NURSE-MOTHERS' PERSONAL INFANT FEEDING EXPERIENCES AND THEIR INFLUENCE ON NURSING PRACTICE

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ABSTRACT

Exclusive breastfeeding has become an important facet of quality care for hospitals providing maternity services. As the primary caretakers of mother-baby dyads, postpartum nurses are responsible for providing breastfeeding support during the maternity hospitalization. The aim of this phenomenological study was to explore the personal infant feeding experiences of postpartum nurses, and examine the influence those experiences have on nursing practice related to breastfeeding. The study employed Carspeken's (1996) methodology. The findings indicated that the nurses' personal breastfeeding experiences were very similar to those of other women. However, they received less support than other women did during the maternity hospitalization. Personal experience changed the way nurses practiced. They promoted breastfeeding in a more personal way, established deeper connections with patients, and worked to prevent women from experiencing the physical or psychological pain they experienced.

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Chapter 1: Introduction

Background

Exclusive breastfeeding has become an increasingly important facet of quality care for hospitals providing maternity services. Over 45 organizations have written position statements endorsing breastfeeding, including the World Health Organization, the American College of Gynecologists, and the American Academy of Pediatrics. The Agency for Healthcare Research and Quality (AHRQ) performed a comprehensive literature review on breastfeeding and formula feeding outcomes and found breastfeeding to be associated with a reduction in infant risk for acute otitis media, atopic dermatitis, gastrointestinal infections, lower respiratory tract diseases, asthma, adolescent and adult obesity, and sudden infant death syndrome. Additionally, AHRQ found a reduction in maternal risk for breast and ovarian cancer (Ip et al., 2007).

The Joint Commission, an organization providing accreditation to more than 20,500 hospitals in the United States, implemented mandatory reporting of exclusive breastfeeding rates for all hospitals with 1,100 or more births per year effective January 1, 2014 (Joint Commission, 2015). They cited vast evidence supporting breastfeeding, and identified the maternity hospitalization as critical to the success of breastfeeding. In addition, Healthy People 2020, a national health promotion and disease prevention initiative (U.S. Department of Health and Human Services, 2010) is focused on exclusive breastfeeding during the maternity hospitalization. By 2020, the U.S. Department of Health and Human Services (2010) strives to reduce the proportion of breastfed infants receiving formula supplementation within the first two days of life from 19.4% (Centers for Disease Control and Prevention, CDC, 2014) to 14.2% (U.S. Department of Health and Human Services, 2014).

The maternity hospitalization is a particularly important period for exclusive breastfeeding. During the first 72 hours of life, the exclusively breastfed infant receives only colostrum (Academy of Breastfeeding Medicine, 2009). This enhances the growth and protection of the gastrointestinal tract (Stockinger, Hornef, Chassin, 2011; Petherick, 2010), and prevents exposure to bovine proteins which up-regulate inflammation in the infant's gut (Host, 2002). Exclusive breastfeeding also prevents the intake of excessive volume (Dewey, Nommsen-Rivers, Heining, & Cohen, 2003), and provides the mother's breasts with the stimulation necessary to program adequate milk production for the course of lactation (Kent, 2007). Additionally, women who have problems during the first week of breastfeeding are at a greater risk of stopping breastfeeding within ten weeks postpartum (DiGirolamo et al., 2005).

Mothers benefit from receiving accurate information and support during breastfeeding initiation; without this, they may not succeed with breastfeeding (Bernaix, 2000). As the primary caretakers of mother baby dyads, postpartum nurses are chiefly responsible for providing this support during the maternity hospitalization, so it is important to enable nurses to enact these responsibilities effectively. Studies found that healthcare providers cited personal breastfeeding experience as an important source of breastfeeding knowledge (Hellings & Howe, 2000; Nelson, 2007; Patton, Beaman, Csar, & Lewinski, 1996). However, no studies exist about the specific information healthcare providers gained from their personal experiences, and how they applied the information to their professional practice.

Patterns of Knowing in Nursing

Carper (1978/1999) examined the body of nursing knowledge that serves as the rationale for nursing practice. Her seminal theory identified four patterns of knowing: *empirics*, the science of nursing; *aesthetics*, the art of nursing; *personal knowledge* in nursing, and *ethics*, or

moral knowledge in nursing. Carper argued that although the primary emphasis in nursing rested within the empirical realm, there was "a tacit admission" (p. 14) around the existence of the other dimensions. She explained that personal knowledge was "concerned with the kind of knowing that promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment" (p. 14). This facet of nursing involved the actualization of an authentic personal relationship between the nurse and patient. Antrobus (1997) asserted the facet of personal knowledge was necessary for nurses to transition into the role of knowledge workers who focused on enabling individuals to achieve health gains.

Although much of the literature focuses on personal experience as something gained while practicing nursing, Bonis' (2009) analysis was more expansive. She purported "…that the concept of knowing in nursing involves a uniquely personal type of knowledge, constructed of objective knowledge interfaced with the individual's awareness and subjective perspective on personal experience" (p. 1330). Bonis indicated knowing was unique to each nurse, and it developed through empirical study and clinical, professional, and personal experiences.

Nurse-mothers' Personal Infant Feeding Experiences

According to Bonis' (2009) conceptualization, nurses' infant feeding knowledge is comprised of empirical facts about infant feeding, clinical experiences of feeding babies and assisting mothers with breastfeeding, and personal experiences including those of feeding one's own infant. Personal experiences may be particularly relevant in maternity nursing. Because female nurses dominate this role, it is common for nurse and patient to share the experience of being a mother. One nurse said it was so routine for mothers to ask about her personal breastfeeding experience that it "became a game" to see if she could get through just one shift

without being asked. She reported that it had never happened (J. Carrasco, personal communication, March 11, 2014).

The literature on women's infant feeding experiences reflected wide variability. Breastfeeding mothers reported everything from feeling deep satisfaction, contentment, and pride; to being overwhelmed, disgusted, and feeling resentment (Burns, Schmied, Sheehan, & Fenwick, 2010; Ryan, Bissell, & Alexander, 2010; Schmied, & Lupton, 2001). In contrast, formula feeding mothers reported a range of feelings including guilt, shame and failure, relief that the baby was being fed, and satisfaction with finding an easier solution (Lee, 2007, 2008). There is a lack of research, however, that looks at postpartum nurses' (i.e., nurse-mothers') experiences of feeding their own infants. Further, while there was an occasional discussion in the literature on the possibility that nurses' personal feeding experiences influence their breastfeeding nursing practice (Bernaix, 2000; Dykes, 2006; Ekström, Widström, & Nissen, 2005; Patton, Beaman, Csar and Lewinski, 1996; Raphael-Leff, 1991), this focus remains unexplored.

Purpose and Significance of this Study

The purpose of my study was to explore the personal breastfeeding experiences of nurse-mothers, and how those experiences influenced their nursing practice related to breastfeeding. Nursing practice for postpartum nurses includes providing breastfeeding education, instruction, guidance and support during the maternity hospitalization.

Understanding the personal infant feeding experiences of nurse-mothers and their influence on nursing practice is critical for hospitals providing maternity care. With this insight, nursing leaders concerned with the quality goal of increased exclusive breastfeeding during the maternity hospitalization may identify and leverage nurses' strengths and address previously

unseen barriers. A deeper understanding of nurse-mothers' personal experiences and their impact on nursing practice will also benefit nurse educators in hospitals. Nurse educators may be able to use findings from this study to develop holistic, comprehensive breastfeeding education programs that incorporate personal, empirical, and clinical knowledge. Further, this study may stimulate all nurse-mothers to reflect on their personal infant feeding experiences, and consider the implicit ways their experiences influence nursing practice, resulting in personal growth and development. As nurses grow and develop, the mother-baby dyads for whom they care will benefit by receiving accurate breastfeeding information and consistent support. Ultimately, an improved understanding of the nurse-mother's personal breastfeeding experience and its influence on nursing practice may contribute to increased exclusive breastfeeding rates during the maternity hospitalization.

Research Questions

1. What is a nurse-mother's personal experience of feeding her infant?
2. How does a nurse-mother's personal infant feeding experience influence her breastfeeding practice with hospitalized postpartum mothers?

Chapter 2: Literature Review

The purpose of this literature review is to provide the reader with context for this study (Creswell, 2014). This review includes two key bodies of work: literature related to infant feeding and literature related to Carper's (1978/1999) patterns of knowing in nursing. The literature search began using Medline and CINAHL databases, and then expanded to include others such as JSTOR, ERIC, and EBSCO. The search for infant feeding literature included the following terms: breastfeeding, experience, formula, infant feeding, mother-baby nurses, personal experience, postpartum nurses, qualitative and support. The search related to Carper's (1978/1999) patterns of knowing in nursing included the following terms: aesthetic knowing, Carper, Chinn, esthetic knowing, knowing in nursing, Kramer, nursing knowledge, patterns of knowing, personal experience, personal knowing, and personal knowledge. Forty-three papers from peer reviewed journals and three books were ultimately included in the review. Most of the literature related to infant feeding was published within the last ten years, though a few seminal studies and Raphael-Leff's (1991) book were included because of the unique nature of these works. Carper's (1978/1999) concept of knowing in nursing is almost forty years old. The review in this area included Carper's original work and Johns' work from 1995, both of which are considered highly influential. The remainder of the literature in this area was published between 1997 and 2015. This wide date range was employed to examine the evolution of Carper's (1978/1999) concept.

This review begins with an exploration of the maternal experience of infant feeding, and then turns to the effect of healthcare professional support on breastfeeding, and the type of support valued by breastfeeding mothers. The section of the review concerned with Carper's (1978) model of knowing in nursing begins with a conceptual overview, and then examines the

present day relevance and application of the patterns of knowing, culminating with a call for research. The final section of the literature review summarizes findings and gaps in the literature, and explains how Carper's model of knowing in nursing will be used in this study.

The Maternal Experience of Infant Feeding

How a mother feeds her infant is a product of interrelated physiological, psychological, and social factors (Raphael-Leff, 1991). This study focused on psychological and social factors. The physiological process of breastfeeding is outside this study's scope, though it is important to note that what occurs during the first two weeks of infant feeding significantly influences the physiological process of breastfeeding (Kent, 2007). Because the vast majority of women in the United States spend some part of the first two weeks in the hospital, what occurs with infant feeding during the maternity hospitalization has an impact on breastfeeding physiology.

The infant feeding decision. Burns, Schmied, Sheehan & Fenwick (2010) asserted that extensive breastfeeding literature positions breastfeeding as "a deeply personal experience embedded within a woman's specific social and cultural circumstances" (p. 202). This reflects the interdependencies of personal and social experiences. Both were prevalent themes in the literature.

Andrews & Knaak (2013) found that culture shaped the individual perception of choice around feeding method. Their study of breastfeeding experiences in Canada and Norway found that Canadian mothers acknowledged both breastfeeding and formula feeding as choices available to them. In Norway, none of the 27 mothers studied could remember making a choice about feeding method: Breastfeeding was presumed to be the only feeding option.

In countries where infant feeding method was perceived as a choice, mothers reported feeling immense direct and indirect pressure to breastfeed (Andrews & Knaak, 2013; Burns,

Schmied, Sheehan & Fenwick, 2010; Lee, 2007; Schmied et al., 2011). The idea of being a 'good mother' was connected with feeding in a number of studies, with mothers citing 'best for baby' as the most influential factor in their initial feeding decision (Burns, Schmied, Sheehan & Fenwick, 2010; Dykes, 2005; Forster & McLachlan, 2008; Larsen & Kronborg, 2013; Marshall, Godfrey & Renfrew, 2007; Nelson, 2006). However, mothers' representations of what was 'best' varied according to their feeding intention. Andrews and Knaak (2013) found those intending to breastfeed considered the medical discourse espousing breastfeeding as the optimal feeding method to be the most the accurate source of information. Conversely, some mothers intending to formula feed questioned or rejected the 'breast is best' discourse and found alternate authorities, most commonly the mother herself (Lee, 2007). Mothers portrayed formula feeding as a choice a 'good mother' would make, explaining their discomfort with breastfeeding could negatively affect their infant (Burns, Schmied, Sheehan & Fenwick, 2010), and formula feeding allowed fathers to be involved, which facilitated paternal bonding (Lee, 2007). Lee (2007) found that formula was "widely experienced as a feeding option with pragmatic advantages" (p. 1080), yet, for many mothers positive sentiments were tempered or outweighed by negative feelings characterized by uncertainty, guilt, and worry about baby's health. Negative feelings were particularly prevalent in mothers who had intended to breastfeed, but were unsuccessful. Lee (2008) concluded that most mothers, both those who decided to formula feed prenatally, and those who resorted to formula feeding after having trouble breastfeeding, had to do internal work to regain their identities as 'good mothers'.

While the discourse around infant feeding generally portrayed feeding method as a private choice, Callaghan & Lazard, (2012) argued, "infant feeding choices are anything but straightforwardly private. They are open to public scrutiny – through health promotion, through

legislation, through representations of women and sexuality and women as mothers" (p. 953). Their analysis of a breastfeeding debate forum on a British parenting website revealed that formula-feeding mothers felt the need to account for their choice in a way that breastfeeding mothers did not. This was understandable, considering that breastfeeding was routinely represented as the "primary and natural" (p. 943) feeding choice, and formula feeding was relegated to the position of the artificial "second best" (p. 943) option.

Early breastfeeding expectations verses reality. Though many women resolved to try breastfeeding, some approached the experience with doubts about their bodies' abilities (Avishai, 2007; Dykes, 2005; Nelson, 2006). Others assumed breastfeeding would be automatic or easy, due to its routine representation as 'natural' (Burns, Schmied, Sheehan & Fenwick, 2010; Callaghan & Lazard, 2012; Larsen & Kronborg, 2012). Regardless of what was anticipated, most mothers found the actual experience of breastfeeding to be significantly different from their expectations (Burns, Schmied, Sheehan & Fenwick, 2010; Hinsliff-Smith, Spencer & Walsh, 2013; Larsen & Kronborg, 2012). The majority experienced difficulties, such as physical pain, lack of sleep, and insufficient infant weight gain (Andrews & Knaak, 2013; Avishai, 2007; Larsen & Kronborg, 2012; Nelson, 2006). Several studies depicted breastfeeding as hard work, calling it "demanding" (Burns, Schmied, Sheehan & Fenwick, 2009, p. 208), "difficult" (Forster & McLachlan, 2010, p.119), and "a huge amount of 'worry'" (Schmeid & Lupton, 2001).

The intense personal experience of breastfeeding. In her metasynthesis of 15 studies on the breastfeeding experience, Nelson (2006) found breastfeeding to be "engrossing" (p. e15), due to the time, commitment, and maternal self-sacrifice required. Burns, Schmied, Sheehan & Fenwick's (2009) meta-ethnographic synthesis of 17 studies of breastfeeding experiences echoed Nelson's findings, citing the recurring themes of commitment and perseverance. Both studies

indicated that mothers' feelings about their breastfeeding experiences spanned from very positive to very negative. For some mothers, breastfeeding created a pleasurable feeling of intimacy, closeness, and connection, while it caused others to "long for separation… or feel that breastfeeding was an 'emotional burden'" (p. e16). Forster & McLachlan's (2010) findings were similar. In a telephone survey of 889 women, 74% made positive comments about breastfeeding such as "'worthwhile', 'excellent', 'positive', and 'fantastic'" (p. 119); 40% made negative comments including "hated" (p. 120), "upset… sore" (p. 120), and "draining" (p.120), and 23% made both positive and negative comments, such as "I felt good – when I wasn't in pain" (p. 119).

There was also a range of emotions associated with breastfeeding cessation (Hauck & Irurita, 2003; Nelson, 2006). While mothers who felt they had a "successful" breastfeeding experience reported feelings of increased self-esteem, confidence and empowerment (Nelson, 2006), those who stopped breastfeeding earlier than intended often experienced feelings of dissatisfaction, guilt and failure (Hauck & Irurita, 2003; Hinsliff-Smith, Spence & Walsh, 2014; Nelson, 2006; Burns, Schmied, Sheehan & Fenwick, 2009).

The absence of the formula feeding experience. Although there exists a wealth of information on the maternal experience of the act of breastfeeding, literature on the maternal experience of the act of formula feeding is virtually non-existent. This is despite the fact that over 80% of families in the United States do at least some formula feeding during an infant's first six months of life (Centers for Disease Control and Prevention (CDC), 2014). Much of the literature associated with the experience of formula feeding comes from breastfeeding studies where mothers had trouble and consequently resorted to formula (e.g. Braimoch & Davies, 2014; Larsen & Kronborg, 2013). In these studies, the emphasis was on the experience of failure, the

decision to use formula, and the meaning of that decision for a mother. They did not include details on the experience of the act of feeding, with one exception. Larsen & Kronborg (2013) relayed one mother's bottle-feeding experience in their study on cessation of breastfeeding. She said, "'You hold him in the same way on your arm, as if you breastfeed and he can feel your heartbeat and smell your body and you have eye contact. I have not missed out on anything on that account'" (p. 852). Raphael-Leff (1991) hinted at the existence of an emotional experience related to formula feeding, saying, "Making up the formula may give the mother a sense of purpose and precision, and washing out the lustily emptied bottle provides a sense of achievement. She knows just how much her baby has taken" (p. 359). Interestingly, she neglected sharing a description of the actual act of feeding. Raphael-Leff's (1991), Larsen & Kronberg's (2013) and Lee's (2007) findings suggested there is some experience associated with the act of formula feeding, however this remains unexplored in the literature.

Reconciling the infant feeding experience. Hauck & Irurita (2003) found infant feeding to be inseparable from the broader experience of motherhood, so it is not surprising that studies found infant feeding experiences had a lingering effect on women. Ryan, Bissell & Alexander (2009) found that women undertook "moral work" (p. 956) to reconcile their experiences with their self-image, while Lee (2007) revealed that formula feeding mothers had to find ways to regain their identities as 'good mothers'. Hinsliff-Smith, Spense & Walsh (2014) indicated, "For all [22] women in this study breast feeding was an unforgettable experience" (p. e19). Nelson (2006) found the long-term resolution of the breastfeeding experience was often difficult and could take months or years.

Although literature describing how nurse-mothers reconcile their infant feeding experiences is lacking, McCreight's (2005) study of nurses who provided support to parents during pregnancy loss may provide some insight. She found:

> Since many of the nurses may have their own personal experience…providing a service for women can raise complex issues for them…. In addition to the grief of the parents, they may be required to deal with their own private grief. It is important, therefore, that the stressful nature of the work of nurses in this domain is fully recognized. (p.444)

While there are obvious differences between pregnancy loss and infant feeding experiences, there are also similarities. Both situations may be emotionally charged for parents and nurses. Nurses may have to display emotions different from what they are feeling, and this can be taxing (Bierema, 2008).

Personal Infant Feeding Experiences' Influence on Practice

Two separate Cochrane reviews indicated very clear evidence for the effectiveness of professional support in extending the duration of any breastfeeding (Britton et al., 2007; Renfrew et al, 2012). Further studies revealed that mothers reported that professionals' actions during the maternity hospitalization had a strong effect on their belief in their breastfeeding abilities (Braimoh & Davies, 2014; Hinsliff-Smith, Spencer & Walsh, 2013), which could affect breastfeeding duration and exclusivity (Blythe et al., 2002; Renfrew et al., 2012).

Healthcare professionals cited their own or their spouse's personal breastfeeding experience as an important source of their breastfeeding knowledge (Brodribb, Jackson, Fallon, Hegney, 2007; Hellings & Howe, 2000; Kaewsarn, Moyle, Creedy, 2002). However, there was little evidence related to the influence of personal experience on professional practice. While some contended that personal breastfeeding experience did indeed influence practice, they

provided little support for this assertion (see Bernaix, 2000; Dykes, 2006; Ekström, Widström, & Nissen, 2005; Patton, Beaman, Csar and Lewinski, 1996; Raphael-Leff, 1991). In their 2008 study of Australian general practitioners, Brodribb, Jackson, Fallon & Hegney examined the relationship between personal breastfeeding experience, attitudes, knowledge, confidence and effectiveness. They found physicians who had a relatively short experience with breastfeeding had the poorest attitudes toward breastfeeding. However, their study did not indicate why this was the case, and their findings should be considered with care due to a sample size proportion of only 55% (89 of 161) of respondents whom were parents. Additionally, it was a study of physicians, not nurses, so the results may not be generalizable.

Nelson (2007) provided some support for the claim that a nurse's personal feeding experience affects nursing practice. In her study on inconsistent professional breastfeeding support, she interviewed 22 U.S. maternal-newborn (postpartum) nurses, and found the positive or negative nature of a nurse's personal breastfeeding experience "influenced not only the suggestions she gave to a mother, but also her whole 'approach' to breastfeeding support" (p. 33). Nurses who had a positive personal experience perceived themselves as having a greater commitment to breastfeeding. However, nurses who had "less than positive" (p. 33) experiences still believed their experiences were valuable, as they created the possibility for shared understanding between the nurse and breastfeeding mother. One nurse-mother whose experience was not positive indicated that her personal feelings sometimes got in the way of how she should have been practicing. She described herself as, "'one of the worst' among her colleagues in relation to her tendency to readily support a mother's request to have her infant bottle fed in the nursery" (p. 34). Nelson also found that several nurses who had formula fed their own babies told mothers that formula would cause no harm. This is significant, particularly when one

considers that DiGirolamo, Grummer-Strawn & Fein's (2003) study found healthcare providers' ambivalence toward breastfeeding was associated with an increased risk of mothers not breastfeeding at 6 weeks. While Nelson's (2007) findings are important, there is more to learn about the influence of nurse-mothers' personal experiences on practice.

Breastfeeding support mothers value. Mothers sought both technical and emotional support from healthcare professionals (Braimoh & Davies, 2014; Burns, Schmied, Sheehan & Fenwick, 2009; Hinsliff-Smith, Spencer & Walsh, 2013; McInnes & Chambers, 2008; Schmied et al., 2011). With regard to technical support, they wanted to be shown how to breastfeed, and desired practical help with things like positioning and latching the baby for breastfeeding. They preferred help from a health care professional with whom they had established rapport. Instead, mothers often experienced a "physically intrusive, distressing, and embarrassing hands-on approach to help" (McInnes & Chambers, 2008, p. 421; Schmied et al., 2011). McInnes & Chambers (2008) concluded, "Building a good relationship [with healthcare professionals] was important to mothers and may be the foundation on which postnatal support rests" (p. 418).

From their metasynthesis of 31 studies of breastfeeding support, Schmeid et al. (2011) suggested, "support for breastfeeding occurs along a continuum from authentic presence at one end, perceived as effective support, to disconnected encounters at the other, perceived as ineffective or even discouraging and counterproductive" (p. 51). During "disconnected encounters", mothers felt undermined, blamed, and pressured by healthcare providers. As a result, they had less confidence, and were less likely to succeed in breastfeeding. Mothers valued an "authentic presence", which meant the support person developed a relationship with the mother, was an effective listener, demonstrated empathy, and provided affirmation. Mothers especially appreciated hearing about the supporter's personal experiences. In her article on nurse

support for breastfeeding mothers, Ebersold et al. (2007) stated, "Personal stories… lead to inaccuracies….Therefore, we must refrain from sharing personal experiences and instead deliver evidence-based information to our clients…" (p. 486). Yet this position may be ill advised. Schmeid et al. (2011) and Dennis (1999) indicated the value of hearing others' breastfeeding stories, explaining that this could build a mother's breastfeeding self-efficacy, which is associated with increased breastfeeding duration (Blythe et al., 2002).

Fundamental Patterns of Knowing in Nursing

Carper (1978/1999) conducted an analysis of the conceptual and syntactical structure of nursing knowledge, and identified four patterns of knowing: *empirics*, or scientific knowledge; *aesthetics*, also called 'the art of nursing'; *personal knowledge*, which involves self-understanding and awareness; and *ethics*, or moral knowledge. She represented the four patterns as interconnected, and all necessary for achieving mastery in nursing.

While Carper's (1978/1999) definitions of the empirical and ethical patterns of knowing were straightforward, her explanations of aesthetic and personal knowing were quite abstract. She gave no succinct definition of aesthetic knowing, and instead indicated the "open texture of the concept of art" (p. 14) defied a single definition. Regarding personal knowing, she explained it as being "concerned with the knowing, encountering and actualizing of the concrete, individual self…. This knowing is standing in relation to another human being as a person" (p. 15). Porter (2010), criticized Carper for her nebulous definitions, saying, "[If these patterns] cannot be tested or even described, then it is very difficult to ascertain how, or even if, they are being used" (p. 7). Likewise, Duff Cloutier, Duncan & Bailey (2007) called Carper's description of aesthetic knowing "unclear and confounding" (p. 2).

Chinn & Kramer (2015) provided clarification. Of aesthetics, they said:

> Aesthetic knowing in nursing involves an appreciation of the meaning of a situation…. [It] allows one to move beyond the surface to sense the meaning of the moment and to connect with human experiences that are unique for each person…. Aesthetic knowing in practice is expressed through actions, bearing, conduct, attitudes, narrative, and interactions. (p. 9)

They described personal knowing as being an "authentic, aware, genuine Self" (p. 8). To illustrate, they provided an example of a nurse who experienced a bias toward a particular individual, and explained that through personal knowing one could recognize and resolve the bias, rather than having to pretend not to be biased.

The evolution and application of Carper's patterns of knowing. Although Carper's model of knowing in nursing is almost 40 years old, there is evidence of its lasting conceptual relevance. In 1997, Antrobus presented a case outlining the heightened importance of the patterns of knowing based on the shift in healthcare from a focus on illness to a focus on wellness. She suggested this change required nurses to expand their knowledge beyond the empirical realm to become "sophisticated interpersonal actors" (p. 830). Arbon's (2004) study of nurse development revealed that nurses experienced development in broad and complex ways, and all types of primary experiences, both clinical and personal life experiences, influenced knowledge development.

Bonis (2009) examined the present-day concept of knowing in nursing by analyzing 134 papers spanning from 1978 – 2007, and concluded:

> The concept of knowing in nursing involves a uniquely personal type of knowledge, constructed of objective knowledge interfaced with the individual's awareness and

> subjective perspective on personal experience; it is a dynamic process and result of personal reflection and transformation. (p. 1330)

A number of theorists and researchers have cited the importance of reflective practice on the development of knowing in nursing (Antrobus, 1997; Arbon, 2004; Bonis, 2009; Chinn & Kramer, 2015; Heath, 1997; Hunter, 2008; Jacobs, 1998; Johns, 1995). However, Johns' (1995) noted that practitioners struggled to reconcile their personal experiences with Carper's ways of knowing. He observed, "…When these practitioners commence reflection, this personal knowledge is tenuous, uncertain, poorly articulated and understood, having been largely ignored as a significant source of knowing and learning" (p. 230). Thus, he constructed a 'model of structured reflection', which provided cue questions for practitioners to consider related to each of Carper's (1978/1999) patterns of knowing, as well as reflexivity questions. His aesthetics questions aimed to aid practitioners in exploring what they were trying to achieve through their actions, and how their actions affected the patient. His personal knowing questions directed practitioners to consider their feelings and other internal factors that exerted influence on their actions. His ethical questions had practitioners consider the alignment of their actions and beliefs; while the empirics question had them examine the scientific evidence that informed their practice. Johns' questions related to reflexivity guided practitioners toward making use the insights garnered by determining how their ways of knowing had changed, and how they could handle future situations more effectively as a result.

There is little disagreement about the existence of different patterns of knowing in nursing. Chinn and Kramer (2015) noted the emergence of literature investigating additional patterns of knowing signaled the current relevance of the idea, and Paley et al. (2007) indicated that recent work in cognitive psychology offers strong support for the existence of different

patterns of knowing. However, there is long-standing disagreement related to the relative importance of each of the patterns. In 1978, Carper noted, to her chagrin, the primary emphasis within nursing was on empirical knowing, to the detriment of the other patterns. This claim has persisted over the years (Fawcett et al., 2001; Chinn & Kramer, 2015), and is reflected in this quote from James, Andershed, Gustavsson & Ternestedt (2010) which emanated from their study of emotional knowing in nursing:

> Emotional knowing is not taken seriously enough in western culture in which the knowledge tradition builds on strict differentiation between rational and emotional knowledge. And rational knowledge – visibly measurable knowledge – is assigned another weight. Today's society demands evidence…. This type of view about knowledge and science can close the door on emotional knowledge. (p. 13)"

Paley et al. (2007) present a counter perspective on this matter. Through their examination of literature from both nursing and psychology, they concluded that individuals naturally default to holistic, intuitive cognitive processes; those processes commonly associated with the aesthetic, personal and ethical patterns. They noted that individuals must consciously activate deliberate, analytical processes to prevent "sincere but false" (p.694) beliefs from becoming dominant. Thus, they concluded that evidence-based knowledge merits "epistemological priority" (p. 692) over the other patterns.

There is one point of strong agreement in this debate: additional research will benefit the evolution of knowing in nursing (Antrobus, 1997; Arbon, 2004; Bonis, 2009; Carper, 1978; Chinn & Kramer, 2015; Duff Clouthier, Duncan & Bailey, 2007; Fawcett et al., 2001; Porter, 2010).

Summary

The experience of infant feeding was found to be intertwined with the notion of what it means to be a good mother and thus inseparable from the broader experience of motherhood (Hauck & Irurita, 2003). It was common for mothers to be unprepared for the experience of breastfeeding, which was usually different from what was expected (Burns, Schmied, Sheehan & Fenwick, 2010; Hinsliff-Smith, Spencer & Walsh, 2013; Larsen & Kronborg, 2012). Breastfeeding required commitment and perseverance (Burns, Schmied, Sheehan & Fenwick, 2009; Nelson, 2006). Though formula feeding was sometimes seen as a practical solution with advantages, the decision to formula feed was a difficult one for many mothers (Burns, Schmied, Sheehan & Fenwick, 2010; Lee, 2007). The decision was typically fraught with ambivalence, and prone to public scrutiny (Callaghan & Lazard, 2012). The intensity of the infant feeding experience was evidenced by its lingering effects (Hinsliff-Smith, Spense & Walsh, 2014), with some mothers taking months or years to come to terms with it (Nelson, 2006), and many having to perform identity work to reconcile their experience and their self-image (Lee, 2007; Ryan, Bissell & Alexander, 2009).

Support from healthcare practitioners increased the duration of both exclusive and any breastfeeding (Britton et al., 2007; Renfrew et al, 2012). Postpartum nurses are chiefly responsible for providing support during the maternity hospitalization, and mothers desired from them both technical help and emotional support with breastfeeding (Braimoh & Davies, 2014; Burns, Schmied, Sheehan & Fenwick, 2009; Hinsliff-Smith, Spencer & Walsh, 2013; McInnes & Chambers, 2008; Schmied et al., 2011), provided within the context of an authentic, empathetic relationship (McInnes & Chambers, 2008).

The quality of knowledge required to provide this type of care is broader than clinical or technical knowledge. This is consistent with Carper's (1978/1999) concept of knowing in nursing, which asserts that nursing knowledge is comprised of empirical knowing, personal knowing, aesthetic knowing, and ethical knowing. In 1997, Antrobus forecasted that these patterns of knowing would take on a heightened importance as the focus of healthcare shifted away from illness toward wellness. Mothers' definitions of supportive breastfeeding care reflected this shift. A more recent study demonstrated that nursing knowledge developed from all types of direct experience, both clinical and personal (Arbon, 2004). A 2009 concept analysis of knowing in nursing indicated knowing was the interface of objective knowledge and an individual's awareness and subjective perspective on personal experience (Bonis). Johns (1995) recognized the value of personal experience in the development of knowing in nursing, but felt it was largely overlooked due to its "tenuous, uncertain, poorly articulated nature" (p. 230). He understood that through reflection, personal experience could enhance knowing in nursing, and constructed "a model of structured reflection" to help nurses reflect and translate their insights into practice.

While it is generally believed that postpartum nurses' personal infant feeding experiences influence their nursing practice related to breastfeeding (see Bernaix, 2000; Dykes, 2006; Ekström, Widström, & Nissen, 2005; Patton, Beaman, Csar and Lewinski, 1996; Raphael-Leff, 1991), there are only two small, loosely related studies that suggest this may be the case (Brodribb, Jackson, Fallon & Hegney, 2008; Nelson, 2007). No studies could be found that explore the nature of nurse-mothers' personal feeding experiences, nor how those experiences influenced nursing practice related to breastfeeding. This study aimed to do just that, using

Carper's (1978/1999) model as the theoretical framework, and Johns' (1995) 'model of structured reflection' as inspiration in the development of interview questions.

Chapter 3: Research Design

This phenomenological study was designed to understand nurse-mothers' experiences of infant feeding, and how those experiences shape their postpartum nursing practice. Phenomenology is used to explore a single concept or idea that has been experienced by a group of individuals. Through phenomenology, we can examine the nature of an individuals' lived experiences and discover the essence of the experience (Creswell, 2013).

I employed Carspeken's (1996) methodology for this study. Though originally developed as a methodological theory for critical social research, Carspecken's approach is "quite universal in the topics it can investigate" (Carspecken, 1996, p. 3) and intended for any social research. Carspecken (1996) endeavored to provide a sound methodological theory by employing understandings from critical social theory. Critical epistemology is the foundation for his methods. An important distinction of his approach is his recognition that though a researcher's values may determine what she chooses to investigate, they should not influence her findings. Thus, his methods are designed to decrease researcher bias and produce results that represent the perspectives of the subjects rather than being dominated by the values of the researcher. His method is notable for its clear, systematic approach, flexibility around data collection and analysis, and "well-theorized measures to increase rigor and demonstrate validity" (Holmes & Smith, 2011, p. 153).

Carspecken's (1996) methods also focused on the role of power in research. He recommended employing various approaches to guard against fallacious results due to power inequities. This was important for this study because I am in a leadership positon at the Pavilion for Women (PFW) and have been responsible for advancing exclusive breastfeeding and implementing the Baby Friendly Hospital Initiative (BFHI). Though I was not in a position of

formal power over the research subjects, it was nonetheless imperative that I use some strategies for neutralizing power to achieve the most accurate results.

Carspecken's (1996) methods have researchers differentiate between three *ontological categories*, that is to say theories of existence, rather than *realities*. By using this approach, researchers can create diverse truth claims: *objective claims* put forth that certain events happened and any observer present could attest to that; *subjective claims* relate to the existence of a subjective state, such as thoughts or feelings; and *normative-evaluative claims* assert what is correct, true or appropriate; in other words, what others should believe. Different truth claims require different types of support, and by using Carspecken's (1996) methods, researchers can achieve valid, reliable results for all three types of claims.

The Researcher's Role

I am a woman, a mother, a perinatal patient educator, and an organization development practitioner. My viewpoint reflects an integration of these roles. I have personally experienced pain and pleasure related to breastfeeding my three children. I remember asking my postpartum nurse after my first birth if she breastfed her baby. I recall her saying yes and walking out of the room, leaving me feeling uncertain, alone, and a bit rejected by her behavior.

I have been in the role of manager of perinatal patient education at the PFW for four years. During that time I have worked with numerous families in the prenatal and postpartum period. I have seen families thrive and struggle. I am committed to helping families increase their confidence and competence around early parenting.

Prior to working in patient education, I was an organizational development specialist at Texas Children's Hospital (TCH) for seven years. I worked with clinical areas across the organization, and came to know and develop a deep affinity with nurses. In a recent

conversation with a colleague she referred to me as a nurse, and when I corrected her, she told me that she had thought I was a nurse for years. When I told her I considered that a wonderful compliment, she dubbed me "honorary nurse". I respect and care for nurses, and have been committed to providing them the support they need and deserve throughout my career at TCH.

The implementation of the BFHI has been a significant undertaking for the PFW. I was chosen to lead the BFHI staff and patient education team. In terms of implementing the BFHI and increasing exclusive breastfeeding, I was filled with ambivalence about both, despite being tasked with advancing them. While the health benefits for women and babies are clear, I have personally witnessed the pressure women felt about breastfeeding, which is well documented in the literature. I did not want to be responsible for adding to that pressure.

I also wondered about asking nurses to wholeheartedly support breastfeeding and tell their patients about the risks of formula feeding, knowing that many of them probably fed their own babies formula. When I looked for literature to inform my perspective, I was surprised to find almost nothing. The nurse's voice is important in the discourse around exclusive breastfeeding, yet it is largely absent. Through this study, I aimed to bring forward the postpartum nurse's voice.

Because I entered into this study with personal experiences and opinions, it was important to employ research methodology to limit bias. Carper's (1996) methods were designed to decrease researcher bias, so by adhering to his methodology, I was able to increase the trustworthiness of my findings. Additionally, throughout the study I engaged in routine conversations with a trusted confidant about what I was hearing in the interviews, how I felt about things, and what I thought it all meant. Through these conversations, I was able to perform some rudimentary analysis, and ensure my own beliefs and feelings remained separate from

those of study participants. Additionally, I came to the study with over 20 years of professional experience conducting interviews. Through the years I have learned to listen deeply, ask follow-up questions, avoid the use of leading questions, and check perceptions. These skills proved invaluable as I conducted my research and analysis for this study.

Population

Study setting. The setting for this study was TCH PFW located in Houston, Texas. The TCH was founded in 1953 with the mission of enhancing children's health and well-being (Texas Children's Hospital, 2014). In March 2012, the Texas Children's health system expanded its mission to include women, and opened the Pavilion for Women, a hospital focused on providing "women, mothers and babies with a full continuum of high-quality, expert heath care" (Texas Children's Pavilion for Women, 2014, Our mission, para. 1). The PFW espoused a philosophy of care called family-centered maternity care. Its main tenant was to achieve the best possible health outcomes for mothers and babies while honoring families' preferences related to their birth and postpartum experiences (Texas Children's Hospital, 2013).

Over 5,300 births occurred at the PFW in 2014. Women labored, delivered, and recovered for two to four hours on the Family Birth Unit, and then move to the Mother-Baby Unit (MBU) for the remainder of their hospital stay. Women who had vaginal deliveries generally stayed on the MBU for two days, while those who had cesarean surgery usually stayed three to four days.

The MBU consisted of 48 rooms spanning two floors. Although each floor included patient rooms and a newborn nursery, the hospital's goal was to have mothers and babies stay in the mother's room together for a minimum of 23 hours per day. One nurse cared for both mother and baby, with a maximum nurse patient ratio of one nurse per four mother-baby dyads.

At the time of the study, the PFW had been working toward achieving Baby Friendly Hospital designation for several years. The World Health Organization and United Nations Children's Fund established the BFHI in 1991 to provide direction, support and recognition to hospitals committed to establishing optimal infant feeding. The BFHI's 'Ten Steps to Successful Breastfeeding' ('Ten Steps') outlined evidence-based practices for hospitals to employ to increase exclusive breastfeeding rates (Baby Friendly USA, 2012). To achieve Baby Friendly Hospital designation, hospitals are required to demonstrate that they have implemented all ten steps. All PFW inpatient nurses received 20 hours of breastfeeding training between December 2013 and April 2015 as part of the BFHI implementation. The hospital completed its designation survey in July 2015, but had not received the results of the survey when this study commenced.

The MBU nursing staff was comprised of 94 registered nurses. All were female, and they ranged in age from 23-65 years, with 76% being age 45 or younger. Thirty-five percent of the nurses were Asian American, 31% were Caucasian, 19% were African American, 15% were Hispanic, and 1% were Native American.

Sample. Following approval by my thesis committee and the Institutional Review Boards (IRB) at both the University of Houston and Baylor College of Medicine (see Appendix A), a director of nursing at the PFW sent an e-mail to all 94 postpartum nurses at the PFW inviting them to participate in the study (see Appendix B). Eleven nurses volunteered to participate, and nine completed the study interview. I excluded one nurse-mother's interview due to incomplete data. Thus, this study included eight participants, five of whom were under the age of 45 years, and three over 45 years of age. Two participants were Asian-American, two Caucasian, one was African-American, and two Hispanic (see Table 1). I informed all

participants of the purpose and details of the study, and all signed informed consent statements prior to their interview commencing.

Table 1

Study Participant Demographics

Pseudonym	Age at time of interview (yrs)	Ethnicity	Tenure as a nurse (yrs)	Tenure as a postpartum nurse (yrs)	Practice area at time of first birth
Melissa	32	Hispanic	5	5	N/A
Dawn	37	Caucasian	15	6	Neonatal intensive care (NICU)
Cynthia	47	African-American	27	17	Postpartum
Karen	30	Caucasian	7	4	Postpartum
Dinah	33	Asian-American	6	4	Postpartum
Bridget	49	Caucasian	30	.5	Labor and delivery
Kali	46	Asian-American	25	8	Medical/surgical
Elisa	39	Hispanic	15	.5	NICU

Instrumentation

My interview protocol followed Carspecken's (1996) guidelines. I used a semi-structured interview guide (see Appendix C) which included four domains: a) how postpartum nurses decide to feed their infants; b) postpartum nurses' experiences with infant feeding; c) postpartum nurses' reflections on infant feeding decisions and experiences; d) postpartum nurses teaching of first-time mothers. I developed a lead off question for each domain, identified covert categories, and drafted possible follow-up questions to use as needed. In addition to the interview questions, five questions related to demographics were asked: age, ethnicity, tenure in nursing, tenure in postpartum nursing, and area of nursing practice at time of their first child's birth.

Ensuring reliability and validity during instrumentation. I established topic domains and covert categories to ensure alignment between the research questions and data gathered

during the interview. This created an interview process that was both structured and flexible. I used Johns' (1995) 'model of structured reflection' as a guide in creating lead off and possible follow-up interview questions. Prior to commencing the study, I conducted a pilot interview with an individual not included in the study to test the interview protocol. The pilot interview yielded the information I was seeking, thus I made no changes to the interview protocol. The pilot interview data was not included in the study's findings.

Data Collection

I conducted a face-to-face interview with each participant in my private office at the PFW. The interviews ranged from 42 minutes to one hour and seven minutes. All interviews were audio recorded and transcribed verbatim.

Ensuring reliability and validity during data collection. I used the same interview protocol with all study participants to ensure consistency during data collection. As recommended by Carspecken (1996), I took care to use primarily open, low-inference questions and paraphrasing; avoid leading; and employ active listening during the interviews. I provided all participants a written transcript of their interview one week before I started data analysis. This enabled them to perform a check for accuracy. There were no changes requested by the study participants.

Data Analysis

I performed reconstructive analysis using Carspecken's (1996) guidelines. Carspecken recommends employing the strategies described below as needed. I started with initial meaning reconstruction and low-level coding, and then used the other steps in a heuristic and iterative manner until the study themes became clear.

Initial meaning reconstruction. During the first step of data analysis, I listened to each interview, and then read the interview transcript, with the intent of gaining a general understanding of what each participant was trying to convey. During this process, I made mental notes of possible underlying meanings.

Coding. I went through each transcript, line-by-line, to develop low-level codes. I divided the codes into two categories: those associated with the nurse-mother's infant feeding experience, and those related to how her personal experience influences her nursing practice. During this process, I identified 425 significant statements, and developed 93 low-level codes. Throughout this process, I engaged in peer debriefing discussions to check my inference levels.

Validity reconstruction. I immersed myself in the data and examined the types of claims (objective, subjective, and normative-evaluative) made by individuals and the meaning of those claims across participants. I then used higher levels of abstraction to identify common themes across participants.

Ensuring reliability and validity during data analysis. During low-level coding, I engaged in peer debriefing with three individuals to check for accuracy. After creating higher level codes, I used strip analysis for my initial validity check. I took broadly defined themes and applied them to sections of the interview transcripts to verify that they were applicable for across the study population.

For my final check, I performed member checks with three study participants. During the member check, I shared the themes I had identified across participants, showed the participant my analysis of her story, and explained how I thought her story fit within the themes. All participants indicated that my interpretations were accurate. One participant provided some

additional information during a member check meeting, and I added the information to the study's findings.

Ethical Considerations

I obtained approval from the IRBs at both the University of Houston and Baylor College of Medicine prior to commencing the study. All subjects were treated in accordance with guidelines provide by the American Psychological Association and the aforementioned IRBs. To protect confidentiality, I gave all participants pseudonyms, and removed any identifying details.

Limitations

This study strived to represent the breastfeeding experiences of nurse-mothers and the impact of those experiences on postpartum nursing practice related to breastfeeding. However, there are some limitations that must be acknowledged. All the participants in this study were volunteers. My recruitment materials specified that I was seeking nurses with children of any age who breastfed, formula fed, or did both. However, none of my volunteers exclusively formula fed. Thus, this perspective is absent from the study.

As a part of the study interview, I asked most participants why they volunteered. Each indicated they had something that they wanted to express and bring to light. This demonstrated that participants had a heightened interest in infant feeding, professional practice, or both. Therefore, the results may not be indicative of nurse-mothers as a whole.

Finally, it is important to note that power relations have an influence in all research (Carspecken, 1996). My formal leadership position at the PFW may have affected participation. Though I had no supervisory responsibilities for postpartum nurses and did my best to neutralize power during interviews, my position likely affected volunteerism. I asked one of the study's

participants if she knew of nurse-mothers who had less positive and supportive feelings toward breastfeeding than she did, and she stated that she knew "lots" but she didn't want to "call them out" by giving me their names. Her statements suggested that she, and perhaps others, saw being less supportive of breastfeeding as something that would merit disapproval, and was therefore 'undiscussable'.

Chapter 4: Results and Discussion

The purpose of this study was to examine the personal infant feeding experiences of nurse-mothers, and the influence of those experiences on nursing practice related to breastfeeding. The results section first reports on the findings related to nurse-mothers' infant feeding experiences, and then turns to how those experiences influenced practice. The discussion section examines the meaning and significance of the findings.

The Nurse-mother's Experience of Infant Feeding

Nurse-mothers' descriptions of their infant feeding experiences revealed four themes: a) the decision to breastfeed; b) the experience of early infant feeding; c) the intensity of breastfeeding; and d) remembering and reconciling the breastfeeding experience.

The decision to breastfeed. The seven participants who were nurses at the time of their first baby's birth specified they made the decision to breastfeed prior to their baby's arrival, with some deciding even prior to pregnancy. When asked why they decided to breastfeed, all but one indicated that the decision was clear; because of their nursing education, they knew breastfeeding was best for their babies, and wanted to give their baby the best. Dawn, Bridget and Elisa explained their decisions to breastfeed this way:

> As a nurse, I knew breastfeeding was best for [my baby] and I wanted to give her the best. (Dawn)
>
> I knew that I wanted to breastfeed because I was educated so much not only in, in as a nurse when I graduated but throughout nursing school, the importance of breastfeeding and so much benefits with it. I felt like it was, there was no really any other option. So I already kinda knew that was set, that that was what I wanted to do for my baby whenever I would have a baby. (Bridget)

> Before I did NICU, I was in pediatric nursing. So I knew that, [breastfeeding] was, you know, the best for the baby (Elisa)

Cynthia was the one nurse-mother who differed in her decision rationale. Although she was a nurse at the time of her first baby's birth, she said that there was little talk in her work environment about the benefits of breastfeeding at that time. She stated that she had heard positive things about bonding through breastfeeding and wanted to "try it out". Between the birth of her first and second babies, Cynthia received additional breastfeeding education. Her second baby was born early, and was small. Cynthia said:

> I absolutely made [the decision to breastfeed], knew that's what I wanted to do because [my baby] was going to be little and, you know, I was having him early.

Melissa was the only study participant who was not a nurse at the time of her first baby's birth. Her reason for breastfeeding her first baby was different. She said she never considered breastfeeding before her first baby's birth. She gave the baby formula during the hospital stay, and then, when her higher volume milk came in, her mother-in-law instructed her to pump it and give it to the baby in a bottle. She fed that way until she took the baby to the pediatrician the first time. She recalled:

> He said, "No, you need to put her to the breast." I just remember having that conversation with him. I then, I remember going home and I remember, "Well, let's just try this." And I put her to the breast, and she just went on, and nursed.

Melissa became a nurse after her third baby was born, and decided to exclusively breastfeed her fourth and fifth children because of the nursing education she received.

Early breastfeeding. All of the nurse-mothers initiated breastfeeding within the first week of their babies' lives. Most nurse-mothers' infants also received formula during the

Table 2

Nurse-mother's Infant Feeding Experiences

Pseudonym	Child's age* (yrs)	Formula feeding	Reason for formula feeding	Breastfeeding Status*	Breastfeeding duration (mos)
		During maternity hospitalization		After maternity hospitalization	
Kali	18	No	N/A	Exclusive	19
	13	No	N/A	Exclusive	26
Bridget	15	Yes	Maternal request	Some	13
Melissa	15	Yes	Maternal request	Some	9
	12	Yes	Maternal request	Exclusive	9
	9	Yes	Medical indication	Exclusive	9
	4	No	N/A	Exclusive	7
	3	No	N/A	Exclusive	10
Cynthia	14	Yes	Maternal request	Exclusive/Some	3/14
	9	Yes	Medical indication	Exclusive	15
Dawn	11	Yes	Medical indication	Exclusive	3
Elisa	6	Yes	Maternal request	Exclusive	3
	4	Yes	Maternal request	Some	14
Karen	1.59	No	N/A	Exclusive	15
Dinah	2	Yes	Maternal request	Exclusive	26

Note: Exclusive breastfeeding status - infant received only breast milk, either from breast or bottle maternity hospitalization. Some breastfeeding status – infant received both breast milk and formula

*Child's age at time of interview

Table 2 provides an overview of study subjects' early feeding details for each of their children.

***Surprise and frustration*.** Without exception, the nurse-mothers experienced challenges with early breastfeeding. These difficulties came as a surprise to most. They expected early breastfeeding to be easier than it was. Dawn, who was a NICU nurse at the time of her baby's birth, reflected:

> I remember, as a little girl watching [my mom] breastfeed. And I was like, "God. Well. That's easy." I mean, you know, it just, I mean my mom didn't look like she had any struggles with it…. Just from what I've seen, and you know, you see TV, and to see, you know, women breastfeeding out a lot of places, and it just, it's natural, it's supposed to be natural. It's supposed to be something that all animals do to feed their babies, how hard could it be? You know, I'm thinking, okay, there's a nipple, it's not inverted, no anomalies, I mean she should just be able to go on and suck it like a bottle. You know, I just wasn't, you know, I, I just didn't think it would be difficult.

Dinah and Karen were postpartum nurses at the time of their babies' births. Though their breastfeeding expectations were more accurate than those of some other nurse-mothers, they still described a gap between her expectations and experience:

> Well, even with all my knowledge, it was still a lot more than I ever thought it would, it would be, to be honest with you. (Karen)
>
> I've seen the struggles with other patients but I didn't think it was gonna take this long [to get the baby to latch] (laughs).

Dinah described the frustration she felt as she worked to establish breastfeeding. She remembered:

> I literally have probably latched on thousands of children…. It was very frustrating that I could not latch my own child on my breast. Very, very frustrating.

Similar sentiments were seen across the nurse-mothers. They used the word *frustrating* routinely to describe their feelings about the challenges of early breastfeeding.

Support during the maternity hospitalization. Nurse-mothers looked to the hospital's postpartum and lactation nurses for help with diagnosing and resolving their problems. Bridget and Karen described their early breastfeeding struggles and the assistance they needed to resolve them:

> I thought I had him on right and turns out I didn't and then I got the whole bleeding and cracked, cracked nipples and all that kind of stuff. And, um, it wasn't until the day I was going home that one of the postpartum nurses… she sat with me for I don't know how long…. And she finally helped me and got him, like got him on the breast like he was supposed to be. (Bridget)

> I did get some blisters because of her lip…. [The lactation consultant] helped me to identify that, that she was doing, you know, officially doing that. I kind of had a feeling that's what she was doing, but you can't see the lower part, so she helped me identify that, and kind of helped me from there. (Karen)

Karen's use of the word 'officially' is noteworthy. At the time of her child's birth, she had two years of postpartum nursing experience. Though her nursing experience led her to suspect there was a problem with her baby's latch, the lactation consultant's expert assessment was required to confirm her suspicions.

Although nurse-mothers desired help with breastfeeding, most stated they received less than they needed during the maternity hospitalization. Several attributed this to the fact that they were nurses. Bridget, Elisa, and Cynthia shared their experiences and conclusions:

> I think a lot of times, too, when you're a nurse, people assume you know - and I didn't know a lot. I mean, you know what you do as a labor nurse. When it came to [breastfeeding], that was all new to me, you know, because I didn't do postpartum then. I didn't know, didn't know that part. And I think people would, even the doctors, assume that you knew a lot as an, as an L&D nurse and I didn't. It was my first baby and, and I didn't know. (Bridget)
>
> I really don't remember, now that I think back, like nurses actually latching the baby on for me or helping me, and it might have been because I was a nurse too…. I think sometimes because they know you're a nurse they don't help you as much because they assumed you're independent…but I guess I wish I would have known… so I could have like a better start. (Elisa)
>
> Nobody came to my room. And I just made the assumption it was because I work there so I must know everything…. So, nobody came to give me any advice, or you know, make sure that the latch was good or anything. You know that kind of thing? I didn't get that support. (Cynthia)

One nurse-mother described asking for help repeatedly and not receiving it. Three others said they felt that they bore some of the responsibility for not getting what they needed at the hospital because they did not ask enough questions or request assistance. Bridget said she asked fewer questions than she should have. She explained, "I guess I didn't want them to think I was stupid and I didn't know."

Dinah and Karen, both postpartum nurses at the hospital where they delivered at the time of their babies' births, were exceptions. They reported they received the assistance they needed. Dinah, in particular, experienced an outpouring of support:

> I was treated much differently [from other patients].... I definitely got more attention. When I came to the floor there were several nurses in my room to help, just whatever they could help with. (Dinah)

Though Karen said she received the help she needed at the hospital, she described being aware of the pattern most of other nurse-mothers described. She said:

> I know from other friends' experience that a lot of our L&D nurses, they have no idea what happens in postpartum, but a lot of the postpartum nurses are like, "Oh, you know what you're doing. No big deal." So I know that's an issue for some people.

Formula use during the maternity hospitalization. Ten of 15 nurse-mothers' infants were supplemented with formula in the first two days of life. The rationale for early formula supplementation varied. Seven infants received supplementation due to maternal request for things such as no intention to exclusively breastfeed, challenges with breastfeeding due to birth complications, and perceived insufficient milk supply. Three infants received medically indicated supplementation; one infant lost excessive weight, one was a late preterm infant, and one had high biliruben. See Table 2 for details.

Nurse-mothers' responses to formula supplementation varied, though the overarching sentiment at the time of supplementation was that it was an acceptable solution given the situation. Dawn and Elisa worked as NICU nurses at the time of their babies' births. Dawn gave supplementation based on the recommendation of her baby's care team, while Elisa used supplementation without medical indication. Despite this difference, the nurse-mothers' rationales

were essentially the same: they wanted to avoid having their baby admitted to the NICU. Dawn and Elisa recalled:

> At the time, you know, being in NICU, um, you know, I felt, okay, well, this is a medical thing. This is medical management. She's not getting enough fluids. You know, if I protest and she continues to get worse she may end up in the NICU. (Dawn)
>
> I mean at the time, it was very rational to me…. Cause I didn't want to end up with like a baby that was sick, you know, that have to go [to the NICU] because of dehydration or because of hyperbili or anything like that. (Elisa)

Melissa and Cynthia were the only nurse-mothers who described having strong negative responses to the medical recommendation to provide formula supplementation. There were similarities in their stories. Both had used formula to supplement an older child, indicating they had not intended to exclusively breastfeed that child. However, after receiving more breastfeeding education, they decided to exclusively breastfeed their next babies. In both cases the infants' medical providers recommended formula supplementation to resolve a medical concern. The nurse-mothers ultimately conceded. Both relayed the strong emotions they felt at the time:

> I remember… thinking, "Yeah, I'm going to have to supplement and it sucks. She's not getting enough." …I felt like I failed because I wasn't giving her enough, you know? Or I failed because my breast milk is making her jaundiced, you know after talking to the pediatrician, that maybe it was breast milk induced jaundice. And I think that yeah, I felt like I failed at doing exclusive breastfeeding. You know I felt like I failed…. (Melissa)
>
> I was sick for that first week. I wasn't well at all. And I didn't produce it. I really didn't produce anything…. He started losing weight. And, um, I remember [the doctor] saying, "I know you wanna breastfeed, but he's definitely steadily losing. We're beyond, you

> know…" …Nobody, um, tried to help me…. I felt like I had no alternatives whatsoever. …It was just, well, "You can't do it," so what else am I going to do? I just felt like I was at a brick wall. …So it was disappointing, cause I really thought in my mind that I would be doing this, you know, from the get-go. (Cynthia)

Despite these challenging starts, both Melissa and Cynthia successfully transitioned to exclusive breastfeeding after leaving the hospital. This was a trend among nurse-mothers. Though many of the nurse-mothers experienced difficulties with early feeding, six described being able to satisfactorily resolve their problems and continue breastfeeding for a prolonged period. Two nurse-mothers found that the breastfeeding issues that started immediately after birth persisted. Both ceased breastfeeding within three months.

The intensity of breastfeeding. During the interviews, nurse-mothers were invited to share their infant feeding experiences. They had virtually nothing to say regarding the formula feeding experience, perhaps because most stated that they primarily breastfed, and formula supplementation was generally reserved for times when they were away from the baby. Thus, the discussions about the experience of infant feeding focused on breastfeeding.

As previously described, two nurse-mothers stopped breastfeeding after about three months, while the remaining six continued breastfeeding for longer durations. Details related to their ongoing infant feeding methods are presented in Table 2.

Love. The six nurse-mothers who were able to resolve their problems recounted positive memories of breastfeeding, and all used some form of the word 'love' when discussing breastfeeding. For example, Cynthia said, "I loved it, I loved the feeling." The nurse-mothers described the psychological satisfaction breastfeeding provided to them. All highlighted the intimate connection created between mother and baby. Most also described the satisfaction of

knowing that breastfeeding was contributing to their babies' physical well-being. Melissa focused on the feeling of connection she experienced:

> I do know that I enjoyed a lot breastfeeding my kids. I really felt that, um, that it was just a bond that only me and the baby had. It felt really nice, and it felt really special to just be the one to nurse the baby, you know?

Kali, Bridget, and Karen's descriptions exemplified the enjoyment associated with the knowledge that breastfeeding was meeting the baby's needs and fostering growth and development:

> She wanted to just suck and eat, and you will you know a feeling of, a mother's feeling, and that you see your child so thirsty, scream, quenched it, you know? And she's satisfied. And that you, when you see with your own eyes, with your own milk supply, it's something amazing. And so I enjoyed it. I enjoyed. (Kali)
>
> And just, just knowing that I was doing such a good thing for him, and that, you know, the love was just so much. (Bridget)
>
> I think that the bonding thing that, that people tell you about is so true, because you, you feel like you're doing something for her, more than just loving her. You're actually nourishing her, you're actually feeding her, and you can see her be happy after she's fed. Um, so the bonding part of that was really nice for me, it was. (Karen)

Struggle. Of the two nurse-mothers who stated they did not resolve their issues, one ceased feeding her baby at the breast after two weeks. She then expressed breast milk and bottle-fed that for ten more weeks, then changed to exclusive formula feeding. The other nurse-mother did some breastfeeding for three months, and then switched to exclusive formula feeding. Both women's

stories were characterized by struggle; neither shared any positive breastfeeding memories. Dawn's recollection of breastfeeding her baby exemplified this:

> I was miserable. She would not latch on at times, or if she did she would get very angry and I just remember her flailing and just kicking her head back…. I felt I was doing everything like I was supposed to, and like, you know, breastfeeding gurus do, and she rejected it….I felt there was something I was doing wrong to [cause her] to respond that way, but I couldn't figure out what it was. (Dawn)

Remembering and reconciling the breastfeeding experience. All nurse-mothers said they thought about their personal infant feeding experiences frequently when at work; many indicated this occurred daily. While that might be expected for nurse-mothers with young children, there was no appreciable difference between those with young children and those with children in their teens. For example, Bridget and Cynthia are both mothers of older children. They shared:

> I always go back. I mean he's 15 but I still go back to those days (laughing), you know, because that's what you're doing. (Bridget)

> It's something you don't ever forget, especially if you're in it all the time, you know. If I was in another area, it probably wouldn't be at the front of my mind a lot of the time. (Cynthia, youngest child aged nine years)

The nurse-mothers who met their breastfeeding goals appeared to have little trouble with their initial reconciliation of their breastfeeding experiences, but those who struggled with breastfeeding and were unable to satisfactorily resolve their problems were different. They wrestled with coming to terms with their experiences. Both nurse-mothers concluded they were harder on themselves than they imagined other mothers would be because they were nurses. Elisa, whose child is now six, told of her present-day feelings:

> I still feel guilty about it…. Thinking back, I should have educated myself more, and then also surrounded myself with, or at least asked…for help, which I didn't…. I know that breast milk is the best for him, would have been the best for him, so I guess I… pushed myself a lot on different things and I didn't push myself in this. So that's the only reason I think. But that's just my personality. I'm like, "I gotta let it go." As a nurse, I feel even more guilty because I am holding myself up to a higher standard that I should know better. Like I should have educated myself more. So I think that's why. I think, I think if, well, I don't know because I'll never know what it's like not to be a nurse, but I think I hold my standards a little bit higher.

Clearly, Elisa was still working to reconcile her experience. She believed that her insufficient preparation hampered her in giving her child "what would have been the best for him" and faulted herself for not being more proactive.

Dawn also indicated that lack of support and education were to blame for her problems. Though she initially blamed herself for her situation, she later shifted to a new understanding. She explained:

> … I feel like from the get go there were so many elements that, you know, either I wasn't supported, I was told to do the wrong thing, I, you know, was not given accurate information or support…. As I learned more and more, I actually became very much, very angry at the experience that I had…. I have forgiveness [for myself] now because I know that it wasn't my fault. You know, I did everything humanly possible I could've done and did everything I was told…. Now that I know what I know, it's easier… for me to say, "You did the best you could… you just weren't given what you needed to be successful by the people here and, you know, even the physicians.

For Melissa, receiving additional education about breastfeeding enabled her to reexamine her experience through a different lens and shift from feeling like she had failed to an understanding that the system had failed her. Across the nurse-mothers, breastfeeding education led them to rethink their personal experiences. Between 2013 and 2014, all PFW nurses received 20 hours of breastfeeding training, and new nursing practices were implemented to improve breastfeeding outcomes. Many expressed the sentiment, *if I knew then what I know now, I would have done things differently.* For instance, Bridget said:

> So we did give him formula. At the time, you know, we didn't have the donor milk and stuff like that, and I didn't know the, the part about not giving the formula because of what it does to the gut and all that kind of stuff…. I was kind of disappointed with myself when I found that out when we were doing our classes because I thought, "Oh, I should have tried harder."

Cynthia had numerous problems breastfeeding her second child in the immediate postpartum period due to some birth complications. She said:

> And when I see today, I look at donor milk, at least that… and just more options when it comes to … like producing milk and more things. Like if I would have known to maybe even just manually express…. But anyways, you know, it was the pump or nothing at that point.

Even Karen, who described her breastfeeding experience as "wonderful", said wistfully:

> The whole skin-to-skin phenomena was not there when I had [my baby] so I didn't do a whole lot of skin to skin, to be honest, but I wish that I had now, seeing all the benefits that skin to skin does as well.

How Nurse-Mothers' Personal Infant Feeding Experiences' Influence Practice

The nurse-mothers in this study strongly agreed that their personal infant feeding experience influenced their nursing practice related to breastfeeding. Three themes emerged as we explored what was different after a nurse became a mother: a) promoting breastfeeding became personal; b) increased connection and credibility; and c) striving to prevent pain.

Promoting breastfeeding became personal. The nurse-mothers in this study all reported that they were strong supporters of breastfeeding. Most told of the benefits of breastfeeding that they had seen embodied in their own children, such as higher levels of intelligence and fewer illnesses. They expressed how this strengthened their conviction around breastfeeding. Dinah professed:

> I saw the benefits of it through my own child. She, I can probably count only two times that she has been to the doctor for something like a virus…. It's different reading bullets on a paper, saying, "Okay, its going to prevent this, this, and this and this." Until you have your own baby and you know that it did actually lower the risk and prevent all of this, because it didn't happen with her. Um, makes, you know, I believe those facts even more.

Nurse-mothers promoted breastfeeding with patients, and often relayed the benefits in a very personal way. They told of talking about their children's good health and the bonding and connection they realized through breastfeeding. However, most said they were careful not to 'push' breastfeeding. All acknowledged the method of infant feeding as a mother's personal choice. They indicated the nurse's responsibility was to provide education about breastfeeding, and then respect a mother's informed choice. 'Pushing breastfeeding' occurred when a nurse

tried to convince a fully-informed mother who had elected to formula feed to change her mind. Bridget detailed her thoughts:

> I've had a couple of moms… say that they think we're Nazis (laughing), you know, because I mean we are trying to promote. We are, but there's a fine line there, and there's a delicate way to explain it and not to offend somebody or upset somebody if that's their choice too…. "I will support you no matter what and, you know, give them a bottle or what have you."

Increased connection and credibility. The nurse-mothers in this study all described becoming a different kind of nurse as a result of giving birth to and breastfeeding a baby. They asserted that nurse-mothers had a deeper understanding of what the patients were going through, and therefore could connect with them on an emotional level in a way that was impossible for postpartum nurses without children. Melissa recounted discussions she had had with other postpartum nurses on this subject:

> They tell me, "I don't have any kids, but that doesn't mean that I don't know what I'm talking about." I'm like, "No, it's true. You do know what you're talking about," I said, "but sometimes it's not so much the education-wise but it's more like that other emotional part that they are looking for…. You might be a great nurse, I'm not saying you're not, but it just depends, you know, on the situation. And some patients will really feel, 'This nurse understood me more because she knows how it is, in a way.'" And it's sad, you know, but it's true sometimes. You can't help it.

Kali's position echoed Melissa's. She said:

> Experience is something which affects you through you, you know, which, um, impact your all personality, all personality. It's there in your blood, your emotions, in your dreams, in your physical body…. So, the one who did not experience that, I'm not telling

> that, you know, maybe they did not get a chance or, you know, they didn't want it, they chose it. I'm not telling that bad, but one who experienced can experience that feeling and talk to [mothers]. That's the difference.

Dinah's description of the change that occurred in her after having her baby was representative of what several nurse-mothers shared. She said:

> Before [my baby] was born it was more, hmmm, it was more, "Okay, you go from step A, B, C." It was like, "Okay, this is what you do." You know it was more textbook, I guess, of how you breastfeed. Versus after I had [my baby] it was more, "I can understand what you're feeling right now." I always put my personal experiences in there. "I was the same way, I felt this way" or I would just put in my two cents about my experience.

Nurse-mothers also reported having higher levels of credibility with patients after becoming a breastfeeding mother. Dinah's and Karen's descriptions of this were especially pertinent because they practiced in postpartum before and after having their babies. They said:

> I definitely saw a huge difference in my patient's trust in me. And they felt like, "Oh, she does know what she's talking about because she's actually breastfed her baby." …They listened more, and they beli-, I feel like they believed me of what I was saying. (Dinah)
>
> Now that I have experience, [my patients] believe me a little bit more…. You know, because a lot of times they would talk about it, they're like, "Oh, how old are your kids?" and I'm like, "Oh, I don't have any…." They kind of brush you off, like, "Oh, okay, you don't really know." … [Now] they'll ask, then they'll ask me more personal questions…. "Did she have any problems latching?" (Karen).

Striving to prevent pain. A primary motivation for a nurse-mothers' practice after having her own experience was the desire to prevent another mother from experiencing the physical or psychological pain the she endured during early breastfeeding. This manifested in two significant ways: Nurse-mothers identified closely with patients who had situations similar to their own and often gave these mothers extra time and attention; and they shared their personal stories and experiences when they thought it would help. For example, Cynthia wanted to exclusively breastfeed her second baby, but was very ill after the baby's birth. She felt she had no support for breastfeeding, and could find no option but to use formula. She explained how the experience changed her nursing practice:

> I was definitely more an advocate [for breastfeeding], and especially if they have issues, medical issues after giving birth, you know. … "Use the warm compresses, you know. Do something to get it- get that out there. Don't give up," and that kind of thing. … Those patients who had complications, I felt closer to, just because of my own experiences…. I know how it feels to feel like you don't have any power over what's going to happen. And so, I tried my best to give them power, uh, with whatever I had at the time, you know, any tricks or anything like that I could do.

Cynthia recalled one particular patient with whom she shared her personal story. She explained:

She was just having so much issues. And she was so discouraged, you know. She was crying and all that, so, you know, I told her about [my experience]…. I just wanted to, um, let her know that I was kinda there for her, and I understood where she was at…. Oh, she responded very, very positively…. She needed someone who was gonna really help her. And so I decided I was gonna be that person. I spent a lot of time in that room."

Melissa had also decided to exclusively breastfeed, and felt like she "failed" because her baby had high bilirubin levels and required readmission to the hospital. Though she struggled with the decision to supplement, ultimately, she decided she was being "selfish" by trying to exclusively breastfeed, and she gave her baby formula. When her baby was well, they successfully resumed exclusive breastfeeding. Melissa said:

> I really don't feel like it's a bad thing to tell parents that it's okay to give a bottle. …I feel they need to understand that it's okay if you supplement. "It's all right. It's going to be okay." … I have some patients who are just adamant about, "This is my my my my plan, and I do not want to deviate from this plan." And I understand where they're coming from, but at the same time I feel like, "You're like me. You're being a little selfish. You're thinking about yourself. And sometimes we need to think about the baby. Do you not want this baby to go home with you? Then just supplement and the baby will be off the lights, and you can go home with your baby and not have your baby stay here another night."

Melissa recalled an interaction she had had with a patient:

> I just got the sense she felt pressured to breastfeed…. I remember talking to her and the mom was also concerned. She was like, "Well, what if she doesn't have enough [breast milk] and what if the baby is not getting fed enough. Baby's always crying." …so I did a lot of education with her regarding [second night syndrome]. Regarding having a choice as to, "You want to breastfeed? Then you're going to breastfeed. Do you want to supplement? Is it okay to supplement? Well, that depends on you. I can't tell you yes or no. All I can tell you is it's okay if you want to supplement. The baby is not going to not breastfeed just because you supplemented once or twice." Again, that's because of my

> personal experience, because I supplemented, and my babies turned out okay. We ended up breastfeeding fine…. I feel like we did a lot of education, a lot of talking, a lot of "Relax, it's okay." I think that really helped her…. I felt good after that because I feel like sometimes that is very overwhelming for some moms.

Dinah described using a different approach to a similar scenario. Like Melissa, her personal tribulations with early breastfeeding shaped her practice. She said:

> I've actually come in at shift change and changed them away from formula and put them back on the breast…. Before I had [my baby] it was like, "Oh, you want formula? Okay, I'll go get it." It was more patient satisfaction verses, "What was your intention when you came in? You wanted to breastfeed. I will help you become successful in breastfeeding." …I had my own baby, and knew that, I knew that frustration of like, of like, "Okay, things are not going as planned." But I knew there was a light at the end of the tunnel… "I know that this is going to work for you because I knew it worked for me. The struggles they are having right now, like I went through it, like it was, I was very convincing (laughs) [when I told my story].

Consider the very different approaches Melissa and Dinah described. As previously discussed, Melissa felt it was acceptable to tell mothers that supplementation was fine, while Dinah prided herself on transitioning babies from bottle to breast. Melissa had experienced psychological pain when she had to provide medially indicated supplementation for her baby. She repeatedly said that she felt like she "failed". Thus, she encouraged mothers to be flexible in their approach to infant feeding and "relax and just see what's best for your baby" which invariably meant using donor milk or formula supplementation at times, even in non-medically indicated situations. By telling mothers to stay flexible, and implying or explicitly saying that

supplementation may be best for the baby, Melissa aimed to prevent mothers from feeling the pain of failure.

Conversely, the source of Dinah's psychological pain was the struggle she faced during early breastfeeding. She requested early supplementation while heavily medicated after a cesarean birth. Though she struggled with breastfeeding for the first week, she found relief by persisting and ultimately succeeding with exclusive breastfeeding. Dinah worked to spare mothers the pain of the struggle by sharing her story and helping them see a "light at the end of the tunnel." She expressed certainty that with patience and effort her patients could work through their challenges and succeed at breastfeeding. This belief stemmed from her own experience.

Elisa's first birth was an unplanned cesarean. She had difficulties with early breastfeeding, and remembered thinking she didn't have colostrum, so she used formula supplementation beginning on her baby's first day of life. She described a conversation during which her mother-in-law told her, "You're just not gonna be a milk producer", and how 'awful' that made her feel. Elisa explained her general approach to providing breastfeeding support. She said:

> I think I'm a little partial to C-section moms. Because a lot of things they verbalize um I was feeling too, so I'm kinda like, "Yes, I know...." Like, of course I give them the, what I learned since from the classes I've attended, and then from my own experience… to encourage them more and say, you know, and try to get them away from the mistakes I made.

She went on to tell about a patient she had worked with recently. She explained that the patient's family was being critical of her because she had had a cesarean birth, and that the patient was also troubled because she thought she was not producing much milk:

> And I kinda shared a little bit of my experience…"I pump[ed] and gave up, I thought I gave up too soon, because you know, this is how the pump works and it's not the same as your baby…." So I kinda hand expressed for her, and showed her that she was getting more than she thought. And, then, "I'll help the baby latch on to you" so she… I think she seemed comforted by what I shared with her.... Oh, I felt great. Yes. Yes. I was like, "Yes!" Uh, I was thinking like, "Oh my gosh, I wish somebody (tearing up)… I'm sorry, I'm like… I wish I had somebody with me that shared that, you know?

Elisa's final comment suggested that she was still working to resolve her own breastfeeding experience, and was doing so, in part, by providing other mothers with the care she wished she had received.

Dawn felt unsupported and misinformed during her maternity hospitalization. As a nursing leader, her personal experience and story exerted a different kind of influence. She said:

> I'm going to make sure [moms on postpartum] get what they need and that support and direction. …I feel that we should do everything possible to provide them the right information, um have the opportunity to be successful which is information, and it's hands on, and it's support…. I feel very strongly it's important for me… to show, show my support, and to be very open and clear of what my expectations were [of others who are] actually supporting breastfeeding on the unit.

Dawn described sharing her personal story with other postpartum nurses in an attempt to influence their breastfeeding practice. She recalled:

> I shared [my story] in one of our quarterly trainings…. You know, hopefully, maybe, the message got across of someone they know, who was a nurse… but still didn't have the level of knowledge to be successful. And I hope that that was something they caught onto, the emotional, um, I guess, yeah the emotional, I wouldn't say scarring, but I still carry that, you know, to this day.

Elisa and Dawn both described very difficult, negative breastfeeding stories. Yet each provided examples of how she supported breastfeeding through her professional practice. Dawn, a nurse leader, originally felt she was doing something wrong that caused her baby to "reject" her, but as she learned more about breastfeeding, she discovered that she had been given insufficient support and incorrect information. She placed a high priority on enabling patients to achieve their breastfeeding goals by improving hospital support systems. She said, "If I could prevent one person from going through what I experienced… if I can help in any way in doing that I just think it would be good." Elisa described being under-informed about breastfeeding before her baby's arrival, and lacking family support. She described how she provided women and their families support and education. Again, we see nurse-mothers' attempts to prevent another mother from having to endure the pain she experienced.

Knowing in nursing. Carper's (1978/1999) patterns of nursing knowledge were detectable in the nurse-mothers' descriptions of their breastfeeding nursing practice. For example, Elisa described using empirics, or the science of nursing, when she said, "I give them what I learned … from the classes I've attended." She provided a specific example of this when she told of using her knowledge of how pumping milk differed from hand expression. She then practiced hand expression to help increase the patient's confidence about her milk production.

A number of nurse-mothers referenced ethic, or moral correctness, when they spoke of 'pushing' breastfeeding. They believed that the method of infant feeding was a mother's choice, and that a nurse should not push the mother to breastfeed when she had made a fully informed decision to give formula. Instead, they felt the correct action was to support the mother's decision.

Dawn exemplified personal knowing when she described her process of coming to terms with her breastfeeding experience. She described learning about breastfeeding and becoming "very angry" at her experience, then later developing "forgiveness" for herself.

The pattern the nurse-mothers' stories best exemplified was that of aesthetic knowing, also called "the art of nursing". Johnson (1994) identified five components of the art of nursing. They included: 1) grasping the meaning of the situation; 2) establishing a connection with the patient; 3) performing nursing activities with skill; 4) rationally determining an appropriate course of action; 5) demonstrating moral conduct in one's practice. These elements were present in several of the nurse-mothers stories of caring for patients. The stories generally involved intervening when a patient was experiencing breastfeeding trouble and associated emotional distress.

Cynthia shared an account that exemplified the art of nursing, and exhibited the elements Johnson (1994) identified. She had a patient who, like her, had had a complicated birth and was experiencing many issues as a result. Because of the similarities between her own and her patient's experience, Cynthia understood the meaning of the situation. She explained:

> Those patients who had complications… because of my own experiences… I knew kind of what they were going through…. She needed someone who was really gonna help her.

Cynthia established a connection with the patient by sharing her account of what happened to her after her son's birth. She explained, "I just wanted to let her know that I was there for her and I understood." Then, Cynthia use her nursing skills to determine and implement a course of action. She said, "These are things we can do that I didn't do and wish I would have. Let's try this." Cynthia said the patient responded "Very, very positively."

Elisa also told a story that demonstrated the art of nursing. She had a patient who felt "really sad" that she had had a cesarean birth. She was experiencing subsequent problems with breastfeeding. Elisa grasped what the situation might mean for her patient, in part due to the similarities between her patient's situation and her own. She decided to tell her patient about her personal story, which fostered a connection between the two of them. After telling her story, she applied her nursing skills. She gave hands-on assistance so that the mother could hand express a little mik and latch the baby. Elisa felt that the mother was comforted. She said, "In the morning she was really anxious and frightened but in the afternoon she was smiling."

Though neither Cynthia nor Elisa specifically referenced the moral aspects of their practice, their actions were in keeping with the mother's wishes and the hospital's goals of advancing breastfeeding, and therefore are easy to interpret as 'moral conduct'.

Melissa's story exhibits many of the facets of the art of nursing, but is less straightforward. She described working with a mother who was exhibiting signs of stress and pressure related to breastfeeding. Melissa developed a connection with the mother, and engaged in teaching about positioning, feeding cues and common infant behaviors on the second night of life. In developing a course of action for the mother, Melissa recounted telling her:

> "You want to breastfeed, then you're going to breastfeed. Do you want to supplement? Is it okay to supplement? Well, that depends on you. I can't tell you yes or no. All I can tell you is it's okay to supplement once or twice."

Melissa explained that her advice was different from what the lactation consultant had advised. Nonetheless, she saw her course of action as appropriate, because she felt that the lactation consultant had put too much pressure on the mother and introducing a more flexible approach would yield better results. Following Melissa's interactions with the patient, both the patient and her mother stated they had more knowledge and insight about breastfeeding, she appreciated the care she received. Melissa felt good that she had made an overwhelming situation more manageable for the mother.

Melissa recognized that telling mothers that non-medically indicated supplementation was acceptable differed from the hospital's position and from what the lactation consultant advised. There were a few factors she considered when deciding to recommend it anyway. She explained that she had recently cared for four physicians, including pediatricians and neonatologists, and all had stated it was "no big deal" if their baby needed supplementation. She also stated that a number of nurses she worked with fed their babies formula. Further, her own experience told her that supplementation would not interfere with longer-term breastfeeding, and that insisting on exclusive breastfeeding was not always "best for baby". Experts' (physicians and nurses) positions that supplementation was "no big deal" aligned with Melissa's personal experience and fortified her stance. Thus, she determined that advising that it was "okay to supplement once or twice" was an appropriate and moral nursing action.

Discussion

The aim of this study was to explore the personal infant feeding experiences of nurse-mothers and the influence of those experiences on practice. Existing literature described women's experiences of breastfeeding and healthcare support related to breastfeeding. From the nursing perspective, researchers have examined the challenges associated with providing breastfeeding support and the impact of these challenges on care. This study was the first to explore the postpartum nurse as both nurse and mother. Dirkx (2006) recommended this sort of practice-based insider research to "honor and give voice to complexity and the multilayered nature of understanding… about the various dimensions of practice" (p.284). This the study extends the existing literature on breastfeeding experiences and professional breastfeeding support by introducing this previously unexamined perspective. While some of the study's findings echo existing literature, many are new.

Nurse-mothers infant feeding experiences. Nurse-mothers infant feeding experiences were remarkably similar to those of other women. Women cited 'best for baby' as the chief reason they decided to breastfeed (Burns, Schmied, Sheehan & Fenwick, 2010; Dykes, 2005; Forster & McLachlan, 2008; Larsen & Kronborg, 2013; Marshall, Godfrey & Renfrew, 2007; Nelson, 2006), as did nurse-mothers. Women had the expectation of breastfeeding being easy (Burns, Schmied, Sheehan & Fenwick, 2010; Callaghan & Lazard, 2012; Larsen & Kronborg, 2012). Likewise, nurse-mothers held this belief. Both groups expressed surprise at the challenges they faced (Burns, Schmied, Sheehan & Fenwick, 2010; Hinsliff-Smith, Spencer & Walsh, 2013; Larsen & Kronborg, 2012). Most women reported difficulties with early breastfeeding (Andrews & Knaak, 2013; Avishai, 2007; Larsen & Kronborg, 2012; Nelson, 2006) and all the nurse-mothers in this study faced difficulties. Members of both groups

indicated they looked to healthcare professionals for assistance (Braimoh & Davies, 2014; Burns, Schmied, Sheehan & Fenwick, 2009; Hinsliff-Smith, Spencer & Walsh, 2013; McInnes & Chambers, 2008; Schmied et al., 2011). Women expressed a range of feelings when describing the breastfeeding experience, from very positive to very negative (Burns, Schmied, Sheehan & Fenwick, 2009; Nelson, 2006). Nurse-mothers stories told of everything from connection and bonding, to struggle and misery.

A point of strong agreement among nurse-mothers in this study was that they received less support than required from health care professionals during the maternity hospitalization. They acknowledged that it was common for any nurse-patient to receive less breastfeeding support. They attributed the lack of support to healthcare providers' inaccurate but commonly held assumption that nurses already had the knowledge and skills required to breastfeed successfully. Some nurse-mothers indicated they did not ask for the help they needed, and explained that this may have contributed to the problem. The lack of information and assistance led some nurse-mothers to see formula supplementation as their best or only option. Seventy percent of the infants who received supplementation during the maternity hospitalization did so due to maternal request. Just one of these mothers indicated that she received the support she needed during the maternity hospitalization.

It is clear that nurse-mothers require supportive breastfeeding care during the maternity hospitalization. Although there are no studies examining the challenges of caring for a nurse-ptient, Domeyer-Klenske and Rosenbaum (2102) examined challenges associated with caring for a physician-patient. They found that some who cared for physician-patients made assumptions about the physician-patients' knowledge. This same challenge was apparent in the nurse-mothers' care. Domeyer-Klenske and Rosenbaum (2102) identified strategies commonly used to address

the challenges of caring for a physician-patient. One strategy entailed having the treating physician explain to the physician-patient that they would care for them as they cared for all other patients. A second approach involved allowing the physician-patient to determine how much they wanted their own knowledge to affect their care. With both strategies, explicit communication between the provider and the patient was essential. Similar approaches may be useful for postpartum nurses caring for nurse-mothers during the maternity hospitalization.

The influence of experience on practice. Nurse-mothers' nursing practice related to breastfeeding changed because of their personal infant feeding experiences. This finding supports the assertions in existing literature that say personal experiences influence practice (Bernaix, 2000; Dykes, 2006; Ekström, Widström, & Nissen, 2005; Patton, Beaman, Csar and Lewinski, 1996; Raphael-Leff, 1991), and extends that literature by providing specific examples of how this is true.

McInnes and Chambers (2008) determined that the establishment of an authentic, personal relationship between healthcare provider and patient was very important to patients. However, they noted the importance was less apparent in practitioner dialogue and in the provision of care. Yet, this study demonstrated that after having their own breastfeeding experience made all aspects of providing breastfeeding care more personal for a nurse-mother. They recognized the importance of establishing a relationship with patients, and often used their personal experiences to forge that connection.

Some nurse-mothers who previously endorsed breastfeeding based on strictly on evidence began including descriptions of the benefits they witnessed in their own children. Nurse-mothers also asserted that having personal experience enabled deeper connections with mothers. They were able to demonstrate genuine empathy in a way that was previously impossible. All told of sharing

their breastfeeding story with patients when they thought it would be of benefit. Additionally, they noted that having personal experience resulted in increased credibility with patients.

A nurse's clinical knowledge and skills may take on a heightened importance when she has developed a close interpersonal relationship with a patient. Marshall, West and Aitken (2013) found that when an individual lacked the knowledge necessary to evaluate clinical information, source credibility became a proxy strategy used to evaluate the quality of the information received. Thus, it is important for nurses to maintain current and accurate clinical information related to breastfeeding and share this with their patients, as it is likely that some patients will uncritically accept whatever information the nurse-mother offers.

Prior to this study, there was just one other that revealed how a nurses' personal experience might influence practice. Nelson (2007) stated, "Whether or not a participant had personal experience breastfeeding her own children, the positive or negative nature of this experience often influenced not only the suggestions she gave to a mother but also her whole 'approach' to breastfeeding support" (p.33). This study confirmed that personal experience influenced a nurse-mother's approach to breastfeeding practice. However, the positive or negative nature of their experiences did not appear to be significant. Instead, the desire to prevent a patient from experiencing the physical or psychological pain the nurse-mother experienced became central to the nurse-mothers' breastfeeding practice. This was true for all nurse-mothers regardless of whether their experience was positive or negative.

The findings from this study revealed a complex relationship between nurse-mothers' experiences and practice. Because nurse-mothers had unique experiences and individualized responses to those experiences, their nursing practice changed in divergent ways. For example, the personal experience of formula feeding during the maternity hospitalization led nurse-mother

to change their practice in unique ways. One nurse-mother stated she felt it was appropriate to tell families it was acceptable to supplement with formula. Another said she strived to get infants away from formula and back to exclusive breastfeeding. A third said she worked to empower mothers to do whatever was necessary to help them breastfeed, while a fourth described working to change hospital systems to support breastfeeding. All stated they based their approach to practice on their personal experience. Given this, it is nearly impossible to predict how a nurse-mothers' practice will change because of her experience without engaging in an in-depth exploration of her experience and its meaning for her.

Nelson (2006) reported that reconciling the breastfeeding experience could take months or years. This was especially evident in the nurse-mothers who faced unresolved breastfeeding difficulties that led to cessation of breastfeeding. McCreight (2005) found that when nurses underwent a difficult personal experience, caring for patients having a similar experience could be stressful and complex, and it was important to recognize the stressful nature of the work. There was some indication in this study that nurse-mothers used their professional practice to help work through their own experiences, and that they sometimes sought redemption by working to improve breastfeeding services and deliver the type of care the nurse-mother lacked.

McCreight's (2005) study demonstrated that when nurses drew on experiential knowledge and engaged in reflection on their practice, they "enhanced their professional capability, deepening their understanding and gaining insights into patient care in ways that would not have been possible had their learning been confined within a positivist paradigm of knowledge" (p. 446). She noted:

> The narrative experience has the potential to offer nurses a neutral and reflective space within which to articulate their professional development across time, and chart

> autonomously the practical, intellectual and emotional tasks with which they are charged. This is an alternative to submitting to an imposed interpretation of their work that may be more prescriptive, and through which their emotional work may have been overlooked. (p 446)

Dirkx (2006) also advocated using reflective narrative processes to improve practice. He noted that the question of "what works" (p.276) evoked "epistemological, moral, and political complexity" (p. 276). We saw this complexity reflected in the nurse-mothers descriptions of how they changed their practice because of their personal experiences. Dirkx (2006) asserted that practitioners should be concerned with improving practice, and using a reflective narrative process "seeks to give voice to the world of practice as perceived, understood, and struggled with from inside" (p. 276). This can lead to learning and change at the individual and organization levels.

Present day breastfeeding education at the PFW focuses primarily on building clinical knowledge, skills, and enhancing communication skills related to breastfeeding. Integrating reflective and narrative processes could enhance this training. It would encourage nurse-mothers to explore how their personal experience influences their nursing practice related to breastfeeding, surface any struggles they have, give them an opportunity to resolve those difficulties, and ultimately determine a plan to ensure they deliver high quality breastfeeding support and care for all patients.

Chapter 5: Conclusion

This study brings the nurse-mother's voice to the breastfeeding discourse by examining the nurse-mothers' personal infant feeding experiences and the influence they have on her nursing practice related to breastfeeding. The following depicts three major conclusions of this study.

Nurse-mother's personal infant feeding experiences were very similar to those of other women; however, nurse-mothers perceived that they received less support than needed during the maternity hospitalization because they were nurses. This study demonstrated that although nurses desire help with breastfeeding in the hospital, some might not request the assistance they need. Thus, it is important for hospitals to provide proactive, supportive breastfeeding care for nurses. The application of two strategies used by physicians when treating physician-patients may prove useful. These include advising the nurse-patient that she will receive the same care as all other mothers, and recognizing the nurse-patients' expertise and enabling her to specify how much her personal expertise should factor in to her care. Open, effective communication between the postpartum nurse and the nurse-patient is essential when employing either of these strategies (Domeyer-Klenske & Rosenbaum, 2102).

Nurse-mothers universally agreed that their personal infant feeding experiences influenced their breastfeeding nursing practice. All aspects of breastfeeding support and care became more personal for the nurse-mother. Having the shared experience of breastfeeding enhanced a nurse-mother's credibility, and enabled her to connect with patients in an authentic and meaningful way. A nurse's clinical knowledge and skills may take on heightened importance in the case of increased connection and credibility, because of individuals' tendencies to accept clinical advice from a nurse they have deemed as credible and trustworthy

without question (Marshall, West & Aitken, 2013). Therefore, it is especially important for nurse-mothers to ensure the breastfeeding information they share with patients is current and accurate.

Finally, a nurse-mother's practice was influenced significantly by her desire to prevent another mother from experiencing the pain she endured. Because both infant feeding experiences and the interpretation of those experience were unique to each individual, nursing practice changed in divergent and unpredictable ways. Those interested in practice change and improvement could interpret this unpredictability as problematic, and could be tempted to insist that nurses practice according to clinical evidence rather than personal experience. It is unlikely that such an approach would be successful, as it is natural for individuals to prioritize intuitive, implicit beliefs over empirical evidence (Paley, 2007). A more effective approach may be to integrate reflective narrative processes into breastfeeding training. In doing so, nurses can explore the alignment of their personal knowledge and the empirical evidence, and determine an approach to breastfeeding practice that honors both sources.

Opportunities for future research

Although this study brings the nurse-mother's voice to the discussion about breastfeeding, this perspective remains under-represented in the breastfeeding discourse. Additional research could expand upon the findings from this study. As previously discussed, a limitation of this study was that all participants had breastfed their babies, and had indicated they were supporters of breastfeeding. Thus, the perspectives of nurse-mothers who did not breastfeed and those who do not identify themselves as breastfeeding supporters remains unexplored. Additionally, this study included one site only. Additional research to include multiple sites and additional perspectives would contribute to the body of literature related to

breastfeeding and nursing practice. Finally, this study included only postpartum nurses. However, outpatient clinic nurses, labor and delivery nurses and antepartum nurses are all involved in delivering breastfeeding care. Therefore, we would benefit from including their perspectives in future studies.

There are many other opportunities for research related to nurses and breastfeeding. I will highlight two that came to my attention during this study. Firstly, breastfeeding among NICU nurses merits investigation. Two of the nurse-mothers in this study were NICU nurses, and both struggled with breastfeeding. They discussed the unique challenges of being a NICU nurse and breastfeeding, but I explored this only superficially in this study. An in-depth investigation of NICU nurses' breastfeeding experiences and the challenges they face would add to the body of literature.

Secondly, a study of the challenges and strategies related to caring for a nurse-patient during the maternity hospitalization is needed. Though this phenomenon is common in maternity nursing, there are no related studies.

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APPENDIX A

UNIVERSITY of HOUSTON

DIVISION OF RESEARCH

June 25, 2015

Ms. Anne Wright
c/o Dr. Consuelo Waight
Dean, Technology

Dear Ms. Anne Wright,

The University of Houston's Institutional Review Board, Committee for the Protection of Human Subjects(1) reviewed your research proposal entitled "Postpartum Nurses' Personal Infant Feeding Experiences and Their Influence on Nursing Practice" on April 17, 2015, according to federal regulations and institutional policies and procedures.

At that time, your project was granted approval contingent upon your agreement to modify your protocol as stipulated by the Committee. The changes you have made adequately fulfill the requested contingencies, and your project is now **APPROVED**.

- **Approval Date:** June 25, 2015
- **Expiration Date:** June 24, 2016

As required by federal regulations governing research in human subjects, research procedures (including recruitment, informed consent, intervention, data collection or data analysis) may not be conducted after the expiration date.

To ensure that no lapse in approval or ongoing research occurs, please ensure that your protocol is resubmitted in RAMP for renewal by the **deadline for the May, 2016** CPHS meeting. Deadlines for submission are located on the CPHS website.

During the course of the research, the following must also be submitted to the CPHS:

- Any proposed changes to the approved protocol, prior to initiation; AND
- Any unanticipated events (including adverse events, injuries, or outcomes) involving possible risk to subjects or others, within 10 working days.

If you have any questions, please contact Samoya Copeland at (713) 743-9534.

Sincerely yours,

Daniel O'Connor

Dr. Daniel O'Connor, Chair
Committee for the Protection of Human Subjects (1)

PLEASE NOTE: All subjects must receive a copy of the informed consent document, if one is approved for use. All research data, including signed consent documents, must be retained according to the University of Houston Data Retention Policy (found on the CPHS website) as well as requirements of the FDA and external sponsor(s), if applicable. Faculty sponsors are responsible for retaining data for student projects on the UH campus for the required period of record retention.

Protocol Number: 15364-01 Full Review: ___ Expedited Review: X

316 E. Cullen Building Houston, TX 77204-2015 (713) 743-9204 Fax: (713) 743-9577

COMMITTEES FOR THE PROTECTION OF HUMAN SUBJECTS.

May 19, 2015

BCM
Baylor College of Medicine

NANCY M HURST
BAYLOR COLLEGE OF MEDICINE
PEDIATRICS: NEWBORN

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H-36671 - PERSONAL FEEDING EXPERIENCES OF POSTPARTUM NURSES: IMPACT ON NURSING PRACTICE DURING THE MATERNITY HOSPITALIZATION.

APPROVAL VALID FROM 5/19/2015 TO 4/7/2016

Dear Dr. HURST

The Institutional Review Board for Human Subject Research for Baylor College of Medicine and Affiliated Hospitals (BCM IRB) is pleased to inform you that the research protocol named above was approved.

The study may not continue after the approval period without additional IRB review and approval for continuation. You will receive an email renewal reminder notice prior to study expiration; however, it is your responsibility to assure that this study is not conducted beyond the expiration date.

Please be aware that only IRB-approved informed consent forms may be used when written informed consent is required.

Any changes in study or informed consent procedure must receive review and approval prior to implementation unless the change is necessary for the safety of subjects. In addition, you must inform the IRB of adverse events encountered during the study or of any new and significant information that may impact a research participants' safety or willingness to continue in your study.

The BCM IRB is organized, operates, and is registered with the United States Office for Human Research Protections according to the regulations codified in the United States Code of Federal Regulations at 45 CFR 46 and 21 CFR 56. The BCM IRB operates under the BCM Federal Wide Assurance No. 00000286, as well as those of hospitals and institutions affiliated with the College.

Sincerely yours,

KJERSTI MARIE AAGAARD, M.D.
Institutional Review Board for Baylor College of Medicine and Affiliated Hospitals

APPENDIX B

From: Hurst, Nancy M.

Sent: Wednesday, August 05, 2015 1:52 PM
To: PW MBU NTN; PW MBU Staff RN
Cc: Bolds, Elizabeth M. (Liz)
Subject: GREAT CHANCE! To participate in an exciting study

Dear Texas Children's Pavilion for Women MBU nursing staff,

Many of the women – 88% to be exact – who deliver at the Pavilion for Women state that they plan on breastfeeding their infants. To assist these mothers in reaching their feeding goals, the nursing staff must provide information, education and instruction on breastfeeding. As research investigators, we are interested in understanding the nurses' personal experiences of feeding their own infants and how they perceive these experiences impact nursing practice related to breastfeeding. We are interested in hearing stories from mothers who formula-fed, breastfed, or did both. It does not matter what age your children are now, they may still be babies, or may now be adults.

If you participate in this study – entitled "Postpartum Nurses' Personal Infant Feeding Experiences and Their Influence on Nursing Practice" – the time required of you would be a minimum of 45 minutes and a maximum of 2.5 hours. If possible, this will take place during your shift. However, if you come in during your own time, we will pay for parking in the lot across from the Pavilion. You will have a private interview for approximately 45 to 60 minutes, set up at your convenience, to share your story. After your first interview, if additional information is needed you may have a follow-up interview for up to 30 minutes. Then, after the information from your interview is analyzed, you may be asked to review and give feedback on the analysis. This could take up to an hour. Anne Wright, the principal investigator for this study, will be conducting the interviews, performing the analysis, and collecting feedback on the analysis.

If you are interested in participating in this study, please contact me, and I will forward your information to Anne.

This project has been reviewed and approved by both the University of Houston Committee for the Protection of Human Subjects (713.743.9204) and the Baylor College of Medicine Institutional Review Board.

Thank you for considering this opportunity,

Nancy Hurst, PhD, RN, IBCLC
Director, Women's Support Services
Texas Children's Hospital / Pavilion for Women Assistant Professor of Pediatrics Baylor College of Medicine
(832) 826-3612 office
(832) 825-7841 fax

APPENDIX C

Interview Protocol

Research Questions

- What is a nurse-mother's personal experience of feeding her infant?
- How does a nurse-mother's personal infant feeding experience influence her nursing practice related to breastfeeding?

Topic Domain One: How postpartum nurses decide to feed their infants

Lead off question:
"To start, could you tell me just a little bit about your children?" (to get her warmed up) "Now I'd like to take a trip down memory lane with me, to the time just after (name of oldest child) was born. I know it was a while back, but I wonder, what do you remember about the first few days in the hospital after s/he was born?"

[Covert categories: How she intended to feed the baby at time of admission; how she made that decision; when the first attempt at feeding occurred, and what method was used; why that method was used; what discussions occurred in the hospital regarding infant feeding; feeding method upon discharge; if feeding method at discharge was different from intention before birth, what made her change her mind]

Possible follow-up questions:

1. Do you remember the first time you fed the baby? Can you tell me about that?
2. When did you decide you were going breastfeed / bottle feed?
3. How did you decide?
4. What do you remember about feeding the baby while you were in the hospital?
5. Do you remember anything special about discharge?
6. (As needed) What made you change your mind?

Topic Domain Two: Postpartum nurses' experience with infant feeding

Lead off question:
"When you think back to your first six months feeding (name), what was a typical day like?"

[Covert categories: Feeding method; if feeding method changed during first six months, when did that happen and why; feeding difficulties and resolutions; satisfaction with infant feeding experience; feeding method for subsequent children; if different, why; satisfaction with feeding method used for other children]

Possible follow-up questions:

1. Do you remember being surprised about anything related to feeding?
2. Many moms say that feeding the baby stressed them at some point. Do you remember a time like that? How did you manage?

3. Did you ever wish you had chosen a different method for feeing the baby? Why?
4. (As needed) When did you stop breastfeeding? Why?
5. (As needed)How did you feel when you changed from breastfeeding/breast milk to formula?
6. How did your experience feeding your first baby affect your decisions about feeding your other babies?

Topic Domain Three: Postpartum nurses' reflections on feeding decision and experience

Lead off question:
"You work with many breastfeeding moms, and we've been doing a lot of breastfeeding education for the past year. Can you think of a time when you were working with a mom or learning about breastfeeding and it led you to think back to your own experience?"

[Covert categories: Current feelings about past feeding decisions; how nurses deal with those feelings]

Possible follow-up questions:
1. How do you feel?
2. How do those feeling affect you?
3. What do you do about that?
4. If you could turn back the clock to the day before you gave birth to your first baby and give yourself some advice about feeding, what would you say?

Topic Domain Four: Postpartum nurses' teaching of first-time mothers

Lead off question:
"Is there a mom who stands out, maybe one you worked with recently, who wanted to breastfeed, but had a hard time with it?"

[Covert categories: How nurses' personal past experiences impact their teaching]

Possible follow-up questions:
1. Did she ask about your personal experience? What did you tell her?
2. How did you work with her?
3. How did you feel when you were working with her?
4. What happened?
5. How do you think things will go when she goes home?
6. If she were a close friend or your sister instead of your patient, what would you have said?
7. What do you think is important for first-time breastfeeding mothers to know that people don't usually tell them?
8. Do you think your personal experience impacts how you teach first-time breastfeeding moms? Why or why not?