within medicalized expert discourse, breastfeeding has assumed the status of moral imperative, inseparable from the conception of 'good mothering'" (p. 2147). In the course of the conversations with nurses, the term "good mother" arose spontaneously among participants. Many participants noted that good mothering is closely equated, in their minds, to the ability to breastfeed infants. Ingrid alluded to good mothering in the following passage:

> Some people are blown away (when they resort to formula) and they feel like a failure what it seems to come down to is, 'I can't nourish my child. I am a failure. I am unable to nourish my child and therefore a failure as a mother.' I see that and feel that kind of deep sadness and sense of shame and failure. And we see, in all of our other children that parents get the most wound up and the most upset about feeding issues. A hundred percent. It doesn't matter how old they are, doesn't matter how young they are. Mothers get really worried about feeding…..It's all about feeding and mothering. You're a good mother if you feed your child. And your child grows and thrives, and if you don't, you fail. So I think that's the bottom line.

As a result of my conversation with Ingrid, I have come to consider that, in certain situations, the infants of mothers who do not envision any option for infant feeding other than breastfeeding could be jeopardized. As Ingrid described, infants are at risk for dehydration and hyperbilirubinemia if nutritional needs are not being met. The message that exclusive breastfeeding is doable for every woman could, under certain

circumstances, present immediate risk. The context of "immediacy" must not be underrated by paying undue attention to claims about the long-term health risks.

Formula is not hidden in Ingrid's practice area. The mother/baby dyads who arrive at the pediatric unit are already nutritionally compromised. In this situation, does Ingrid ever encounter women who are unwilling to comply with formula use? No. Does she ever encounter nurses who attempt to discourage formula in light of continued efforts at breastfeeding? A smile and a reassurance. No.

Clearly this is a different culture from the one that exists in the postpartum unit that is steps away…yet a world away…from the pediatric unit. Is it possible that mothers and nurses are actually able to relax into an alternative to breastfeeding when bio-medical influences dictate? I wonder how mothers make sense of a message of support for taking an entirely different course than what was encouraged in another setting only days before? The dogmatic yet persistent call of scientific privilege alerts me to the risk of inconsistent messaging.

As I listen to Ingrid, I am comforted by the peace she emanates as if, by extension, I can relax into a phrase that encompasses the complexities of infant feeding support. "Feed your baby" and all will be well. I became increasingly interested in the relationship between infant feeding support and "good nursing." As I review my texts, the conversations suggest that infant feeding support is closely equated to notions of good nursing. Each participant, however, identified particular struggles in their attempts to achieve good nursing.

Rita discussed the importance of responsiveness to mothers:

> I think it's (breastfeeding) is an amazing experience when it goes well, so to me, being a good nurse is becoming more in tune with that woman, being more in relationship with her. And knowledgeable about the risks that the baby is facing. And somehow making decisions with her and guiding her, but always being very responsive to her. I suppose that's the thing that's changed; my responsiveness has improved. It probably has a ways to go. But I used to get a niggling feeling in my gut that I'm upsetting her. I can feel her resistance. She's frustrated. She's getting angry now. And I'd know that and I'd push through it. That's what I mean by saying I'm pushing my agenda. Not that those words were ever spoken between us, but I could feel it. And you know what I mean, you can feel it? And now when I get that, I stop. And it's okay to take a break.

Kathleen elaborated on the importance of the non-verbal communication as a key component of excellent nursing care. She talked about the ability to lower one's voice when telling a woman something that is difficult for her to hear. She also emphasized the importance of approaching a woman with gentleness and sensitivity. In the context of my question about "good" nursing, Kathleen stressed the need for inexperienced nurses to empower and trust themselves. She emphasized that it was important for nurses not to take over in a given situation since that makes mothers feel disempowered. As she noted:

> There was a time when a 'good nurse' was the one who spent a lot of time in the patient's room, and helped the woman hold her breast, and dribble milk on the baby's mouth. No more. I always tell the parents how to do it. I show them how, but I don't do it for them anymore. The good nurse is the one who shows the parents to trust themselves.

Tickbox nursing. My dialogue with Olivia evolved into a discussion about the mechanics of enacting infant feeding support, including the checklists that nurses use to document patient teaching. For her, it ensured that a number of topics related to infant feeding were "covered" including the risks of formula. Olivia offered a vision of good nursing care where women received the necessary information so they could make an informed decision. She alludes to nurses' desire to help women make sense of confusing information in the context of their own lives by adhering to BF guidelines. She said:

> There are these beliefs among some cultural groups that colostrum is not very good for the baby, that it's not enough for the baby. So when mothers ask for a bottle of formula, I find that it's helpful to have a document to go over and then I'll say to them, of course, I'll bring your formula, if that's your choice, but I just need to make sure you understand the risks. And when you check your choice, I'll have it in the chart so that all the nurses following me will know we've already reviewed the document and they don't need to discuss it with you. So I feel that checklists are useful for that…

As a public health nurse, Helena discussed the ethics and implications of administering screening tools. She outlined what sorts of questions are asked during the process of assessment:

> I would have to say that my colleagues question the validity of going through a screening process. And not all women feel safe. Women aren't stupid. So they read, for example, just the registration sheet. It's got a number of questions and, depending on the answer, public health nurses might invite a woman into a relationship and start home visits during pregnancy. But not everyone's going to

> fill that form out when it's baby number two and maybe they've had some involvement with the Ministry of Children and Family and now this form arrives. Their doctor gives them a form. Gee, why don't you fill this out for Public Health Services? And they're asking about whether you've completed your grade twelve education, whether you have someone that supports you and can drive you to visits. What your mood is like. I'm not so sure they're going to feel all that comfortable filling that form out. Who's getting this information? Where's it going?

It is challenging to feel like a good nurse when there are so many obstacles and complications. I remember countless times when I was at the bedside with a checklist on a clipboard. Perhaps I was looking at my watch and planning my next task. I am trying to be a good nurse but, over time, I begin to see the checklist is woefully inadequate as a panacea for good nursing. It cannot capture the complexity of nursing care.

Later in our conversation, Olivia addressed her concerns about disseminating information to mothers that outlines the risks of formula:

> Where I found it difficult was if I reviewed the document with the mom who was intent on breastfeeding. She just read all about the risks, but she's still ticking off breastfeeding and then suddenly her baby's blood sugar drops, and I say, I'm sorry we don't have access to Human Donor Milk. I have to give your baby formula to bring the blood sugar up and then she's broken hearted and scared because she's just read the document about all the risks of formula. So that's an example of where I found the document not very useful at all. Because now I've scared her and I'm saying 'You have to give it in order to help your baby.' So that

was always a struggle.

Staying the Course and Navigating Conflict

Participants identified the challenges associated with their decisions to practice nursing and engage in infant feeding support. Many recounted times when their commitment waivered because of the many complexities that I explore in this study, including the potential for conflict with other practitioners and sometimes with mothers.

Gloria experienced inner conflict when it came to infant feeding support, since historically she had followed the "rules," for example, in her prenatal classes by not talking about formula. But she struggled with that expectation, knowing that her position and security in that position could be compromised. Her teaching did not fully reflect her perspectives. The security of her position is now at risk because she discusses formula. With reference to medical evidence, she believes that it has merit, but feels it must be overrated, given that a whole generation of people was raised on formula.

Nurses navigating moral distress. It seems that, in many cases, participants' experience with infant feeding support involved significant moral distress. For example, Jemma expressed intense frustration with her workplace, which is a busy post-partum unit where many of the typical medical interventions (surgery, catheters, intravenous therapy) occur. The culture of her unit interferes with the kind of support she aspires to practice. She said:

> Yeah, I have big time distress. The very first buddy shift that I had with another RN, halfway through report I had to leave because I was crying. I was not used to the way that moms and babies are treated. And I had my own kids at home with midwives and I had a great experience postpartum and then with La Leche

> League support and everything, so it was really difficult for me to hear the way that moms were birthing.

Jemma's engagement with the La Leche League evolved in a natural way, and she described how her involvement in the organization influenced her:

> Jemma: I have a community focus because of all the volunteering I do with La Leche League. I like postpartum, but it hurts me a little bit inside at times.
>
> Researcher: Tell me about that.
>
> Jemma: Well, it's just so difficult to actually help moms with what they really need help with. It's so busy. We get five dyads each and that's too busy, I find. You can't do what you need to do. You can only do what's on the tick sheet. And then I'm very passionate about helping moms breastfeeding, so that's what I try to do with them.

Later in the conversation, Jemma described working with mothers who are feeding their infants with formula. She said:

> Almost all of them have had birth interventions. So they'll come with catheters and IV's and things that are making it more difficult for their breastfeeding. And there's just a lot of formula! If someone is a second-time mom or something and they had troubles with the first one, they automatically want to go to formula. And unfortunately, it's just like 'well okay, of course, it's your choice, but you don't have any opportunity to…you just say yeah, okay, like you're kind of happy about it. You're a bit relieved because there's more time freed up for you to help someone else.

Jemma's candor opens me to her distress. I understand what she is saying. I picture her well-meaning efforts trying to care for too many mothers and infants in a given shift, and in an environment that appears to lack consistent approaches or encourage professional dialogue. She is trying to help women breastfeed. As I listen and consider her words, I recognize the pressures that nurses face in day-to-day care delivery.

Lorraine also identified the limits of the workplace to enact excellent practice:

> Breastfeeding teaching takes a long time. Breastfeeding support is hard work-it's a lot of hard work. And bottle feeding, well, almost everyone has done it at some point, so it's almost second nature for people. So to throw a bottle in a parent's hand, it's almost like you don't even have to be in the room; you just do it and leave. With breastfeeding you have to position, talk them through it, make sure that they understand and their partner is supportive, and all the rest of it.

During our conversation, Jemma expressed both understanding and frustration when she described her interaction with a mother as a La Leche League (LLL) volunteer. I had asked Jemma about what dilemmas nurses confront when they try to encourage women not to give up, which sometimes leaves the impression that they are coercive or biased. Our dialogue evolved into a discussion about a mother's history of sexual assault:

> That one, I don't how that strikes me because I know definitely there are women out there that if they didn't have the support on and on and on, they wouldn't meet their goals. Definitely, it's so hard with depression. And also I feel like there's a major influence of sexual assault that we do not recognize. That makes it damn near impossible for some women to breastfeed. [Here Jemma describes a woman who had not made her history of sexual assault known to many people,

but it was known to Jemma.] She was fixated on over-active letdown, but it's not really the problem. So, you know that her underlying issue was her incomplete understanding of her breasts and plus she's also single and depressed. So all of this, but she projected it all onto breastfeeding as if everything was because of breastfeeding. And she did that just because breastfeeding's hard. Not because of her history. Not because of her depression. Not because of anything else that was going on. Because of breastfeeding! So then a lot of times when there's these profound failures of breastfeeding, but we really don't know what's going on. And then she said online afterwards that she got all the help she could; she stopped breastfeeding about four, five months in. She said she had received all the breastfeeding help that she could. She said she went to La Leche League, but I just felt like, really, you're saying that we couldn't help you. But that's not really true. And we've talked about it before, with other leaders, moms cannot, I mean I would never expect them to, but they won't say: 'I don't want to do it.' Or to say, 'I was molested as a kid and I can't stand anybody touching my breasts, and I'm not going to do it.' They're not going to say that. There's the odd woman that does, but really, they don't say that. And they blame the breastfeeding (problems) because what else do you blame it on? It's really more complicated than that.

Adherence to evidence-based rhetoric in the context of informed consent can also obscure other forms of evidence that bear consideration. For example, women may live with histories of sexual abuse or mental health challenges. As Jemma indicates, women may lack the will to try or continue breastfeeding for reasons that may never be disclosed. However, if diversity and vulnerability are not recognized in the context of evidence-

based-practice, the unintended consequences can be troubling for women who are in need of sensitive and thoughtful nursing approaches.

I am reminded of the history of LLL as an example of an organization that originated at the grassroots level among a group of mothers in the US, and now has global influence. According to Weiner (1997),"The La Leche League reconstructed mothering in such a way that was both liberating and constricting and so ironically offered both prologue and counterpoint to the emerging movement for women's liberation" (p. 383).

Jemma honors LLL imperatives to support breastfeeding. Was it depression, history of sexual assault, or a "real" breastfeeding problem that caused the mother she spoke about to stop breastfeeding? I wonder how knowledge of a woman's background, or lack thereof, shapes practices. I also wonder if it is possible to tease apart the reasons. I sense that Jemma is struggling to reconcile situations where infant feeding decisions appear incongruous. In my own practice, I have learned that women are often unable to articulate for themselves the reasons for decisions. It is challenging to understand our patients' decisions at times, and it is difficult for nurses to let go of perceived needs to understand what lies behind a mother's actions. There is often more at play than what initially meets the eye. Jemma's journey unfolds, but I am at a different place. I understand that I don't necessarily need to understand everything about mothers' decisions.

Jemma continued her conversation about her involvement with breastfeeding support:

Jemma: Nurses have so much influence, and nurses do come up quite a bit at our La Leche League meetings. And I don't necessarily mention that I'm a nurse.

Researcher: (Laughing) So, you're leading a double life, in other words.

Jemma: I'm a mole. A lot of women mention their nurses as a big part of their journey, if it was either positive or negative. And unfortunately, it's a lot of negative. And then, not all nurses are bad, but we have such a strong influence. Theresa Pitman says about new moms: it's like they have no skin. They're so vulnerable and we have to be so careful about what we say. And I know for sure, there are a lot of nurses that work in my area that have never had children. So you don't necessarily understand it in the same way, about what that little word of encouragement means to someone. *Or how the well-meaning persistence of a nurse 'not to give up' can be interpreted as coercion.* Or that little mention of, don't let the baby use you as a pacifier. How deeply that can sink in and engrain in someone.

Olivia related the distress she feels about discharging mothers before their breastfeeding has been established. She articulated:

These moms are discharged from us-we keep them twenty-four hours roughly, if they're a vaginal delivery. Forty-eight hours for a section. And they're leaving us. And then that's it, they're in the community. And there is, as far as breastfeeding help goes, there's a health unit, a two-hour window, two days a week. So I don't know-how can we stress the importance of breastfeeding on these moms and then send them off with no help? I think that's setting them up for failure and

> absolutely, horrible feelings of guilt. We've told them how important it is and then they're not successful, of course they're going to feel guilty.

I suspect that the complexities of mothers' vulnerabilities could unravel in the context of nursing practice or a La Leche League gathering. I consider the need for infant feeding support to develop with advanced levels of wisdom and sensitivity. Suggesting formula feeding may introduce doubt and undermine a woman's confidence; not suggesting formula feeding can be understood as imposing societal expectations.

Challenges with language. Participants referred to the need for caution when talking to mothers about infant feeding. Ingrid referred to the exquisite vulnerability of new mothers, and the need for sensitivity in linguistic approach. She said:

> And for a woman that's a new mom, that mother is going to hear one sentence and it's going to stick in her head. I think the problem is that people who are teaching this stuff (referring to nurses' goals to keep women breastfeeding) are emotionally invested. There's a right and a wrong, and there just shouldn't be.

Noreen elaborated:

> Whether it's their choice to bottle-feed or whatever the choice is, I think our language has been detrimental to a large part. And when you're trying to shift the pendulum the other way, from a bottle-feeding culture back to normalizing breastfeeding there is some fallout. And there are definitely some zealots I think who take a hard line.

I wonder, though, what it looks like to be a "zealot" and to take a "hard line." When we have strong views about breastfeeding and/or breastmilk, do we see ourselves as zealots? Or are the zealots always someone else?

Noreen expressed her frustration with being misunderstood by mothers. She said:

> I'm trying to pay attention to not being hardnosed one way or the other. And I think (trying to breastfeed before making up their minds) allows moms an opportunity to think through the feeding instead of immediately saying 'I've been made to feel guilty.' I'm not trying to undermine mental health issues or depression, because I know that's very complex and very serious. But it's also frustrating as a health care professional to say that I've made her feel guilty, when I've actually just tried to explore. That's not my intent at all and I'm trying to carefully watch my language.

I also see that language is important. Noreen's excerpt reproduces assumptions about what is "normal." In other words, consistent with the BF recommendations, there is an attempt to construct breastfeeding and breastmilk as optimal and normal.

Olivia shared her sentiments about meanings of "normal" as they apply to infant feeding support:

> I'm not sure how to articulate this. But if breastfeeding is the normal way to feed your baby, then that makes formula feeding abnormal. Yet I feel as though in society still, the way that society thinks of feeding a baby (with a bottle) is still normal. So then if the bottles are normal then I think you can argue that women who breastfeed also feel abnormal. For example, feeding in public, I think that society still sees bottle-feeding as the normal way to feed a baby in public. So then those moms either have to set themselves away or battle that. And feel abnormal about breastfeeding their baby in public.

I think there are two sides to this coin. I heard another lecture from someone who referred to the fact that breastfeeding is the biological normal. That can't be disputed. But as far as the word 'normal' goes, there's so many ways to interpret that. I've just started to think about this, using this word, and the way we use that language, is that fair? I don't know.

Women are considered abnormal for bottle-feeding and ridiculed in public. Women are considered abnormal for breastfeeding and ridiculed in public. What is wrong with our society? Why can't women feed their infants and celebrate mothering without fear of ridicule or being judged? Olivia's perspectives are thought provoking.

It is interesting to interrogate the notion of "best practice" especially as it pertains to the language and assumptions about mothering. For example, the slogan "Breast is Best" pervades pro-breastfeeding publications (Murphy, 1999). But the word "best" may reinforce the binary that suggests that women are either feeding their babies in the best way or in a way that is perceived to be substandard. The language that pits breastfeeding against "artificial" feeding constructs formula is "second best," which can have detrimental consequences when it comes to fostering confidence in mothering.

Noreen reiterated her frustration about language:

I don't think it matters what language you use, you're going to offend somebody. *Nathoo and Ostry (2009) state: "Historically, breastfeeding promotion has been open to the same critiques as the majority of other health promotion activities,* I think through at least over the last fifteen, twenty, years, they've tried all sorts of different language and someone's been offended *namely, that it is individualistic and victim-blaming" (p. 206).* I don't know how you can get around that.

Noreen's frustration with the language of health promotion, and Nathoo and Ostrey's remarks depict a tension that is difficult to diffuse. How can we promote health without assigning blame? Given institutional expectations to enact BF approaches as well as the presence of breastfeeding promotional literature that is widely available to women through publicly accessible means, it can be difficult for nurses to moderate the messages they convey to mothers. Many mothers report that the message from nurses is clear: formula use does not align with idealized notions of mothering (Beck, 2009; Humphries & McDonald, 2012; Martin & Redshaw, 2011; Shakespeare et al., 2006). Perhaps ***this*** *was the beginning of my hermeneutic address.*

Am I any closer to understanding what may be "at play?" What did Gadamer actually mean when he suggested that phrase as a conduit to understanding? So far, my interaction with the texts has revealed many fascinating perspectives, but there must be more to this exercise than collecting interesting comments. I need to persevere, keep unpeeling, keep uncovering, keep searching. My senses must guide me.

Perinatal Nursing Practice and the Health Care System

Olivia spoke about the expectations that exist in the broader context of health authorities and our health care system:

> Olivia: How, if they're (the health care system) saying it's going to save billions of dollars in the long run if more children are breastfed, because of the health benefits later in life, then I think that the government does have to encourage breastfeeding. But I also think that the government doesn't do enough to help support the moms who are trying their best to give it a go and are really struggling. I think there aren't enough resources for them in the community to make it, to be

successful.

Jung (2015) addresses this issue and cites an article in 'Pediatrics' (2010) medical journal that claimed that the 'failure to breastfeed cost the United States $13billion dollars/year in health care costs, infant deaths, and the lost lifetime earnings of those dead babies.' (p. 9) Jung goes on to dissect the fallacy of these and other claims that make direct links between not breastfeeding and long term escalating social costs.

And yet, Olivia expressed some doubt. Despite the messages conveyed about the dangers of formula, under some circumstances, health care providers recommend it:

> Olivia: Exactly. The health authority has to get on board too. And either change the language and stop advertising it as such a devastating issue, that feeding a baby is setting it up for life-long health risks. If that's not the case then we need to stop saying that.

Olivia is calling for clarity about what is true and what is not. But this truth, it seems, is not so easily revealed.

Self-Reflective Nursing Practice

I asked Lorraine if she had ever experienced a time when a woman told her she felt coerced by her support for BF guidelines. She responded that no patient had ever said it about her, but she had heard women complain about other nurses. Her words generated further questions about our ability to be self-reflective and see ourselves as others see us. Lorraine shared an experience that verified my unease:

> I haven't had patients say that to me (that she was coercive). I've had friends definitely say that to me. And they've delivered where I've worked. These friends tried everything-domperidone, lactation consultant, and never produced enough

> milk. Never, never, ever, ever. So the second time, she said 'I'm not going through this. I tried my damndest. I'm not doing it again.' And she said she felt like, in postpartum, they negated everything she had already tried in the past and basically said, you should be trying this again. And she found that was very hurtful. That was a very difficult decision for her and it had been long and hard and she shed a lot of tears. And then to have them make her feel like it was the wrong decision was not fair. So I have heard that for sure. So I think they need to be cognizant of where people are coming from and what led them to arrive at the decision that they made and actually ask them, 'can you tell me more about your choice to bottle feed,' without sounding like you're trying to trip them up on saying that they made the wrong choice. But just say, 'I want to understand better.'

I was stymied at this moment in our conversation and could not respond. Why does a nurse need to understand what may be a private decision? In reflecting on the conversation, I realize that if a nurse told me that she wanted to "understand better" what my infant feeding decision was, I would feel coerced. The supremacy of breastfeeding practice and nurses' desires to enact visions of good nursing must surely be at work here.

Lorraine was clear that it was wrong for nurses to push women too hard with the BF guidelines:

> There are definitely people who are more on board with BFI type things than others. They tend to be the people who breastfed in their personal life or who tend to be more supportive of the natural process of labour and birth. Especially anyone with a LC (lactation consultant) background would be more on board.

> And so some of the ones who aren't (on board) tend to, 'oh, you're over reacting, or you push everyone into this way.' Or the other way-you let everyone bottle feed without explaining. You do hear some of that stuff.

You "let" everyone bottle feed without explaining… what?

I asked Lorraine about the issue of informed consent and the complexities associated with that, but I failed to engage Lorraine in that dialogue.

It is sometimes difficult to engage my participants in the questions I have. Is it possible that as nurses we find it impossible to see ourselves-and our practice-clearly? No nurse that I know would intentionally coerce, and I suspect any nurse would be mortified to think that may be how she is being perceived.

My thoughts shift to 'Tit-Nazi's' and 'Breastfeeding Czars' These descriptions of nurses emerged from somewhere, but where? They are, no doubt, used by mothers and nurses who feel silenced by breastfeeding advocacy that is perceived as too rigid. But how to argue when the facts are so clear? Whispers in the community, and whispers on the night shift about the nurse who "pushes breastfeeding" but never, it seems, a conversation. Only whispers.

Mothers who are unlikely to complain. Nurses who are stymied.

In my journal, I wrote:

> One of the things that has emerged out of this research process is that nurses do not see themselves as the "ones" who are viewed by mothers as coercive. Nurses may agree that women should not be made to feel badly about their choices, but fail to recognize problematic approaches that they, themselves, enact.

Social, historical, and discursive conditions of hermeneutic understanding congeal in hermeneutic spiraling. So many thought provoking ideas-so much inspiration! I contemplate the task ahead, for I must now make further meaning of the conversations. I must make sense of it all.

Chapter 5: Coming Up for Air

That day at the beach seems so hard to recall

I've seen so much that I must share

A world lies beneath, but I long to breathe deep.

I am rendered aghast while suppressing a gasp.

A world so alluring, my senses are stirring.

But now I must come up for air.

I have conversed with nurses. In Chapter Four, I conversed with participants' texts, framing theoretical and reflective comments in a dialogic relationship. In part, my responses reflected the temporal aspect of seeking a fused horizon of understanding. To reach the horizon of understanding, however, remains an elusive prospect, for no horizon can ever quite be "reached." Nevertheless its vision remains ever-present.

I begin Chapter Five by re-visiting the research experience using metaphoric poetry about struggling to breathe. I integrate some analysis in the process, since my experience as the researcher is very much enmeshed with the understanding I work towards. As the chapter progresses, I access Grondin's (2015) suggestions about "sensing" a way forward or, in this case, back towards the shoreline, with renewed insight. The chapter includes final thoughts about the research, including limitations and ideas for future study. I conclude by discussing the principles of Reproductive Justice as a possible fulcrum from which to progress.

Key themes include descriptions of the research process, participants' disclosures, and interpretation. I integrate my interpretations throughout the discussion. My analysis

is both retrospective and futuristic. The temporality of understanding is a persistent companion in my quest to find meaning in nurses' experiences of infant feeding support.

How Do I Find Myself Here, Treading Water?

The work of staying afloat continues. I have travelled around circles of understanding only to find myself here, treading water, wanting to take stock, re-focus, and find my breath again. In my conversations, I encountered currents that catch nurses in their practice. Their words "caught" me. The undertow of unintended consequences carried me to unexpected places in my research. At many junctures, I doubted the efficacy of my concerns and I wondered about the importance of the work I have done. Am I mistaken in suggesting that dilemmas associated with infant feeding are as important to women and nurses as I claim them to be? Have I wallowed in a "First World" problem? The valorization of science presents itself as a current that sweeps me along at unexpected moments. Science is a seductive influence, but I remind myself that scientific questions are only part of the whole. Other questions needed to be asked in order for me to breathe easy.

There was turbulence associated with the participants' disclosures. Taken-for-granted ideals of best practice were, at times, displaced in the dialogue, and replaced with wonderings about what might be helpful. Many participants discussed their attempts to circumnavigate whirlpools of bullying, challenging nursing conditions, corporate approaches to care, and divergent attitudes. Some found peaceful waters in the midst of the turbulence. Each participant presented evidence of personal commitment to excellent nursing care. The discursive currents of evidence-based care, interdisciplinary input, outcome focused actions, power relationships within professional nursing, informed

consent, risk, and feminist discourses of essentialized, "natural" mothering were embedded in the conversations. They attract ongoing analysis.

I find meaning by considering the conditions for understanding, for nurses allude to the currents (and the current forces) that have the potential to impede optimal nursing care. My understanding is contingent upon my facility to assimilate the many forces that are at play.

I wanted to see past the mist: Surprises and epiphanies. I found myself, at times, considering the difficulty of the task that I had undertaken, for the depths of complexity that are associated with infant feeding support are formidable. The diversity of perspectives and approaches among my participants made it difficult for me to make meaning of what I was hearing and reading, and see the "whole" amidst the "part." It was important for me to work towards understanding in an enigmatic milieu. The mist was thick and the vision remains clouded. Social, historic and discursive conditions of understanding dart through the conversations and through consciousness.

The presence of Dasein is implicit. Within each participant's dialogue, there are indications that infant feeding support is intrinsic to their nursing practice, their profession, and their existence. My frame of reference, in the context of philosophical and theoretical discussions of the issue can easily revert to binary understandings, as though one form of infant feeding is mutually exclusive of the other. My conversations with participants demonstrated that this need not be the case, for many participants advocated for the temporary use of formula under certain circumstances. Some participants found it difficult to address situations when formula was appropriate. The

divergent messages found in BF guidelines have the potential to weaken trust in health care professionals when formula is medically necessary.

In many cases, dialogue with participants does not surprise me, for their comments often reflect what I have problematized about infant feeding support. Reconciliation and resolution elude me. On other occasions, however, I was startled that many of my participants did not engage with my questions about the impossibility of exercising "autonomous" informed choice. As discussed, when breastfeeding is so highly promoted, and because there are so many influences at work in society to support breastfeeding, it is difficult to fathom that informed choice can occur. Gustafson and Porter (2014) draw on intersectional insights when they say:

> Autonomous choice assumes an atomistic individual disconnected from all other external influences and relationships, to say nothing of their social location. Autonomous choice also presumes that decision-making is without moral conflict and can be freely undertaken, ignoring influences from multiple powerful sources. (p. 23)

Divergent currents collide, complexity is exposed.

I wonder if nurses interpret informed choice as a signal that absolves the need for further support. As Helena said:

> The approach is very medicalized and scientific, and it's almost like 'We don't want to be responsible for your poor choices'. So we don't want to be held responsible, because really, it's the mom's life, it's her baby.

Much may lie beneath the surface for this mother. She may be living with significant disappointment and regret over her failure to achieve successful breastfeeding.

I wonder how care would shift if nurses considered *other* questions related to a mother's well-being. Helena's insight is striking. My ruminations include the possibility that once a woman makes a choice, it is considered to be an informed choice, and nurses see themselves as absolved of the responsibility to address the mixed messages about the dangers of formula. If there is no attempt to address a mother's need for reassurance, nurses may unwittingly contribute to her emotional fallout, especially if the mother thinks she if feeding her infant with a risky substance.

It's her (poor) choice. It's her life. It's her baby.

Keeping My Head above Water

It was daunting to surface after I was caught in the undertow of the unexpected. In many cases, my response to the dialogue was also unexpected, as I attempted to find ways to understand comments that I had challenged in the past. The aim to identify conditions for understanding sustained me. In some instances, the understanding was intuitive and immediate in the context of the entire conversation. In others, understanding came only with engagement with the texts. Here too, individual comments assumed meaning in the context of the larger conversation-the ebb and flow surrounding the part and the whole was lived out in my quest to achieve understanding.

In the course of the conversations, I would be fascinated, but the hope of making meaning of the part in the context of the whole eluded me for quite some time. I needed to assume a more remote perch.

On the history of feminist interviewing DeVault & Gross (2012) say:

Looking back, we can see that these efforts were sometimes flawed by a failure to work out the broader politics of the 'personal'; that is, the institutions, processes,

> and interactions shaping women's experiences were sometimes overlooked, and the unequal relations among different groups of women were often unaddressed. (p. 210)

This quote pertains to my dilemma, since the research dialogue shifted back and forth between nurses' personal approaches and the unique environments of the maternity settings where they practiced. Jemma, for example, highlighted how environmental demands influenced practice decisions. Others describe the effect of peer dynamics.

I was frequently reminded of the richness of nursing practice and my own nursing career, which spans decades and occurred in many locales. My age and experience positions me in a particular way to make meaning. As I was engaging with my participants, my own history as a perinatal nurse in both rural and urban settings offered a place to begin the interpretations.

At the end of many exchanges, I would "know" that it was time for the conversation to end, but overall understanding would elude me. I had failed to reach a comprehensive understanding in the moment, but the comments had been rich. I had faith that, with time and over the course of many interviews, insight would emerge about what was "at play" among nurses. For predictable and extended periods, I was unable to glean any sense of what I might offer to the broader conversation about infant feeding support among nurses. However, I was sustained by the hope that there would be important things to uncover about nurses' participation in this area.

When I consider how meanings became co-constructed, deliberate on the infinity of the unsaid, or honor the listening that enabled exquisite negotiation of shared understanding, I do so with the knowledge that these dynamics occurred between two

women, who were discussing professional practice that involves other women (who are mothers). It was a privilege to speak with these dedicated nurses-these women - and I leave the experience with a sense of gratitude about what I gleaned. Just as DeVault (1990) observed, there were times when my own emotions and frustrations drove the conversation, and other times when I exited the interview feeling humbled, knowing that I had born witness to professionalism and dedication beyond my imaginings. In keeping with feminist thought as well as Foucauldian notions of power, I was conscious of fluctuating power dynamics between the participants and me. At times, participants alluded to my doctoral aspirations with a sense of awe. At other times, participants demonstrated their own professional confidence and challenged me. I found myself resisting the impulse, at times, to correct or argue. Perhaps, though, this is the stuff of the fused horizon of understanding. The "back-and-forthing" of hermeneutic dialogue assumes many dynamic layers.

When participants made comments that took me aback, the context of their experience, and my own, helped me to sense what was at play in a way that I might not have been otherwise able to. I strove to keep my head above water. When nurses speak of the day-to-day challenges involved with staffing, overcrowding, and unreasonable workloads, I understand how that can distract nurses from providing optimal care. I know the feeling, as a nurse, of doing the best that I can under circumstances that are less than ideal, and participants' descriptions of their working conditions, often rang true. My constituted nursing history was indeed an active participant in the interpretation.

I will not pull anyone down. I wondered about my interviewing style and my desire to make the participant feel warmly welcomed into the interview (DeVault, 1990).

As DeVault points out, participants may not always associate a research interview with relationship building and friendliness. Normative white privilege and how I am implicated in it may be at play as I consider my participants. I also wondered if the research process intimidated some nurses. Did they view me, the researcher, as an "expert?" At many times during the conversations, these educated and capable women would indicate their insecurity regarding the value of what they had said or question whether they were answering my questions "correctly" as if to imply a power dynamic between us that could be associated with the researcher/participant authority that DeVault and Gross (2012) describe.

This often meant spending time at the beginning of the conversation establishing rapport, and getting "a sense" of the participant. I also hoped that the participant would get a sense of me. In the conversations, I aspired to "open boundaries" and "create space" (p. 99) so that dialogue could reveal the reality of these nurses' professional lives. To me, the interviews seemed like interesting conversations I might have with colleagues over coffee or even with nursing friends when discussing aspects of our practice where there is shared passion, questions, or insights. All of this reflected a kind of research interview that mirrored "everyday women talk" (DeVault, 1990, p. 101). Only in this case, the "talk" was among nurses about nursing!

DeVault (1990) also spoke about the "personality" of the participant. I intuitively attempted to honor that while engaging. As I reflect on the dynamics that often characterized the conversations, I recognize that dialogue transpired in spontaneous, human, and perhaps *womanly* ways - a perspective that reflects DeVault's attention to women's relationship with language and conversation. I treasure the possibility that my

conversations did not devolve into a more "strategic" and less genuine dialogues. All of these dynamics unfolded under the backdrop of Gadamerian hermeneutic dialogical intention:

> Hermeneutics is dialogical in its orientation because it takes the view that the other might be right. Hermeneutics is dialogical in its intent because it seeks, not to have the last word, but to keep the conversation going. Hermeneutics is dialogical in its method in that it is driven by the interplay of question and answer. (Moules et al., p. 68)

The above purposes, both at the moment of the conversations and, upon reflection, greatly assisted me. It was not my intention to judge or critique the participants who were giving so generously of their time in the interests of improving nursing care. However, as a researcher I do have a responsibility to identify problematic practice and perhaps disrupt dominant discourses that may compromise care. The exercise of seeking understanding proved to be rigorous and, at times, uncomfortable.

I attempted to engage participants by discussing the possibility of unintended consequences. In some instances, participants engaged with those ideas, and, in others, they did not. In the moment, I was left with a choice as to how much to press a particular question. I knew that it takes courage to disclose certain ideas and I was cognizant of the need to maintain participants' trust in me during our conversations. There is a tension between these impulses.

I wrote in my journal:

> This evening I went into the conversation after a very long and challenging day at work and hoped that the interview would be over with as soon as possible. Instead,

> we talked for almost two hours! It's far too much data-there is enough for my entire dissertation in this one interview- but the longer we talked the deeper the conversation became. Some of the dialogue took me aback, and I found myself blindsided. How to respond? How to make meaning? I wouldn't want to miss out on much of what was said, but I am curious about the amount of time that it took to establish trust and engage with the comments that shocked me. What if I had cut the interview short? I would not have nearly as much to think about. As I reflect on the interview a couple of hours later, I am immersed in what I must interpret. I must return to the interview, read the text, and listen to it all once again.

Gasping for Air: Examining the Meaning of Support

Well into the interpretative process, I began to question what I meant by the word "support." DeVault (1990) addressed the inadequacy of linguistic terms that adequately describe women's "work," and I was called, in the course of my analysis, to re-consider the meaning of the word "support." In the context of "infant feeding support, " the term is laden with pre-conceived assumptions about nurses' contributions. I make the assumption, for example, that "support" incorporates many aspects of caring for women and their infants, including infant feeding, but also including a myriad of other sophisticated nursing skills. Decision making, leadership, empowering mothers, interpretation, listening, intuiting, teaching, reassuring, and executing knowledge are only some of the activities that make up nurses' activities. However, the word "support" could be interpreted as a less essential aspect of nursing presence. Is it possible that I chose a woefully inadequate term to depict the complexity of nurses' offerings?

The online Encarta Dictionary (English, North America) defines support as: "to keep something or somebody upright or in place, or prevent something or somebody falling" and "to give active help, encouragement, or money to somebody or something" or "to give encouragement to somebody by being present at an event" and "to give assistance or comfort to somebody in difficulty or distress."

The Online Etymology Dictionary (http://www.etymonline.com/) suggests the noun "support" is derived from the verb (first documented in the late fourteenth century) and means "to aid," "to hold up, prop up, put up with, tolerate." From the Old French word, "supporter" means "to bear, endure, sustain, support." The word is also associated with the Latin "supportare" or to "convey, carry, bring up, bring forward." Clearly the word and its implied meaning has a significant history in English and in the Romantic languages. Its history suggests a long-standing cultural expectation of human assistance.

In response to the hermeneutic question: "What is your experience of infant feeding support?" the participants responded in diverse ways.

Nurses' attention appears to revolve around breastfeeding promotion and support, since that activity requires much more time from nurses than educating a woman about formula preparation. In the latter case, a pamphlet about formula preparation and a word about positioning the baby may suffice. I speculate about the relationship between "support" and "dedication." Nurses' dedication is implicit when providing breastfeeding support. It takes time and energy to attend to mothers' needs, especially when they are struggling with lactation issues or issues with achieving a latch. As Jemma explained, in some cases, nurses are relieved when a woman is not breastfeeding, since it frees them up to help others. There is too much to do and too many to help. I understand, but I also

wonder how support for non-breastfeeding mothers is enacted. I wonder how nurses perceive a mother who is feeding with formula, especially a mother who has struggled with breastfeeding and "given up." Perhaps she appears not to need support. Perhaps nurses' disappointment over a mother's infant feeding choice is a barrier to support.

Participants conveyed what meanings infant feeding support entails. Support can be holding the baby in the correct position for breastfeeding. Support by promoting breastfeeding. Support by dripping milk from the mother's breast into the baby's mouth. Support by not holding the baby and dripping milk into the baby's mouth. Support by talking to the mother about positioning instead of doing it for her. Support by using syringes and tubes to deliver pumped breast milk to an infant. Support by encouraging pumping. Offering emotional support to the mother who is discouraged. Offering emotional support to the family around infant feeding issues. Encouraging women not to give up breastfeeding. Supporting women to make an informed choice. Supporting the notion of informed choice. Supporting women's choice. Supporting breastfeeding by limiting choice. Supporting BFI ideals. Supporting women who need help with breastfeeding. Support using language that is gentle. Support using language that reflects BF ideals. Supporting cultural differences. Support by educating about the risks of formula. Support by standing up to other nurses. Support by introducing new evidence-based protocols into the workplace. Supporting the baby's nutritional needs. Supporting the infant's rights to breastfeed. Supporting the mother's rights to breastfeed. Supporting mothers' need to sleep. The list goes on.

I wonder whether my research would have unfolded differently if I had used the word "education" or "choices" instead of "support." For example, "What is your

experience educating women about infant feeding?" Like Knaak (2006) and Williams et al. (2012), such a study would have focused on breastfeeding materials. "What is your experience of dealing with infant feeding choices?" That inquiry would have focused on choice - a worthy area of exploration that Nathoo and Ostrey (2010) and Sokolon (2014) each address. "What is the meaning of infant feeding support?" Although that was not the question that I asked, the participants often responded as though it was. Participants presumed a particular understanding of the word "support" in their responses. No one asked me what I meant by support and it only now, in the process of interpretation, that I discern multiple interpretations of the word "support." Perhaps the choice of that word ultimately contributes to my ongoing understandings about the messiness and complexity of the perinatal setting. Perhaps, too, the various assumptions that underlie notions of nurses' infant feeding support will be forever embedded in my understanding.

The topic of infant feeding "support" is in the news. The American College of Obstetricians and Gynecologists (ACOG) are in the media spotlight because, in their most current guidelines, they reference the need to support women who are not breastfeeding. On February 10, 2016, a CBC radio feature, "*The Story from Here"* interviewed two mothers who were responding to ACOG's highly publicized document (Retrieved from: http://www.cbc.ca/radio/thestoryfromhere). The women's responses were thoughtful. One mother applauded the attention to perinatal mental health in ACOG's 2016 document, and the link that was made between infant feeding difficulties and postpartum depression. She emphasized the influence that infant feeding has on a mother's sense of emotional well-being. She stated that "Mental health is still health," highlighting that there is more than "just" physical health to be concerned about in the

perinatal period. One of the women also noted that the new ACOG guidelines said very little, really, about supporting non-breastfeeding mothers since most of the document was about supporting breastfeeding. The woman mused that there was one insignificant statement "towards the bottom" of the document that mentioned the need to support non-breastfeeding mothers. The following appears to be the definitive statement:

> However, all providers should respect and support a woman's informed decision whether to initiate or continue breastfeeding as each woman is uniquely qualified to decide which feeding option is best for herself and her infant. (Retrieved from: http://www.cdc.gov/breastfeeding/pdf/optimizing-support-for-breastfeeding-as-part-of-obstetric-practice.pdf).

Two things may be important to consider here. First, the document implies that specialist physicians are the authoritative voice for infant feeding support. However, it is nurses, not physicians, who are most involved in the day-to day practice of this. Second, the meaning of the word "support" once again comes into question. I am drawn, with circuitous persistence, to the beginnings of my inquiry, when I first asked how we can support women's choices not to breastfeed when there is so much attention placed on the risks of that decision. I also contemplate the media attention that accompanied ACOG's statement (above), which is nestled innocuously in the midst of comments about the advantages of breastfeeding, the advantages of employing the WHO's Ten Steps, and other BF initiatives, in order for women to achieve their goals to breastfeed successfully. I wonder if, by framing infant feeding support using the language of "goals," there is an assumption that the goal will be and, should be, breastfeeding.

I extend the notion of support into BF language. The 2009 version of the BFHI document includes references to being "mother-friendly." The comment refers to supporting women who feed with formula, citing a desire to support the mother/baby dyad in the context of all infant feeding. For example:

> This revised version of the assessment includes specific questions related to the training staff has received on providing support for 'non-breastfeeding mothers' and what actual support these mothers have received. The inclusion of these questions does NOT mean that the BFHI is promoting formula feeding but, rather, that the Initiative wants to help insure that ALL mothers, regardless of feeding method, get the feeding support they need. (p. 24)

This statement is an example of a message that is difficult to comprehend. What exactly is meant by the intention to "support" all mothers? The document also attempts to be responsive to this language, by stating the following: "The importance of addressing 'mother-friendly care' within the Initiative was raised by a number of groups as well." (WHO, 2009 p.1) However, the term "support" refers to supporting the idea that breastfeeding is best for the mother as well as the infant, citing the research that aligns breastfeeding with lowered rates of cancer and heightened bonding with the infant (WHO, 2009).

I Just Need to Sense What's Behind

From a more distanced perspective and, in retrospect, I wonder if my conversations with nurses sometimes assumed essentialized views of mothers, situations, and approaches, as if we were aiming to find universal truths about infant feeding support. Of course, I would say that was not the intention, but I am aware of a human tendency to

look for those "silver bullets" that unlock a key to understanding. Hankivsky et al. (2010) warned of this tendency (Appendix IV) and, indeed, I recognized the need for caution. In the conversations, participants often spoke of mothers in ways that implied that a homogeneous approach was required, based on nursing principles that were founded on laudable ideals and passion for supporting women in the perinatal sphere. My questions, too, may have encouraged that tendency, since I asked about the meaning attached to certain nursing practices and attitudes.

With this insight, however, I am reminded of my own critique of global statistics that guide practice, and the way they imply that women's situations and living conditions are all identical. Importantly, the statistics often do not address the many variables that shape women's lives and those of their infants. For example, White (1999) explains that many of the babies, who reportedly die as a result of not being breastfed, are actually victims of malnutrition because the formula was not mixed according to recommendations. Contaminated water supply, mothers' poverty, mother's literacy, and exposure to diseases are important variables that factor into infant mortality rates (White, 1999; Williams et al., 2012). However these are rarely highlighted when statistical risks associated with formula are reported. Clearly, many of the issues affecting women in Africa or marginalized Canadian communities are not shared by most First World mothers, yet the statistics of infant mortality are expressed as though the "risks" associated with formula are the same across the globe. Knaak (2006) contends that risk aversion has not been appropriately contextualized in breastfeeding discourse. She points to the tendency to communicate the risks of formula based on global epidemiological

studies, which are skewed by poor sanitation and clean water access, and therefore "unsuitable for the assessment of risk in the Canadian context" (p. 413).

Porter-O'Grady and Malloch (2015) approach risk from a nursing leadership perspective. Their words inform many levels of leadership, including leadership that occurs between a nurse and a mother during the moments of interactions between them:

> All decisions and actions are rife with risk. Risk cannot be eliminated and should not necessarily be decreased because courses of action that possess great value tend to be associated with higher risk. What is important to determine is not whether the risk can be eliminated, but whether the level of risk is appropriate for the actions undertaken and, if so, what strategies can accommodate the risk. (p. 29).

All of these ideas suggest a sense of what has been hidden and what needs to be revealed *(aletheia)* in order to better understand who are served by the guidelines and who may be left behind. Globally, only a certain strata of women are able to experience the benefits of BFHI strategies. Only women who are financially and socially privileged (Maher, 1992; Knaak, 2006) are able to access the resources required to sustain BFHI's idealized version of breastfeeding for two years or more, or even the minimum recommended time frame of exclusive breastfeeding for six months (WHO, 2009a). As such, the principles of social justice are missing in the BFHI guidelines. Many women lack the emotional capacity (Humphries & McDonald, 2012) to persevere with difficult breastfeeding, in spite of the many supports (such as breast pumping) endorsed by BF guidelines. Importantly, only certain clinical situations lend themselves to the dictates of

BFHI. The emphasis on risk and the subtext that good mothering occurs only in the context of breastfeeding raises questions of what it is to mother.

The View of the Shore is So Distant: Envisioning the Good Nurse

I was unable to engage many participants with the issues that I have been concerned about, such as the usefulness of universal guidelines and their capacity to address each mother's needs. Participants described maternity settings where there is little time, energy, or disposition to question the ethics of BF initiatives. Many participants appear to use them to serve mothers as best they can. However, mothers' responses to best practice guidelines, and the nursing approaches that stem from BF principles did not always occupy participants' attention.

Each participant was highly conversant about the challenges and joys associated with assisting women to establish successful breastfeeding. I was highly aware of nurses' desire to do their best. I am drawn, once again to contemplate Heideggarian notions of meaning that surround participants' ideas of good nursing. Each participant appeared to link their dedication to excellent nursing practice to personal conceptions of morality, all of which is realized in the context of their lives-their temporal existence-their *Dasein*. Rita succinctly summarized:

> I think we're trying to do the right thing. If I look back at my young self I believed everything and I was trying to do the right thing, and I was confused by what advocacy meant, in a sense. Advocacy for whom? I had this idea that if we could just push you through it would be better for everybody, and really believing I was doing the right thing. And I see nurses doing that, some of them. Doesn't matter where they are coming from, they're trying to do the right thing.

There are many indications that breastfeeding support is very much tied to nurses' identities as "good nurses." Notions of good nursing, among many of my participants, appeared to be contingent on successful breastfeeding promotion and support. I speculate about what role breastfeeding support has in how nurses feel about their careers and their lives-at least during these moments of our interaction. Practitioners who communicate the irrefutability of BF evidence to mothers are fulfilling their obligations. Good nursing care can be viewed in the context of supporting informed choice and advising mothers about the risks of formula. Nurses may cover the bases of risk as a way of ensuring good nursing.

In some cases, participants nudged me to wonder if the fervor for breastfeeding support represented a reductionist approach to practice, since breastfeeding support is so often described by some as the most significant and rewarding aspect of the nursing role. Helena mused about the same possibility:

> Breastfeeding is what sets us apart. It's public health nurses' expertise, and it sets us apart, and it sets apart our practice from other nurses, from family physicians, and from other health professionals. It's what we do.

The institutional demands surrounding workload, expectations to comply, and/or concerns with breastfeeding success rates all contribute to the pressure that nurses feel in practice to do the best they can in the time they have. However, sometimes nurses' "best" does not meet women's needs. It's not vindictive; it's just survival. I understand.

I am called once again to contemplate public health perspectives on health promotion as the dominant impetus that underlies nursing care. I wonder how it is possible to both promote health using global initiatives, and be in relationship with

mothers - to temper broad constructions of health promotion according to women's situations. The quest to reconcile evidence-based approaches with individualized care remains unfulfilled.

Many participants referred to "women's goals" for feeding. As Pamela so candidly shared, that is an idea that bears attention, including the need to critically ask ourselves, as nurses, if we are fulfilling the mother's goals or our own professional goals to enable successful breastfeeding.

Statistical evidence. The language of breastfeeding success rates (WHO, 2009b) is an example of how statistical evidence achieves unquestioned ideological primacy and serves nurses' (and others') goals to promote breastfeeding. The impetus for health administrators to observe breastfeeding success rates shapes policy and practice, suggesting that achievement of a certain statistic is a true measure of the quality of nursing care and a gauge of the population's health.

In Canada, this perspective becomes particularly problematic when addressing the situation of Indigenous mothers. It seems, that despite many societal and historic factors, such as the ongoing effects of colonization, there is a will to increase breastfeeding success rates among First Nations mothers with the same fervor as is the case with other female populations. However, that approach does not acknowledge the realities of Indigenous women's lives (Gauld, 2010). In the context of Aboriginal health, statistical measurements of breastfeeding success are at odds with an intersectional approach. BFHI promotes the same set of guidelines in underprivileged and marginalized communities, which can lead to ambivalence, guilt, and shame among women who not breastfeed (Gauld, 2010; Murphy, 1999; Shakespeare et al, 2007; Humphries, 2011).

That shore looks so distant from here. The experience of conversing with nurses has uncovered disparate meanings of infant feeding support among nurses. I now consider the milieu of infant feeding support through a more fulsome lens.

Participants were critical and morally distressed about current approaches in dissimilar ways. Some (Jemma and Noreen) were frustrated because their facilities failed to enact BF initiatives more faithfully. Others critiqued those same initiatives. For example, Gloria bemoaned the lack of autonomy that she felt she had as a prenatal educator. She and Rita, in particular, were highly sensitive to the fact that infant feeding challenges could result in a negative experience of mothering. Rita shared her seasoned perspective, and said:

> I say this to women when I can feel their suffering because breastfeeding isn't going well, or if they have mental illness and they have to make a choice between a risk of relapse or breastfeeding. I try to say: 'What's better for your baby right now? To have a mother that is loving, engaged, energized, feeling good? Or this questionable idea that breast milk is going to solve all your problems? And it's clearly, babies need mothers. And there are millions of us that are alive and well that never had a drop of breast milk. But I want to give a woman that message: that she is more important and what she has to offer that child and that family is more important than what comes out of her breast.

Without exception, each participant referred to her own mothering experience and how that has shaped her approach. I am intrigued by that, although not entirely surprised. Gadamerian notions of history and bias suggest that it might be so. The voyage of motherhood and the memories of the early days and weeks following birth indeed find

their way to everyday nursing practice.

I wonder if anyone sees me. I wondered how the participants perceived me when they agreed to participate in an interview. Did they anticipate that I would challenge current practice, and were they surprised when I did? At times, our identities fused with common understanding. At other times, I felt as though I was unable to see where I was going and desperately tried to reach the surface, where I could once again breathe, regroup, and ponder the meaning of what I had been told. DeVault (1990) cautioned that research conversations have the potential to intensify power dynamics between the researcher and the participant, and indeed there may have been times when both the participants and I felt powerless to think and respond in the moment.

The honesty and candor of the participants created openings and spaces for me - and us - to uncover whilst communing in the deep waters of dialogical exchange. It seemed that the conversation about nurses' experience of infant feeding support was a conversation that many nurses wanted to have and longed for. Oftentimes I was challenged by what was said. I was frustrated with some of the assumptions I encountered which I seek to contest. I surfaced, inhaled, and sought new horizons. The quest to attain a clear vision of the comfortable shore served as an elusive but motivating force.

In the course of the dialogue, for example, the participant and I would each entertain possibilities that might shed light on dilemmas, strengths, and pitfalls associated with current conceptions of infant feeding support. I would reflect on my own experience as would my participant. We would look at ourselves and at our practices. At times, there would be a glimmer of recognition as if to say, "Ah, this is what is going on!" only to be

followed by a contradiction or doubt as in, "Ah, this is what is more important!" For instance, among participants, the authority of evidence or a nod to women's informed choice as a "solution" to a complicated situation would often erupt as a conclusive approach to infant feeding support.

I was aware that at one point of the conversation, participants would share their frustration with institutional expectations and the "company line" of breastfeeding promotion. They would share a desire to offer women more individual care. At other points in the interview, participants would then valorize scientific evidence and/or refer to notions of "natural mothering," such as using breasts for what they were intended. As the researcher, I had to overcome the inclination to seek refuge in the comfortable shores of consensus. It became clear that I needed to rest with the contradictions and ambiguities that surfaced in the dialogue about what it means to support mothers with infant feeding.

I often felt flummoxed and unsatisfied because I identified with the participants' frustration. At other times, I was tested by participants' comments. Sometimes, I was able to offer a meaningful response at the time of our conversation, but in other cases, that would occur later when I communed with the texts. I also became aware that, in my quest to "understand," it was important not to conflate "understanding" with "overlooking" certain statements, as if to assume a position of understanding where I could rationalize everything that was said to me. I strove to sense what was at play and drew on my own nursing experience, the research that I conducted and read about, and other "altogether" gasps of insight that Heidegger and Gadamer indicated as constituting understanding.

As mentioned above, I also wondered how participants saw themselves. Was it only "other nurses" who went "too far" with breastfeeding advocacy? There were times

when I wondered about what participants had described as supportive nursing practice. Might some of these practices be the very ones that mothers interpret as coercive? For example, while I understand Noreen's passion to promote any amount of breastfeeding, her candid disclosure about limiting mothers' choice left me wondering about the ethics of presenting breastfeeding as the only normal and natural method of infant feeding.

I must question what I believed: learning more about milk banks. Under some circumstances, BFHI endorses the use of formula, or more ideally, breast milk that is obtained through a milk bank or pumped and stored by the mother (WHO, 2009c). In emergent situations, such as when the infant is experiencing a hypoglycemic event and cannot latch to the breast, or in the case of mothering an adopted infant, the milk is most often administered to the infant using those same artificial methods (artificial nipples and bottles) that are soundly discouraged under The Code. The message is mixed, but artificial infant feeding equipment is apparently acceptable when feeding with human milk obtained from a milk bank. In these instances, concerns that artificial feeding methods will interfere with infant bonding are minimized, since using human milk from a milk bank will require artificial methods. I develop this idea below.

Jung's (2015) work emphasizes the need for more careful attention to the distinction between breast milk as a "product" and breastfeeding as an activity that promotes bonding, and is associated with other maternal physical benefits. In my practice, human milk has not been readily available to mothers since I live in a location where there is no milk bank. However, as a result of Jung's work, I am increasingly aware that pumping human milk for distribution has become big business. It seems, according to Jung, that breast milk is being likened to "superfood," with corporations including it in a

growing list of products, including nutritional supplements, soap, ice cream, baking, and "momsicles," which are popsicles made of breast milk for teething babies.

Jung (2015) posits that there is a fanaticism ("lactivism") associated with pumping breast milk to ensure that formula is never introduced to the infant. In the United States, the lactivism cause has spawned an industry of buying and selling human breast milk online, which can cost $1500/month for an infant between one and six months of age (as compared with $100 per month for formula). The unregulated selling of breast milk is worrisome since the milk is often contaminated with staphylococcus or streptococcus and sometimes diluted with cow's milk (Jung, 2015). There are other risks, including the possibility that the milk is contaminated with HIV, hepatitis A, hepatitis B, syphilis, or drugs and alcohol that have been ingested by an unknown donor.

Regulated milk banks are seen as a means to mitigate the risks that are outlined above. The problem is that, in Canada, very few milk banks exist. On July 24, 2015, the CBC program, The Current, hosted by Piya Chattopadhyay, explored the issues of milk banks, and the possibility of "for profit" sales of human breast milk in Canada. Her guest was the director of the Calgary Milk Bank, Janette Festival. According to Festival, the three milk banks in Canada (located in Vancouver, Calgary, and Toronto) have enough milk to supply the needs of NICU babies. However, if infants are not housed in a NICU unit mothers face significant expenses to transport the milk safely. Although it was not mentioned in the program, women who donate their breast milk must pay for their own bottles, and cover the cost of transport and storage of the milk to the milk bank. There are also mothers, other than those who have infants in NICU, who would like to feed their infants human breast milk (as evidenced by the risks that women take to purchase breast

milk online from unregulated sources) but there is not enough milk in Canadian milk to meet that need. Therefore, women have limited access to safe human breast milk for their infants.

Yet, current BF approaches view formula as "alternative," "risky," and as something to be hidden from view, and administered as medicine. Best practice guidelines maintain that formula preparation information should only be shared after the mother has made a decision not to breastfeed. However, Gloria suggests to her class that keeping a can of formula at home is a good idea, but with the caveat that no one "heard it from me." As Benner, Hughes, and Sutphen (2008, p. 6) explain:

> Clinicians must develop the character and relational skills that enable them to perceive and understand their patient's needs and concerns. This requires accurate interpretation of patient data that is relevant to the specific patient and situation.

Gloria's clinical judgment in this situation is shrouded in secrecy and shame, and has the potential to influence her employment status. I envision a time when seasoned clinicians can openly exercise clinical judgment without fear of reprisal.

I glimpsed nurses' frustration and my sense of the incomplete remains. I am nonetheless enriched the conversations which offer infinite possibilities for interpretation to which Gadamer and Heidegger attested. I have the sense that I have traversed a myriad of currents and current forces, all coming from different directions both above me and below, as I try to understand what is going on and what is at play. When considering the texts as a whole, there are many things at play and I attempt to make headway. My practitioner participants suggest that they, too, are navigating opposing currents. Some question the current guidelines and others believe that the guidelines are not applied

rigourously enough. Metaphorically speaking, participants are struggling to find their bearings and struggle to breathe just as I do. I become subsumed in the eddy of hermeneutic circling.

Linguistic Currents

I explore the larger scope of possibilities of unexpected consequences for nurses and women who encounter Baby-Friendly language.

The term Baby-Friendly has become synonymous with a general impetus to acknowledge and encourage breastfeeding "Anytime, Anywhere." This latter slogan is used extensively in breastfeeding campaign posters and is visible in many health care settings. In Canada, the slogan is aligned with the Canadian Charter of Human Rights and Freedoms, which guarantees that women are able to breastfeed in public places without fear of exclusion (Retrieved from: http://www.infactcanada.ca/breastfeeding_rights.htm). Certain public settings are coined "Baby-Friendly" by women in the community based on the warmth with which breastfeeding behaviors are welcomed. UNICEF and WHO endorse an annual Breastfeeding Awareness Week (Retrieved from: http://worldbreastfeedingweek.org/), which includes a Breastfeeding Awareness Day, on which women gather and breastfeed in a public place. This is one of the ways that Baby-Friendly initiatives hope to normalize breastfeeding practice, since breastfeeding promotional initiatives clearly state that breastfeeding is the "normal" way of feeding infants (BFHI, 2009). Ironically, during the mid-1960's, women who wanted to breastfeed were seen as "abnormal." This shift may reflect Foucault's ideas about replacing the epistemic language. In this case, language of the 1960's, which depicted "breastfeeding" as abnormal, was replaced with alternate language as a result of the 1990

WHO Innocenti Declaration. The more recent language depicts "formula feeding" as abnormal. Currently, as participants discussed, there are questions as to whether BF notions of "normal" infant feeding (breastfeeding) are coercive (Murphy, 1999, Wolf, 2011). Is another shift in language on the horizon?

I wonder what possibilities may exist for the further evolution of infant feeding language, given the vulnerability of new mothers and their desire to conform to self-sacrifice and self-control in accordance with the image of "good" mothering (Badinter, 2011; Lewis, 1997; Weiner, 1997), language can influence in profound ways. Mothers are under surveillance in hospitals with nurses scrutinizing their infant feeding and where posters tout the superiority of breastfeeding. If a behavior is not Baby Friendly, what is it? Is formula feeding seen as an "unfriendly" gesture towards one's infant?

Delving more deeply into hermeneutic sensibility, I wonder what meanings are associated with the word "friendly." The Encarta Online Dictionary: English (North America) (n.d.) define friendly as "affectionate and trusting, helpful, on the same side, pleasant and welcoming, not fiercely competitive, and easy to use." I associate the word with comfort and giving, which are qualities associated with ideal mothering. However, I speculate that for women who do not breastfeed, Baby-Friendly messages can be confusing, and perceived as coercive and judgmental. Mothers can feel misunderstood and mistrustful as a result. (Knaak, 2006; Shakespeare, Garcia & Blake, 2007; Williams, Kurz, Summers & Crabb, 2012; Wolf, 2011).

As stated above, the pillars of breastfeeding initiatives globally can be traced to three important words: "protecting, promoting and supporting." These words underpin the position taken by the World Health Organization (WHO) in the original 1990

Innocenti Declaration (Retrieved from: http://www.infactcanada.ca/breastfeeding_rights.htm) and appear emblematic of the way that breastfeeding promotion has been approached ever since, given the frequency with which they are cited and integrated into breastfeeding promotional literature and global initiatives. If breastfeeding is protected, what is it protected from? I suspect the answer would be formula companies, given the historic legacy of the Nestle boycott (Appendix V1) and the current allegations of medical risk associated with formula that are articulated in this dissertation.

No single epiphany occurs. I remain unable to identify what would weaken the force of the discursive currents other than to pause, step back, and cherish what understanding I have achieved about contesting influences and challenges in practice. Participants offer helpful ideas about offering infant feeding support, but their statements were often self-contradictory, and participants' descriptions of their approaches frequently contradicted each other.

I become immersed in the possibility that a mother's ability to establish goals for infant feeding, which may be unique and contextual (Nathoo and Ostry, 2009) are also at risk for being washed away in a tide of scientific evidence that supports breastfeeding. There is more than scientific evidence to consider. For example, women who have been victims of sexual abuse may or may not share their histories with nurses, but view breastfeeding as a trauma revisited (Beck, 2009). What kind of support do mothers receive in such circumstances? Nurses are advised to question patients about their understanding of the potential risks of formula if they indicate they are choosing not to

breastfeed (WHO, 2009). I picture the exchange, imagine a dialogue, and speculate about what may be at play for both the mother and the nurse:

Nurse: Are you breastfeeding your baby? (Nurse asks the question according to BF recommendations and supports the imperative that breastfeeding is the normal way of feeding)

Mother: No, I'm going to formula feed. (This decision has been thoughtfully and tearfully made based on factors that are sensitive, private, and part of her history).

Nurse: Are you aware of the risks associated with feeding your baby formula? There is a higher incidence of Type 1diabetes, SIDS, death, lowered intelligence, allergies, ear infections, respiratory infections, and other diseases. Here, I'll give you this pamphlet that outlines the risks so that you can make an informed choice.

Mother: Yes, I'm aware of the risks. (I'm feeling terrible. I wonder what that nurse thinks of me? She must think I'm a horrible mother. What am I doing to my baby?)

Nurse: Well, it's your choice. (I have nothing further to contribute. I respect women's choice.)

To what extent should the evidence about risk shift ideas about infant feeding support? It is possible, for example, for infant feeding to become a personal choice, based on thoughtful and supported consideration. Otherwise, mothers are charged with the responsibility of avoiding any possible risk that may compromise their child's life.

In spite of my many questions about current practice, enacting BF practice was so highly valued and embraced by several participants that I felt, at times, lost to the forces that I had questioned all along. The waters of doubt seep predictably into my

consciousness. These nurses are passionate and committed to their patients and dedicated to BF evidence. Who am I to question?

I turn to the discursive, social, and historic conditions of understanding. I sense the tension between these ideas, pondering participants' lived experience over time and how their histories have contoured their approaches to infant feeding and created a source of moral distress among some. The discourses of naturalistic mothering and science also emerge, aligning with the passion with which some participants enact breastfeeding promotion. These participants indicated they respect evidence-based-practice as a good nurse does and celebrate the allure of naturalistic assumptions associated with mothering and the act of infant feeding. Mothers' perceptions of success are associated with successful breastfeeding (Else-Quest et al., 2003). Nurses' support has the potential to reinforce those notions of success. Diverse currents of complexity bubble to the surface as the tensions are exposed and remain unresolved in the midst of power struggles among nurses, institutional pressures, and sweeping societal expectations.

This is human. This is what happens. I inhale.

The Breath of Understanding

Sense and Sensibility

I return to hermeneutic notions of sensing and acknowledge sensibility as a possible avenue to illuminate a way forward based on the experience of hermeneutic interviewing and the analysis that has occurred to this point.

According to Grondin (Personal communication, May 20, 2015), it is the capacity to *sense* that indicates our *sensibilities.* I remain open to the future and hope to contribute to nursing practice in a *common sense* way that will have practical benefit.

However, the common sense that I envision does not subscribe to the dominant discourses about prescriptive approaches to infant feeding. Instead, common sense in this context would include Gadamerian notions of phronesis (practical wisdom), social justice perspectives, including ongoing attendance and flexible approaches.

Grondin (2015) suggests that hermeneutic sensing is "what we do all the time" as we engage in interpreting meanings of the everyday. Our senses are part of our earthly experience and constitute aspects of human intelligence. They accompany us at all times, often unacknowledged, and they influence our decision-making and judgments. The senses of where things could be going, combined with our abilities to sense what is before us, encapsulate the contextual and temporal knowledge so implicit to hermeneutic understanding. Indeed, metaphorically "swimming alongside," can be envisioned as an attempt to understand, to *sense* what another is all about. The attempt to *sense* what is at play for an individual in a certain situation contributes to the "art" of the hermeneutic process (J. Grondin, personal communication, May 20, 2015). I proceed, buoyed by Dr. Grondin's assurances, that sense and sensibility are critical to hermeneutic interpretation. With these ideas in mind, I open myself to possibilities and uncover ongoing wonderings about nurses' participation in infant feeding support. In the paragraphs that follow, I include notions of rationality, which are part of but not the whole of, hermeneutic sensibility. I savor the potential that over time and with the unique sensibilities of others, there will be opportunities to unearth alternate or deeper interpretations.

My Senses Must Guide Me

The process of engaging with the texts continues to open me to possibilities. As Gadamer (1975/2004) stated, "For the interpreter to let himself be guided by the things

themselves is obviously not a matter of a single, 'conscientious' decision, but is 'the first, last, and constant task'" (p. 269). The danger, as Grondin suggests, is relying on rationality, instead of remaining open to what our senses may teach us and where they may lead (J. Grondin, personal communication, May 20, 2015).

Participants (Jemma, Olivia, Ingrid) described settings wherein there is less focus on Baby Friendly approaches than the contexts that I have encountered in my own nursing career. I am reminded that navigating the waters of best practice is never easy for nurses who practice in rigid Baby Friendly settings or in sites where BF practice is inconsistent. Nurses always face complexities that have not been addressed in the guidelines. It was enlightening for me to understand more about how nurses traverse the waves of workload, bullying, and fatigue. Their words opened me to new understandings, and confirmed others, about the realities of nursing practice in a corporate structure where it seems there are never enough nurses to function optimally. The fallout for the individual nurse is something to consider since, over time, it may become increasingly difficult to maintain professional goals to "support." Institutional obstacles can obscure the view of the horizon.

Hermeneutic ideals for fluid and reflexive engagement also emerged. The need to interpret, in the course of conversation, immediately presented a challenge since participants' responses and commentary frequently invited me to further unwrap significance. I heard myself asking, "Tell me more about that comment," as I attempted to interpret the meaning of various statements. I shared my own bias and history openly with participants as I simultaneously attempted to understand their perspectives. Later, when I described the experience of conducting hermeneutic research interviews to

interested parties, I was often met with incredulity about the notion of speaking for one hour or more with each participant about the experience of infant feeding support. And yet, each interview flew by. Participants were clearly interested in investing time and thoughtfulness in each encounter.

The participants, although diverse in their opinions and approaches, were each committed to their nursing practice. In many cases, the participants did not seem to agonize over theoretical complexities such as meanings of evidence, informed choice or BF universal approaches to infant feeding. These issues plagued me - but I sensed that many of the participants were simply trying to get the job done and do the best they could. They do the best they can under their specific workplace circumstances. Some, like Jemma and Gloria, struggle to stay afloat, albeit for different reasons.

I am reminded of the chaotic nature of many nursing units, the pressure to discharge women, and the protocols and documents that seek to optimize care. The discharge checklist, for example, is a way of ensuring consistency and standardized practice. It does not, in itself, lend itself to authentic and genuine interactions, but it could be a springboard for a meaningful conversation with mothers if time only allowed. I remember how it felt to be pressured with the requirements of a busy maternity unit to provide good care, or at least care that was "good enough." The implied conditions for understanding- the corporate/ efficiency discourses that underpin maternity settings- inform me. Over time, and with more education, my expectations for nursing practice have evolved, but I sense what it is to navigate the challenges of a hectic day in practice.

Sensing Tradition

Nursing preparation has historic roots in apprenticeship models and, more recently, in scholarship. Ideas about the art and science of nursing often surfaced in the conversations and assumed a place of common understanding between the participants and me. As I review the texts, though, I identify the tension between "hands-on" approaches to nursing practice (in this case, the practice of assisting with breastfeeding) and scholarly approaches to nursing care that emerged (Olivia, Noreen, Kathleen). I build on these tensions and envision the possibilities for strategizing sensitive, competent, and thoughtful infant feeding support.

I speculate about how nursing evolved under the apprenticeship model and muse about integrating this model and a scholarly approach. Alluding to the theoretical/practical binary that allegedly exists in nursing, Keogh (1996) surmised that it is partially the history of nursing as an "apprenticed" experience that creates identity confusion about professional identity among nurses. Today, the theoretical component, including the discourse of "nursing science" in nursing education, is promoted. This is in keeping with the desire to elevate the stature of professional nursing. The allure of scholarship perhaps conceals the advantages associated with mentorship, apprenticeship, and practical "hands on" approaches to care. The practical nature of nursing practice, however, can obscure the need to attend to scholarly approaches in professional nursing. *Aletheia* is lived out in questions related to infant feeding support and nurses' education.

I learned in my research conversations that the preparation to practice in perinatal settings varies from region to region. Many perinatal settings do not require nurses to have any formal preparation to assist with infant feeding support, although it was clear in

the conversations that all perinatal nurses are conversant with BF guidelines. It was Olivia's contention, for example, that the older nurses in her unit (who most often did not have baccalaureate education or breastfeeding education) knew enough about BF approaches to dismiss them. It seems, therefore, that the need to examine nursing practice in its entirety is overlooked. It is not sufficient for nurses to lack critical appraisal of the evidence. It is not sufficient for nurses to dismiss BF approaches as if they do not exist.

In the context of our conversation about the "art" of nursing, Kathleen shared her worries that young university trained nurses are missing something that existed in the apprenticeship model of nursing education. She spoke of the "three drawers" that are important to infant feeding support. The top drawer is where the nurses' personal values and opinions are kept. The second drawer is where evidence is kept. The third drawer is where clinical judgment and trusting a nurse's intuition and a mother's abilities are kept. She uses that metaphor to explain to nurses the importance of making sure that one of the drawers doesn't get "stuck." Kathleen mused that young nurses are reluctant to exercise clinical judgment. In her role, she tries to empower nurses to exercise sound clinical judgment, to trust themselves and then to *trust the mother*.

Kathleen emphasized the need to acknowledge that infant feeding support is not something that can be exclusively learned from a textbook or through a course. She describes the rewards associated with helping young nurses develop confidence about their ability to provide infant feeding support. She spoke of spending time with new nurses in order to help them develop clinical judgment. I think of what it may mean for inexperienced nurses to be mentored. Kathleen embodies the idea that supporting nurses will ultimately support mothers. It's common sense.

Helena discussed the preparation she received from her breastfeeding course, which prepares doulas, volunteers, and nurses at all levels, and hence, took a multi-disciplinary approach:

> I'd have to say that when I took that breastfeeding course a lot of it was - it's like a practical course, really, about the anatomy and physiology of the breast and about breastfeeding and techniques and complications. And then you finish off the course looking at the Baby Friendly Initiative and how's that playing out in your workplace? And globally, what's going on globally with breastfeeding, more of a discussion that way. And we did a group project related to breastfeeding, so that was shared with the class. That's how we finished up. And we mostly used a single textbook. So we didn't read a lot of articles or research, which I guess that in itself is kind of interesting, when I think back.

In response to Helena's comments, I wonder if the multi-disciplinary approach embedded in BF initiatives is sufficient for registered nursing practice, which operates in a milieu of responsibility for many aspects of mothers' and infants' well-being. I return to previous questions that I had about nurses' experience with interpreting research. I remain curious about the relationship between apprentice models, practical approaches, and critical approaches to research. I also consider the influence of non-nursing involvement in infant feeding support (such as non-nursing lactation consultants, childbirth educators, and doulas) and how multi-disciplinary influence might shift nursing approaches.

I envision nursing preparation that is both practical, and scholarly, and steeped in nursing literature that is not exclusively science-based. Other theoretical lenses are

relevant to registered nursing practice, including feminist, intersectional, and social justice perspectives, all of which may be introduced in Bachelor of Science in Nursing (BSN) education. Specialized preparation for perinatal nursing, in the context of infant feeding support, could extend these important theoretical approaches to care with the knowledge that the ideas are consistent with undergraduate nursing education, and therefore consistent with and reflective of nursing practice. These approaches, and others, could be specifically integrated into nurses' preparation for infant feeding support, and thus, assist nurses to enact sophisticated and thoughtful practice. It also makes sense to include a great deal of mentoring and "hands-on" practice. This would prepare perinatal nurses to provide infant feeding support with as much skill as possible and would examine the complexities of perinatal nursing practice, which is so consumed with breastfeeding support.

At the start of our conversation, Olivia stated:

> It is a big topic and I think the time has come to open it up. I'm glad you're doing this research. Because I think if that it is the case that women are feeling terrible about what's going on, then we absolutely have to address this and it needs to be in the nursing student curriculum and we need to be prepared for handling it. We have our ethics training and our values training.

Her words lifted my confidence to persist and informed my analysis.

Addressing Knowledge Development

Based on my conversations, as well as my experience in clinical settings, nurses' preparation needs to include developing skills in interpreting evidence, including statistical evidence. Significantly, many participants did not seem inclined to question the

evidence that is presented by trusted organizations such as WHO. Instead, the BCC's authority is unquestioningly accepted as what it purports to be: the Canadian authority for WHO messaging.

In British Columbia, there is, at present, an initiative to establish research competencies for nurses based on level of education and experience. This movement is featured at the University of Victoria in Victoria, British Columbia and, in part, was introduced to address and assess nurses' abilities to interpret and participate in nursing research. The following is a summary of the Health Services Researcher pathway:

> A new resource commissioned by Michael Smith Foundation for Health Research (MSFHR) will help define how nurses progress throughout their careers in developing knowledge, skills, and competencies related to research and research use. The Health Services Researcher Pathway, developed through the BC Nursing Research Initiative, describes five distinct levels of nurses' research competency. The document is intended to support greater use of research at the point of care, where most nurses work. This framework was informed by published literature, as well as consultation with stakeholders from across BC, including nurses in practice. (Retrieved from: http://www.msfhr.org/health-services-researcher-pathway-0)

In the context of BF approaches, there will be continuing opportunities and responsibilities for nurses to engage with evidence as a way of providing comprehensive and sensitive care. There is also reason to value ongoing efforts in student nurses' undergraduate education in many Canadian nursing schools, where students are trained to

critically evaluate research, so that nurses' research sensibilities are as refined as possible before entering professional nursing practice.

Nurses' training in critical evaluation of research in the area of infant feeding support would also tackle such fallacies as cause and effect arguments (accepting the risks of formula without considering the broader context of overall risk in life), sweeping and hasty generalizations (essentializing mothers' needs), faulty analogies (dismissing mothers' needs of support if they are not breastfeeding) and others (Retrieved from: http://commfaculty.fullerton.edu/rgass/fallacy3211.htm). I support the call for nursing education to include exposure to philosophical thought in order to promote thinking and clinical reasoning. In my conversations, there were times when participants expressed the value of critically evaluating research, but it was clear from their comments that they were struggling to do so themselves.

McIntyre and McDonald (2013) call for engagement with philosophical ideas as a way for nurses to structure ideas and theorize for themselves. They posit that nurses' lack of familiarity with philosophical thinking serves as a barrier to addressing human health issues. In the area of infant feeding support, it is clear that there are multiple opportunities for nurses to examine practice and assess what is at play, how that could be known, and what the ethical implications are (for example, the ethical consequences of "scaring women" under the guise of offering informed choice). Nurses' ability to engage with these questions would address ontological, epistemological and ethical considerations of nursing practice. Clear articulation of philosophic frameworks has the potential, then, to influence and enhance nursing practice in the domain of infant feeding

support. Greater attention to *Geisteswissenshaften* and an appreciation for the humanities could materialize as a foundational approach to human situations.

Thorne and Sawatsky (2014), too, advocate for enhanced philosophizing and theorizing to advance nursing disciplinary knowledge and support nurses in practice. They say:

> The practice world requires thinkers and leaders who can guide nurses in recognizing their responsibility not only in building evidence-based protocols and practice guidelines but also in working out the defensible bases upon which variations and individualized applications of these entities can be justified. (p. 14)

Their vision of integrating evidence and individualized approaches speaks to the heart of the dilemma that I identify: the quest to reconcile the multi-disciplinary claims of globally inspired evidence-based approaches to infant feeding support with the individual needs of the mother. They envision greater attention to nursing conceptual models and nursing disciplinary perspectives, which could help to deconstruct situations in which evidence and practice knowledge surface as competing discourses.

Sensational Language

The conversations often evolved into discussions about language (Lorraine, Noreen, Olivia, Ingrid). I am drawn to consider the possibility of tempering our language. Do we need to reconsider our conception of risks or replace the word “risk?” As Olivia suggested, associating risk with statistical prevalence can incite fear among mothers. I wonder if mothers, for example, understand that just because statistics suggest the odds of attaining a particular outcome, there is no way of predicting whether or not that outcome will manifest in the individual case. As Gloria suggested, accompany any

statistical information and "evidence" that emanates from statistics should be distributed with caution. Yet this information is widely distributed and posted in maternity settings for all to see.

Sokolon (2014) succinctly addresses the myriad of forces that are at play when providing infant feeding support. Like Wolf (2011) Sokolon offers a synopsis of the evidence and critiques the supposed health benefits of breastfeeding. She concurs that scientific evidence supporting breastmilk superiority is often based on "very few, non-replicated studies" (p. 210). Importantly, Sokolon offers strategies that acknowledge intersectional influence. Referring to Canadian policy on breastfeeding, Sokolon points out,

> Included in these guidelines is an emphasis on a child-centered discourse of 'baby-friendly' hospital initiatives intended to promote practices that increase breastfeeding rates, especially targeting 'unsuccessful' groups, such as women in certain ethnic groups or of lower socio-economic status. The Canadian policy emphasizes a medical perspective that assumes a highly essentialized view of a woman's body as a reproductive body with a corresponding idealized perspective of nature, motherhood, and the family. Such discourse also assumes strong moralizing judgments long associated with breastfeeding practices. What is missing from the Canadian policy discourse is a 'woman-friendly' perspective that recognizes the diversity of acceptable infant-feeding goals and understands the practice within the larger scope of a woman's reproductive life. (p. 212)

I am interested in knowing more about how mothers respond to breastfeeding promotion in Canadian maternity settings. Such a conversation may reveal the need to

alter some aspects of our practice, including taking a critical look at the Ten Steps, The Code, and the breastfeeding policies that guide nurses' approaches and institutional expectations. The use of formula in medical emergencies contradicts published materials that emphasize the danger of even one exposure to formula. Embracing the needs of women who do not breastfeed remains important, even in busy nursing practice, where breastfeeding mothers require support and attention. The physical and theoretical architecture of maternity settings, and the institutional expectations to use BF language, approaches, and visual images, is designed to support breastfeeding. Ethical care must support all mothers, though, and participants confirmed that unintended feelings of marginalization arise among mothers who live with connotations of second best, alternative, and risk. Also, as stated, when formula and/or bottles are recommended in maternity settings, as may be medically necessary, such messages have the potential to extinguish a cherished trust in caregivers, who may be delivering mixed messages about the risks of formula (Olivia).

I worry for women who are excluded from the inviolability of breastfeeding superiority. Referring to formula as "medicine" has far-reaching implications in terms of how mothers accept alternate feeding methods. Viewing formula feeding as an "alternative" is similarly provocative. I wonder about those who are excluded from the "breastfeeding bandwagon." Perhaps there is other language- a move away from BF references that would not elicit undue fear among women who are struggling with their infant feeding decision or who have reached a decision not to breastfeed. I explore the possibilities below.

The language of "choice." Gustafson and Porter (2014) examine the many barriers involved with delivering comprehensive health information, and discuss how that affects women's ability to make meaningful reproductive choices. Their words offer an alternative way of conceiving "informed choice" in the context of infant feeding:

> ….we prefer the concept of *meaningful choice* (authors' italics). Meaningful choice operates when women are self-aware and well informed, have a set of realistically available options from which to choose, and are able to communicate a decision. Not all women enjoy the same range of options from which to choose and the same degree of power to exercise a choice. This perspective acknowledges those relational factors that may at any given historical or political moment to be construed as oppressive or limiting agency or free choice. (p. 24)

Their concept of meaningful choice is provocative in the context of my inquiry. It aligns with my discussion about the use of language. Their statements also suggest that applying universal guidelines to meet the needs of all women is impossible. This consideration has indeed been a focus of my own work.

As a result of my conversations, I interpret another dimension of inquiry. I consider how enhanced support for non-breastfeeding mothers could be enacted. Although none of the participants argued for decreased support for non-breastfeeding mothers, I sensed, as I have sensed many times in my clinical practice, that there is a tendency for nurses to give less attention to mothers who do not breastfeed. The phrase "It's their informed choice" can slip off the tongue easily, as indeed it did for several participants. I wonder if information about risks is considered to be enough to make an "informed choice." If so, the approach appears inadequate as a conduit for understanding

a mother's experience, which may include sensibilities of fear, guilt, and societal pressures to breastfeed in a "Breast is Best" world.

The prospect of discussing choice as "meaningful" as opposed to "informed" as Gustafson and Porter (2014) suggest, may align more readily with overall attention to women's complex social identities.

"Best" language. The power of the "Breast is Best" rhetoric is well documented (Badinter, 2012; Murphy, 1999; Shakespeare et al., 2007; Wolf, 2011). My own online explorations confirmed that some women are sensitive and offended by the slogan. For example, I encountered a blog entitled "Fearless Formula Feeders" (http://www.fearlessformulafeeder.com/). This blog offers women who are feeding their infants with formula the opportunity to express their feelings of being misunderstood. The existence of the blog and its contents demonstrates the power of the breastfeeding advocacy that reaches women and how it can engender frustration. For example, in response to the "Breast is Best" mantra the following comment was posted:

> Well, that buck stops here, folks. Let's take back the word "best." Best is subjective. Best means your personal best; how best is defined for your family; what is best for your particular child. Your "best" is…well….best.
>
> How's that for a slogan? (Retrieved from: http://www.fearlessformulafeeder.com/)

The entry is provocative. It approaches "best" from an alternative paradigm. "Your best is best," or, in the context of a postpartum mood disorder where sleep hygiene is recommended, "Rest is best" (Humphries, 2009) have the potential to support women in a more fulsome way. Or perhaps the word "best" should be eliminated from the

conversation, so as to diffuse the "problematic allure of the binary" (Thorne, Henderson, McPherson, & Pesut, 2004).

Sensitive listening. Just as the researcher must *listen* carefully and sensitively to women's conversations (DeVault & Gross, 2012), it follows that sensitive listening to mothers has the potential to enhance nursing practice. Common sense dictates that listening is important. However, I am called to examine the challenges that are associated with listening to women. I sense the need to engage with increased levels of individualistic support in the context of standardized global guidelines that assume similarities and the potential for successful breastfeeding among all women. Helena alluded to these challenges:

> There has been a shift in public health to recognize that we really have to listen and respect what women want. And sometimes that can get a bit smothered if you're so busy trying to fix the problem with the breastfeeding, and ensure that breastfeeding carries on.

Noreen shared a supportive strategy that reflects her perspective that any breastfeeding at all constitutes a "victory." Her approach assumes careful listening and a desire to work with mothers:

> I know one of the analogies I sometimes use with my families is that it's like running a marathon. You have this race to run and you should have several goals. One goal might be to just finish. One goal might be to finish in a certain amount of time. And is that okay? Yeah. That's okay if I finish in that amount of time, but I really like to get this other time. Okay, and if I have a really super time, maybe I can get this time to finish it. And so then we look at all these goals and then, okay,

> is it okay if you actually don't finish the marathon? Are you going to be okay if you just get halfway through? You know what, that's okay, I'm okay with that. And so then we look at your ideal with your feeding, which is exclusively breastfeed for a year. Okay if we don't make it quite that far, I'm okay with that. I made it to nine months. Or all I could do, I really couldn't tolerate breastfeeding but I pumped for six months. I'm okay with that. I tried. So I have used that analogy with some of the moms who are struggling through feeding - usually it's with breastfeeding, sometimes it's with parenting, or even attachment with the family. Whatever the situation is, is this your goal? What are some of the other goals, and are you okay if we get only this far?

Rita emphasized the value of developing a relationship with mothers by pausing, resting, and listening:

> The intuitive relationship that the mother and nurse have is a guide. I think I used to ignore that because I wanted to do the 'right thing'. And now I'm older and wiser and I'm aware that an intuitive relationship is very, very important. And the other thing that I'm aware of is that the party line was 'If you're not going to get it right here, you're not going to get it right. Or you've got to get it right in that first two hours after that baby is born, otherwise it's game over. I'm realizing that we can pause. We can relax. There is time. And we are more resilient if we have rest, if our baby had something to eat, and we can try again tomorrow.

Interweaving in multivocal and ambiguous ways (Jardine, 1992). Following one of my interviews, I wrote in my journal:

> By the end of the interview, the participant had pretty much done an "about face"

> regarding the profile of evidence in the context of infant feeding support - I had asked her about the meaning of evidence in her practice, and how it informed her approach to infant feeding support. She appeared to have undergone a bit of a shift as a result of our conversation - she was questioning some of her own assumptions about informed choice, evidence, and was questioning the unintended consequences of current best practice. What would it be like for there to be time and space for nurses to explore their practice and the implications of universal, standardized guidelines, or many other aspects of nursing practice for that matter? It seems that the time and space - the opportunity - to discuss and reflect was significant in this instance.

My understanding of participants' responses is rooted in the context of workload, efficiency, and other manifestations of the day-to-day practice of nurses in busy maternity settings. As stated, there may be too many mothers who want help with their breastfeeding to focus on the infant feeding needs of those who do not. It follows that once the initial explanations are given about the mechanics of feeding an infant with formula, the task of "support" can be seen as having been accomplished.

Sensing the unsaid. At times, my sense of what was occurring reflected not so much what was said, but what was left unsaid, a notion that pervades Gadamerian explanations as well as DeVault and Gross's (2012) approach to feminist interviewing.

> We ponder what lies behind and in front of life in order to sense the significance of life-meaning and grasp the inner sense of the utterances. It is for us to uncover and sense the meaning of the world that is already there. It is for us to become conscious of the world and sense it (J. Grondin, personal communication, May 21, 2015). These ideas

hold promise not only for researchers, but also for practitioners, who "do" hermeneutics in their everyday lives, when interpreting the meaning of their care, and sensing the needs of patients, which includes attention to the unsaid.

The process of conversation and engaging with the texts opened me to the undercurrents of the unsaid. In the moment, I was sometimes aware that dialogue was occurring on two levels, where the words reflected unarticulated meaning. For example, in the conversations, the participants associated lactation consultants with a specific type of expertise. BF initiatives, for most participants, assumed an unsaid authority, almost as if to imply that questioning that authority was unsayable and, at times, even unthinkable. From an intersectional perspective, it bears repeating that the unquestioned opportunity to breastfeed is mainly available to privileged women who have paid maternity leave for the recommended six months and beyond. Other indicators of privilege associated with successful breastfeeding include having the money to hire lactation consultants and having the necessary partner and family supports.

Comments from the participants implied a common understanding about the fears and anxieties that surround the early mothering experience. It was, therefore, possible to move forward with our dialogue, building on mutual understandings of mothers' situatedness. Current nursing realities of challenging workloads and chaotic environments were also assumed in the dialogue and that enabled me, as an interviewer, to establish - even in the moment of dialogue - the influence of corporate cost-saving measures and institutional power differentials that undermine nursing autonomy.

In other cases, though, I contemplated the unspoken only through communion with the texts. Helena, for example shared that, "Women aren't feeling like it is safe to

share with the nurse that ‘you know what, I don’t want to breastfeed’.” The unsaid here denotes power differentials between the nurse and the mother, where women are too intimidated to share their true feelings because they are going against the nurses’ wishes and beliefs. Ostensibly, the nurse is seen as representing an unspoken authoritative presence that looms large in mothers’ experience. I also see many examples in the texts that indicated an unspoken acknowledgment of the symmetry between infant nutrition and confident mothering. In some of the comments, I also uncovered the unspoken belief that all women should be able to breastfeed – a view that is supported by much of the BF literature. Participants’ comments (Lorraine and Noreen) suggested their unspoken desire to press women into breastfeeding, based on their passion for breastfeeding practice. Their explanations indicated that they did not always yield to that desire, but it is meaningful to contemplate the depth of commitment that can accompany breastfeeding promotion in perinatal settings.

At times, I was aware that participants were frustrated for reasons that they had not yet conceptualized for themselves, such as the notion that BF recommendations have unintended negative consequences. Marlese, for example, shared her frustration with the lactation consultant’s desire that their hospital become a certified Baby-Friendly facility. She said that, “I don’t think they (the lactation consultants and hospital administration) fully understand the challenges that are faced by moms to do complete (exclusive) breastfeeding.” Her words suggested an unspoken, not-yet-conceived understanding that the reverence for credentialing maternity settings as “Baby Friendly” could be problematic.

I envision enhanced support for non-breastfeeding mothers as including all the warmth and attention that nurses can give. Non-breastfeeding mothers require a very specific kind of support - one that attends to media and societal pressures and includes strategies to overcome doubts about inferior mothering and enhance confidence. I hearken to Ingrid's experience of "selling" the idea of formula to a mother in crisis. I consider once again the unintended consequences associated with disseminating fear-based BF notions of informed choice.

Discharge Sensibilities

Recently, the British Columbia Coalition of Nursing Associations (BCCNA) gathered to develop a Call for Action, an initiative that is intended to improve British Columbia's health care system. Among other priorities, the issue of discharge planning was identified, which includes the need for more transitional care. The assembled group stipulated that nurses should assume responsibility for the discharge plan, which would incorporate community support, assessment, and, importantly, the context of a patient's life. As I reflect on the participants' words about discharging women following birth, I wonder if nurses think that mothers require less in the way of discharge planning support, by virtue of their youth, good health, and assumed abilities to advocate for themselves. Intersectional realities and the emotional well-being for mothers can be overlooked, however, if their needs are compared to the complex medical and social needs of chronically ill or infirmed older individuals who compete for resources and nurses' time. Yet, several of the participants illuminated the difficulties mothers may experience as a result of a lack of support, their own or their partners' substance issues, and other

extremely challenging social realities. Being a young mother might also have its' difficulties.

Women and mothers have historically been viewed as resilient and the transitions and trauma associated with childbirth have been, and continue to be, overlooked. In the context of being discharged from the hospital, however, the transition to motherhood can be mired with the emotional and physical side effects of hormonal surges, the possible need to recover from surgery, traumatic delivery, and, in the context of this study, possible infant feeding challenges. Mothers' vulnerability is palpable and transition to the mothering role is transformative (Bergum, 1989). Improved transitional care in the maternity setting requires well-defined strategies for community follow-up and support. Even when the delivery is straightforward and the breastfeeding is going well in hospital, it is too soon to know whether breastfeeding is well established or not when mothers are discharged, as Olivia explained. New mothers often find themselves having to problem-solve infant feeding issues when they are feeling emotionally vulnerable after childbirth. Ingrid's discussion about the complications of neonatal hyperbilirubinemia and dehydration serve as a sharp reminder that physical complications can arise for infants as a result of breastfeeding challenges, which may not be fully known to the new mother.

I turn to the Canadian model of midwifery care in the post-partum phase. Midwives visit mothers every day at home for several days following delivery whether the delivery occurs at home or in the hospital. This model could potentially guide care for all women. It would require significant investment in public health nursing and home visits, since not all women receive midwifery care. As explored, infant feeding is not always a natural and problem-free experience. Yet, women who wish to breastfeed are

discharged from the hospital with minimal resources in place should they need to seek assistance with infant feeding issues. Mothers' social locations may reduce access to transportation, lactation consulting, or any number of necessary supports when faced with breastfeeding challenges. Conceptions of what is natural can undermine women's confidence when infant feeding challenges arise. Corporate notions of cost-saving in the health care realm fortuitously collude with discourses that valorize natural birthing and infant feeding, and result in a lack of support for mothers' transitions. I sense that this is the way things go.

I wonder, too, if nurses are attuned to the level of confidence (or shame) among non-breastfeeding mothers upon discharge. It is possible that many nurses are so committed to enacting breastfeeding support that they are not focused on a mother's confidence/shame about not breastfeeding. Although nursing approaches can have unintended consequences (some of which are directly derived from BF recommendations), the responsibility to address those consequences may not be on the "radar." In fact, as I write, I wonder what institutional infrastructure would support nurses' engagement with these ideas. Noreen suggested that the guilt associated with not breastfeeding is another "choice" that women make. I wonder whether it is possible, given current expectations, for perinatal nurses to engage with mothers' lack of confidence, their shame, or other vulnerabilities. I suspect that this aspect of care does not find its way on any "checklist," but perhaps attention to these potentials could find their way into routine assessments and conversations between nurses and mothers.

Where infant feeding is concerned, if a mother is seen to struggle with breastfeeding while in the hospital, I ponder what would evolve for a nurse and mother if

the nurse gave information about formula preparation. I suspect that that sort of discussion would enable confidence for a new mother, and she may then be discharged with fewer feelings of isolation and shame, as well as the knowledge to mix formula safely. It would not be enough to assume that the public health nurse will take over with breastfeeding support or education about formula for in these changing and challenging times of corporate fiscal restraint, community resources and support for mothers are dwindling. If nurses were to consider the lived experience of mothers who are struggling with infant feeding in the "here and now" we could bypass theoretical constructions of ideal infant feeding and practice according to individual assessment and understanding of intersectional realities.

Nurses' sensibilities and nurses' silence. I note that some participants indicated they do participate in the kinds of interactions that have been described above, but when they do, they are violating BF principles. In the process of my interpretation, I examine the meaning that nurses ascribe to swimming against the currents of best practice guidelines. I wonder how we will shift the discourse towards using the "best available knowledge and evidence" to support individual women and support family centered care.

My conversations uncovered possible repercussions for nurses, which participants related when they exposed bullying, and institutional and peer reprisal. These are unpleasant potential consequences to be sure, but it seemed that most participants were able to navigate these challenges be it through secrecy or by ignoring the forces that they found threatening. Neither one of these strategies has the capability to address professional communication or nurses' moral distress about inadequate care. I consider the hierarchal organization of nurses' work that influence nurses' response to conflict.

These discourses inform my understanding and illuminate a dynamic that was revealed by some participants. It seems that infant feeding support can engender unhealthy communication between nurses, which is rooted in the institutional and societal imperatives to offer infant feeding support in an authoritative, prescriptive manner.

Whether expectations are embraced or rejected in the workplace, the possibilities for satisfying nursing practice are threatened. It seems that open, emotionally safe exchanges between nurses and within institutions could benefit many maternity settings. Nurses' professional satisfaction is important, notwithstanding the secrecy and silence that appear to accompany differences of opinion about enacting infant feeding support. I am curious about nurses' and employers' relationship to the concept of guidelines. This relates to the process of taking up guidelines as rules, rather than applying principles to guide care.

I am struck with the possibility that enthusiasm for participating in this study may reflect a desire for nurses to engage in emotionally safe exchanges. I imagine the possibilities for enhanced clinical nursing judgment that could occur in maternity settings if open and honest dialogue could occur among nurses about mothers' infant feeding dilemmas.

In my interviews, I observed a pattern. Initially many participants celebrated Baby Friendly initiatives, almost as though they assumed that was what I wanted to hear. However, as the conversations progressed, I sensed more of a desire among participants to explore the complexities and the dilemmas associated with infant feeding and what it means to support mothers. I am struck with the possibility that discussing and deconstructing practice is a way to enhance thoughtfulness. I suspect there are few

opportunities in practice for this kind of interchange to occur and I wonder whether a model of engaging nurses in dialogue holds promise for shifts in practice.

Limitations of Research

It is challenging to identify the limitations, knowing the lens of hermeneutic perfection guides my interpretation. In other words, the beauty of making meaning of what lies before me, propels my belief that the research conversations inform a greater understanding of perinatal nursing practice. It is true that I did not have a conversation with an Indigenous nurse nor did any of my participants disclose any non-normative identities that may have added richness. No men responded to my recruitment strategies. Repeated exposure to the texts of the research conversations assure me, however, that the diversity of approach among the participants offered a meaningful foundation upon which to build analysis and understanding. This is an important consideration when considering the limitations. In other words, the diversity of approaches among the participants that I attracted to the study has offered a foundation upon which to build analysis.

Future Research Possibilities

After undertaking two studies on this topic, I envision a third that would also focus on perinatal care. This would involve interviewing women who gave birth more than a decade ago, in order to investigate the link between infant feeding and women's overall feelings of successful mothering. When I explain my current topic to friends and acquaintances, I am frequently met with the beginning of a conversation about regret. My current work appears to invite disclosures of disappointments that occurred long ago. The potential research would be about how the experience of unsuccessful breastfeeding, even

after a long passage of time, can shape women's feelings about their mothering experience. I believe such a study would align well with hermeneutic notions of mothers' *Dasein* and the importance of the experience of infant feeding as it relates to successful mothering, and to overall meaning of a mother's existence.

Conclusion

It was difficult to select excerpts from the conversations with participants, since each interview was rich and thought provoking and there were many possible avenues for interpretation. I have considered my own history and biases as well as the influence of dominant discourses and unintended consequences, which shaped the conditions in which fused horizons of understanding could be discovered. My biases were challenged and I doubted the efficacy of my inquiry. Yet I was motivated by the desire to see what was at play among nurses in the arena of infant feeding support. The view was, at times, uncomfortable.

I recount the virtues of hermeneutic thought and the impossibility of finding universal meaning. I too, have been looking for something "universal" to embrace. In retrospect, I was ironically perhaps, pursuing a unifying idea that could disrupt WHO's (2009) universal approach to infant feeding support. As a way of reconciling this revelation, I invoke Foucault, whose work first alerted me to the possibility of examining unintended consequences associated with breastfeeding promotion. Mills (1997) elucidated a key element of Foucauldian discourse theory, arguing that discourse exposes a "messy, complex vision of the future" (p. 27). The discourses that I explored in Chapter Four uncovered a wash of complex and contradictory forces that are at play for nurses involved in infant feeding support. These discourses appear to shape nurses' approaches

to care in ways that have the potential to be supportive to women as well as marginalize and silence women during the important perinatal period (Beck, 2009; Humphries & McDonald, 2012; Murphy, 1999; Shakespeare et al., 2004; Wolf, 2011). At the end of my research, I have not achieved any unified understanding of the dilemmas. Instead, I have a deeper appreciation of the complexity and "messiness" of nurses' interactions with women in the context of infant feeding support.

Is it possible to forge a different conception of the binary between breastfeeding and formula feeding? This was my hope, but the act of analysis and interpretation reminds me of the limitations of language and perhaps the limitations of my own human ability to conceptualize. According to Grondin (2003), it was by identifying *Dasein* as man running towards death that Heidegger suspected he had created yet another "groundedness" approach, reflecting the difficulty to conceive understanding as "grounding-free." The desire to escape philosophical grounding, as Heidegger intended, and his eventual perception that he had in fact created it, is a fascinating example of paradoxical philosophical angst, and exposes the challenge associated with the quest to disregard familiar frames of reference, such as conceptual notions of binary or theoretical grounding. Yet, participants such as Rita and Noreen hinted at the possibility that infant feeding need not be reduced to the exclusive "either/or" binary, including options for mixed approaches. The practical difficulties associated with mixing formula feeding with breastfeeding are, however, not straightforward. Lactation can be compromised as a result of inconsistent suckling, and relegate mothers to a regime of pumping. Equally important, the discourse surrounding formula risk would need to be reconciled before

many women would be willing to consider occasional use of formula, or any combination therein.

I return to the multiple social realities that complicate women's responses and nurses' approaches to breastfeeding best practice guidelines. Each nurse brings to her practice a combination of experience, educational background, and social location that shapes her attitude and approach towards infant feeding support. In my study, these factors appeared to influence responses and approaches to mothers, whose social locations are diverse and complex. The intersectional lens must also be applied to mothers. Breastfeeding practice thrives, for example, in social situations where women enjoy the support of a partner and extended family and they are able to access assistance from health care initiatives if breastfeeding challenges arise. Financial freedom, emotional stability, problem-solving capacities, and many other variables factor into women's social location and shape their infant feeding experiences. Knaak (2006) suggests that, "In general, the mothers least likely to breastfeed are those with insufficient resources in terms of time, energy, material and social support" (p. 412).

It is prudent to acknowledge that many women will successfully feed their infants with formula, with no health repercussions to themselves or the infant. Some mothers and infants will face health challenges that are associated with formula in spite of a history of successful breastfeeding. A tempered perspective would ensure that it is the fullness of mothers' lives, instead of mothers' breasts, which leads nursing practice in the perinatal period. Nursing practice would therefore be *informed* by current knowledge and *guided* by clinical wisdom.

Current breastfeeding literature emphasizes strategies for increasing breastfeeding success rates and strategies for encouraging women to persevere with breastfeeding. It also promotes empiric perspectives about breastfeeding superiority that draws on WHO (2009) Baby Friendly principles that has been circulated internationally since the 1990 Innocenti Declaration. However, for women who struggle with maintaining optimal health and/or stability, there are other considerations besides breast milk superiority. The prominence associated with global WHO literature, and the discourses embedded therein appear to challenge, as well as uphold, day-to-day nursing practice of the participants.

The intersectional realities of women's lives, including lack of support and education, poverty, limited English, and the increased vulnerabilities that accompany those realities require nurses' attention given their influence after birth. Reproductive justice would suggest that limited choice and limited exposure to alternative infant feeding methods constitutes a violation of women's rights to full reproductive information. It is clear that there are several aspects of BF approaches that violate the principles of reproductive justice. Women's "reproductive rights" and the specifics of "reproductive health" and "reproductive justice" offer a relevant starting point to discuss infant feeding policy that shapes nursing practice.

I detected that some participants' approach to infant feeding support was primarily concerned with honoring the task at hand, which was breastfeeding promotion without considering the individual situations of the women. The "real-life" experiences of women and girls are key components in the quest for bettering their lives and creating healthier families and more sustainable communities. This is a basic principle of all social justice movements, including the reproductive justice movement (Retrieved from:

http://www.protectchoice.org/section.php?id=28). To what extent, however, are we addressing women's and girls' "real life" issues? Instead of presenting breastfeeding as the "normal" and "natural" way to feed the infant, we could be asking: "What is best for this woman and this family?" One suggestion is to offer comprehensive information to all women about formula preparation prenatally and while in hospital, and to ensure safety and comfort with that option. This suggestion defies BF guidelines, which dictate that mothers are only told about the risks of formula. Unfortunately, as Gloria indicated, the decision to discontinue breastfeeding may occur tearfully at home, or in isolation. The negative messaging about formula they received from hospital or community nurses could haunt them, but the fecundity of mothers' regret seems unimportant in the context of promoting normal, healthy, and best.

Although the process of reconciling infant feeding approaches is elusive, the reproductive justice movement may offer a starting point for a societal paradigm shift. For example, by featuring *what else* is at play in women's lives, we honor intersectional perspectives, the principles of reproductive justice, and Gadamer's call to engage with the *other* questions need to be asked and answered. Gadamer's (1996a) projections of enigmatic health also evoke an image from which to proceed, wherein mothers move forward joyfully with their mothering adventures without the encumbrances of self-doubt, self-recrimination, or regret about their infant feeding method. I imagine nurses' participation in this image and a vision that nursing practice will support maternal confidence, contentment, and emotional well-being.

These are sustaining images when the discussion becomes burdened. This venture included ongoing references to the discourses that underpin infant feeding support. We

have, at every turn, considered the forcefulness of those currents as we approach understanding. The undertow of the unexpected has pulled us to new and surprising places. However, as was the case before my research unfolded, I sense significant disarray and complexity related to the practice of infant feeding support.

In Heideggarian terms, I remain immersed in a mother's sense of "Dasein" and "*Being."* The fullness of her existence - her experience - is cherished in the context of her unique history and the promise of her future on which mothering can confer significant meaning. I am drawn to embrace, yet again, the contextual realities associated with each unique circumstance, and the importance of sensitive nursing presence in the perinatal realm.

Moules (as cited in Moules et al., 2014) suggests that, "Language is fundamental to Gadamerian hermeneutics… because it has the universal significance of being the air that understanding breathes" (p. 39). The breath of understanding, as realized through dialogue with nurses, holds the promise to disrupt, enlighten, and fuel further contemplation about a delicate component of perinatal nursing care.

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Appendix I

The Code of Marketing of Breastmilk Substitutes

(WHO/UNICEF, 2009a, p. 49)

The main points in the Code include:

• No advertising of breast-milk substitutes and other products to the public;

• No free samples to mothers;

• No promotion in the health services;

• No donations of free or subsidized supplies of breast-milk substitutes or other products in any part of the health care system;

• No company personnel to contact or advise mothers;

• No gifts or personal samples to health workers;

• No pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;

• Information to health workers should only be scientific and factual;

• Information on artificial feeding should explain the benefits of breastfeeding and the costs and dangers associated with artificial feeding;

• Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

Appendix II

Ten Steps to Successful Breastfeeding

(Retrieved from: http://www.unicef.org/newsline/tenstps.htm)

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in – that is, allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Appendix III

Fraser Health Document

fraserhealth Better health. Best in health care.

Prenatal Decision-making Tool

- **Breastfeeding is the normal way to feed your baby.**
- **Sometimes breastfeeding is hard at first. We can help you!**

DID YOU KNOW…?

- **Although most babies grow on formula, studies show the routine use of formula comes with some risks to both mothers and babies**
- **For the first 4-6 months babies can't protect themselves from infections very well; breast milk helps protects them. The protection lasts as long as they breastfeed – and longer.**

Colostrum (the first milk) coats and protects baby's gut:

- **Even one feed of formula can damage that coating and make illness more likely.**

Babies who do not receive breast milk are more likely to get *significant illness and disease*:

- **Diarrhea and vomiting** *(~68% higher rate)**
- **Colds, flus, ear and chest infections** *(77% more hospitalization for chest infections)**
- **Diabetes** *(~ 20 - 42% higher rate)**
- **Certain childhood cancers** *(Leukemia: ~ 16 – 20%)**
- **Bowel diseases**
- **Obesity** *(~ 7 – 26% higher risk)*
- **Sudden Infant Death Syndrome** ("SIDS" *~ 38.5% higher risk*)*

Also, non-breastfed children may score a bit lower on IQ tests**

Mothers who mainly feed their babies formula have some higher risks:

- **Type II diabetes** *(usually ~ 4 – 13% higher risk)*
- **Bleeding problems after childbirth**
- **Breast cancer before menopause** *(~ 30% higher rate than women who breastfed for 1 year)*
- **Ovarian cancer** *(~ 22% higher risk)**

And…mothers can take longer to lose their pregnancy weight ***

- **Even small amounts of breastmilk can help your baby.**
- **When you can't feed your baby your own breastmilk or banked breast milk, commercial infant formulas are next best.**

Fraser Health Breastfeeding Practice Advisory Council, December 2012

*Ip, Chung, Raman, Chew, Magula, DeVine, Trikalinos, Lau. Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries. Agency for Health Care Research & Quality , Pub. No. 07-007. April 2007.

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Mother-Baby Feeding Plan _____

Canadian Pediatricians (baby doctors) recommend breastfeeding. You may have valid reasons for choosing formula. Please read this, talk to your nurse/midwife/doctor about feeding your baby, and check off and initial your plan.

However you feed, in the first few weeks remember to spend daily skin-to-skin time with your baby. This helps your baby's development.

☐ ***BREASTFEEDING*** _____ (Initials)

I choose to breastfeed and do not want my baby to get any formula or bottles. I know that breastfeeding early and often (at least 8 times/24 hours) helps us both:

- my breast milk supply will increase sooner and faster
- my breasts will not get so hard and sore (engorged)
- my baby will have lots of practice breastfeeding

If my baby is unable to breastfeed initially, someone will talk to me about milk expression and methods other than bottle to feed my baby.

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☐ ***MIXED FEEDING*** _____ (Initials)

I want to breastfeed, but there will be times when baby is hungry and I want my baby to get some formula. I know giving bottles in the early days of breastfeeding can cause problems:

- my baby may have trouble going back on the breast after using a bottle nipple
- my baby may not want to breastfeed if full from formula
- my breast milk supply may take longer to increase because my baby is not sucking as much at the breast
- my breasts may become hard and sore (since my baby is not removing the milk). Then my baby could have trouble latching on, and my milk supply could eventually go away.
- if I continue giving formula it is likely I won't have enough milk for my baby's needs.
- I understand that formula feeding increases the risk for my baby and myself for the conditions listed on the opposite page.

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☐ ***INFANT FORMULA FEEDING*** _____ (Initials)

I want my baby to be formula fed. I know that:

- formula is provided free while I am in the hospital
- once I am at home, I will need to buy formula for nine to twelve months (extra costs from $60 to $150 /month)
- I will need to learn how to prepare formula and bottles under sterile conditions and proper concentration to protect my baby's health.
- powdered formula is not sterile, so I will use liquid formula if my baby is premature or ill (unless my doctor gives different instructions).
- it may be hard to change to breastfeeding after a few feeds/days of formula feeding.
- I understand that formula feeding increases the risk for my baby and myself for the diseases listed on the opposite page.

Mother's Name: _____ *Date*: _____

FH Breastfeeding Practice Advisory Council, December 2012; adapted from BC Women's Mother-Baby Feeding Plan Printshop # 256687

Appendix IV

Cautions for Intersectionality Research

Canadian health researchers who explicitly used intersectionality analysis attended to the following questions about their research (Hankivsky et al., 2010, p. 4).

1. Who is being studied? Who is being compared to whom? Why?
2. What issues of domination and exploitation are being addressed by the research? Is the power at the centre of all analyses?
3. How will human commonalities and differences be recognized without resorting to essentialism, false universalism, or obliviousness to historical and contemporary patterns of inequality?
4. How do researchers make sure that they are not seeing what they want to see in their research?
5. In order to affect social change, does the research include representation from all key stakeholder groups such as policy makers, grassroots activists and community groups, including multiply oppressed communities?
6. Is the research framed within the current cultural, societal, and/or situational context?

Appendix V

Recruitment Advertisement

(Canadian Nurse, October, 2014, Volume 110, Number 7, p.41)

NURSES' EXPERIENCE OF INFANT FEEDING SUPPORT

Perinatal nurses (past and present) of diverse ethnicity, age, experience and gender are invited to participate in a nursing doctoral study. The study aims to enhance understand of the issues facing perinatal nurses who support women with infant feeding. Approval for the research was granted by the University of Victoria Human Research Ethics Board. If interested please contact: Joan Humphries RN PHD© @jmhumphri@uvic.ca.

Appendix VI

Historic Contributions to Understanding

I did not encounter participants who articulated experience working with women who lived with HIV/AIDS, or who had engaged with the history of WHO. I believe that the information informs my analysis in an "altogether" way (Blattner, 2006) by offering a nuanced understanding of breastfeeding promotion history.

According to White (1999), and Jung (2015), WHO have not always been motivated from the altruism that accompanied the creation of the 1990 WHO Innocenti Declaration. That milestone international event is linked with current approaches to breastfeeding promotion, and responded to two decades of corporate influence in Third World countries. Briefly stated, formula companies, during those years, exploited vulnerable populations. Mothers began to purchase and feed their infants with formula, as they responded to marketing campaigns by companies such as Nestle. This shift in maternal/child practice in the Third World resulted in thousands of infant deaths, because mothers were mixing the formula with contaminated water, and diluted the formula in order to save money, resulting in widespread malnutrition and death. An international boycott of Nestle products resulted, and culminated in the WHO Innocenti Declaration.

However, twenty-five years since the inception of the WHO involvement in breastfeeding promotion, I wondered who may be benefitting from the shift away from formula towards breastfeeding. I came away with enhanced understanding about the history of WHO and its failure to acknowledge the risks of HIV/AIDS in breastmilk, as articulated by White (1999) and Jung (2015) below. I acknowledge the surprise that I first

felt when acknowledging WHO's tendency to "turn a blind eye" about the dangers of spreading HIV/AIDS in breastmilk.

Variables around infant feeding choice are distinct according to geographic situatedness worldwide, socioeconomic status, historical elements (Maher, 1992) and other influences such as the prevalence of HIV/AIDS (White, 1999). Edith White (1999) offers an important perspective on the topic in *Breastfeeding and HIV/AIDS: The Research, the Politics, and the Women's Responses*. Her work is particularly jarring, given her own background as a well-known advocate, respected author, and activist for breastfeeding practice during the 1970's and 1980's in the United States (US). But White began to question the thrust of breastfeeding promotion that was emanating from international sources as early as the late 1980's, when questions around HIV and possibilities for transmission through breast milk began to surface. Interestingly, White (1999) relayed that up to and including the year 1997, there was a surprising advocacy to protect and promote breastfeeding in WHO policy, even though the risks associated with HIV transmission had been long proven to be of significance. In the WHO policy statement of 1997, for example, the language of informed consent pervaded the document, intimating that it was entirely appropriate for a woman to "decide for herself" (p. 8) once she was given information about HIV transmission, and the benefits of breastfeeding in spite of the "risks" and "possible advantages" (p.8) to other methods of feeding. This policy statement was published at a time where there was knowledge that approximately 40% of breastfeeding mothers passed the HIV virus onto the infant (White, 1999). In this case, it is perplexing to see the language of informed choice employed in the context of disenfranchised women in Africa living with HIV. Indeed, the whole notion of informed

choice is one that emulates from Western bio-medical ethics, which assumes a certain level of capacity and background with the culture of ethical decision making-an assumption that is not likely to be defensible when considering the situation of many marginalized women who are being so counselled. It seems, therefore, that the notion of informed choice in the context of BFI recommendations is problematic on a number of levels, for women throughout the world.

Clearly, there is much to consider about infant feeding decisions that HIV infected women make. It would be unfair to suggest that is solely the influence of the WHO and their policy statements that have led to situations wherein women risk transmission of HIV to their infants by breastfeeding. However, the lapse that occurred on the part of the WHO with respect to releasing clear communication about the risks of HIV transmission through breast milk throughout the 1990's raises some interesting questions, given the profile of influence that is held by that organization and other organizations that operate in tandem.

White challenged the interpretations of research studies touted in breastfeeding advocacy. The literature suggested that more babies would die from not breastfeeding than would die of HIV/AIDS. It also extolled the advantages for birth control by suckling, suggesting that birth control would be undermined by a failure to promote breastfeeding. These statistics surely muddied the issue at hand, which was the risk of HIV transmission by breast milk.

White offers a noteworthy insight by distinguishing the *research* dialogue from the *advocacy* dialogue around breastfeeding, since each will offer "very different frameworks for interpreting controversy over infant formula" (p. 65). I am drawn to

consider the possibility that research and advocacy interests are often conflated in the interests of BFI promotional efforts worldwide. Most significantly, White alludes to a conspiracy of silence that existed among the influential WHO and associated organizations such as United Nations International Children's Education Fund (UNICEF) and United Nations Program on HIV/AIDS (UNAIDS) starting in the late 1980's, when it was becoming clear that HIV/AIDS was a devastating reality worldwide.

It is perplexing to understand what may have been at play. What was there to be gained by breastfeeding promotional efforts in the midst of a health crisis of global proportions?

Although there are many possibilities, I am drawn to White's (1999) implications of organizational dynamics. She draws parallels about the pitfalls associated with attaching to a "cause," especially when that cause is challenged with new and conflicting perspectives or information. By extension, in the context of the *industry* associated with Westernized international guiding bodies, the implications of reversing or altering perspectives may be steeped in budgetary commitments, high profile careers, research obligations, and political association-all of which have the power to coerce and even corrupt the fundamentals that shape the very existence of the organization.

I wonder to what extent similar organizational influences exist in Canadian perinatal settings.

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