

“It Seemed the Natural Thing To Do”

A Heideggerian Study of Choice for Mothers Who Breastfeed

by

Catherine Sheffer

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy

at

Dalhousie University
Halifax, Nova Scotia
June 2015

© Copyright by Catherine Sheffer, 2015

TABLE OF CONTENTS

ABSTRACT	viii
GLOSSARY	ix
ACKNOWLEDGEMENTS	xi
CHAPTER 1: Introduction	1
<i>The Postpartum</i>	3
<i>Maternal Decision Making</i>	4
<i>Feeding Choices</i>	5
<i>Choosing to breastfeed</i>	5
<i>Choosing to formula-feed</i>	6
<i>Autonomy</i>	7
<i>Nurses ‘In-Relation’</i>	8
<i>Study Purpose</i>	9
<i>Research question</i>	10
CHAPTER 2: Literature Review	12
<i>Introduction</i>	12
<i>Preparation for Motherhood</i>	13
<i>Prenatal preparation</i>	13
<i>Postnatal care</i>	16
<i>Motherhood</i>	17
<i>Becoming a mother</i>	17
<i>The socially constructed mother</i>	20
<i>Influence of healthcare providers</i>	22
<i>Choosing to Breastfeed</i>	23
<i>Choice in quantitative research</i>	27
<i>Choice in qualitative research</i>	32
<i>Relational experiences of breastfeeding</i>	39
<i>Relational Autonomy</i>	40
<i>Autonomy traditionally</i>	40
<i>Reproductive autonomy</i>	41
<i>Relational theory</i>	43

<i>Relational experiences</i>	45
<i>Experience of body</i>	45
<i>Experience of breasts</i>	46
<i>Experience of infant</i>	48
<i>Autonomy in postpartum</i>	50
<i>Research support</i>	51
<i>Implications for Relational Practice in Nursing</i>	59
<i>So What?</i>	62
CHAPTER 3: Philosophical Underpinnings	67
<i>Introduction</i>	67
<i>My Philosophical Assumptions</i>	68
<i>Phenomenology as Philosophy</i>	69
<i>A Brief History of Phenomenology</i>	70
<i>Husserlian influence</i>	71
<i>Cartesian duality</i>	72
<i>Heidegger and ‘Being-In-The-World’</i>	72
<i>Temporality</i>	73
<i>Dasein</i>	74
<i>World</i>	75
<i>Experiencing the world</i>	76
<i>Facticity</i>	77
<i>Being-in-the-world</i>	78
<i>Embodiment</i>	79
<i>Spatiality</i>	79
<i>Being-with</i>	80
<i>Mood</i>	81
<i>Authenticity</i>	82
<i>Autonomy</i>	84
<i>Interpretive Phenomenology</i>	86
<i>A personal metaphorical experience</i>	87
<i>The lived experience of past research</i>	88

<i>The influence of Heidegger</i>	88
<i>Phenomenology in Nursing Practice</i>	90
<i>Phenomenology and relational practice</i>	92
<i>Why Interpretive Phenomenology?</i>	92
CHAPTER 4: Study Design	95
<i>Introduction</i>	95
<i>Hermeneutical Inquiry</i>	96
<i>Dialogue</i>	97
<i>Prejudice</i>	97
<i>Understanding</i>	98
<i>The hermeneutic circle</i>	98
<i>Ensuring accuracy of interpretation</i>	99
<i>Methodological Strategy</i>	100
<i>Study Design</i>	101
<i>Participants</i>	101
<i>Inclusion Criteria</i>	101
<i>Recruitment of participants</i>	102
<i>Data collection</i>	103
<i>Conversations</i>	103
<i>Conversational prompts</i>	105
<i>Transcription</i>	106
<i>Researcher reflective journaling</i>	106
<i>The interpretive process</i>	107
<i>Aspect 1</i>	107
<i>Aspect 2</i>	108
<i>Aspect 3</i>	109
<i>Aspect 4</i>	109
<i>Aspect 5</i>	110
<i>Rigour in Research</i>	110
<i>Strengths and Challenges</i>	111
<i>Some Final Words</i>	112

CHAPTER 5: The Participants	115
<i>Introduction</i>	115
<i>Piper: Preparation and Commitment</i>	116
<i>Alex: It's My Job</i>	118
<i>Suzanne: Embodied Wonder</i>	120
<i>Tasha: Just Stop the Noise!</i>	121
<i>Nicole: An Exploration of Difference</i>	123
<i>Setting the Mood</i>	125
<i>Heidegger and Rubin – A Small Degree of Separation</i>	127
CHAPTER 6: Breastfeeding: An Embodied Process	130
<i>Phenomenological Embodiment</i>	130
<i>Heidegger and Technology</i>	133
<i>Technology and the birth experience</i>	135
<i>A Breastfeeding Prelude</i>	135
<i>Just focus – you can do it</i>	136
<i>For the sake of the baby</i>	138
<i>Take-away messages</i>	141
<i>Breastfeeding as an Embodied Activity</i>	143
<i>Breasts as objects</i>	144
<i>Well, this is different</i>	145
<i>This is MY baby</i>	149
<i>Why breastfeed?</i>	154
<i>I like breastfeeding</i>	154
<i>I AM a good mother</i>	154
<i>Technology of breastfeeding</i>	158
<i>Trusting my efforts</i>	160
<i>Adventures in pumping</i>	160
<i>Battle of the bottle</i>	162
<i>Ending the Relationship</i>	165
<i>In Closing</i>	167
CHAPTER 7: “It Just Seemed Natural” – Breastfeeding and Commitment	169

<i>Theoretical Musings about Commitment</i>	169
<i>I DO Intend to Breastfeed</i>	172
<i>Committed to Doing My Best for My Baby</i>	174
<i>I Can't Do This Without You</i>	176
<i>Committed Time</i>	180
<i>It's very overwhelming</i>	180
<i>The Juxtaposition of Commitment and Discomfort</i>	184
<i>Oooh, it's going to hurt</i>	186
<i>Digging Deeper</i>	189
<i>It's not easy</i>	189
<i>I need to do this for my baby</i>	190
<i>Some Final Words</i>	191
CHAPTER 8: <i>Being-with Me: The Importance of Relational Support</i>	193
<i>Heidegger, Mood and Being-with</i>	194
<i>Being-with and Being there – Presence in Support</i>	197
<i>Healthcare providers</i>	197
<i>“He helped me” – Husbands and support</i>	204
<i>The support of family</i>	208
<i>Support of Past Experience</i>	209
<i>“I remember this”</i>	209
<i>“She knew what I was going through”</i>	209
<i>“Will You Give Me the Support I Need?”</i>	212
<i>Summing Up</i>	220
CHAPTER 9: <i>Conclusion: A Weaver's Reflections and Final Thoughts</i>	221
<i>Where They Are: Piper</i>	221
<i>Alex</i>	222
<i>Suzanne</i>	222
<i>Tasha</i>	223
<i>Nicole</i>	223
<i>Weaving It All Together</i>	224
<i>Back to the Beginning – Making the Choice to Breastfeed</i>	226

<i>Recognizing the role of mood in decision-making</i>	227
<i>Relational mood</i>	228
<i>Embodied mood</i>	228
<i>Sustaining the mood</i>	230
<i>Enhancing the mood of understanding</i>	230
<i>So, What About Autonomy?</i>	232
<i>Study Strengths and Limitations</i>	235
<i>So What? Recommendations for Nursing</i>	236
<i>Implications for Future Research</i>	239
<i>My Final Thoughts</i>	240
REFERENCES	241
APPENDIX A Hermeneutical Principles for Research	271
APPENDIX B Consent and Authorization Documents	272
APPENDIX C Information Letter to Potential Participants	276
APPENDIX D List of Research Questions	277
APPENDIX E Research Poster	278

Abstract

A personal struggle to make sense of science that espouses ‘breast is best’, and evidence from practice indicating a large divide between breastfeeding initiation and duration triggered critical reflection upon personal and professional experiences thereby fuelling a desire to dig deeper. Given the general physical and emotional upheaval experienced in the first few days following childbirth, are women able to function as truly autonomous beings when making feeding decisions about their infants? This study employs a phenomenologically grounded, hermeneutic process (Conroy, 2003) to co-constitute meaning and understanding of the lived experience of maternal decision-making around breastfeeding. As maternal experience of autonomy is a possible factor influencing the choice of feeding method, an attempt was made to provide visibility to a phenomena that is not well understood or recognized.

Expressing an intention to breastfeed upon delivery of their babies, five women were recruited prenatally to participate in this study. Conversations were conducted between 4-8 weeks postpartum. Following transcription of audiotaped interactions, a framework outlined by Conroy (2003) for interpretive inquiry was used to interpret the findings. Three themes emerged influencing the experience of choice – embodiment, commitment and relational support. The process of embodiment of breastfeeding, initiated at birth, was perceived as both a positive and negative experience. Pain and fatigue were common experiences in the early postpartum, but became more manageable over time. A strong commitment to breastfeeding was required to move through the process of embodiment, often tested when pain endured. Support of significant others perceived to be meaningful was helpful to sustain commitment to the breastfeeding journey. Long-term, ongoing painful feeding episodes coupled with a perception of decreased meaningful relational support contributed to a loss of commitment, and an eventual paradigm shift leading to a desire to make a different infant feeding choice. Autonomous behaviour of breastfeeding mothers remains less well defined; perhaps this is not a word well suited to the experience of women during this time period, especially in relation to breastfeeding.

Completion of this research has made visible the Heideggerian notion of *mood* as having a role in the sustainment of breastfeeding as a feeding choice. Attunement to the provision of care, borne of the ontological experience of *mood*, extends to feeding choices, as understood within the *situatedness* of the mother. Women will choose to engage in baby-care practices supported within their worlds, irrespective of their own mode of existence. The choice to breastfeed may originate from a stance that is authentic, inauthentic or undifferentiated; if *situatedness* in the woman’s world supports this choice of infant feeding, then many women will declare their intention to feed their babies this way in order to *be* a ‘good mother’.

Implications for nursing center upon the realization that breastfeeding is hard. Many women experience some difficulty in the first few days, even weeks until their level of comfort with this activity provides some personal satisfaction resulting in an embodied relationship with their infant. This research provides evidential support to the collective nursing voice calling for recognition and revision required for nursing support to meet the needs of new mothers as they embark upon the challenges of caring for their infants.

Glossary

- a priori*: Formed or conceived beforehand; presupposed from experience
- After-pains: uterine contractile discomfort exacerbated with breastfeeding associated with the normal progression of postpartal involution
- Attunement: awareness of our surroundings as a function of mood; delineates what is important, what stands out, what matters
- Authenticity: one lives up to what one feels to be significant even if it is at odds with what is socially acceptable.
- Dasein: Germanic in origin, meaning ‘to be there’; a neutral term that allows us to see man as consciousness instead of a biological being; has no determinate essence as being consists in its possibilities; not confined to a particular space or time (Inwood, p. 189, 2005)
- Facticity: the idea that we are able to understand ourselves as bound up in our own as well as others’ destiny. We ‘dwell alongside other persons.
- Forestructure: involves temporality; an explicit understanding of the *Background*; involves fore-conception, fore-having, and foresight
- Inauthentic: mode assumed by someone who actively adopts a way of doing something, even though the person does not necessarily value that way of being on the surface; covers one’s genuine way of *being*; discord (distress) between what one says and what one does; we have lost ourselves in things and other persons while existing in the everyday world; although it is necessary to regard scientific things in this objective way in healthcare, inauthentic in a moral sense refers to regard of people as things to be used for one’s own purposes.
- Ontology: branch of metaphysics; the science of being embracing the nature of existence, categorical structure of reality (Lowe, p. 670, 2005)
- Postpartum: the time period six to eight weeks immediately post-delivery (Blackburn, 2007)
- Present-at-hand: mode of non-engagement with people, where entities are context-free; Cartesian duality of body/mind is the norm; context free engagement with the world; ahistorical understanding; mental representations; skilled scientific activity
- Ready-to-hand: seamless, transparent coping in the ‘background’ of the world; can move gracefully in a relationship characterized by mutuality, reciprocity, particularity; characteristic of an engaged agent functioning with embodied intelligence

Temporality: Heidegger's notion that our past and future projections or desires affect our present situation and choices

Thrownness: our situatedness within the world

Undifferentiated: a mode where one is lost in a world where one passively assumes a stance picked up from the public collective way of not taking charge of oneself; person goes uncritically 'with the flow'; people exist in this mode most of the time; many of life's activities happen while we are in this mode

Unready-to-hand: mode of engagement with the world which can be entered into *conspicuously*. Conspicuousness occurs when a person pauses, hesitates because unusual tools are needed - the old tools are not appropriate for the context; obstinacy occurs when the distressing 'object' becomes manifest; obtrusiveness occurs when there is a total breakdown in our usual coping methods; nothing 'works' the way it normally does for us; activity is very apparent to us, and we turn to more theoretical reflection about how to cope

World: the entire constellation of beliefs, values, assumptions, background meanings, possibilities, and cultural organization shared by the members of a given community; Heidegger deems the world of society to be always prior to one's own world (Dreyfus, 1991); it incorporates the world inhabited in the past; it is directed towards the future; a person can exist in three interdependent modes - authentic, inauthentic, undifferentiated; organised equipment and practices in which *Being* is involved

Acknowledgements

First and foremost, my heartfelt thanks and gratitude is extended to the participants of this study who shared their breastfeeding stories with me. Their honesty and frankness regarding a very intimate subject enhanced my understanding of their journeys.

I would like to extend many thanks to my committee. Your time and patience proved inexhaustible as you read and reread these chapters. As my supervisor, Dr. Megan Aston provided a critical eye for my writing and a discerning ear in her efforts to support. As my co-supervisor, Dr. Sherrill Conroy demonstrated online patience and encouragement as I learned, and then lived, Heideggerian phenomenology. Always ready to provide encouragement, Dr. Judy MacDonald and Dr. Christy Simpson were invaluable for their particular ways of seeing the world, aiding me to be open to influential nuances not previously realized in my scholarly journey. All of you graciously gave of your time to see this project through to the end – thank you.

Thank you to the nurses of the Perinatal Center at the IWK Hospital. Your assistance and cooperation provided the introduction to this study resulting in the eventual enrolment of the participants. I greatly appreciate your time and efforts.

To my husband Greg, thank you for your love, support and encouragement, and for not ever letting me give up.

CHAPTER 1

Introduction

A woman becomes pregnant, and her life is forever altered. The romance of motherhood has beguiled young women for centuries; in fact, survival of the species depends somewhat on this idyllic dream of a beautiful infant to hold and care for, coming to fruition. Of course, not all women indulge in such fantasy. Reality is such that women everywhere, everyday endure pregnancy and childbirth, whether by choice or circumstance, and humankind continues (McQuillan, Greil, Shreffler & Tichenor, 2008). Women have fulfilled their biological ‘destiny’ – they are mothers (Cancellaro, 2001; Figs, 1998; Meyers, 2003; Phoenix & Woollett, 1991).

But is this all that is required to becoming a mother? Researchers have demonstrated that motherhood is a developmental process incorporating not only physical events, but emotional changes as well (Mercer, 1995, 2004; Rubin, 1984). In becoming a mother a woman was (and would be) influenced by her past, present, and future experiences of this role (Varcoe & Doane, 2007). She was culturally situated, often emulating behaviors of mothers to whom she had been exposed. As she experienced pregnancy and childbirth, awash in the hormonal roller coaster that so often accompanied this process (Blackburn, 2007; Odent, 1992), she became aware of the physicality of another being (Wynn, 2002) and actively pondered her future. Upon delivery of the infant, first impressions often gave way to the weight of responsibility inherent in this role of mother, that of caring for and nurturing this infant.

Within a career grounded in clinical practice and academia, I cared for women and their families in all phases of the childbearing cycle – antepartum, intrapartum and

postpartum. I have been privileged to observe the evolution of women and men transitioning to the role of parents while becoming acquainted with their baby throughout the developmental process that is pregnancy, childbirth and early postpartum. The delivery of a healthy infant was an event often thought to be a joyous and momentous occasion for all involved (Beck, 2002; Driscoll, 1990; Prialx, 2004; Ruddick, 1995; Winson, 2003). But, is it? Figs (1998) writes:

When my first child was born, I was unprepared for the great landslide of physical, sensory, emotional and psychological upheaval that motherhood brings and I had never seen, let alone held or looked after a newborn baby before. Antenatal classes, handbooks, friends and family focused on the birth, but no one mentioned the aftermath other than in the vaguest terms. I considered childbirth to be the grand finale and the greatest hurdle to the physical process of reproduction, after which life would quickly settle back to normal. I didn't realize that the birth of a child brings with it a whole new definition of normal. I was convinced during my first pregnancy that I would carry on working, thinking, feeling and behaving socially as I had always done; and then I felt incompetent and inadequate as a mother and as a woman when I couldn't because of my new child.

Childbirth is just the beginning of a process and not the end. The birth of a child can provoke profound change in a woman. Life turns upside-down for a while and every mother enters a period of transition with a new child when she has to get used to life as it is now. Some women adjust in a matter of weeks, others take

far longer, but no woman can adjust overnight to every aspect and new demand of motherhood. But I didn't know this (pp. 1-2).

Informal discussion with women within the first year after the birth-day mirrored Figes' words, making visible a common sentiment of having felt overwhelmed in this initial postpartum phase (George, 2005; Goering, 2009; Kaitz, 2007). These same informal discussions revealed that in fact, the meaning of being a mother was only discovered post birth (Bottorff, 1990; Harwood, McLean & Durkin, 2007; Nedelsky, 1999; Nelson, 2009; Reich, 2005). This recounting of their experiences demonstrated that due to their own strong focus on the processes of childbirth, most women spent little time prenatally reflecting on life post-parturition, and what it might mean to 'be a mother', a fact supported in the research literature (Aston, 2002; Figes, 1998; Harwood et al., 2007; Winson, 2003). Thoughts of 'what now' often came to the forefront upon departure of the supporting casts of health care professionals, family and friends. The excitement was over, and the woman was left alone (either physically as her partner returned to paid employment, and/or emotionally due to relational dynamics), with the culmination of her childbirth efforts – the infant (George, 2005; Goering, 2009; Mercer & Walker, 2006; Rubin, 1984).

The Postpartum

The postpartum period is a time of great adjustment for women as they experience a loss of self, previous lifestyle, and role performance, while concurrently taking on a new persona – that of mother (Rubin, 1984). Success in attaining this transformation can be constrained due to physical and emotional limitations, lack of family support, lack of professional support, limited community resources, sociocultural situatedness, and

personal barriers such as an unwillingness to seek assistance due to lack of knowledge, or a perceived need to appear independent (Chalmers, 2013; Chalmers, Levitt, Heaman, O'Brien, Sauve & Kaczorowski, 2009; Driscoll, 1990; Goering, 2009; Mercer, 1995; Rubin, 1984, Varcoe & Doane, 2007). When healthcare professionals are consulted for advice and help during this time period, ideas and values deemed important by professionals may not mesh with those of the client, potentially creating a sense of confusion and uncertainty as to how to proceed (Cody, 2003; McLeod, 2009).

Maternal Decision Making

Embedded within the negotiation of this emotional roller coaster is the process of maternal decision-making regarding care issues for the infant (Nelson, 2012; Sheehan, Schmied & Barclay, 2009, 2013). Decisions regarding choices for infant care are made unilaterally, or in tandem with the maternal support network and care team (Lothian, 1994; Rempel & Rempel, 2004). Being situated within a culturally and socially constituted world, many decisions may have a 'taken for granted' quality as women continue child-care practices of their forebears, and family and friends are consulted frequently regarding care of the new infant (Campbell & Gilmore, 2007; Cricco-Lizza, 2004; Earle, 2000; Hannon, Willis, Bishop-Townsend, Martinez & Scrimshaw, 2000; Ingram, Johnson & Hamid, 2003; Keith, 1997; Leahy-Warren, 2007; Reid, Schmied & Beale, 2010; Sheehan, Schmied & Cooke, 2003). More importantly, decision-making processes are frequently overlaid with a desire to be 'the good mother', a socially constructed ideal often requiring women to sacrifice their own needs in the interest of meeting the needs of the infant (Arendell, 2000; Brown, Small & Lumley, 1997; Ludlow,

Newhook, Newhook, Bonia, Goodridge & Twells, 2012; McQuillan et al., 2008; Medina & Magnuson, 2009; Speier, 2001; Sutherland, 2010; Varcoe & Doane, 2007).

Feeding choices. The focus of my research arose from a particular interest of one facet of motherhood – decision-making related to feeding choices, more specifically decision-making surrounding the process of breastfeeding. How do women make decisions about the initiation (or not) and sustainment (or not) of breastfeeding?

Choosing to breastfeed. As a natural biological progression of the childbirth process, much is known about the science of breastfeeding offering solid evidence for this choice of feeding method, in turn providing the foundation for worldwide health-care provider support. Evidence-based recommendations support exclusive breastfeeding for the first six months of life (Newton, 2004; UNICEF et al., 2005; World Health Organization, 2009). Breastfeeding researchers continuously produce evidential support that strongly encourages health care professionals to build and maintain supportive measures to increase breastfeeding rates in Canada (Earle, 2002; Jansen, de Weerth & Riksen-Walraven, 2008; Steube, 2009; Steube & Schwarz, 2010). In fact, many institutions in this country providing care to women and infants have adopted a goal of ‘baby-friendly’ designation, ensuring high rates of breastfeeding initiation upon discharge from hospital (Chalmers et al., 2009; WHO & Unicef, 2009).

And yet, statistical information about breastfeeding in Canada does not reflect long-term sustainment of breastfeeding for women in this country. A breastfeeding initiation rate of 89% for all Canadian women (2011-2012) falls to 26% by six months post-delivery (Gionet, 2013). Strong intentionality to breastfeed is well correlated with high initiation rates, but appears to have no effect upon breastfeeding sustainability over

the long term (Chalmers et al., 2009; Goksen, 2002; Sheehan et al., 2009). Examination of the reasoning offered for not choosing, or sustaining this method fails to resolve a notable tension between the possibilities and the realities of breastfeeding rates (Ahluwalia, Morrow & Hsia, 2005; Brown et al., 2013; Chalmers et al., 2009; Hamlett, Wagner & Brevard, 2004; Health Canada, 2012a). So, what forces prompt women to reject, or change their minds about this method of feeding? What influences are at play in this turn of events?

Choosing to formula-feed. Current literature abounds with information as to why women choose not to breastfeed. Social determinants of health can strongly influence the choice of feeding method (Ludlow et al., 2012). Lower levels of maternal breastfeeding self-efficacy were correlated with cessation of breastfeeding efforts much earlier than recommended (Blyth, Creedy, Dennis, Moyle, Pratt & De Vries, 2002; Dennis, 2002; Kools, Thijs, Kester, de Vries, 2006). A need to balance family responsibilities and relationships with the perceived risks inherent in formula feeding the infant (eg. questions regarding quality of nutrition, need/desire to be seen as a good mother, root of maternal identity formation) was a strong consideration for women in the face of the health-promoting message ‘breast is best’ (Earle, 2000; Hauck & Irurita, 2003; Ludlow et al., 2012; Sheehan et al., 2013). Some women bravely admitted to their dislike for the breastfeeding process (Friedman, 2009). In exercising their choice of infant feeding, women were willing to risk societal disparagement – to be seen as less than adequate as mother - to formula feed their infants (Knaak, 2005, 2010; Lee, 2012), expending energy to validate and defend their actions (Nelson, 2012). But, was there something else?

Autonomy

As I struggled to make sense of science that espouses ‘breast is best’, and evidence from practice indicating a large divide between breastfeeding initiation and duration, I remained very puzzled. Engagement in critical reflection upon personal and professional experiences fuelled a desire to dig deeper.

Further reading illuminated the possibility that the experience of personal autonomy may be a factor in this puzzle. In my search for literature to increase my understanding of this issue, I chanced upon an article that resonated deeply within me. Goering (2009) writes of her postnatal experiences following the birth of her daughter. Given the general physical and emotional upheaval experienced in the first few days following childbirth, Goering questioned the ability of women to function as truly autonomous beings when making decisions about their infants.

A dearth of literature supporting this notion encouraged this path of exploration. What if the experience of autonomy is an underlying factor in the decision making surrounding breastfeeding for childbearing women (Koestner, 2008; Schmied & Lupton, 2001; Sheehan et al., 2013)? Is it possible that a woman who feels more autonomous in her decision making about feeding practices might choose to breastfeed her infant? Or, does increased personal autonomy result in choosing not to breastfeed? Could there be some truth in such a notion? Brison, a philosopher who experienced horrific personal violence prior to becoming a mother, writes of her newborn son, “he is the embodiment of my life’s new narrative, and I am more autonomous by virtue of being so intermingled with him.” (1997, p. 32). This statement intrigued me. Does this sentiment arise solely

as a triumph over her past, or was there a commonality in her maternal experience of autonomy that could be made visible in my own work?

In an effort to tease out the influence of autonomy upon the decision-making process, I believe a deeper understanding of women's overall experience of decision-making is required (Goering, 2009). In the literature review that follows, a discussion of motherhood and breastfeeding ensues. I then examine the traditional understanding of autonomy. However, as I am writing of a woman-centered experience, I argue that this is not enough. I propose that examination of the concept of autonomy using a relational lens is better suited to the experiences of women, and mothers in particular. I will provide support for this idea as I explore the concept of relational autonomy and the process of breastfeeding for women in relation with their bodies, their infants, and their world. Completion of this exercise strengthens my argument for the need to explore the notion that the experience of autonomy grounds, and strongly influences the lived experience of decision making processes for women regarding breast-feeding (McCarter-Spaulding, 2008; Meyers, 2003; Sheehan et al., 2013).

Nurses 'In-Relation'

As a nurse, I would be remiss to ignore the role of nursing in maternal decision-making about breastfeeding. As nurses work in-relation with women in the mother role, it became important to reflect upon the moral obligation inherent in relationship development with clients (Bergum, 2003; Bergum & Dossetor, 2005; Cody, 2003; Doane & Varcoe, 2007). Doane and Varcoe (2007) write that 'good' nurse-client relationships incorporate respect, trust and mutuality: within a collaborative partnership, nurses work with clients to enhance health and health outcomes (p. 193). Researchers have shown

that women rely on nurses for information, role-modeling and confidence building surrounding choice of breast-feeding in those first few days of the postpartum period (Christie, Poulton & Bunting, 2007; de Montigny & Lacharite, 2008; de Montigny, Lacharite, & Amyot, 2006; Gagnon & Bryanton, 2009; Hauck, Fenwick, Dhaliwal, Butt & Schmied, 2011; Nelson, 2007; Schmied, Beake, Sheehan, McCourt & Dykes, 2011). Research evidence correlates an increase in length of duration of breastfeeding with the provision of dedicated ‘one-to-one’ nursing time, and individualized interventions to support breastfeeding activities at the time of initiation (Brown, Raynor & Lee, 2011; Manganaro et al., 2008; Rossman & Ayoola, 2012; Schmied et al., 2011). Given current workload environments in hospitals, with a resulting reprioritization of workload outcomes (and strong potential for subsequent lack of meaningful relationship development), concern about the possibility of decreased opportunity for relational nursing practice mounts (Aktan, 2007; Doane & Varcoe, 2007; Goering, 2009; MacKenzie & Stoljar, 2000; Mullin, 2005). In light of such evidence, how do nurses exercise their ethical responsibility to their clients around feeding support when there is no time to build a relationship?

Study Purpose

The primary purpose of this study was to employ a phenomenologically grounded, hermeneutic process (Conroy, 2003; Heidegger, 1927/1962) to co-constitute the meaning and understanding of the lived experience of maternal decision-making around breastfeeding. By creating a mutually respectful relational space, I engaged women who had recently delivered an infant in conversation about their experiences. My hope was that engagement in this interpretive process would increase my depth of

understanding by making visible maternal practices of the decision-making process as it related to breastfeeding. As maternal experience of autonomy is a possible factor influencing the choice of feeding method, I attempted to provide visibility to a phenomena that is not well understood or recognized.

Canadian women are situated in a culture of choice regarding infant feeding (Bottorff, 1990). As mothers, they experience multiple factors – personal, relational, socio-cultural, political, and economical – that influence their negotiation of decision-making processes resulting in their final choice (Brown et al., 2013; Chalmers et al., 2009). If an understanding of this life experience was realized, goals for supporting choice, and decision-making processes around breastfeeding that reflect current evidence-based research could be set that were more collaborative, realistic, and mutually satisfying for both health care providers and child-bearing women. As well, I hoped that a deeper understanding in particular of the role of nursing as an influential factor in maternal decision-making would be realized.

Research question. How do women as mothers experience the decision-making process in choosing (or not) to breastfeed their infant?

Sub-questions of this research inquiry that enhanced understanding of this process included:

- What components of women's' lived experience of decision-making around breastfeeding are most influential in this process?
- What relationships, if any, deemed important by women wield the greatest influence upon the decision-making process (embodied, personal, interpersonal, professional)?
- What understanding do mothers derive from the decision-making process?

- What meaning do women derive from their choice of infant feeding?
- What does autonomy mean to women in the maternal role?
- How do these women describe their experiences of autonomy?

I began my thesis with a description of my initial internal dialogue from which the idea for this research work was generated. I now present a review of literature in Chapter 2 believed to be relevant to this research. A description of the philosophical underpinnings and methodology, along with a description of the study design used, including plans for data collection, data synthesis and validation of findings, and anticipated ethical concerns (Conroy, 2003; Creswell, 2007) follows in Chapters 3 and 4, respectively. An introduction to the participants begins a presentation of the findings of this study in Chapter 5. These findings are discussed in greater depth in Chapters 6 through 8. I conclude this work in Chapter 9 with some final thoughts about my findings, the impact for nursing, and ideas for future research.

CHAPTER 2

Literature Review

Introduction

As with any research study, a review of the literature is required. To ensure my research query was well founded, I prepared an extensive review of available works I believed to be relevant to this endeavour. I began with readings offering insight into maternal preparation for the role of motherhood through all phases of the puerperium, including theory pertaining to maternal role attainment. From this I segued to the socially constructed mother, its discursive influence on women today, and the role of healthcare providers in perpetuating this oppressive interpretation. Choosing to breastfeed incorporates research from both quantitative and qualitative studies providing evidence about decision-making around breastfeeding. Although all studies provided substantial insight into the breastfeeding woman's world, I posited that this was not enough to understand this process, so investigated literature pertaining to the relational aspects of breastfeeding, and in particular the experience of relational autonomy. A discussion ensues about traditional autonomy, relational theory, and relational experiences of body, breasts, and the infant. As my proposed focus of study occurs in the postpartum, I examined the postpartum experience of autonomy.

As a nurse, it is important to consider the implications of this study for nursing. My discussion provides support for my belief that by engaging in relational practice I will be morally and ethically responsible to my clients. I complete this literature review with words of support for the need for increased research of the postpartum phase of childbirth, particularly around the experience of relational autonomy. Given the dearth of

phenomenological studies exploring the lived experience of the postpartum woman, perhaps it is time.

Preparation for Motherhood

Prenatal preparation. Upon confirmation of pregnancy, many women living in North America seek access to a healthcare provider (obstetrician, general medical practitioner, and midwife) to care for them while monitoring this developmental process (Aston, Saulnier & Robb, 2010). In what is largely a healthy population in Canada, physical health care requirements are often temporally influenced. Much more pressing are the educational deficits (perceived and real) that dominate women's thinking as they prepare for the 'big event' – the actual day of delivery. Expectant women are often inundated with childcare advice and suggestions from family, friends and varied media presentations. My previous research and experience as a health-care provider demonstrated that women desire to be seen to 'be a good mother' to their infant, and in doing so, will strongly consider advice regarding pregnancy, labour and delivery from 'the experts' more often than counsel offered by family and friends (Gage et al., 2012; Sheffer, 2000). My clinical experience demonstrated that much of the time spent with health care providers involved sharing of information, sorting through questions and concerns, making plans for the 'birth-day', and seeking emotional validation for maternal thoughts and feelings. Concurrently, women and their supporters also enrolled in childbirth preparatory classes, seek out current literature and media, and review electronic resources to ensure knowledge of what to expect, the 'normal' progression of pregnancy, labour and childbirth, and choices regarding infant care issues, all activities

described in current literature (Dennis, 2002; Gage et al., 2012; Greenhaigh, Slade & Spiby, 2000; Keith, 1997; Lothian, 1994, 2010; Vonderheid, Norr & Handler, 2007).

The first year of a child's life creates a foundation for developmental potential in physical and psychological growth. Parental efficacy is often directly correlated to healthy infant development, a determinant of future health outcomes (Hertzman & Power, 2004; Raphael, 2004). In preparation for this life-changing experience of parenthood, many parents-to-be have attended to care-of-self with regular health care provider visits, and care-of-infant with preparatory reading, and often, content offered within prenatal classes. Traditional childbirth education classes are in fact that – a preparatory curriculum about pregnancy, the 'birth-day' and the very immediate postpartum time period (Goering, 2009; NS Department of Health, 2008a, 2008b; Ockenden, 2002; Parent Health Education Resource Working Group, 2008).

Perhaps due to a 'taken-for-granted-ness' about childrearing in past generations, formal preparatory opportunities for the postpartum period are not readily available, nor often sought out prior to the actual delivery of the infant (Dally, 1982; Figs, 1998). An assumption exists that 'mothering' comes naturally; women will know how to care for their newborns as a matter of course, as this is what women 'do' (Aston, 2002; Badinter, 2010; Goering, 2009; Speier, 2001). Content specific to the postpartum phase delivered in prenatal classes usually includes infant communication (NCAST, 1990), infant nutrition requirements, infant safety, and promotion of maternal mental health. In Nova Scotia, written materials addressing general concerns are available post-delivery in hospital as well as online from Public Health (PHERWG, 2008). Aston (2002), Beck (2002) and Nelson (2009) acknowledge that private classroom and web-based programs

focused solely on postpartum issues do exist, but the focus of such activities is currently more often concentrated on the maintenance of maternal mental health during this time period.

General assumptions of health care providers hold that with adequate prenatal preparation, such as is currently offered, women should transit through the postpartum period with little difficulty. Informal discussion with women within the first year after the ‘birth-day’ often revealed a common sentiment: ‘I was really not prepared for the reality of bringing a new baby home’. Many researchers corroborated experiences of questioning women (and men) that often revealed feelings of being overwhelmed in the first few weeks after birth with the responsibility of parenting in general (Christie et al., 2007; de Montigny & Lacharite, 2004, 2005; de Montigny et al., 2006; George, 2005; Goering, 2009; Harwood et al., 2007; Kaitz, 2007; Reich, 2005). Research by George validated my own personal clinical experience of the scenario of a ‘well-prepared’ woman in tears, completely frustrated in her perception of apparent ineptitude for mothering.

George (2005) discovered that maternal confidence is often diminished as feelings of helplessness and despair become overwhelming, especially in addition to the normal fatigue experienced in the early days of the postpartum period. Using grounded theory, 21 first-time mothers were interviewed within four weeks of delivery, using open-ended semistructured questions. Following thematic analysis, followed by comparative comparison analysis, a theory entitled ‘lack of preparedness’ was generated. One theme underpinning this work included ‘a change in priorities’, described as a need to reorganize everything. Mothers in this study described the ‘overwhelming responsibility’

they experienced with the addition of their infant to their life. ‘Unclear role expectations’ defined the physical and emotional transition to the role of mother for the participants.

All participants described a large ‘knowledge deficit’ during this time period regarding infant feeding, baby-care, and self-care. Although such information was provided during the hospital stay, participants felt overwhelmed by conflicting voices, and confusion arising from the volume of information in such a short period of time. Underlying these themes was a feeling of abandonment by the health care system due to lack of supportive resources following discharge from hospital. This increased the sense of isolation experienced by many participants and their families. This study highlights the need for continued support of families during the course of the postpartum, especially around infant feeding, infant care, and self-care (George, 2005).

Postnatal care. Advances in maternal-child medicine have afforded the opportunity for health care providers to shift focus for postpartum care provision to be more family-centered and capacity enhancing (Health Canada, 2000; NS Department of Health, 2003; Sittner, Hudson & Defrain, 2007). As a result, a model of care initiative bridging medical and population-based approaches to postpartum care is currently recommended to address the needs of this population. To this end, more community health resources have been mobilized to address postpartum client needs.

In Nova Scotia, community health nurses now conduct in-hospital assessments of all newly delivered women prior to discharge. Based on this assessment, requirements for home visiting needs are prioritized. Although the national guidelines of the Society of Obstetricians and Gynecologists of Canada (SOGC) recommend a home visit by a health care professional within 48 hours of discharge for all families discharged from

hospital less than 48 hours post-delivery, it is recognized that in most communities, not all families receive a home visit due to accessibility issues, lack of available personnel, and program cutbacks (SOGC, 2007). In Nova Scotia (at the time of this study), families identified to be requiring extra support, as assessed using the Parkyn Screening tool (Browne, Doane, MacLeod & McLellan, 2010) were afforded higher priority, and were offered home visits, and opportunity for assessment to the 'Enhanced Home Visiting Program' (Lilley & Price, 2003). Families not included within this cohort, but voicing concerns were further assessed over the telephone and offered a home visit if assessed to be in need. There were community based 'drop-in' clinics available to all families of young children in urban areas, where public health nurses were available to discuss with new parents postpartum issues including breastfeeding, physical growth, general care, child development and mental health (NS Department of Health, 2003; 2005).

Motherhood

Becoming a mother. Education and health care support are certainly factors ensuring successful transition to taking on the maternal role, as noted above. However, I must direct attention to the developmental and psychological tasks all women face during pregnancy in the process of maternal role attainment as originally researched and described by Rubin (1967a, 1967b, 1975, 1984), a process still supported by more current research (Martell, 2001; Mercer, 2004). These tasks are entitled: 1) seeking safe passage for self and her baby, 2) ensuring acceptance of baby by significant others, 3) binding-in to the unborn baby, 4) and learning to give of self.

Seeking safe passage derives from a need for the woman to protect the self and the baby. Activities that illustrate this task may involve seeking early prenatal care and

making changes in lifestyle to reflect culturally specific, healthy lifestyle choices.

Women seek to *gain acceptance of the child* by the most important persons of their lives, such as her partner, mother, and other children. How do others of import to this woman receive this infant? Research has shown the importance of social support received from these relationships on decreasing maternal stress, increasing maternal self-esteem, and as a correlate to preterm labor and delivery (Rubin, 1975; Mercer, 1995).

Binding-in or attachment to the fetus is developed during the pregnancy, and is described as being trimester related (Mercer, 1995; Rubin, 1975, 1984). Attachment to the pregnancy is the primary task of the first trimester. Although still early enough that others are not aware of the pregnancy, bodily sensations and changes stimulate maternal experiences of fantasy and enhanced imagination as the woman reflects upon the role of mother and the relationship she will have with this child (Merleau-Ponty, 1964; Rubin, 1967a, 1984; Solchaney, 2001; Wynn, 2002). In the second trimester, the tactile sensation of fetal movement enhances the awareness of the baby being 'here and now', boosting the binding-in process (Rubin, 1984). Idealization of the baby occurs as a result of a romantic love born of this heightened tactile sensation (Rubin, 1984). As levels of estrogen and progesterone increase, feelings of wellbeing about the pregnancy are enhanced, redefining this love for baby as a possessive love, and stimulating maternal protectiveness. Possessive love is tested in the final trimester, as the woman desires an end to the pregnancy but not at the expense of the child (Rubin, 1984). The process of binding-in can be delayed or non-existent for women with experience of previous perinatal loss, infertility, a history of personal abuse and violence, and mental health

issues (Rubin, 1984; Solchaney, 2001; Stainton, Harvey & McNeil, 1995). When this process is disrupted, the quality of the future maternal-child relationship is often affected.

Giving of oneself evolves as the woman learns to postpone self-gratification for the wellbeing of another, such as her baby. Through these tasks of pregnancy, women attempt to define a new self (as mother) while keeping the old self, intact (Mercer, 1995; Rubin, 1967a, 1984). Successful completion of these tasks is believed to enable successful transition to the maternal role (Mercer, 1995; Rubin, 1984; Solchaney, 2001).

Upon delivery of the baby, Rubin described two significant processes of the transition to the maternal role. The first was ‘taking-in’, the period of time two to three days immediately post-birth where the mother is somewhat self-absorbed as she processes what has just occurred during her labour and birth experiences. She is somewhat dependent on others, seeking care and knowledge as she begins to appreciate post-birth body sensations including uterine and perineal discomfort, breast sensations such as let-down of milk and nipple pain, changes in elimination processes, and fatigue. During this time, she begins the identification and claiming process by holding, smelling, watching and hearing her baby, all activities inherent to successful attachment. By three days postpartum, the woman moves to the ‘taking-hold’ phase as she shifts focus to her developing relationship with her baby. Although still fatigued, physical recovery from the birth process enables better concentration upon learning mothering tasks, such as infant care and feeding (Rubin, 1984).

Rubin’s work has provided a foundation for the work of many researchers – Ament (1990), Rogan, Schmied, Barclay, Everett and Wyllie (1997), Martell (2001), Nelson (2003), Mercer (2004), and Lothian (2008). Over time, findings described by

these researchers reiterate very similar processes as women transition to motherhood, albeit on more concise timelines.

The socially constructed mother. Developmental and psychological milestones are described in the process of maternal role attainment, each requiring successful completion to enable transition to the maternal role (Mercer, 1995; Rubin, 1967a, 1967b, 1984; Solchany, 2001). However, similarities might be drawn between Rubin's description of the maternal tasks of pregnancy (primarily rooted in psychology), and more modern discourse surrounding the social construction of the 'good mother', a discussion believed more relevant to my research (Boyd, 2010; Brown, Small & Lumley, 1997; Dally, 1982; Oakley, 1979; Phoenix & Wollett, 1991).

The social sciences are often the foundation for much of the research and opinion formation regarding the social construction of 'good mothering'. Brown, Small and Lumley (1997) reported upon a small portion of a mixed methods study exploring the experience of motherhood involving ninety mothers in Australia in the first two years post-birth. In tape-recorded interviews as part of the larger study, mothers were asked "How would you describe a good mother?" (p. 185). Interview responses to this question were coded using three domains – qualities and attributes, child-care tasks, and balancing/sense of self. Qualities and attributes of a 'good mother' recorded as important to the study group (identified by more than ten percent of the study group) included being caring and loving (38%), having patience (25%), and being calm and relaxed (11%) as most valued traits. Other traits scoring less than 10% included, but were not limited to, the ability to listen to and talk with children, being consistent, not being perfect, never losing one's temper, doing one's best, and being fair, to list a few of the eighteen

recorded. Child-care tasks most valued in ‘the good mother’ included spending time with children (26%), fostering children’s emotional development (16%), and doing the basics/attending to feeding and hygiene (11%). Disciplining children, being there for children, and keeping children under control completed this domain. Interestingly, notable tension underlined the description of the continuous juggling required to balance housework and childcare as housework tasks continuously detracted from being a ‘good mother’. The domain of balance/sense of self included ‘good mothers are good at what I’m not good at’ as the most common response (15%). Traits scoring less than 10% included children come first, being confident about oneself, and keeping a sense of own interests and needs (Brown et al., 1997).

This portion of the larger study is important as it provides a window to what women define as ‘good mothers’ as described by women themselves. Highlighted in Brown, Small and Lumley’s findings was the “heavy burden on women of attempting to reconcile pervasive beliefs about being a ‘good mother’, with the many competing demands in women’s lives at this stage in their lives” (1997, p. 185). The women in this study remained steadfast in their axiomatic belief in the socially constructed duality of motherhood - if one was not a ‘good mother’, then one was a ‘bad mother’, regardless of situational intangibles such as poor health, exhaustion, and temperamental infants (Brown et al., 1997).

Motherhood is viewed by many as a social construction rooted within a patriarchal system. Boyd opined the ideology of motherhood, as a gendered experience, constrained the experience of autonomy as women strove to attain the expected outcomes as dictated by society at large (2010). Many researchers agreed that being a ‘good’

mother was often a socially constructed status, with indicators for success derived from political, social, racial, ethnic, gendered, cultural and class-based agendas (Arendell, 2000; Badinter, 2010; Medina & Magnuson, 2009; Sutherland, 2010; Vincent, Ball & Braun, 2010). Arendell wrote “mothering and motherhood are viewed as dynamic social interactions and relationships, located in a societal context organized by gender and in accord with the prevailing gender belief system” (2000, p. 1193). Aston (2002), Ben-Ari & Weinberg-Kurnik (2007), Kukla et al. (2009), Marshall, Godfrey & Renfrew (2007), and Wall (2001) wrote that maternal desire to *be* a good mother was often sublimated to feelings of obligation to partake in activities related to mothering, in order that she might be *viewed* as a good mother. Donchin wrote that women were expected to engage in socially constructed roles that subordinated their needs in favour of their child’s, risking a normalization of relationships of inequality and oppression (2001, p. 379). This sentiment was well supported throughout the literature (Arendell, 2000; Badinter, 2010; Boyd, 2005; Boyd, 2010; Earle, 2000; Friedman, 2009; Horwitz & Long, 2005; Kukla, 2006; Lee, 2012; McCarter-Spaulding, 2008; Rempel & Rempel, 2004; Varcoe & Doane, 2007). Validation of ‘good mother’ status was sought within the relationships held by women as mothers. Given that women depend on, and feel responsible for others, these relationship values can affect decision-making processes as a result (Badinter, 2010; Donchin, 2001; Ho, 2008; McLeod, 2002).

Influence of healthcare providers. Researchers agree that healthcare providers were often influential in their relationships with women (Hauck et al., 2011; Nelson, 2007; Schmied et al., 2011). In Canada, access to health care is location dependent, often with more options regarding choice of provider in urban settings. Magri and Hylton-

McGuire wrote that although access to midwifery services was slowly on the rise in Canada, the majority of childbearing women access traditional health care venues, often hierarchical in nature, with physicians and nurses providing care, and hospitals as the physical setting for childbirth activity (2013). Birthing choices were still very much influenced by those in charge – the health care professionals. After delivery, these same professionals directed infant care as they monitored the infant’s successful transition to extrauterine life. Again, many researchers agreed that the social discourse of mothering was reinforced here, encouraging women to engage in socially correct ways of being a mother, to make the ‘right’ feeding decision, so as to be viewed as ‘the good mother’ (Dykes, 2005; Knaak, 2010; Kukla, 2006; Ludlow et al., 2012; McCarter-Spaulding, 2008; Nelson, 2012; Sheehan et al., 2013; Taylor & Wallace, 2011).

In light of this information, I wondered how often women sublimate their true desires in pursuit of ‘good mother’ status. When women choose a method of feeding, are they choosing said method as a response to their own psychological transformation, their increased education, and/or a need to be, or be seen as the ‘good mother’? Is there something else? Reflection upon current theory and clinical practice experiences has led me to consider the concept of autonomy, how women experience it in the childbearing phase of their life, and how best to pursue a study of such an idea.

Choosing to Breastfeed

Researchers support the current notion of exclusive breastfeeding for the first six months of life, continuing with the introduction of other food sources until the child is at least one year of age (Feldman & Frati, 2008; UNICEF et al., 2005; WHO, 2009). Health portfolios in both provincial and federal legislative organizations strongly support and

encourage this ideal (Health Canada, 2012a, 2012b; NSDHW, 2011). Professional health care organizations also endorse this policy (AWHONN, 2015; Boland, 2005). In recent years, health care professionals have actively promoted breastfeeding as the ‘gold standard’ of feeding methods (Newton, 2004). And yet, recent statistics continue to demonstrate suboptimal breastfeeding rates across the country, and the world (Gionet, 2013; WHO, 2013).

Personal experience and research support demonstrated that although overwhelmed by the totality of the childbirth experience, most women do enter the postpartum phase having given prior consideration to feeding options for their infant (Archabald, Lundsberg, Triche, Norwitz & Illuzzi, 2011; Lothian, 1994; Sheehan et al., 2009). The topic had usually been discussed with family and friends at some point during the pregnancy. The opinion of a woman’s partner was often a strong factor in her desire to begin and continue the breastfeeding process (Rempel & Rempel, 2004). Most health-care providers will address feeding methods during prenatal care provision; most will promote breastfeeding as the method of choice, given the official stance adopted by governmental and professional agencies (AWHONN, 2015; Health Canada, 2012a; NSDHW, 2011). Information about breastfeeding was easily located in professional and lay publications, electronic media, and visual presentations in all health care facilities, both public and private (Shaw, 2004). Concurrently, information regarding formula feeding was equally available (albeit not as much in Canadian health care facilities), and often portrayed as an equally suitable alternative to be considered should breastfeeding efforts be experienced as substandard or ineffectual (Schulze & Carlisle, 2010; Taylor & Wallace, 2011).

Breastfeeding, that most ancient of feeding methods, is an integral part of mothering, and it, too, is a learned art. Just because the breasts fill with milk upon the birth of a child does not mean that breastfeeding occurs easily and universally. How it is done, how often, and by whom varies within communities, and among generations (Baumslag & Michels, 1995).

Reasons given nationally for cessation of breastfeeding included ease of formula feeding, medical conditions interfering with breastfeeding, the unappealing nature of breastfeeding, and the belief that formula is 'as good' as breast milk (Gionet, 2013). Other reasons cited in the literature include maternal physical discomfort, inadequate milk supply, easy access to formula, and perception of lack of infant satiation (Ahluwalia et al., 2005; Dubois & Girard, 2003; Gage et al., 2012; Kools et al., 2006; Nelson, 2006a; Rempel, 2004; Riordan & Wambach, 2009; Schmied & Barclay, 1999; Schmied et al., 2011; Sheehan et al., 2009; Sloan, Sneddon, Stewart & Iwaniec, 2006).

Sore nipples, the most common source of maternal discomfort, were not always the result of visible trauma. Findings of a small quantitative study by McClellan et al. (2012) indicated that although pain experienced by women with visible nipple trauma was more intense, women with no visible nipple trauma still experienced the same sensory, affective and evaluative properties, thereby influencing higher rates of early breastfeeding cessation. Women experiencing nipple pain were recruited into two study groups – those with persistent pain and no trauma (n=29), and those with pain and visible trauma (n=18). Following demographic information collection, participants were asked to complete a McGill Pain Questionnaire (measuring pain type by description), a visual analogue scale measuring pain intensity, and a brief pain inventory measuring pain

interference for activities of daily living. Statistical analysis demonstrated no significant difference in group response to the McGill Pain Questionnaire, although women with nipple trauma more often chose words such as *frightful, terrifying, piercing, tight* and *tearing* to describe their breastfeeding experience. Women with no visible trauma more often chose *radiating* to describe their pain. For both groups pain experienced interfered with breastfeeding activity, mood, general activity and sleep. Intensity and duration of pain was significant to the level of interference of breastfeeding activities and subsequent cessation. Although pain associated with visible nipple trauma was easily understood (and expected in this study), persistent pain with less nipple trauma was less so, with the potential to be easily dismissed by health care providers. This study highlighted the deleterious effects of the pain experience for women's lives and the need for extra support in their breastfeeding efforts. Further study is required to investigate causes and effective interventions for persistent nipple pain that can result in sustainment of breastfeeding for these women (McClellan et al., 2012).

Although the veracity of the aforementioned points is well documented, I cannot help but wonder if there is more to the persistent statistical phenomenon of suboptimal breastfeeding rates than is immediately apparent, an idea supported by Friedman (2009). Experiences of pain with breastfeeding can be more positively supported. Assessment about objective data regarding adequate milk supply, and infant satiation can be easily shared with, and successfully used by women. Formula can be made inaccessible (in health care institutions) and information supplied regarding the cost/benefit of this method of feeding. Again, is there something more in the lives of women I am not seeing?

Choice in quantitative research. Although very much a personal choice, the final decision to breastfeed is influenced by many factors, both structural and contextual in nature. Quantitative research studies I have reviewed for this project demonstrated that social determinants such as maternal educational level, socioeconomic status, and quality of social support have proven to influence breastfeeding initiation and duration rates. As well, maternal age, employment status, duration of maternity leave, and choice of health care provider could influence women in this decision-making process (Ahluwalia et al., 2005; Dubois & Girard, 2003; Gage et al., 2012; Kools et al., 2006; Rempel, 2004; Sloan et al., 2006). Please note I remain true to the authors' use of 'mother' throughout these reviews.

Dubois and Girard (2003) obtained and analyzed data from a representative sample (n=2223) of all infants born in Quebec in 1998. Face-to-face interviews were conducted with mothers at five months postpartum; information was collected about breast and other methods of infant feeding, and demographic and social indicators (maternal age, education level, family income, and maternal employment status) deemed important in relevant breastfeeding literature. Using statistical analysis, the impact of these selected indicators upon the experience of breastfeeding from birth to four months postpartum was measured. Exclusive breastfeeding rates for this time period fell from a 72 percent initiation rate to six percent at four months postpartum. Maternal education levels were the most important factor for initiation and duration of exclusive breastfeeding at three months; maternal age was the most important factor for exclusive breastfeeding at four months. Maternal socioeconomic status was noted to be an

inconsistent factor influencing breastfeeding duration in this study (Dubois & Girard, 2003).

Gage et al. (2012) conducted a five-country European project studying influences upon infant feeding decisions for first-time mothers, in particular sources of information deemed most influential at birth and then over the next eight months postpartum. Questionnaires were used to collect data on sources of information about infant feeding, as well as for demographic data, beginning in 2007 (minimum of 400 mothers/country). The initial questionnaire was completed at birth (n=2071), the second at eight-months (n=1619 -78.2% follow-up rate). Mothers choosing to complete the second questionnaire were noted to be older, in a higher income bracket, better educated, and in full-time employment prior to pregnancy when compared to those mothers lost to follow-up. No significant difference in intention to breastfeed was noted between the two groups. Using statistical analysis, the antenatal midwife, books, and maternal partner were found to be the most influential sources of information at birth and at eight months postpartum, although data indicates that many sources of information were accessed. The importance of the significant partner, and family and friends increased over the eight month period, providing evidence that mothers valued social networks higher than health care providers as sources of information regarding infant feeding over time, an important fact in the pursuit of increased breastfeeding rates in these countries (Gage et al., 2012).

Kools et al. conducted a study underpinned by the Integrated Change Model, a social-cognitive model incorporating ideas from other models, such as the Theory of Planned Behavior, Social Cognitive Theory, and the Health Belief Model (2006, p. 395). Using it to derive an understanding of health behaviours, motivational factors, resulting

from awareness factors that include predisposing influences (behavioral, psychological, biological, social cultural), and informational influences (messages, channel, source) were examined. Study participants completed survey questionnaires prenatally (n=373), at one-month postpartum (n=341), and at three-months postpartum (n=272). Data collected included maternal demographic information, history of intention to breast or formula feed, previous breastfeeding experience, delivery information, family medical history, maternal history of smoking and alcohol consumption, and current infant-feeding experiences. Of the original 341 mothers in the study, 248 mothers initiated breastfeeding, with 132 mothers continuing to breastfeed for three months or longer. Similar to the previously discussed studies, mothers with higher education and non-smokers were more likely to initiate breastfeeding. The decision for most to initiate breastfeeding was made prior to, or during pregnancy. Motivational factors for continuing breastfeeding were greater social acceptance and support, strong beliefs of the benefits of breastfeeding, and increased self-confidence. Reasons for switching to formula-feeding included pain with breastfeeding, a fear of insufficient breastmilk supply, repeated inability to soothe baby, a return to employment, and the influence of the maternal partner, family and friends. This study demonstrates the need for further study of determinants for both initiation and continuation of breastfeeding, as two distinct but related processes (Kools et al., 2006).

Rempel (2004) explored influential factors of long-term breastfeeding mothers. Similar to the study by Kools et al. (2006), she used the theory of planned behavior as the conceptual framework (2004). Rempel posited that breastfeeding behavior is predicted by breastfeeding intention, including maternal attitude to breastfeeding, degree of

approval of significant others about long-term breastfeeding, and level of maternal perceived control over continuation of breastfeeding. Three hundred seventeen volunteer study participants in Waterloo, Ontario were assessed prenatally regarding feeding choices, strength of intention to breastfeed, maternal attitude, perceived subjective approval of others, and perceived control – 298 of this cohort initiated breastfeeding upon delivery, with 80 mothers still breastfeeding at nine-months, albeit not exclusively. Assessments completed at one, two, four, six, nine and twelve months postpartum measured feeding behaviours, and intention to continue breastfeeding. At nine and twelve months, maternal attitude, perceived subjective approval of others, and perceived control were again measured. Data collection was completed by telephone interviews, home visits and postal questionnaires. Statistical analysis of the data demonstrated strong correlations between perceived control over breastfeeding and positive social support for long-term breastfeeding. Strong intention to breastfeed at each stage of data collection was also a positive determinant for long-term continuance of breastfeeding (Rempel, 2004).

A retrospective study conducted in Ireland by Sloan et al. (2006) used semi-structured interviewing techniques to collect demographic factors including maternal age, parity, education level, socioeconomic and employment status from 274 families with infants (mean age of infant was 12 months). A follow-up semi-structured interview was conducted to collect information about feeding practices. Statistical analysis was performed, testing for association between breastfeeding initiation and duration, and factors including maternal age, education, employment and parity. Data revealed that 179 mothers intended to breastfeed prior to delivery of their infants. Intention was

strongly correlated to the health promotion message ‘breast is best’ across all ages, however only 65% of all participants initiated breastfeeding. Rates of duration of breastfeeding fell to 36% of initiators by six months postpartum and 9% at twelve months, with return to work most commonly cited as the reason for stopping, especially for older mothers. Younger mothers described concerns about overall infant intake to explain breastfeeding cessation. Strong association was noted between breastfeeding initiation and duration, and higher maternal age, higher educational level, and improved socioeconomic status than those not choosing to breastfeed. The need for maternal support from professionals, family members, and employers is highlighted in this study (Sloan et al., 2006).

Ahluwalia et al. (2005) conducted a similar retrospective study with similar results. Using data retrieved from the Pregnancy Risk Assessment and Monitoring System (a national data system in USA), statistical analysis was conducted measuring breastfeeding behaviours, reasons for breastfeeding cessation, periods of vulnerability for cessation, and association between antenatal intention and post-delivery actualization of breastfeeding behaviours. Data demonstrated a breastfeeding initiation rate of 68%, with 51% still breastfeeding at one month postpartum. Young maternal age and decreased socioeconomic status were significant for early cessation of breastfeeding; reasons cited were sore nipples, inadequate milk supply, and maternal perception of persistent infant hunger (Ahluwalia et al., 2005).

These researchers certainly demonstrate commonalities within their findings. Demographic factors influencing maternal age, level of education, and support of significant others were shown to be significant in a woman’s decision-making efforts

regarding initiation and duration of breastfeeding. However, this does not provide me with insight as to the experience of maternal autonomy in the decision making process.

Choice in qualitative research. Wamback and Koehn (2004) described their findings of their study of disadvantaged adolescent mothers and their experiences of infant feeding decision-making. This work is noted to be the starting point for a larger randomized control study. Using the theory of planned behavior to guide questioning, five focus group interviews were held with 14 pregnant adolescents (aged 14-18) between 18 and 39 weeks gestation. Data was analyzed using content analysis and a computer software program. Two themes were identified in this process: benefits versus barriers of methods, and independent choice versus social influence. Both themes were founded upon a web of ambivalence and uncertainty. Although most participants were cognizant of breastfeeding benefits for the infant, they struggled with individual constraints such as freedom to leave the baby, breastfeeding in public, and educational deficits about the breastfeeding process. Attitudes toward ease of feeding method certainly supported formula feeding as being simpler. Although all realized feeding choice was ultimately their own decision, all described the influence of others (family, counsellors) when exercising their options. Wamback and Koehn note that these findings must be viewed using a developmental lens, however mature adolescents are capable of making 'competent choices' (2004).

Brown et al. (2011) conducted a descriptive qualitative study exploring health care provider and maternal perceptions of factors influencing feeding choices. With study participants located in a lower socioeconomic area of the United Kingdom, the researchers interviewed 20 health care providers (midwives, health visitors, community,

family and social care workers, breastfeeding counselors) and 23 mothers. Following demographic information retrieval, health care providers were questioned about their experience working with breastfeeding mothers, and their beliefs and opinions regarding current low breastfeeding rates. Upon retrieval of demographic information, mothers between six and twelve months postpartum completed semi-structured interviews about their infant feeding experiences. Mothers ranged in age from 17 to 36 years, with some having more than one child. Fifteen mothers initiated breastfeeding at birth; all had switched to formula by six weeks postpartum (Brown et al., 2011).

Following content analysis, Brown et al. (2011) identified five overriding themes, the first being that formula feeding was the ‘norm’ for UK mothers. Both professionals and mothers corroborated this belief. Breastfeeding and body image constituted the second theme. Mothers reported negative attitudes about the impact of breastfeeding on the physical body, attitudes well known to professionals. A third theme encompassed the idea that formula feeding was perceived as more convenient for baby and family. Babies settled easier with formula, and feeding interactions were less time consuming, providing more opportunity for predictable lives. The involvement of others to feed infants was attractive as the mother was not the sole provider of nourishment, thereby providing opportunity for all to share the burden of infant care. The fourth theme addressed the perceived difficulty of breastfeeding. Problems centering upon pain and discomfort caused by breastfeeding were unexpected. With little perceived education and support to anticipate and work through them, ensuing feelings of guilt were experienced upon cessation of breastfeeding. The final theme addressed a lack of self-confidence about the breastfeeding process – mothers were unsure of milk production, breastfeeding infants

fed much more frequently, and breastfed infants were perceived to grow slower than formula-fed infants. Given health care provider and social (family and friends) emphasis upon weight as the principle measure of successful infant feeding, mothers were filled with doubt regarding their efforts. Recognizing the value of breastfeeding for infants, both groups reiterated the need for increased professional and social support of breastfeeding efforts to increase duration rates (Brown et al., 2011).

Schmied and Barclay (1999) explored the experience of breastfeeding with 25 Australian first-time mothers. Using data from two semi-structured interviews (the first conducted in late pregnancy, the second at six months postpartum), discourse analysis was used to analyze the findings. Intention to breastfeed was strong for all mothers in this study; all participants initiated this method of feeding at birth. By six months post-delivery, 18 mothers were still breastfeeding. All participants described breastfeeding as a natural way to feed, best for baby, and representative of ‘good mothering’. What becomes significant about this study is their experience of breastfeeding as an embodied process. Eight of the participants described much pleasure with “breastfeeding as a connected, harmonious and intimate embodiment” (p. 328). They enjoyed sharing their body with their infants, describing the experience as intimate, sensual and pleasurable, providing a closeness only they could enjoy.

The remaining participants expressed mixed feelings and emotions regarding the breastfeeding experience. Some women were unable to resolve “the ambiguities and contradictions between the embodied experience of breastfeeding, the pro-breastfeeding discourse of professionals and public rhetoric, and the prominent notions of rational autonomy [prevalent in western society]” (p. 329). The remaining women described

breastfeeding as dissatisfying overall, resentful of the constant demand of their emotional and physical bodies. Eight women described very painful breastfeeding experiences, further highlighting the distorted embodiment noted in this group. This somewhat dated study emphasizes the need for greater understanding of the breastfeeding process and current thinking about women's autonomy (Schmied & Barclay, 1999).

Nelson, an American nurse researcher, completed two qualitative metasynthesis projects about breastfeeding (2006a, 2012). Both projects used Noblit and Hare's (1988) comparative method of synthesizing qualitative studies as the underlying framework. In her metasynthesis about breastfeeding, 15 qualitative reports incorporating methods including phenomenology (7), grounded theory (4), interpretive discourse analysis (1), ethnography (1), focus groups (1) and semistructured interviews (1) were studied. Numbers of study participants ranged from three to twenty-six, exhibiting ethnic and socioeconomic diversity, as well as diverse parity.

One overarching theme was revealed – the breastfeeding process is an “engrossing, personal journey” (Nelson, 2006a, p. 15). Four subthemes provided substance to this statement. Breastfeeding was an embodied reality, not just a process informed by social convention, a finding similar to that of Schmied and Barclay (1999). Mothers in all studies described the physical connectedness and deep satisfaction experienced in breastfeeding, while concomitantly speaking about the physical concerns many shared such as milk quantity and quality, physical changes effected through the lactation process, and resulting discomforts such as nipple pain and engorgement associated with breastfeeding. A second subtheme, becoming a breastfeeding mother, incorporated the decision to continue breastfeeding and the adaptive processes required in

making this decision. The ‘need for support’ was the third subtheme described in this work. The need for family, friend, professional and societal acceptance of breastfeeding efforts was important to mothers in all studies. The fourth subtheme, ‘the journey must end’ referred to the weaning process. Whether a chosen endpoint, or a natural progression of the process, mothers experienced a range of emotions regarding their breastfeeding experiences that required reflection, acknowledgement, and resolution to be able to move on in their lives. This metasynthesis highlighted the need for increased sensitivity of health care providers around maternal meaning and significance of breastfeeding. The importance of family inclusion in the planning and supporting the breastfeeding process is made visible in this work (Nelson, 2006a).

Nelson’s second metasynthesis project examined infant feeding decision making (2012). Fourteen qualitative studies using grounded theory (2), semistructured interviews/focus groups (8), ethnography (2), and phenomenology (1) were selected. Again, research participants demonstrated a wide demographic, ethnic and socioeconomic diversity. Following application of the metasynthesis process, two central processes were delineated: making a personal choice, and defending that choice (Nelson, 2012).

Making the decision to breastfeed was ultimately described as a personal choice, albeit with social and personal influences. Many mothers described feeling professional and social pressure to do the ‘right thing’. Many were aware of the ‘breast is best’ message, espousing the benefits of breastfeeding, however some still chose to formula feed as formula was not viewed as harmful. Strong commitment to breastfeeding was often not enough to break through the barrier of perceived non-acceptance for

breastfeeding in public, resulting in feelings of embarrassment and guilt when choosing to formula feed in this venue. Personal comfort and a sense of control were strongly correlated to the decision to breastfeed. Strong personal confidence and commitment was important in the early days following delivery to sustain breastfeeding efforts. Long-term support was described as key to success of breastfeeding efforts, not just at the time of delivery. Family was noted to be the primary source of support post-delivery. Breastfeeding was sustained for a greater length of time when deemed compatible with maternal lifestyle (Nelson, 2012).

In concert with making a personal choice was the need to defend the choice (Nelson, 2012). All mothers in all studies felt the need to defend and qualify their choice of infant feeding on moral grounds, especially if choosing to formula feed their infants. In seeking support to do their best, regardless of infant feeding choice, mothers consistently sought non-judgmental validation of their efforts. This metasynthesis highlights the need for accessible and individualized support for mothers that could improve breastfeeding exclusivity and duration (Nelson, 2012).

The process of ‘deconstructing best’ results from a study of Australian mothers undertaken by Sheehan, Schmied and Barclay (2009). Using a constructionist grounded theory approach, 37 women were recruited and interviewed within nine weeks following birth. When interviewed, 14 women were breastfeeding, seven were feeding their infants a combination of expressed breastmilk and formula, and 16 were formula feeding. Of those mothers providing formula, 12 had initiated breastfeeding but had since weaned their infants. Presented as a narrative, the process of ‘deconstructing best’ was the result of this interpretive research method.

Deconstructing best is contextually situated within four categories, and is realized in seven phases. The first phase was *planning*, as all mothers plan how they will feed their infants. This was contextually situated in the category of ‘it’s really best to breastfeed’. Personal and social pressure to breastfeed intensified. The next phase, *realizing*, described grappling to understand the breastfeeding process as an unknown activity. Preconceived ideas of breastfeeding could turn *expecting* to *questioning* when these ideas proved to be non-valid. These phases, situated within the category labeled ‘it’s the unknown’ described the process of mothers beginning to question themselves physically and emotionally when breastfeeding did not go as planned and problems were encountered. The phase *getting on with it* was the end result, however mothers chose to feed their infants. This resulted from the realization ‘it’s not the only thing going on’, another category of this process. Mothers weighed the positive and negative factors of their lives, and made decisions that fit their world, as experienced by them and the realization that breastfeeding was not the only consideration of a mothers’ postnatal world. The final phases of *defending* and *qualifying* their decisions were contextually realized as ‘everybody’s best is different’. This study reiterates recognition of women in their totality when providing individualized support during the infant feeding decision-making process in the face of the ‘breast is best’ message (Sheehan et al., 2009).

Similarities are noted in all qualitative works I have reviewed. All authors provided insight regarding the ambivalence experienced by women about the breastfeeding process, and the tension created between ‘doing the right thing’ and the actual experience of breastfeeding not meeting expectations. All authors reiterate the need for individualized support for women as they negotiate these tensions. Schmied and

Barclay (1999) do intimate a need to address the connection between maternal autonomy and decision making about breastfeeding. However the exploration of the lived experience of decision-making around infant feeding for women was not a part of any of these studies. I believe such a study could fill in the gaps of my understanding of this process.

Relational experiences of breastfeeding. In hospital following delivery, personal clinical experience has been that a woman choosing to breastfeed will usually be mentored and supported by her health-care providers to quickly learn the ‘art’ of breastfeeding. She is praised when she is able to latch her infant independently, a fact corroborated by Friedman (2009). Having been apprised of the value of exclusive breastfeeding, and the timelines espoused by the ‘experts’ for this endeavour, she is deemed ready to return home, infant in tow (NSDHW, 2011).

However, when health care professionals are consulted by a woman for advice and help during this time period, ideas and values deemed important by professionals may not mesh with those of the woman due to the social construction of her world view (McLeod, 2009). By ‘just doing their job’, normalized oppressive relationships may be enacted as health care professionals provide information and advice grounded in ‘good science’, without benefit of a complete understanding of the lived experience of the recipient, the woman. Aston (2008) wrote that how we share information is as important as what we share. Unfortunately, such relationships are perpetuated as the woman attempts to meet the socially constructed ideal of meeting all her child’s needs (Varcoe & Doane, 2007). Donchin highlights the importance of understanding that personal autonomy cannot be isolated from a woman’s experienced life world, and that care

practices can become overwhelming when autonomy is not respected (2001). A relational exploration of how infant feeding decisions are made could provide the necessary information required to guide health care professionals in their provision of care. What are the relationships influencing a woman's choice to breastfeed, or not? What other factors influence the decision-making process regarding breastfeeding?

Relational Autonomy

Autonomy traditionally. Beauchamp and Childress defined personal autonomy, or self-determination (a descriptor often used in lieu of autonomy), as “personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding” (1994, p. 121). Simply put, a person must possess both liberty (the state of being free from oppressive restrictions imposed by others on one's way of life, behavior, or political view), and agency (the full capacity to act on one's choices) to enable self-determination (Beauchamp & Childress, 1994; Emirbayer & Mische, 1998; Friedman, 1997, 2003).

This traditional definition of autonomy has roots in Kantian writing, and is espoused as a tenet of liberal theory. It is an individualistic belief of personhood, and patriarchal (born of and for men) in its conception (Benner, 2000; Code, 2000; Friedman, 2003; Mackenzie & Stoljar, 2000; Nedelsky, 1989; Sherwin, 1992). As Heideggerian phenomenology is both philosophy and methodology in this study, there is a need to present another view of autonomy. Dreyfus (2004) explains Heidegger did not embrace such a Cartesian view of autonomy. Heidegger replaces the notion of Kantian autonomy with *authentic resoluteness*. Authentic resoluteness is defined as in being true to oneself (accepting one's ontological limitations), one can let go of rigid roles and identities,

becoming sensitive to marginal practices from the past, thereby effecting opportunities to make change within one's world (Blattner, 2013; Dreyfus, 2004). I will explore this concept further when I discuss Heidegger and interpretive phenomenology.

Reproductive autonomy. Purdy (2006) and Zeiler (2004) defined reproductive autonomy as the self-governing ability to make reproductive decisions, especially regarding childbearing. Purdy wrote, "reproductive autonomy is central to women's welfare both because childbearing takes place in women's bodies and because they are generally expected to take primary responsibility for childrearing" (2006, p. 287). I believe this statement has merit as it reflects the reality of many women today. To this end, much has been written about reproductive autonomy in the preconception and prenatal phase of the reproductive cycle (McLeod, 2002). However, Goering (2009) questioned the capacity of women to be autonomous beings during the postpartum period. She wrote,

...mothers come face to face with myriad issues that demand careful attention but appear in a context (inexperience, sleeplessness, anxiety, exhaustion from major physical exertion, and strong surges of emotion, as well as entrenched ideologies about proper parenting and especially appropriate mothering) unlikely to provide opportunities for extended or clear-headed critical reflection (p. 9).

As a nurse having provided care for this population, this notion intrigued me. Do women who exercise full personal autonomy pre-childbirth experience life as fully autonomous mothers in the postpartum phase? How does the 'context' alluded to by Goering affect the experience of autonomy for women during this time? Do the decisions made in this context demonstrate a loss of personal autonomy during this time period?

Or, does this woman defer or dismiss her own self-defined experience of autonomy and make decisions that do not truly reflect her own goals and interests, in an attempt to be seen as ‘the good mother’? Might this explain the poor breastfeeding rates of duration seen in Canada? If there is a glimmer of truth to this, how can and should nurses support and nurture a woman’s autonomous self while providing care in the postpartum setting?

Being autonomous has long been valued by men, and was embraced by liberal feminist scholars in the 1970s (Friedman, 1997). Increased study and enhanced understanding of the lived experience of women in the 1980’s saw a shift in feminist thinking. The traditional definition of autonomy was criticized for its inherent support of individualism, and subsequent denial of the social context and interrelatedness of human beings in the main (Donchin, 2001; Friedman, 1997; Nedelsky, 1989; Sherwin, 1992). Feminists issued a call to reconfigure the concept of autonomy within a relational context, situating the experience of autonomy within the social web of relationships and community as lived by humans (Banks, 2011; Friedman, 1997).

Arendell (2000) wrote that with the birth of the infant, mothers became part of a dyad, interconnected with, and interdependent on the baby while constantly in relation with others – partner, family, and community, including healthcare professionals. The sociocultural organization of, and meaning ascribed to the resultant nurturing activities of motherhood as situated within these relationships created personal interest in the experience of autonomy as an alternative way of studying this experience. By viewing autonomy experiences of postpartum mothers through a traditional lens, the interconnectedness they experience is negated (Goering, 2009; Goldberg, 2003). McLeod (2002) provides support for the notion that focus upon the interdependence and

interconnection with partners, family, and friends, as well as the infant, provides grounds for an exploration of this concept using a relational lens.

Relational theory. Feminist scholars have been largely responsible for the advancement of relational theory in the study of women. Relational theory begins with the notion that humans are not in the world as fully autonomous, independent, and self-reliant beings (Koggel, 2012). Humans live an interdependent existence “within a web of interconnected (and sometimes conflicting) relationships” (Sherwin, 1998, p. 35). Being socially constituted within the world, women’s self-identities are reflective of interaction at the personal, societal and institutional level. The intimacy and interdependence of personal relationships inform female identity formation. Woman’s location within the world is realized through social and institutional relationships (Baylis, 2012). Inversely, relationships are a requirement for existence as relationships of the past, present and future are incorporated into identity formation (Baylis, 2012; Gergen, 2009; Koggel, 1998; Tronto, 1998, 2003; Walker, 2011). Women are defined by their relationships, as much as they, in turn, define their relationships. Llewellyn and Downie write, “the human self is...constituted in and through relationship with others. We define ourselves in relationship to others and through relationship with others,” (2012, p. 4). Parallels may be drawn between relational theory as described above, and the writings of Buber (1934), Heidegger (1927/1962) and Macmurray (1961), as they highlight relationships as a component of understanding the existence of the self. “Persons, therefore, are constituted by their mutual relation to one another” (Macmurray, 1961, p. 24).

Gilligan (1986, 1993) is often credited with highlighting the importance of the relational quality of women’s lives while challenging Kohlberg’s theory of moral

reasoning. She stated Kohlberg's theory was grounded in paternalistic values that sought a morality that was abstract and universal. She maintained his theory was individualistic, promoting independence and disconnection from others, and favoring autonomy above all else. Based on these characteristics, women would never achieve the highest level of morality as espoused by Kohlberg as they identified with the value of attachment, demonstrated in attributes of caring for, and being interconnected with others (Friedman, 2003; Gilligan, 1993). Gilligan writes "we know ourselves as separate only insofar as we live in connection with others, and that we experience relationship only insofar as we differentiate other from self," (1993, p. 63). Although offering a somewhat narrow focus in that her ideas focused on women's caring, and reliance on interdependent relationships to realize moral authority (Sherwin, 1998), Gilligan's work was important as it created dialogue about how differently men and women experience the world (Gilligan, 1993; Walker, 1989).

Koggel, a feminist scholar, expanded on Gilligan's contributions by looking past the personal to a notion of men and women embedded within a network of relations that are culturally construed and socially constructed (1998). As such, all relationships, including those of gender, power, authority, oppression and disadvantage are equally important to understanding concepts of autonomy, justice and equality. Koggel's exploration of the concept of equality, especially for women, supported the notion that understanding of this concept is heightened using a relational lens. Contextual qualities observed in relational interactions, whether positive or negative can provide insight and understanding into conditions that might have remained invisible, especially in taken-for-granted instances of oppression and gender difference (Koggel, 1998; Llewellyn &

Downie, 2012). Personal becomes political when coping strategies are teased out and made visible while exploring resulting relationships of inequality, thereby increasing understanding of women's place in the world (Friedman, 2003; Koggel, 1998, 2012; Nedelsky, 1988).

Relational experiences: *Experience of body.* Sherwin (1992) and Young (2005) expressed the notion that a woman's experience of autonomy could be directly linked to the experience of self-esteem. Personal perception of physical attributes of the body, as influenced by dominant western culture, correlates directly with levels of esteem for many young women. Women are socially constituted as sexual beings, resulting in their objectification within a dominantly patriarchal society. Advantage and privilege awarded women who meet culturally signified body standards perpetuate continuing oppressive conditions for women. And yet, feeling good about the body, no matter how socially constructed the measure, often increases feelings of esteem for women. A relationship is developed with the body as an instrument of self-worth, disregarding the oppressive atmosphere in which it was born (Sherwin, 1992; Young, 2005).

Simms (2001) and Young (2005) wrote of the embodied experience of childbearing as one intensifying the relationship a woman has with her body, both positively and negatively. Many women experience a paradigm shift in personal perception from sexual objectification to a tool of reproduction. They are in awe of the privileged knowledge of the fetus growing inside, while marveling at the bodily changes enabling such development, and the strength inherent in delivering a child (Simms, 2001; Young, 2005). Davis-Floyd (2003) provided support as she wrote that women experience their pregnancy within a socially constructed world, one that they will return to upon

delivery of the child. Their experiences of pregnancy, childbirth and the postpartum are grounded in and through this environment. Expectations about these events reflect beliefs and values manifested within their life-world, and influenced by past experience, life-partners, family, friends and health-care providers (Davis-Floyd, 2003).

Experience of breasts. “Lactating, full-of-milk breasts, physiologically well-functioning breasts, seem to be erased by other cultural functions breasts (and women) have, due to the sexual fetishization of large breasts in popular culture,” (Gannon & Muller-Rockstroh, 2005, p. 44). A long-held symbol of femininity and sexuality in Western culture, breasts are central to the process of breastfeeding. Researchers agreed that how a woman perceived her breasts could influence the outcome of her breastfeeding experience (Burns, Schmied, Sheehan & Fenwick, 2010; Hausman, 2007; Schmied & Barclay, 1999; Simms, 2001). How the breasts look, feel, and even smell while breastfeeding will affect a woman’s relationship with her breasts. Although sometimes expected, more often feelings that arise from the act of breastfeeding are unexpected due to their sexual nature, and rarely discussed. Such feelings can be disconcerting to a woman, and may adversely affect breastfeeding efforts. Schulze and Carlisle (2010) and Young (2005) agreed that resolution is required if and when tensions arise from the notion of breasts as objects of sexuality versus the notion of breasts as objects of nurturance to be successful in the breastfeeding process. Successful resolution of these very tensions prompted Young to write this passage expressing her joy and satisfaction about breastfeeding her daughter.

After some weeks, drowsy during the morning feeding, I went to bed with my baby. I felt that I had crossed a forbidden river as I moved toward the bed, stretched her

legs out alongside my reclining torso, me lying on my side like a cat or a mare while my baby suckled. This was pleasure, not work. I lay there as she made love to me, snuggling her legs up to my stomach, her hand stroking my breast, my chest. (2005, p. 88).

According to Schmied and Barclay (1999) and Young (2005), increased respect of health-care providers for maternal embodied knowledge and her boundaries of intimacy (asking permission before viewing or touching her breasts) can enhance the breastfeeding experience, strengthening a woman's relationship with, and confidence in her 'breasted' abilities. Dykes (2005) and McLeod (2002) provided support to Young's (2005) discussion around the medicalization of the breastfeeding process (setting objective parameters for every aspect of the experience such as timing of feeds, length of time between feeds, weight gain of the infant, etc.) potentially disenfranchising a woman's often fragile embodied trust in her ability to successfully provide adequate nutrition for her infant. Gannon and Muller-Rockstroh (2005) provided further support to the notion that the experience of unwanted touch and perceived violations of privacy may serve to negatively strengthen the perception of 'breast as object', and diminish breastfeeding efforts.

Use of a relational lens to explore the tensions arising from a desire to breastfeed in the face of sociocultural influences related to the embodied experience of breasts might help health-care providers to fully understand the meaning of the breastfeeding experience for women (Lee, 2012). Is breastfeeding truly a desired experience? What interventions might be used to relieve tensions arising from oppressive experiences (overt

and covert) around breastfeeding? How best might health-care providers support women experiencing oppression of their breastfeeding efforts, whether validated or not?

Experience of infant. It does take two to breastfeed, and so I explored the maternal experience of the infant. Factors known to impact the burgeoning maternal relationship with her infant were the experience of pregnancy, the childbirth experience, initial impressions of the infant, temperament of the infant, and early breastfeeding efforts. Women begin building a relationship with their fetus during pregnancy, coming to know individual responsive characteristics as a result of various interactions (Rubin, 1984). Movements made by the fetus may be perceived positively or negatively, often in concert with other lived experiences such as mental health issues, physical health issues, and sociocultural factors (Wynn, 1997; Young, 2005).

Experiences of labour can influence these perceptions for better, or worse. The length of time in labour, perceived levels of (dis)comfort, and mode of delivery – vaginal or surgical – can influence the relationship between woman and infant. Maternal production of oxytocin, a hormone required to drive the process of labour and delivery, can affect maternal response to the infant. Odent (1992) wrote that the release of oxytocin – implicated in feelings of pleasure, contentment, and extreme affection for the newborn, and referred to as the love hormone – was physiologically necessary for the process of labour and initiation of subsequent lactation events. As labour reaches its climax with delivery of the infant, a surge of oxytocin is emitted within the woman. Should the labour process be dysfunctional, or even non-existent in this era of ‘caesarean section on demand’ (Weaver, Statham & Richards, 2007), this hormonal overload at the

time of delivery does not occur, with potential to impact the developing maternal-infant relationship (Jansen et al., 2008; Odent, 1992).

Rubin (1984) and Mercer (1995) wrote of the process of construction of a fantasy baby experienced by many women during pregnancy, imagining desired physical, emotional, and gendered attributes in the future child. At delivery, divergence from this imagined ideal created a visceral response with the potential to impair or fracture the developing relationship (Mercer, 1995; Rubin, 1984).

Flacking et al. (2012) wrote interrupted or delayed contact with the newborn at delivery out of medical necessity on the part of the infant and/or mother created distance within the developing relationship, as reported by SCENE - Separation and Closeness Experiences in the Neonatal Environment group – an international working group outlining recommendations regarding the benefits of early parent-infant contact in preterm infants. The ability to hold the infant in the early hours post-delivery, resulting in increased tactile knowledge and opportunity for ‘mutual gazing’ between mother and infant, was known to enhance maternal desire to nurture and protect the infant, knowledge espoused by Riordan and Wambach (2009). Such knowledge grounded the development of interventions promoting increased physical closeness (eg. kangaroo care), and encouragement of early production and introduction of maternal milk until breastfeeding was possible for infants admitted to high-risk care units post-birth (Spatz, 2012).

A relational lens is required to examine the woman’s experience of her infant. Wynn wrote, as the role of mother was constituted in the relationship with the infant, so it was also constituted through this relationship (1997). What supports are in place to

facilitate this growing relationship in a positive manner, if any? What meaning does this relationship hold for this woman? What impact does this maternal-infant relationship have on the decision-making process?

Autonomy in postpartum. The perinatal spectrum, including pregnancy, birth and postpartum, is primarily focused upon the experiences of women, albeit women constantly in relation with others – their fetus/baby, partner, family, and community, including health care professionals. A woman is situated within relationships informing the world, as she knows it. Ben-Ari and Weinberg-Kurnik (2007), Guttman (1983), and McQuillan et al. (2008) wrote that when fulfilling her ‘biological destiny’ by becoming a mother, a woman engaged in what is largely perceived to be a culturally gendered and normal expectation. She used relationships with others to reflect and validate her feelings of ‘normal’ during her journey through pregnancy into motherhood. Positive feedback from relationships informed her actions to enhance or improve these feelings of normal, a status socially constructed for each woman (Aston, 2002; Ben-Ari & Weinberg-Kurnik, 2007; Kennedy Shannon, Chuahorm & Kravetz, 2004; Marshall et al., 2007).

I believe that a study of the concept of autonomy in the postpartum period also requires a relational lens. Rubin (1984) wrote that a degree of maternal autonomy is required in the dedifferentiation process of infant separating from mother, a precursor for healthy maternal-child relationship development. Guttman writes, “True autonomy is a precondition for effective mothering rather than a hindrance to the task. Autonomy involves the recognition of one’s own rights and needs as well as those of others” (1983, p. 234). Although a dated reference, the need for a relational lens to view autonomy was deemed important even then. Women must have a strong sense of maternal identity

while maintaining a high degree of connectedness with the infant (Guttman, 1983; Rubin, 1984; Smith, 1999). Barclay (2000), Donchin (2001), and Simmonds (2008) agreed that the traditional notion of autonomy as an individual construct was morally incomplete. As noted previously, Goering (2009) and Goldberg (2003) explained that viewing the experience of autonomy for postpartum women through this traditional lens negates the interconnectedness of participants. As has been demonstrated above, women depend on, and feel responsible for others. Such relationship values could affect decision-making processes as a result (Donchin, 2001; Ho, 2008; McLeod, 2002).

Research support. Research data specifically related to the experience of autonomy in the postpartum period is sparse. An extensive search (as part of a course-related metasynthesis project) revealed six qualitative studies that have provided some insight related to the experience of autonomy in the postpartum phase of childbearing. Smith (1999), author of the oldest study, explored the psychological processes endured by women in their first pregnancy as they transitioned to the maternal role. Interviewing three women, case studies were created using recorded conversations from four semi-formal interviews, and information collected from weekly diary entries. From the case studies, a thematic analysis was conducted, as well as repertory grids designed (a quantitative correlational measure). Using the writing of Mead (1934) to underpin his analysis, Smith found that the development of the maternal persona is heavily reliant on a symbiotic process (the conception of the self and other as intimately connected), a process that highlights the relational self. Personal autonomy was noted to be important, but not related to the symbiotic process; Smith notes the emphasis on the relational self in

his findings runs counter to the individualistic concept of autonomy, and argues that autonomy should be viewed from a relational standpoint (1999).

Smith's first recorded theme is directly related to Mead's writings; the other three are inductively created from the first theme. Overriding his themes is the notion that identity is intrinsically social and relational. His created themes are: 1) conception of self and other are dynamically interdependent; 2) psychological relationship of self and other is facilitated and accentuated during the pregnancy by social occasions; 3) convergence of conception of self and significant others occurs developmentally during pregnancy; 4) increasing psychological engagement with significant others can facilitate psychological preparation for becoming a mother. He discusses the importance of recognizing connection as well as separateness. His findings run counter to the current privileging of individualism (separateness and autonomy) over connection and affiliation. Although demonstrating some valuable information, this study sample was very small, and should be repeated with a larger group (Smith, 1999).

Aston (2002) wrote of women's experiences of pedagogical practices in postpartum classes offered by public health nurses. Using feminist post-structuralism to underpin her study, she recruited six first-time mothers and two public health nurses. As an observer/participant in classes taught by both nurses, Aston recorded her observations at the end of each class. In addition, she conducted recorded interviews with each woman in a place chosen by the participant. By deconstructing the interviews, she was able to see how the perception of social positioning affected the relationship between the women and nurses.

Maternal concerns and aspirations - 'connections to cultural and institutional ideologies' – were evident as women described social psychological complexities in existence for them. They described being isolated – physically and in other ways. They experienced knowledge isolation – they expressed a need for expert advice (medical knowledge) rather than 'just that provided by other mothers'. The women described not being able to trust their own self-knowledge, so looked to the nurse for expert information due to a perception of superiority of medical knowledge about mothering. As well, the social construction of the 'normal mother' required these women to seek out medical information so as to be seen to be doing the 'right things'. The nurses attempted to support and empower women by eliciting instances of self-knowledge and experiences of the women. However, it was difficult for the nurses to 'empower' women as they sought expert advice. This highlighted a tension between the problem-based learning style and that of supportive learning. The practices of normalization engaged by women included comparing themselves to others, a practice not found to be helpful, as it raised more questions than it answered. Aston writes that the pedagogical structures for programs for postpartum women must be structured to account for social structures of isolation, investment in medical discourse, and processes of normalization. As this research was conducted with a largely homogenous population, a more diverse study population may increase the usefulness of these results (Aston, 2002).

Kennedy, Shannon, Chuahorm and Kravetz, (2004) presented findings of a study of midwives and their clients, exploring process and outcomes of midwifery care. Fourteen midwives and four care recipients participated in this study. Researchers solicited videotaped stories from each participant. The videotapes were transcribed,

checked for accuracy, then analyzed using Atlas.ti software. Narrative analysis (Geanellos, 1996) was incorporated to interpret the data. Findings built on two previous studies by Kennedy (1995, 2000).

Three themes became obvious - 1) midwife in relationship with woman – she must maintain an engaged presence instead of a clinical gaze; 2) orchestration of environment of care – this relates to both the physical and emotional environments to provide a safe and nurturing environment where a woman can meet her expectations. The midwife is both an advocate and a conduit, moving into foreground and background as required; 3) life journeys – the midwife provides compassionate care that enables a woman to learn, grow and be transformed by her experience. Such care included trust and belief in woman. At the end of this study, there was a realization of how little is known about impact of clinician's action on a person's life memories. A new finding is that the researcher was left with clear sense of outcome and journey for the midwife. The study emphasizes the relational aspect of midwife care and its importance to mothers. This study was limited, as the voices of women dissatisfied with care were not heard. As well there is a lack of ethnic diversity, and only 'exemplary' midwives participated (Kennedy et al., 2004).

Marshall, Godfrey and Renfrew (2007) presented experiences of new mothers as they negotiated factors influencing decision making around breastfeeding. Their intent was to explore the experience of breastfeeding in the context of everyday living while considering how breastfeeding was valued and managed within the wider context of becoming and being a mother. The study was grounded in the belief that there was a perceived shift in personal identity as breastfeeding was the new moral imperative and

equated with concept of 'good mother'. As well, the authors expressed the idea that new mothers in western countries may have lost embodied knowledge of breastfeeding and experienced a lack of confidence in their own bodies, notions further complicated by media portrayals of breasts as sexual objects. Twenty-two women and eighteen health professionals were observed (with field notes created to substantiate observations). In-depth recorded interviews were conducted with 'some' participants – note is made of evidence of 'gatekeeping' activities by health professionals when selecting participants. The transcribed interviews were coded using computer software (NVIVO). Comparative analysis was used to sort data (Marshall et al., 2007).

Findings included: 1) Factors shaping the decision to breastfeed: mothers made the decision to breastfeed late in pregnancy as a means to benefit baby's health. Breastfeeding was perceived as the 'normal thing to do', a notion influenced by the participants' mother and significant other. 2) Women's experiences of breastfeeding encompassed confidence and uncertainty as key concepts. 3) Learning to breastfeed: 'getting started' meant acquiring the skills required, sorting through information conflicts, and dealing with a lack of support in hospital. 4) Keeping going at home: mothers experienced a heightened vulnerability upon going home, requiring much emotional support at home. With increased support, their confidence grew, and they were able to work through many issues on own, even discounting health professional advice when warranted. 5) I wasn't sure there was enough milk: mothers struggled with confidence about milk supply and making the invisible, visible. They often deflected questions about suitability of breastfeeding from their family, noting that an insufficient milk supply was an acceptable reason for breastfeeding cessation. 6) Being a 'good mother':

When breastfeeding was going well and the babe was healthy, the process was seen as 'good mothering'. 'Bad mothering' was inferred when breastfeeding was not going well, or the baby was not content, and/or not gaining weight. A summary discussion states contemporary women are challenged by the ideology of intensive mothering (where the baby's needs are paramount and responsibility of the baby's welfare lies solely with mother) when resuming important activities, involving partners in baby work, and resuming employment. This study highlights a need to explore normative and ideological imperatives of breastfeeding as managed within the context of women's lives. The study also highlights a need to explore how 'expert' or medicalized discourse shapes breastfeeding practices (Marshall et al., 2007).

Mumtaz and Salway (2009) presented an ethnographic study drawing attention to incongruities between the concept of women's autonomy and their gendered social, cultural, economic and political realities within a selected community. The researchers – one male and one female anthropologist – lived onsite with the study participants. Data was collected through observational study, thirty-five informal semi-structured interviews and six focus groups of six to ten respondents. The study was conducted within four phases: 1) social mapping and informal house-to-house survey; 2) observation of daily life and informal interviews; 3) informal semi-structured interviews and focus groups; 4) creation of case studies (Mumtaz & Salway, 2009).

Findings demonstrated that autonomy is not appropriate for explaining gendered influences on reproductive health in this study. Themes described included: 1) an interconnected society with undue emphasis on women's independent, autonomous action that ignored the strong emotional and structural bonds that tie men and women (p. 1351) -

participants in this study were strongly vested in their families due to gendered inequalities regarding access to resources beyond the home. 2) over emphasis on the husband-wife relationship: woman-to-woman bonds were very important to these participants. Interpersonal relations were key to receiving access to health care. 3) a lack of attention to men and masculinities: young men were leading a change in attitude about birth control due to a rising cost of living. Men had limited knowledge of symptoms of danger in pregnancy, yet were still expected to bear the cost of health care provision so would prefer to limit number of pregnancies experienced by wives. 4) a lack of cultural specificity in measures of women's gendered position: women were not to be seen to be making decisions. Women working for wages were seen to be a sign of men's inability to provide. Women that did work handed over earnings to strengthen financial status of house. 5) a discounting of the multi-sited constitution of gender relations and gender inequality: all women were disadvantaged by gender, however higher caste and socio-economic status can help. Girls' opportunity for schooling remained less than that of boys. 6) change in women's position was erroneously presented as unidirectional: the linear process of autonomy failed to take into consideration the multidimensionality of a women's gendered position. Gender hierarchies remained intact. 7) the uptake of reproductive health services was erroneously assumed to be an indicator of greater autonomy. Overall, this study questioned the applicability of the concept of autonomy when researching women without recognition of the connectedness of women and their partners, the social relatedness of women, and the knowledge and lived experiences of women (Mumtaz & Salway, 2009).

Ben-Ari and Weinberg-Kurnik (2007) examined the experience and construction of reality as constituted by personal, familial and social challenges for adoptive single mothers. Thirteen single, Jewish, heterosexual women were selected using purposeful criteria-based sampling. Semi-structured, in-depth interviews were recorded then transcribed. Each interview was open-coded to produce a thematic analysis. Then a cross-case analysis was conducted creating meaning clusters based on the core themes. Axial coding was employed to assemble the data, making visible connections between major themes. The data was understood in terms of movement into and between two phenomenological dimensions: the personal/private (moving toward empowerment and independence, and a deep sense of autonomy) and the interpersonal/social (challenges and confrontations related to social attitudes regarding normative family structures).

The data provided insight into the concept of autonomy as experienced by these women in that the traditional individualistic description of autonomy was not sufficient in this instance. As these women worked through their exploration of their own internal dialogues, they realized that autonomy was relational, and inseparable from the context of social relationships and social factors such as race, gender, and class. It appeared that there was a need to analyze the implications of the intersubjective and social dimensions of selfhood for conceptions of individual autonomy and moral and political agency to be understood. In this study it appears that autonomy developed in a fluctuating or spiraling way, highlighting a fundamental duality in their reality. The adoption narrative, mostly described in terms of decisions, acts and operations, contained almost no element of self-reflection about emotional aspects of their life. The single motherhood narrative encompassed emotional qualities, difficulties, ambivalence and doubts. Their

experiences of autonomy vacillated (like a spiral) between personal and social influences (Ben-Ari & Weinberg-Kurnik, 2007).

Common threads connecting these six studies included the ‘need to be normal’, the desire to be seen as a ‘good mother’, and the achievement of personal autonomy. These were all notions embedded within the relational, socially constructed environment of the woman (Aston, 2002; Ben-Ari & Weinberg-Kurnik, 2007; Kennedy et al., 2004; Marshall et al., 2007; Mumtaz & Salway, 2009; Smith, 1999). From this review, I believe I can state unequivocally that there is little research about specifically exploring autonomy in the postpartum period and its effect upon decision-making. All studies presented address the concept of autonomy as important in some way to maternal role attainment, and requiring further exploration. I believe that using interpretive phenomenology to explore the lived experience of maternal decision-making around breastfeeding can help to illuminate the concept of relational autonomy as correlated with this experience.

Implications for Relational Practice in Nursing

From introduction to the natural end of the relationship, nurses must invest time and personal availability to create and sustain each relational bond. Ethically nurses have a moral obligation to attempt to develop such relationships with their clients, as part of their professional caregiving practice (Austin, 2007; Doane & Varcoe, 2007; Kendrick & Robinson, 2002). Relational ethics in nursing practice are enacted as the nurse discovers and responds to moral commitments through the experience of responding to the needs of self and other (Bergum, 2004, p. 497). In doing so, we are attending to the “moral space created by one’s relation to oneself and to the other” (Bergum, 2004, p. 486). Inherent in

this action is the need to attend to the ethics of each situation, encounter, and client through an awareness of themes of environment, embodiment, engagement and mutual respect (Bergum, 2004; Goldberg, 2003; Simmonds, 2008).

When discussed relationally, environment is viewed as a living system inhabited by the client, with changes effected by individual acts of self and other. Embodiment addresses the need for nurses to be respectful of the client's 'lived body' while caring for the 'object body', supporting the reconnection of both bodies while in care, in order that client autonomy is enabled and preserved. Nurses who care only for the 'object body' are in danger of becoming objects, or disembodied themselves (Bergum, 2004; Wilde, 1999).

“Nursing is...an engagement with people in living with and negotiating safe passage through the vagaries of health...” (Gadow, 1995, p. 213). Essential to relationship development, engagement is the act of being true to oneself while being present 'at this moment to this client in this place' (Bergum, 2004; Goldberg, 2005). Engagement requires being responsive to the needs of other in a meaningful way within a relationship grounded in ambiguity, uncertainty, openness, trust and respect (Evans, Bergum, Bamforth & MacPhail, 2004). As an intersubjective process, all participants come to a mutually constructed understanding of the relationship by engaging in empathic and reciprocal behaviors (Evans et al., 2004).

The development of meaningful relationships with clients requires time. Having stated this, the idea of time must be qualified. Although valuation for relational time needs to be recognized when planning for nursing work requirements, individual nurses need to also recognize the concept of lived time. Lived time is described as the time we

are fully open and present to another (Bergum, 2004). Bergum writes, “By being truly present to another through engagement, we make it possible to expand time – at least for that moment,” (2004, p. 498).

Given the rhetoric regarding healthy child development in recent past, it is time to reflect on care provided in the postnatal phase. A key determinant of health directly related to the perinatal phase is healthy child development, although all determinants are connected and can have great impact on this particular population (Raphael, 2004). How can health care provision to new families be enhanced to improve outcomes ensuring optimum infant and child development? What do families want from the health care system to support their parenting efforts?

Over time, I have observed many changes in health care policies that directly impacted postpartum nursing care provision. Evidence-based practice guidelines, infant feeding policies, length of stay guidelines, and evolving community public-health support policies have all influenced the provision of postpartum nursing care. Thomasma (1994) and Varcoe and Doane (2007) speculate that many nurses will work less in a relational capacity, as they are encouraged to take on more delegating and coordinating roles within the health care system. I am beset with frustration about how to marry my knowledge and beliefs about nursing with these changes in health care provision. To appreciate what we are losing in this current environment, it becomes necessary to reflect on one primary belief I hold about nursing. Nursing is relational. I am not a nurse, without clients. Formal and informal education has provided many types of knowledge – empirical, aesthetic, personal, ethical and political (Aktan, 2007; Carper, 1978) - to enhance my practice of nursing, but relational experiences with clients are what keep me returning to

work each and every day. Bergum and Dossetor (2005) write “When a role is understood as a *way of being*, relationships are involved” (p. 89).

Decision-making about feeding practices can be influenced by nursing. Some researchers support the notion that breastfeeding rates can be directly correlated to nursing practice – women who receive one-to-one emotional and educational support will often breastfeed for a longer period of time after they are discharged from hospital (Davis, Stichler & Poeltler, 2012; Magri & Hylton-McGuire, 2013; Thurman & Allen, 2008). Breastfeeding rates are currently less than optimal (PHAC, 2008, 2009), however positive changes in rates have occurred in the last ten years. Although not solely attributable to nursing practice, a correlation between improvements in perinatal health outcomes and evidence-based changes in nursing practice can be argued, especially in the areas of perinatal client education and nursing care provided to women in the antepartum and intrapartum phases of pregnancy. There have been many positive changes in the delivery of perinatal care as a result of the influence of nursing research informing the creation of current standards and policies, and subsequent implementation of evidence based perinatal nursing practices (AWHONN, 2015). Studies abound regarding factors that positively and negatively impact the breastfeeding experience. Research by Brown et al. (2011), Nelson (2007), and Rossman and Ayoola (2012) demonstrates that the availability of emotional support for the breastfeeding woman is one of the most important factors for long-term continuance of this activity.

So What?

The postpartum period is a time of great adjustment for women as they experience a loss of their ‘old’ self, previous lifestyle, and role performance, while concurrently

taking on a new persona – that of mother. Success in attaining this transformation can be constrained due to physical and emotional limitations, early hospital discharge, lack of family support, limited community resources and personal barriers such as an unwillingness to seek assistance due to lack of knowledge, or a perceived need to appear independent (Driscoll, 1990; Goering, 2009; Mercer, 1995; Rubin, 1984). When health care professionals are consulted for advice and help during this time period, ideas and values deemed important by professionals may not mesh with those of the client due to the social construction of the client's worldview (McLeod, 2009).

Viewing autonomy from a relational perspective makes visible, and enhances understanding of the influences on the woman's social, political, and cultural circumstance. Donchin writes that health care professionals caring for women following childbirth should understand that a woman's personal autonomy cannot be isolated from her life world, and that health care practices can become overwhelming when her autonomy is not respected (2001). In viewing autonomy relationally, emphasis is placed on: the importance of supportive interpersonal relationships; the perception of autonomy as a skill set, or competency (eg. self-trust); the comprehension of ways oppressive social circumstances, and individual agents can coerce decisions, notions supported in the writing of Goering (2009), McLeod (2002), and McLeod and Sherwin (2000). It is worth noting that enactment of skills required to exercise autonomy are most likely only possible in the company of supportive others (Sherwin, 1998).

The idea that following the birth of a child, a woman's capacity for autonomy could be compromised is already noted (Goering, 2009). This state of compromise may rest on the ability to engage in the skill of self-trust. Goering (2009) and McLeod (2002)

describe self-trust as an obligation to live up to a self-defined moral standard. Women employ self-trust in their own abilities to care and nurture their own baby, as they believe they will ‘instinctively know what to do when the time comes’. When women assume that ‘maternal instinct’ – again, a socially constructed belief - will carry them through the unknown of caring for a newborn, self-trust in their own parental competence is eroded when this in fact does not occur (Goering, 2009). This will often result in diminished self-worth, shame and guilt, especially in light of the physical and emotional demands of the postpartum period (Goering, 2009). Perhaps with support from significant relationships to resist the overwhelming social constructions of good mothering, women could be encouraged to remain trusting of their own knowledge, beliefs, and instincts (Goering, 2009).

It appears there is very little written about this subject, and therefore I believe an in-depth qualitative study of the experience of autonomy specific to the postpartum period would enhance personal and professional understanding for nurses. With greater insight, the effects of gender, culture, society, race, ethnicity, and class on the autonomy experience can be uncovered and understood. Care modifications that support and promote the maternal experience of autonomy might be enabled through sharing of this knowledge with nurses providing care to these women.

Decision making about feeding choice is situated within this milieu. As previously written, statistics provide data indicating that in-hospital choices to breastfeed are often overturned upon the return to home. There is some research evidence to explain such occurrences, as noted previously. But is there anything else? Is this a result of the socially constructed discourses of breastfeeding that are discarded once out of sight of

professional observation? Is this a result of the relationship dynamics experienced in the health-care and home setting? Is this in any way related to the woman's experience of autonomy in the postpartum period?

Goering (2009) writes of her experience of the postpartum, after the delivery of her baby.

My confidence in myself as a good care-giver and decision-maker for this new little human was shaky from the start, and yet I felt as if I ought to know what I was doing. In that sense, I was worried not only about my actual skills but also about my ability to live up to my commitment to be a good mother” (p. 10).

The notion of self-trust or self-defined obligation to maintain a level of moral standard comes to the forefront as women await the arrival of ‘maternal instinct’, a socially constructed belief (Arendell, 2000; Goering, 2009; Ludlow et al., 2012; McLeod, 2002). With the realization that such an instinct is unavailable, and indeed a fallacy, women may experience a lessened sense of competence in themselves and in their mothering abilities. Demands of the postpartum period heighten their perceived incompetency, resulting in feelings of shame and guilt (Goering, 2009; Sutherland, 2010). Support from valued relationships may aid in the resistance of the oppressive pressures realized from the social constructions of ‘the good mother’, encouraging women to trust their own self-knowledge, beliefs, and instincts as they engage in decision-making (Goering, 2009; Mullin, 2005).

The list is long of feminist scholars applying relational theory to the study of many different facets of women's lives and others living in oppressive conditions due to political, religious, and/or economic circumstances (Koggel, 2012; Sherwin, 1998, 2012).

Social expectations of women as sole caretakers of the mothering role require greater insight into the effects of gender, culture, society, race, ethnicity, and class on the autonomy experience be made visible. Only by exploring the relationships within the woman's world can we begin to understand her experience of mothering and the impact this has on decision-making regarding the infant. With enhanced understanding, care provision can be modified to enable women to address their needs regarding personal autonomy in the postpartum period in a timely fashion.

I believe that an understanding of maternal decision-making processes, and the underlying influence of maternal autonomy could be realized using interpretive phenomenology and offering women the opportunity to tell their stories of their postpartum experiences. The use of interpretive phenomenology to explore the lived experience of decision making as situated and influenced within the relationships of women's lives could inform an enhanced understanding of the experience of autonomy for women as mothers. By exploring all relationships influencing the life world of a woman, it may be ascertained how she is constituted within, and is constitutive of the role of mother. Interpretive phenomenology provides the framework to use opportunities of conversational engagement with women to co-create an understanding of their lived experience of decision-making about breastfeeding.

CHAPTER 3

Philosophical Underpinnings

Introduction

To really understand women and their decision-making processes there exists a need to converse with women about their lived experience, and understand it from their point of view, as described in their words; hence the choice of a qualitative method (Creswell, 2007; Fish, 1998). Sandelowski and Barroso (2003) write, “qualitative research findings contain information about the subtleties and complexities of human responses ... essential to the construction of effective and developmentally and culturally sensitive interventions” (p. 782). This chapter begins with personal reflection upon the philosophical underpinnings of my chosen methodology, and the degree of congruence with my own world-view (Koch, 1995; 1999). In this spirit, I open with a description of my philosophical stance regarding interpretive phenomenology. I follow with an overview of phenomenology as both a philosophy and a methodology. A historical foundation of phenomenology, segueing into a more detailed description of Heideggerian hermeneutical phenomenology ensues. I include a brief, overall explanation of interpretive phenomenology, with a more detailed discussion about Heidegger’s vision of the hermeneutical process. I highlight my thoughts on how Heideggerian phenomenology can be applied to conversations with women as I pursue a more in-depth understanding of the lived experience of women in relationships, maternal decision-making processes, and maternal autonomy. I then provide support for my decision to underpin this study with interpretive phenomenology, and conclude this section with some final thoughts for this chapter.

My Philosophical Assumptions

As an experienced practitioner in maternal health nursing and life-long learner, authors I encountered have presented ideas that have resonated within me, aiding in my own personal understanding of nursing and the phenomenological research process while influencing my ability to clearly articulate my own beliefs. I refer to them here. I am a nurse. My clients are my *raison d'être*. I believe that to be the best nurse possible, I require an understanding of my clients within the context of their lives, a notion supported in the writings of Bergum (2003), Bishop and Scudder (1997), Gadow (1995, 1999), McConnell-Henry, Chapman and Francis (2009b), McIntyre (2003), McNiesh (2010) and Thomas (2005). Ontological research derived from an interpretive paradigm resonates deeply within me (Carter & Little, 2007; Creswell, 2007; Fish, 1998). To fully comprehend what it is to 'be in the world' for my clients, I must consider their lived experiences in the context of their lives. What is it like to be them?

In practice, I am influenced by Nelson (1982), Cameron (2004) and Goldberg (2005) as I engage authentically with clients to co-constitute relationships that are trustworthy and meaningful. Within this relational space, a shared interpretation of the meaning of their health needs may ensue. By committing to a shared participation in their health care, I aspire to co-create a plan of care that is both client-centered and reflective of professional nursing practice. In doing so, I provide nursing care that is morally and ethically sound (Benner & Wrubel, 1989; Bergum, 2004; Healey-Ogden & Austin, 2011; Pask, 2003).

To complete this proposed project, I used a methodological framework grounded in phenomenological principles outlined by Conroy (2003) to engage in, and then

synthesize conversations I held with women about their experiences of infant-feeding practices. With the participants' involvement, a meaningful interpretation of their experience was created providing an increased depth of ontological knowledge, and therefore a deeper appreciation of their *situatedness* (Orbanic, 1999).

Phenomenology as Philosophy

I begin with a description of phenomenology, then follow with a brief historical overview of key influential phenomenologists, as attention to the historical aspects of phenomenological development aids in making sense of this philosophical entity today. Phenomenology began as a philosophical approach to studying human experience (Smith, Flowers & Larkin, 2009). Phenomenology provides epistemological and ontological knowledge useful in understanding lived experience, or, what it is to be human (Mackey, 2005). Where natural science pushes us to investigate predetermined variables relating to human experience, phenomenology seeks the development of meaningful description and/or interpretation of human experience grounded within intersubjectivity and social context (Anderson, 1991; Dreyfus, 1991; Gadamer, 2000). Phenomenology is a philosophical and methodological approach to research adopted widely by many in the social sciences, including nurse-scientists (Earle, 2010; Mackey, 2005; Wojnar & Swanson, 2007). Studies using both descriptive and interpretive methods make human experience visible, generating descriptive and explanatory narratives that contribute to a more rich and complete understanding of the holistic sphere of human life (Finfgeld-Connett, 2008; Mackey, 2005; Van der Zalm & Bergum, 2000).

A Brief History of Phenomenology

The birth of the phenomenological movement is primarily attributed to the German psychologist, Franz Brentano and his philosophical reformation efforts to provide alternatives to organized religion. Brentano is attributed with describing the value of inner perception, and intentionality of thinking (Cohen, 1987; Dowling, 2007). Edmund Husserl, a student of Brentano, was a mathematician disillusioned with the use of natural science methodologies to study the ‘lifeworld’, or lived experience of man (Earle, 2010). Husserl furthered the notion of intentionality as a way of knowing. He espoused the belief that only through phenomenological reduction could a description of the true essence of experience be produced (Cohen, 1987).

Martin Heidegger, a student of Husserl, came to philosophy via theology. Strongly influenced by Aristotle and Dilthey, Heidegger differed from Husserl in his belief about phenomenology, in that it should be an ontological, interpretive effort (Dreyfus, 1991; Heidegger, 1927/1962). To this end, he advocated the use of hermeneutical methodology to make visible the notion that lived experience is a relational, interpretive process (Dowling, 2007). His ontological perspective centered on the discernment of man ‘being-in-the-world’, or existence (Dreyfus, 1991). Embodiment, temporality, spatiality, authenticity, and mood are important phenomenological concepts threaded throughout Heidegger’s written works. Hans-Georg Gadamer (1989) articulated a philosophy of hermeneutics built upon Heidegger’s phenomenological principles. Gadamer postulated that through a “fusion of horizons” of researcher and participant, understanding is created (1989). Dialogic encounters promoting openness and listening encourage a dimension of reflexivity, and interpretation (Koch, 1999, p. 31).

Maurice Merleau-Ponty, a French philosopher, built upon the writing of Husserl and Heidegger. Advocating a reductive approach similar to that of Husserl, Merleau-Ponty proposed a phenomenological goal of “relearning to see the world” centered upon perception (Thomas, 2005, p. 65). “Perception is not a science of the world, it is not even an act, a deliberate taking up of a position; it is the background from which all acts stand out, and is presupposed by them,” (Merleau-Ponty, 1962, pp. x-xi). He highlighted the notion of ambiguity in perception and self-knowledge, in that interpretation of experience is dependent on the storyteller of an event. Key tenets of Merleau-Ponty’s phenomenology include ambiguity of behavior, spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived human relation) (Dowling, 2007; Merleau-Ponty, 1964; Thomas, 2005).

Husserlian Influence. Husserl is widely regarded as the ‘father’ of transcendental phenomenology. In his efforts to understand lived experience, he hypothesized that knowledge is realized pre-reflectively, as a function of consciousness. He believed the intention of phenomenology was to generate an objective descriptive recounting of pre-reflective (prior to interpretation), decontextualized life-experiences as realized within consciousness (things as they appear). He believed man could only ‘know’ his world through activities of *intentionality* - by intentionally bringing an object or phenomena to consciousness, knowledge of that same object or phenomena could be constituted (Dowling, 2007).

To broaden this epistemological pursuit of knowledge, ‘phenomenological *epoché*’, or suspension of judgment must take place. This occurs with the ‘bracketing’ of preconceived notions regarding the phenomena to ensure phenomenological reduction in

order that the true essence of the phenomena may be realized. As a phenomenon is brought to consciousness, it is separated from its context, dissected for intense study and confronted on its own terms by suspending any related preconceived notions held by the researcher. In this way, the phenomenon's eidetic structures, or essences might be revealed and then described (Dowling, 2007; Koch, 1995; McConnell-Henry, Chapman & Francis, 2009a; Sandberg, 2005; Walters, 1995; Wojnar & Swanson, 2007).

Cartesian duality. Husserl, essentially a positivist, believed that objectivity and rigour were achievable in the study of phenomenology (Lopez & Willis, 2004; McConnell-Henry et al., 2009a). Maintaining a Cartesian approach, Husserl ascribed to a subject/object metaphysical approach to lived experience (Baier, 1981; Husserl, 1931/1960; Sowaal, 2004). Believing the mind to be separate from the body, Husserl maintained that man comes to know the world as a cognitive experience only, as a thinking 'subject' reflecting upon the observable 'object' within his sphere of consciousness (Leonard, 1994). In this reflective activity, embodied, historical and social knowledge and meaning is denied, favoring the retention of scientifically measurable attributes (Aho, 2009; Benner, 2000; Goldberg, 2002; Koch, 1995; Lopez & Willis, 2004).

Heidegger and 'Being-In-The-World'

Heidegger disagreed with Husserl about his Cartesian approach to phenomenology. He believed that the self could only come to know herself in and through herself, as understood within a relational world of shared social practices (Dreyfus, 1991). He held the self as an embodied being, temporally situated within a relational, culturally specific space (Dreyfus, 1991; Orbanic, 1999). Heidegger intuited

that “prior to any theoretical speculation about beings, we exist, a concerned existence that makes it possible to theorize in the first place” (Aho, 2009, p. 11). Instead of an epistemological knowledge of man’s lived experience, Heidegger sought an ontological understanding of being (Chanter, 2001). To this end, he repudiated the Cartesian influence of Husserl’s phenomenology, focusing upon the experience of *being-in-the-world* (Leonard, 1994; McConnell-Henry et al., 2009b; Wojnar & Swanson, 2007).

Heidegger adopted an interpretive stance in his study of being and life experience. By making sense of relationships within the everyday world – the taken-for-granted – and ascribing meaning to them, only then could he understand what it was to be-in-the-world (Dreyfus & Wrathall, 2005). To this end, he created a lexicon suited to his needs to explain his thinking processes. It will be helpful to outline these words and terms (noted in italics) in an orderly fashion, to facilitate understanding and application.

Temporality. “Dasein is not a being that moves along in time. Rather Dasein – as an already opened clearing of intelligibility – *is* time” (Aho, 2009, p. 62). Fundamental to Heidegger’s philosophy is the concept of *temporality*, as it relates to the intelligibility of the world, and existence of humans (Heidegger, 1927/1962). According to Heidegger, *temporality* is constitutive of being (Leonard, 1994). Time for Heidegger is not measured as real time, in hours or seconds; time is lived-time measured by and within moments of significance, experienced as phenomenological time (Fisher, 2009; Mackey, 2005). Humans are always situated within a moment upon a continuum of time, with the past stretching behind them, and their future ahead, denoted by Heidegger as *world-time*. Features of world-time include *significance*, *datability*, *spannedness*, and *publicity* (Bambach, 2011; Fisher, 2009; McMullin, 2009; Williams, 1990). The birth of

a child, or a child's graduation from university is a significant moment in time, meaningfully situated as a temporal experience. *Datability* denotes the relatedness of a temporal event, not measured by a calendar. *Spannedness* addresses temporal stretching, bringing the past into the future in a meaningful manner. *Publicity* refers to shared-time, as temporal meaning is constituted inter-relationally (Bambach, 2011; Fisher, 2009; McMullin, 2009). As engaged beings, humans stretch to meet the *possibilities* of the future, their journey informed and shaped by their background (Aho, 2009; Taylor, 2006). Heidegger believed that *temporality* was the overarching constitutional factor of existence, as it is the dynamic structure of being human (Aho, 2009; Conroy, 2003; Dreyfus, 1991), encompassing "memories from the past, a quality of engagement in the present and more or less projection into the future" (Benner, 2000, p. 10).

Authors agree that the *historicity* of a woman's lived experience informs her perception of choices for infant feeding (Nelson, 2007; Sheehan et al., 2013). Faced with decision-making inherent in caring for infants, a woman's past informs her present. Feeding stories told by contextually situated women of past generations, personal observations of feeding activities, expectations about future possibilities resulting from choices made, and diverse discursive interactions surrounding all of these experiences inform decision-making processes of this woman, today. Significance of what has been seen, what has been learned, and the very situatedness of the woman at this point in time is weighed when choosing how to nourish this baby. Encouraging my study participants to describe these stories was helpful to increase understanding of their experiences.

Dasein. *Dasein* is human *be-ing*. "Thus to work out the question of Being adequately, we must make an entity – the inquirer – transparent in his own Being. ... This

entity which each of us is himself and which includes inquiring as one of the possibilities of its Being, we shall denote by the term *Dasein*” (Heidegger, 1927/1962, p. 27).

Directly translated from German, *da* means ‘here’, *sein* means ‘to be’ (here-being).

Dasein is not the self, but is within the self as the self-interpreting activity of a human being. Heidegger created this term to articulate the everyday universality of being, or existence - *Dasein*’s way of being is existence. *Dasein* is indefinable in that it is not an entity, an event, or a process. *Dasein* is not a conscious subject – it is the way of being for humans (Dreyfus, 1991; Esfeld, 2001). “Departing from the metaphysical notion of human being as a being, a spirit, a subject, or material body, Heidegger defines *Dasein* as a unique self-interpreting, self-understanding way of being” (Aho, 2009, p. 12).

Without predetermined function, humans, being minded-beings, create themselves through self-determining activities centering upon possibilities (Esfeld, 2001, p. 51). *Dasein* inhabits a defined stand on what it is to be, demonstrating a self-interpretive intelligibility of its own existence. “*Dasein* always understands itself in terms of its existence – in terms of a possibility of itself: to be itself or not itself” (Heidegger, 1927/1962, p. 33). *Dasein* does not interpret existence as a conscious activity of subject related to an object, but within a pre-ontological understanding of culturally relevant everyday practices (Leonard, 1994). What is encountered is encountered as something, as “nothing is encountered independent of our background understanding” (Leonard, 1994, p. 52). The realization of import about the concept of *Dasein* is that “every human is a meaningful being” (McConnell-Henry et al., 2009b).

World. “*World* is the meaningful set of relationships, practices and language that we have by virtue of being born into a culture” (Leonard, 1994, p. 46). Heidegger

believed the *world* as *a priori* in the relationship *Dasein* incurs with the everyday. The intelligibility of the *world* is realized within the shared skills and practices of *Dasein*'s world. *Dasein* makes sense of its existence by way of living within its everyday *world*, as it is situated within a web of meaningful, everyday activities and discursive practices (Aho, 2009; Esfeld, 2001; Leonard, 1994; Orbanic, 1999). As *Dasein* adopts the ways of its *world* in a non-reflective manner, in doing so it is constitutive of, and co-constituted by the *world* (Leonard, 1994).

Dasein's interpretation of the world rests upon what Heidegger referred to as the *forestructure*. The *forestructure* is a threefold construction, consisting of *fore-having* (a taken-for-granted background), *fore-sight* (a sociocultural perspective from which to approach the world), and *fore-conception* (a preconceived notion about the world, related to time) (Plager, 1994; Dreyfus, 1991; Wojnar & Swanson, 2007). In this way, *Dasein* understands the world in a circular, or hermeneutical fashion, moving circuitously between the known and the knowable (Dreyfus, 1991). A more detailed explanation of the ways humans experience the world, and the notion of facticity follows.

Experiencing the world. Humans engage with the *world* in three ways, according to Heidegger. Much of the *world* is experienced as taken-for-granted, a way of being that Heidegger called *ready-to-hand*. A great deal of what we encounter in our lives is located in the everyday, as meaningful objects or subjects that are 'always there' (Dreyfus, 1991; Parsons, 2010). We do not consciously apprise ourselves of their existence – they are always available to us. To illustrate - I select a fork from the drawer in my kitchen to eat cake, a dessert I love. Adopting an effortless, non-reflective stance, I am fully engaged in this activity. I do not think about what makes a fork a fork; I do not

think about why the fork is in the drawer, or why this drawer, in this kitchen. I have always used a fork to eat cake; the fork is always located in the drawer, in the kitchen (the *forestructure* of this experience). However, when I am unable to locate a fork in the drawer, I pause in my activity. My engaged stance is usurped, and I can no longer take my activity for granted. My way of being has broken down – I inhabit an *unready-to-hand* mode of being. I must consciously think about where to locate a fork (Benner & Wrubel, 1989; Dreyfus, 1991; Johnson, 2000).

Heidegger described one further mode of engagement with the world – that of objectivity, or *present-at-hand* (Johnson, 2000). As I am unable to locate a fork, I assess the functionality of a spoon for this activity. Taking a detached stance, I objectively assess the properties of the spoon, revealing its *occurrentness*. Previously only used to eat cereal, I recontextualize that which I know about the features of the spoon – its ease of use, its weight in my hand, its ability to hold an adequate mouthful of cake. I make a decision to use a spoon to eat my cake (Dreyfus, 1991).

Facticity. Mention must be made of the notion of *facticity* at this point as *facticity* signifies that world of meanings and relations that cannot be detached from life itself (Dahlstrom, 2013). *Facticity* denotes unchangeable characteristics of humans interpreted within the social context of their world. For example, a woman is contextually interpreted as feminine. She cannot be clear of her culturally defined *facticity*, and endures the taken-for-grantedness of being female within the relations and practices of her world (Dreyfus, 1991). “The concept of facticity implies that an entity ‘within-the-world’ has *Being-in-the-world* in such a way that it can understand itself as bound up in its ‘destiny’ with the Being of those entities which it encounters within its own world”

(Heidegger, 1927/1962, p. 82). *Facticity* may be experienced *occurrently*, as this woman steps back to reflect on the meaning of being a woman in her world.

From a Heideggerian perspective, it is believed that as women become mothers, their experience of world is realized as they comport themselves in ways that reflect the culture and relationships within which they are situated. Experiences of mothering are rooted within these familiar cultural practices where exposure to mothering situations may vary. Women come to know themselves as mothers as a result of these *forestructures*. In addition, the cultural response to the needs of the infant will influence the way of being of the woman (Wynn, 1997). Meaning ascribed to infant feeding is constituted between familiar and unfamiliar worlds as the woman navigates the knowledge, values, and practices of cultural import, and relational support of family and friends (the familiar), and that of the health care world (the unfamiliar). Dialogue with study participants elucidating ways-of-being regarding their own facticity was helpful in the creation of understanding of their experiences.

Being-in-the-world. “Dasein never ‘finds itself’ except as a thrown Fact” (Heidegger, 1927/1962, p. 376). As a source of *Dasein* (Esfeld, 2001), a human being comes to know her world as a result of what Heidegger calls *thrownness* (Dreyfus & Wrathall, 2005). She dwells within a relational *world* often not of her making, but one of cultural, historical and familial practices that come before her (Young, 2000). She knows her *world* pre-ontologically, as she is *always already situated as being-in-the-world* (Leonard, 1994, p. 46). As humans are inseparable from the *world*, their “lived experiences cannot be separated from being-in-the-world” (Orbanic, 1999, p. 139). Heideggerian language is used to describe the worlds of the participants, as shared by

them during our conversations. An understanding of concepts related to *being-in-the world*, including *embodiment*, *spatiality*, *mood* and *authenticity* is helpful to the reader, and now ensues.

Embodiment. “The phenomenal body is the body aware of itself” (Benner & Wrubel, 1989, p. 75). Heidegger believed intelligibility of this world was constituted not only by the aforementioned shared practices and skills. As *embodied* beings, intelligence is mediated in and through bodily experiences inclusive of perceptual capacity (Benner, 2000; Heidegger, 1987/2001; Leonard, 1994). Lived experience is embodied experience, not just a discursive experience. Merleau-Ponty believed humans exist as part of the world; therefore the body is not ‘in-the-world’ allowing for the experience of embodied knowledge of the taken-for-granted everyday (Benner, 2000; Borrett, Kelly & Kwan, 2000; Merleau-Ponty, 1964; Thomas, 2005). Interpretation of experience is required to understand embodied existence within a world shaped by societal, historical and personal relationships. “As embodied beings, we know the world through shared understandings, making the world a social and intersubjective experience” (Wilde, 1999, p. 28).

As women demonstrate embodied competence elicited through residing in meaningful worlds and relationships, so do I reveal a socially constituted embodied agency. Engaging in *phronesis*, an embodied and socially embedded knowledge of practice with moral capacity, I am able to understand the lived world of women as mothers (Benner, 2000; Gadamer, 1989). As such, we co-created a space for dialogue and interpretation, thereby enhancing my understanding of their lived experience.

Spatiality. Heidegger addresses notions of space as *lived-space*. Emotional disposition affects *lived-space* (Bollnow, 1960; McConnell-Henry et al., 2009b).

Existential *lived-space* addresses psychological distance of things of concern. In turn, concerns might be *available* or *occurrent* (Dreyfus, 1991). For example, a woman might be described as not being in the right head-space to breastfeed her infant. As an *occurrent* option for feeding, she may never have thought of/been introduced to breastfeeding as an option to feed her baby due to the *forestructuring* of her world. Now she consciously considers what breastfeeding might mean to her. Or, what once was an *available* concern is now distanced due to more pressing anxieties of a physical, psychological, or relational nature. She is too battered from childbirth, too depressed, or not supported by her partner to engage in breastfeeding her infant, and now distances herself from this choice. In this way, the woman foregrounds the issues most concerning to her and pushes others to the background, depending on her own situation of *being-in-the-world*, and the space she occupies (Dreyfus, 1991; Mackey, 2005). “The spatiality of Dasein’s encountering the available depends on Dasein’s ‘concernful being-in-the-world’” (Dreyfus, 1991, p.130).

Being-with. “Dasein as Being-with lets the Dasein of Others be encountered in its world...Only so far as one’s own Dasein has the essential structure of Being-with, is it Dasein-with as encounterable for others” (Heidegger, 1927/1962, p. 157). *Being-with* ‘others’ (subjects or objects) is essential to *Dasein* as the foundation for relational activity. As a function of temporality, *Dasein-in-the-world* is always looking forward seeking out possibilities (existing). Embedded in the act of being thrown into the world not of her making is the notion that each person (*Dasein*) is dependent on other persons with whom she exists. Thus, the seizing of possibilities necessitates interaction with

Others (Esfeld, 2001). And so, this temporal activity fosters an understanding of the whole person, experienced as care (Olesh, 2008; Orbanic, 1999).

Personal existence is only possible with the realization that the essence of *Being-with* is constitutive of *Dasein*. “Thus as Being-with, *Dasein* ‘is’ essentially for the sake of Others” (Heidegger, 1927/1962, p. 160). Persons must be in relation, all the time, as a function of their being (Olesh, 2008). Macmurray writes, “I exist as an individual only in a personal relation to other individuals” (1961, p. 28). He contends that the relational qualities of persons are constitutive of their existence. Individuals may only reach full potential within a community of caring relationships (Macmurray, 1961), a notion echoed in the writing of Buber (Buber, 1934; Tallon, 1973).

If one believes that a woman is situated within a web of relationships constituting her *world*, it then follows that relationships with her infant, partner, family and community all have significance for the woman, and impact her infant feeding decisions. According to this lens, past experience of these relationships will influence the perception of possibilities, as the woman contemplates her future with her infant. Conversations with study participants elicited information regarding significant relationships in their lives, again enhancing understanding of their lived experience.

Mood. *Mood* is a ubiquitous lived experience, influencing events and choices of *Dasein* (Broome & Carel, 2009; Dreyfus, 1991). *Moods* influence human thinking about, and understanding of the world. As *mood* is both *a priori* and shared, the embodied being experiences *mood* individually (“She’s in a mood”), or publically (“Fans were overjoyed with the victory”) (Aho, 2009; DeLancey, 2006; Freeman, 2014). *Moods* are expressed discursively and non-verbally. *Mood* affects the experience of ‘already-there’

facticity in the choices made regarding the unchangeable facets of human lives, therefore framing a particular way of being and relating to the world (Conroy & Dobson, 2005). The choice to live authentically and meaningfully, or inauthentically is grounded in the experience of *mood* (Broome & Carel, 2009). *Mood* reflected in past experience, is projected onto future determination of existence (Conroy & Dobson, 2005). “The mood has already disclosed, in every case, Being-in-the-world as a whole, and makes it possible first of all to direct one-self towards something” (Heidegger, 1927/1962, p. 176).

Moods are more than ‘feelings’. *Mood* provides a background to all experiences of self and other in a taken-for-granted world, contributing to *disposedness*, or *attunement* (Dreyfus & Wrathall, 2005). Therefore, interviewing women necessitated an understanding, and appreciation of both woman and researcher moods. Personal reflection upon my own mood (as researcher) was a necessity prior to, during, and after each interview as I reflected upon my own attunement to the information being shared (Conroy, 2003).

Authenticity. Heidegger writes of three modes of existing within the world. *Authentic* existence refers to intentionally living one’s life meaningfully and with significance, possibly in the face of social disapproval (Conroy & Dobson, 2005). To be *authentic* is to stand directly in a first-person relation to oneself (Carman, 2005; Taylor, 1991), being an individual in the face of group sentimentality. Living authentically is making the choice to exist in accordance with one’s limited possibilities, as revealed in looking from the past to the future. Women as mothers are thrown, yet are able to participate in their *thrownness* (Rodemeyer, 1998). The *mood* pervading an *authentic* existence is positively disposed, or *attuned* to these life choices. An *authentic* person

lives life resolutely and in control, committed to achieving goals. She lives life genuinely, valuing her course of action (Bessant, 2010; Conroy & Dobson, 2005; Dreyfus, 1991; Johnson, 2000; Oshana, 2007).

Persons intentionally adopting ways of being that mirror public expectations in the face of personal dissonance and devaluation of such actions are said to be living *inauthentically*. An *inauthentic* person engages in actions over-determined by personal *facticity*, allowing for the abdication of responsibility for significant, meaningful choices. Such an individual experiences discord between action and *mood*, creating distance from the positively disposed, or *attuned, authentic* self. Life is lived disingenuously, and untrue to the self (Conroy & Dobson, 2005).

Heidegger also describes a state of *undifferentiated* existence, an unreflective mode of being inhabited much of the time (Dreyfus, 1991). Humans existing in their non-reflective, taken-for-granted everyday can act authentically out of habit (*authentic/undifferentiated*). Should an occasion arise that lifts the taken-for-granted to consciousness, they then have the choice to act authentically, or not. In an *inauthentic/undifferentiated* existence, humans assume a non-reflective public stance that has no meaning or significance, and is insincere to the self. They minimize inner discord due to the lack of significance or purpose to their actions. The role of *mood* upon the *inauthentic/undifferentiated* state might be demonstrated as a lack of *attunement* between person, action and *mood*. The prevailing *mood* may attempt to simulate *attunement*, all the while concealing the fact there is none. The person may adopt the prevailing *mood*, resulting in the oblivious concealment of the existing lack of *attunement* (Conroy & Dobson, 2005; Dreyfus, 1991).

Women living an *authentic* existence will make choices within their sphere of possibilities that have positive significance for them. Their choice may not be that of relational import, however they have the inner strength – *resoluteness* - to remain true to their inner conviction to follow through with their actions. Women living *inauthentically* will make choices that mirror public significance. For example, community expectation might be that all women should breastfeed, so a woman endures, in spite of her personal abhorrence of the process. Inner dissonance is experienced in this instance, creating distance from an *authentic* existence.

Women choosing to breastfeed may do so as a result of an *authentic/undifferentiated existence*. As noted previously, breastfeeding is advertised as ‘best for baby’, so without a strong personal conviction, but still wanting to ‘do good’, she decides on this method. A woman living an *inauthentic/undifferentiated* existence may unthinkingly assume a culturally significant stance to formula-feed her infant, adopting feeding methods commonly accepted within her cultural community (Cricco-Lizza, 2004; Hannon et al., 2000; Hedburg, 2013). However she concurrently may mask feelings of discord, as she believes she might not have made a ‘good’ choice.

Autonomy. A sub-question of this research project addresses the experience of personal autonomy as having influence upon maternal decision-making processes regarding breastfeeding. I present some thoughts about autonomy, relational autonomy and the Heideggerian perspective of authenticity. As noted in Chapter 2 and drawing upon Kantian philosophy, personal autonomy is often defined as the possession of both liberty (the state of being free from oppressive restrictions imposed by others on one’s way of life, behavior, or political view), and agency (the full capacity to act on one’s

choices) to enable self-determination (Beauchamp & Childress, 1994; Emirbayer & Mische, 1998). Feminist scholars view autonomy relationally, placing emphasis upon the importance of supportive interpersonal relationships, the perception of autonomy as a skill set, or competency (eg. self-trust), and the comprehension of ways oppressive social circumstances, and individual agents can coerce decisions (Friedman, 2003; Goering, 2009; McLeod, 2002; MacKenzie & Stoljar, 2000; McLeod & Sherwin, 2000).

Never addressing autonomy as such, Heidegger instead discusses authenticity (Freeman, 2011). As *Dasein* (the self) exists as a relational being, the self can never achieve full self-determination in Heidegger's estimation. Upon being *thrown* into the world, the self-endures a situated freedom resulting from the culturally constraining effects of shared history, language, culture, purposes and values (Leonard, 1994; Lopez & Willis, 2004; Taylor, 1991). The future oriented grasping of possibilities is dependent upon the degree of participation in one's *thrownness* (Rodemeyer, 1998), and interaction with others (Esfeld, 2001). "Anxiety makes it possible for us to resolutely own up to the unsettledness of our existence, an unsettledness structured by the very movement of time as "thrown projection" itself (Aho, 2009, p. 63).

As noted in Chapter 2, Heidegger instead proposes *authentic resoluteness* (Blattner, 2013; Dreyfus, 1991, 2004). "Resoluteness means 'allowing oneself to be called up' from a forlorn, mindless conformity to the group (the They)" (Dahlstrom, 2013, p. 184). In resoluteness, *Dasein* is authentically oneself while being-with others (occasionally even being the conscience); the resolute *Dasein* is not independent from its world, but is solicitously (in a caring way) engaged directly with the anxieties and conditions as *being-with* others (Dahlstrom, 2013).

I believe there is similarity between the definition of relational autonomy and descriptions of Heideggerian authentic resoluteness. In my conversations with women about their experiences of their own decision-making processes, I endeavoured to explicate the experience of authenticity, or other modes of existence from their stories, in order that I might remain true to Heidegger's philosophy. I did so as I listened to the words spoken, observed accompanying non-verbal activity, and interpreted *mood* in the attunement of word and actions. I remained hopeful that reflection upon my observations and subsequent interpretation would provide a window to the experience of relational autonomy and in turn, a foundational understanding of this experience.

Interpretive Phenomenology

The task of interpretation is to bring out this evocative given in all its tangled ambiguity, to follow its evocations and the entrails of sense and significance that are wound up with it... These striking incidents make a claim on us and open up and reveal something to us about our lives together (Jardine, 1992, p. 55).

Lived experience is defined as the everyday taken-for-granted skills, practices, and meanings of life that remain largely unnoticed by human beings. Such life experiences factor into the constitution of the person, while enabling her to make sense of her world by creating possibilities and conditions for action (Chan, Brykczynski, Malone & Benner, 2010; Leonard, 1994; Sandberg, 2005; Smith, Flowers & Larkin, 2009). "Lived experience is the starting point and end point of phenomenological research" (van Manen, 1990, p. 36). Interpretive phenomenology is the study of lived experience (Dreyfus, 1991). The overarching goal of this methodology is to identify and describe enhanced meaning and interpretation of a phenomenon of interest, resulting from a

melding of shared participant stories, researcher understanding, and data from other relevant sources (Wojnar & Swanson, 2007). The hermeneutic process is used to come to understanding in interpretive phenomenology (Creswell, 2007; Koch, 1999).

A personal metaphorical experience. During my doctoral journey, I was lucky to be able to visit the Dali Theatre-Museum in Figueres, Spain. Within this museum devoted to the works of Salvador Dali hangs a painting of Dali's nude wife (1975) looking out to sea upon a variegated background. Viewing the painting through the lens of a camera, hence lessening the physical distance, provided a different scenario – that of a pixelated portrait of Abraham Lincoln; the nude disappears. A surrealistic work of art, yes, but I believe also a metaphor enabling an appreciation of interpretive phenomenology as methodology. Descriptive phenomenology requires I strip the background from the phenomenon of interest (the nude), and provide a detached description of it as it stands before me. As a result, the meaning of the painting is not available to me. However, interpretive phenomenology requires me to adopt a relational stance and move closer to engage the scenario in its totality. My embodied experience of this painting tells me that situated within the background that is Lincoln is representation of the love Dali bore for his wife, Gaia, interpreted in the beauty of the exquisite form of the nude. A modicum of modesty is interpreted where Dali has embedded the nude within the vibrancy of the painting as a whole, perhaps as a gesture of respect. The choice of color was vibrant, perhaps representative of a sense of joy within his life. Beckoned by my husband I moved on, having enjoyed and acquired personal interpretation and understanding from this artwork.

The lived experience of past research. Review of past nursing research work highlighting interpretive phenomenology as the methodology of record underscores a mixing and matching of philosophical beliefs to underpin the methods used (Earle, 2010; Koch, 1995; Wojnar & Swanson, 2007). Attempts to retain scientific rigour and distance resulted in the use of methods incorporating Husserlian phenomenological tenets such as bracketing, phenomenological *epoche*, and a detached researcher stance to isolate the studied phenomenon (Benner, 1994). Such methods are not ontologically appropriate for interpretive phenomenology (Koch, 1995).

Interpretive phenomenology is grounded on the belief that meaning of the everyday is constituted within the relational practices of the world and therefore must be studied within its existential context, engaging both participant and researcher in the process (Gadamer, 1989). To this end, researchers need to reflect upon personal ontological and epistemological beliefs prior to taking on interpretive projects (Koch, 1995; Lopez & Willis, 2004). Interpretive phenomenology is well suited to the researcher who engages in the hermeneutical process, seeking the shared nuances of difference and ambiguity embedded within the contextual uniqueness of lived experience (Wojnar & Swanson, 2007).

The influence of Heidegger. As Heidegger distanced himself from Husserlian influence, he embraced the notion of *Dasein* (the self) and the *world* being co-constitutive of knowledge (Dreyfus, 1991). Parts cannot be interpreted as separate from the whole, and so he envisioned a circular process whereby understanding is not one possible behavior of *Dasein*, but is a mode of being (Hoy, 2006). Hermeneutics is the science of understanding (Stein, 1980). Understanding is the most basic ability for living and

coping skillfully within the world (Dreyfus, 1991; Hoy, 2006). Dreyfus writes, “hermeneutics begins at home in an interpretation of the structure of everydayness in which Dasein dwells” (1991, p. 34). Meaning is acquired through interpretive understanding of the self, situated within a web of relations (Hoy, 2006; Macmurray, 1961; McCaffrey, Raffin-Bouchal & Moules, 2012).

Heidegger believed in two essential notions for interpretation, the historicity of understanding and the hermeneutic circle (Koch, 1995). Context for meaning is provided within the *forestructure* of understanding (Geanellos, 1998a). Thus the historicity of understanding is circular in that there must already be a context of intelligibility for something to be understood. The circle of understanding is never closed due to the projective nature of understanding (Dreyfus, 1991). Humans move around the circle by building on what is known through new discoveries and reinterpretation of prior understandings – returning to the things themselves (Hoy, 2006). As a result, the circle opens into a spiral, whereby interpretations build upon those of others over a period of time (Conroy, 2003).

Heidegger (1927/1962) writes that *temporality* is the foundation of existence. Humans are thrown into a culturally and socially constituted *world* that informs their understanding of their situatedness (Freeman, 2007). Interpretation of the *world* makes sense of the *world* as it is, situated within a context of *historicity* or *forestructure*. Nothing is encountered within the world without reference to the *forestructure*, or background of the person (Hoy, 2006). “For Heidegger, the basic meaning of the historical is dependent on the temporal meaning of factual life” (Zaborowski, 2011, p. 18). *Facticity* is defined as the socially interpreted, unchangeable characteristics of

humans (Dahlstrom, 2013). Humans are situated factually; who they are, is not separable from what they do (Hoy, 2006). They become who they are by becoming what is already possible for them to become (Dreyfus, 1991). Interpretation is necessary to understand who they are and how they can continue to be who they want to be. They become who they are through interpretation of themselves and of the possibilities they encounter in a pre-interpreted public world (Hoy, 2006).

Heidegger's experience of the 'hermeneutic turn' (Hoy, 2006) resulted in a new level of thinking taking him beyond the everyday hermeneutics of interpretation. Centering his thinking upon the relational aspect of being, he put forward his idea of a philosophical hermeneutic. Philosophical hermeneutics, as described by Heidegger, "emphasizes neither the text [participant] nor the reader [interpreter]; rather, the focus is on the event of understanding or interpretation as it occurs in the encounter between reader and text" (Freeman, 2007, p. 926). Understanding is less than exemplary if focus is not centered upon the interpretive process itself (Brown, Debold, Tappan & Gilligan, 1991; Koch, 1996). As understanding becomes the central phenomenon of being – existence - thus philosophy becomes hermeneutic (Hoy, 2006; McCaffrey et al., 2012).

Phenomenology in Nursing Practice

Nursing practice grounded in phenomenology can enhance the development of meaningful relationships with clients if concepts from this philosophical and methodological perspective are implemented. Phenomenology is "a philosophy intent upon being an 'exact science', but it is also an account of space, time and the world 'as lived', " (Merleau-Ponty, 1956, p. 59). To successfully use phenomenology in practice is to accurately interpret experience in terms recognizable to those experiencing it (Benner,

1994; Leonard, 1994; Merleau-Ponty, 1962; Thomas, 2005). Sensitivity to the needs of clients is increased as nurses learn about human experience (Van der Zalm & Bergum, 2000).

“All knowledge takes place within the horizons opened up by perception, and all meaning occurs through perception,” (Thomas, 2005, p. 69). Perception of phenomena occurs contextually within the culturally specific narratives describing background and foreground of human embodied experience (Gadow, 2000). As background and foreground shifts within consciousness, perception inevitably will change. Intentionality infers relatedness to the world, a connection resulting between persons and their lived world as they focus attention upon specific events, objects and phenomena. Dialogical efforts enhance relationships with other people, creating connections with all who cross our paths. Through these efforts to achieve common ground, mutual understanding and meaning is realized (Thomas, 2005).

Embodiment is the phenomenological tenet most paid attention by nurses. The world, including experiences of health and illness, is known and understood through both object and subject body (Wilde, 1999). Time becomes a subjective contextual descriptor moving temporally through the foreground and background of our lived experience. Temporality, or lived time, is directly related to the meaning of events within lived experience. By recognizing our intentionality, situating ourselves temporally and freely, and engaging in embodied dialogue, we attend positively to the morality of a relationship (Thomas, 2005).

Nurses employing a phenomenological approach to practice in an interpretive fashion can achieve understanding and meaning for clients by uncovering commonalities

and differences through use of dialogue. Attending to situation, embodiment, temporality, concerns, and common meaning (Benner, 1994) along with mood (Conroy & Dobson, 2005; Freeman, 2014) are inherent in interpretive phenomenology. Taking time to fully engage in narrative experiences with clients as embodied practitioners will in turn provide a level of understanding for self, and meaning often missing in the hurried health care practices of today. Munhall (1994) writes,

The point of phenomenological investigation is to create in us a more thoughtful and tactful way of relating in and experiencing our world. Phenomenology leads to action. To reflect is to be engaged, engagement reveals meaning, meaning yields awareness, and awareness can strengthen thoughtful action, (p. 125).

Phenomenology and relational practice. Nurses employing a phenomenological approach to practice in an interpretive fashion can achieve understanding and meaning for clients by uncovering commonalities and differences through use of dialogue.

“Engagement between persons within the healthcare relationship, whether they are practitioners or people coming for care, requires conversation,” (Bergum & Dosseter, 2005, p. 126). Taking time to fully engage in narrative experiences with clients, as embodied practitioners, will in turn provide a level of understanding for self, and meaning often missing in the hurried health care practices of today. Only when I fully comprehend the ‘situated’ interpretation of decision-making for women can I hope to modify my nursing practice, should change be required (Dreyfus, 1991).

Why Interpretive Phenomenology?

Given my proposed investigative population consists solely of women and their experiences related to breastfeeding, the question arose as to why I did not primarily avail

myself of feminist theory to underpin this study. Support for my choice of Heideggerian interpretive phenomenology to structure my study follows, Heidegger's lack of declared feminist sympathies notwithstanding (Freeman, 2011).

Heidegger's philosophy of phenomenology is founded upon the ontological notion of relational existence. As such, Heidegger offered a philosophy to aid in the understanding of existence within the ontical world, as known and interpreted by human beings. Heidegger has been criticized for his asexual presentation of *Dasein*. He defends this stance in that *Dasein* is not a corporeal being but is the essence of being. *Dasein* is an open space of meaning; it is a priori, and therefore neutral, to the ascription of meaning, one example being gender, a notion supported by Glazebrook (2005) and Aho (2009). However, human beings (entities of *Dasein*) dwell in the world, recognized ontically as male or female. Interpretation of this fact of being is constituted as gender within the relational, social and cultural practices of the human world. Therefore, the *facticity* of biological females (as feminine) is socially constituted as a gendered way of behaving (Dreyfus, 1991; Meynell, 2009). Surrounded by this world, a female 'becomes' a woman, as defined within the limitations of these social and cultural practices (Butler, 2007). As such, the *female* can never be free of her *facticity* to interpret existence in a new way (Dreyfus, 1991).

Thus, feminist theorists agree that herein is positioned the grounds for always using feminist theory to study a woman-centered activity (Butler, 2007). However, Heidegger himself provides a refutation for this argument in that *temporality* is the "horizon for all understanding of Being and for any way of interpreting it" (Heidegger, 1927/1962, p. 39). *Temporality* grounds all factually realized *authentic* or *inauthentic*

modes of existence, and therefore the interpretation of being (Hoy, 2006). As phenomenology is ultimately a philosophy of being, studies using this philosophy must go “beyond the body and the hierarchical relations of sexual difference to the formal conditions of meaning” (Aho, 2009, p. 70).

Fisher writes feminism and phenomenology can co-exist as “a potentially fruitful and significant [development], promising to enhance and extend both feminism and phenomenology in important new directions” (2000, p. 9). Meynell posits Heidegger rejects somatophobic dualism in his accounts of facticity and ‘being-in-the-world’ as embodied beings (2009, p. 3). I believe interpretive phenomenology will serve best to resolve my research query as an investigation grounded within Heideggerian phenomenological principles using a hermeneutical methodology will ‘cast a wide enough net’, and provide a greater richness of data to better comprehend the lived experience of decision-making for the women in this study.

I am aware that many women are situated within worlds that are negatively constituted as a result of issues of gender, power, and/or the political. Should the need have arisen, a feminist lens would have been employed to aid in the interpretive process as I believe the literature supports the use of a feminist perspective concurrently with Heideggerian phenomenology to further an understanding of this lived experience. (Aho, 2009; Glazebrook, 2005; Levesque-Lopman, 2000; Meynell, 2009). However, as this study progressed, I came to see that the ontological nature of this methodology necessitated no need for additional interpretive support, a belief I will discuss further in my concluding remarks in Chapter 9.

CHAPTER 4

Study Design

Introduction

Sandelowski and Barroso (2003) write, “qualitative research findings contain information about the subtleties and complexities of human responses ... essential to the construction of effective and developmentally and culturally sensitive interventions” (p. 782). Inherent to my practice of nursing is the need to understand the meaning of lived experience from my clients’ point of view as described in their words prior to making truly informed decisions regarding care-giving practices; hence the choice was clear to incorporate interpretive phenomenology (Creswell, 2007; Earle, 2010; Fish, 1998; Van der Zalm & Bergum, 2000; Wojnar & Swanson, 2007). In the spirit of these beliefs, I completed a study describing and interpreting the lived experience of maternal decision-making related to breastfeeding, and attempted to make visible the influence of personal autonomy upon this process. Using hermeneutical methods, I have synthesized audio-recorded conversations with women who had recently delivered infants and who had initially chosen to breastfeed upon leaving hospital care.

In Chapter 3, I provided an overview of interpretive phenomenology as methodology. I focus now upon the hermeneutic process that enables interpretation within phenomenological research. To open, I discuss the salient points of hermeneutical inquiry. I follow with an outline of my plan for organization and implementation of this study, highlighting the influence of Heideggerian concepts upon my preparatory efforts. I then outline the interpretive process followed as I synthesized the data. A few words are offered about rigour in qualitative research and the strengths and challenges realized

in its pursuit. I close this chapter with some final words regarding interpretive phenomenology.

Hermeneutical Inquiry

Hermeneutical inquiry is the method of interpretive phenomenology. It seeks to "uncover the meaning of being of human beings," (Plager, 1994, p. 65). Hermeneutics is an ancient discipline derived from Greek mythology. The Greek messenger Hermes, as transmitter of messages to the mortals, was able to deliver and interpret the words of the gods intelligibly and meaningfully (Creswell, 2007; Gadamer, 2006; Ortiz, 2009; Parsons, 2010; Thompson, 1990). Schleiermacher and Dilthey were philosophers instrumental in the advancement of hermeneutics as a method of inquiry grounded in epistemology (Gadamer, 2006; McCaffrey et al., 2012; Nelson, 2008; Ortiz, 2009).

Heidegger, in his study of being, equated hermeneutics with "philosophy proper, which he equates with ontology" (Zaborowski, 2011, p. 23). Gadamer, a student of Heidegger, was instrumental in actualizing Heidegger's ideas about interpretation as general hermeneutics (Hoy, 2006). Hermeneutical analysis seeks meaning in the written and spoken word, knowing the written word is shared culturally, historically, and linguistically between researcher and participant (Allen & Jensen, 1990; Geanellos, 1998a, 1998b; McCaffrey et al., 2012). Building upon the Heideggerian practice of using metaphors to explain key concepts in his philosophy, Gadamer (1989) metaphorically described key philosophical constructs used in the hermeneutical process. A discussion about dialogue, prejudice, fusion of horizons, and the hermeneutic circle now follows (Gadamer, 1989; Koch, 1996).

Dialogue. Humans understand and interpret themselves within a world that is socially, culturally and contextually situated, and so the use of language to interpret their world mirrors this condition, as language too is situated socially, culturally, and contextually (Koch, 1999). Language is the medium of hermeneutical inquiry, and so we engage in conversation with each other (Frank, 2005). Understanding is realized within this relational activity. “Discourse opens on to the intersubjective nature of being in the world and makes disclosure a shared activity with others, in which a communication involves not only speaking but also hearing, listening and keeping silent” (Koch, 1999, p. 30). In seeking a co-constituted interpretation of lived experience, I engaged in dialogue with study participants, embracing an accessible, authentic attitude. By adopting a listening posture fully focused upon the participant, I opened myself to the world of the participants, making myself available to hear the stories being shared in their own words. Clarification was sought using prompts and questions to further elucidate (looking between the lines) and ensure shared understanding of elements of significance (Conroy, 2003; Gadamer, 1989; Koch, 1996). Self-interpretation requires a self-reflective stance, and so this was encouraged of both participant and researcher as part of the dialogic process (Conroy, 2003; Heidegger, 1998).

Prejudice. Heideggerian prejudice, a metaphor for pre-understanding, resides in the *forestructure* of understanding, previously described as background (Conroy, 2003). Understanding of the world is filtered through these prejudices, reflecting the historicity and cultural context of both the researcher and the participant. Prejudices can be linguistically conveyed. Prejudices are revealed by both researcher and participant in their shared *fore-groundings* (taken-for-granted background), *fore-conceptions*

(preconceived notions about the world, related to time), and *fore-sights* (sociocultural perspective from which to approach the world) (Conroy, 2003; Dreyfus, 1991; Wojnar & Simpson, 2007). Prejudice is not something to be eliminated from the hermeneutic process. Instead it should be acknowledged as a condition of how the world is viewed, and as a factor constituting being (Conroy, 2003; Gadamer, 1989; Koch, 1996, 1999). Throughout this process, I reflected upon my own preconceived notions and assumptions, personal biases, and stereotypes to aid in bringing them to consciousness. I recorded these thoughts within a journal throughout the research process to make them visible, thereby acknowledging their *facticity* within my world.

Understanding. As noted above, understanding occurs as a relational activity. “We cannot at any time stand outside our relational ties, but ought to be made responsible, accountable to them – to what we can and cannot know. The interpretation of texts is such a relational activity to which we ought to be accountable” (Brown et al., 1991, p. 44). Being open to the viewpoint of others fuses ideas together, influencing the interpretation of all involved. In this way knowledge is co-constituted as a relational and temporal activity (Freeman, 2007; Koch, 1996). Interpretation is a continuous activity as we are always within a web of relations and temporally situated. “Our understanding and interpretation of the world is co-constituted and synergistic” (Conroy, 2003, p.39).

The hermeneutic circle. The hermeneutic circle, as described by both Heidegger (1927/1962) and Gadamer (1989) is a metaphor for the process of sharing of meaning and experience within a common linguistic community that defines understanding. Understanding is experienced dialectically by moving from a historical background of shared meaning to a more focused experience within it - from whole to part, and back

again (Annells, 1996; Benner, 1994; Leonard, 1994; Thompson, 1990). “All claims to understanding are, for Heidegger, made from a given set of forestructures which cannot be eliminated, but only corrected and modified” (Koch, 1995, p. 832). Therefore, from within the circle the world is understood and interpreted. With heightened understanding, more possibilities become available to be experienced and interpreted, creating reciprocity within the encounter of the hermeneutic circle (Gadamer, 1989, 2000; Heidegger, 1927/1962; Koch, 1996; Parsons, 2010; Plager, 1994). The researcher is integral to this process (Koch, 1996). With shared understanding of the phenomenon of interest, the circle becomes a spiral, allowing “the research process to grow and include interpretation of others rather than just the primary researcher and study participants” (Conroy, 2003, p. 39).

Ensuring accuracy of interpretation. Thematic analysis, identification of paradigm shifts and development of exemplars are methods used to enhance hermeneutical understanding of phenomena (Benner, 1994; Conroy, 2003; Leonard, 1994). I began this interpretive process with much reading and reflection upon the phenomenon of my interest. Beginning with the first conversation, each ensuing conversation was compared and contrasted as I sought commonalities related to Heideggerian themes of historicity, embodiment, significance, authenticity and mood. Reflection upon the narrative highlights similarities and differences of these concepts between and amongst participants and myself, providing opportunity for the re-interpretation of lived experience and co-constitution of knowledge (Carson, 2012). Paradigm shifts are “a change in a way of ‘seeing’ and coping with the world” (Conroy, 2003, p. 54). As re-interpretation transpired, I observed a change occur in the values,

beliefs and attitudes originally expressed for both myself and the participants. Positive shifts reflected a stronger commitment to an authentic way of being; a negative shift for one participant constituted a move toward a more inauthentic mode of existence (Conroy, 2003). Exemplars have been used to demonstrate difference or commonality of experience. “Exemplars substitute for ‘operational’ definitions in interpretive research because they allow the researcher to demonstrate intents and concerns within contexts and situations” (Benner, 1994, p. 117).

Hermeneutical inquiry engages researcher and study participant in a dialogic exploration of a phenomenon of shared interest (Freeman, 2007). As the phenomenon is explored in its entirety, a more complete understanding is co-created. Moules and McCaffrey (2015) wrote “understanding is the ultimate hermeneutic wager: that understanding matters and will make a difference in matters of human consequence of living well in conditions where suffering often exists” (p. 2). A search of the literature revealed only one author/researcher - Conroy - who has developed and used a methodological framework true to the notion of Heideggerian interpretive phenomenology. Conroy’s (2003) framework for interpretive inquiry is commensurate with my aspirations for this project, therefore I used this framework to guide my own preparations.

Methodological Strategy

In this next section I outline my strategy for implementing this chosen methodology. As I have followed the methodological framework outlined by Conroy (2003), I first address Conroy’s Hermeneutical Principles of Research (HPR) (Appendix A). Developed by Conroy, these twenty principles apply Heideggerian values of

interpretive phenomenology to encourage focus upon the goal of this research – maintaining and valuing the engagement of participants and researcher within the hermeneutic circle and spiral to foster a heightened understanding of the studied phenomena of maternal decision-making around breastfeeding, leading to the creation of an interpretive spiral (Carson, 2012; Conroy, 2003). These guiding principles provided focus and structure for both the development of my research method and the implementation of the interpretive process as I completed this research project. As I discuss this strategy as it relates to my project, I indicate in brackets the HPR being actualized.

Study Design

Participants. Using purposeful sampling, women experiencing pregnancy were recruited from within Halifax Regional Municipality (HRM). I had hoped to interview eight to ten women in total for this study, however out of eleven expressions of interest, I was only able to recruit five women. A large number was not required (but was desired), as knowledge is created with full understanding of the individual experiences (Carson, 2012). Participants self-selected their involvement in this study (Creswell, 2007; Luborsky & Rubinstein, 1995) (HPR 1).

Inclusion criteria.

- women planning to breastfeed their infant upon delivery
- were experiencing a singleton gestation
- attended prenatal care clinics at the IWK, or were clients with perinatal care-providers located within Halifax Regional Municipality
- agreed to be interviewed at 4-8 weeks post-delivery

- were over 18 years of age
- were able to speak and read English

Recruitment of participants. Recruitment took place prenatally. Upon receiving ethical approval, I provided an information session with nurses working within the perinatal center to explain my study and the recruitment criteria listed above. Information posters were posted within each examination/client room of the perinatal center, and within care-provider offices to enhance participant inquiries. As well, I crafted a letter of introduction (Appendix C) to be given to each woman who attended the perinatal center by the nurses working in the clinic and to women attending offices of health care providers outside the IWK. This letter provided an introductory explanation of my study intentions and my contact information. Women with interest in my study were able to contact me at their convenience and without coercion to participate in the study, as my contact information was provided within the letter of introduction and on posters.

Upon notification of a participant's interest in participating in this study (always by email), I made arrangements to meet each woman prior to delivery at an agreed upon time and place. I met four women at the IWK, and one at a local coffee shop. During these initial meetings I described the study in detail, answering any questions that arose. Although partners were welcome to attend these introductory sessions, none accompanied any of the participants. Upon verbal agreement to participate in this study, I obtained written consent (Appendix B). Completed consent forms are filed in my Dalhousie office within a locked cabinet. I again provided contact information in order that they (or their designate) would contact me upon delivery of the baby. Participants

had the option to withdraw at any time prior to data analysis, however all remained involved in this study (HPR 12).

Upon notification of a successful delivery (no issues with mother or baby), I confirmed the participant's desire to continue within the study by email. As previously noted, statistical information about breastfeeding rates demonstrate a significant decrease within the first six weeks postpartum. Therefore, in order to capture experiences about decisions to continue or not continue with breastfeeding, I conducted all conversations after six weeks postpartum. Arrangements were made with all participants to meet six to eight weeks after delivery of the baby and accuracy of contact information was reviewed.

Data collection. Data collection proceeded in the following ways:

Conversations. Conversations conducted for phenomenological research are directed towards gaining knowledge about certain phenomena. "The purpose of the phenomenological [interview] is not to explain, predict or generate theory, but to understand shared meanings by drawing from the respondent a vivid picture of the lived experience, complete with the richness of detail and context that shape the experience," (Merkle Sorrell & Redmond, 1995, p. 1120).

My goal as researcher was to enter the hermeneutic circle authentically, maintaining an open stance and engaged attitude as the circle opened into a spiral. In accordance with this type of conversation, I was available to the participant, and actively listened to what the participant was saying. As I actively listened to what was said, I also engaged in an ongoing interpretation from any previous conversations with this particular participant. Because of this, I maintained a questioning attitude throughout, seeking clarification as required to ensure a more complete understanding of the experience being

presented. As well, I focused upon the participant, observing for what was being relayed non-verbally, searching for congruency with the spoken word. As interpretations were compared and contrasted throughout the dialogic process, meaning was co-constructed (Koch, 1999).

Conversations were open-ended and unstructured, flexible enough to provide some control and comfort to the participant. They were dialogic conversations - the dialogue came from the participant, or storyteller, with prompts from myself (Munhall, 1994). Participants were encouraged to provide an interpretation of their experience. After stating the focus of the study to begin the conversation, I used questions or a reframing of statement to encourage clarification of salient points in the story, and further description of concurrent activity while experiencing the phenomena. Prompts to elicit description of feelings and moments of significance for the participant as experienced at the time of the event being described were used. Periods of silence were respected as self-reflective experiences (Brown et al., 1991). Participants were encouraged to verbalize thoughts they had during these periods of silence, as descriptions of these could add to the overall understanding of the experience.

For this study, participants were invited to converse one on one with me at a location of their choosing. All participants were initially interviewed between six and nine weeks postpartum. A second chance to meet was offered to all participants so that I could affirm my own understanding of the experiences previously described, and provide opportunity for clarification and/or enhanced description of the researched phenomena. I received email feedback from one participant in lieu of another face-to-face meeting; I was fortunate to be able to have a second face-to-face conversation with two participants.

During our second meeting, I outlined what I had heard and understood in our initial conversations. Both participants provided valuable feedback that proved instrumental in my attainment of a deeper understanding of their breastfeeding experiences. Follow-up emails to the remaining two participants went unanswered. Face-to-face conversations lasted between 60-120 minutes in length (HPR 1-20). Each resulting conversation and transcript was coded with a number and a pseudonym.

Conversational prompts. Following social pleasantries, I began the dialogic process with my initial preamble, similar to that noted below. I then used the following questions and statements to prompt each participant, when required, during our conversation. I present them now, along with Heideggerian themes I believe they address.

1. By sharing your experiences to date, I'd like you to help me understand your experience(s) of decision-making regarding your choice of feeding method for your baby.

Addresses coping, comportment, temporality

2. What influenced you the most in making your decision? The least? Who influenced you the most? The least?

Addresses historicity and fore-structures of the woman's world

3. Can you share with me your feeding experiences? What thoughts or emotions do you experience when you feed your baby?

Addresses coping with the process of feeding; embodied knowledge; authenticity

4. What does it mean to you to feed your baby?

Addresses significance of feeding for woman, authenticity, mood

5. What is the most important thing to you about feeding your baby? The least important?

Addresses significance, coping, authenticity

Transcription. I digitally recorded all conversations in their entirety from beginning to end. Recordings were then transcribed in full by a professional transcriptionist who provided a signed confidentiality form prior to taking on this work. Following the transcription process, I read the printed transcript in its entirety, while listening to the recorded interview, making corrections to transcription errors if required, and entering details regarding silences, participant non-verbal activity, and field note data. Detailed field notes, containing thoughts and observations prior to, and at the end of each contact with the participant were reviewed, adding context to the interview process and providing a greater depth of understanding about each conversation. I printed a written narrative of each conversation for my own use. All printed transcripts have been stored in a secure location, as per ethical guidelines for Dalhousie University. All data storage devices such as memory stick and computers have been appropriately password protected or encrypted depending on the software capabilities (HPR 6, 19, 20).

Researcher reflective journaling. As the researcher is integral within the process of knowledge co-constitution, it was important that I maintain a reflective journal throughout my research journey. This was my workbook. Initial written notes recorded my own values, beliefs and assumptions about infant feeding choices. I recorded the reflective process I engaged in with myself, as I sorted through my impressions of personal experience, conversations about this topic, readings and other thoughts and feelings relevant to this project. I recorded my thoughts, observations, highlights and low

points of this journey as they related to this research experience. I reviewed and reflected upon my writing as part of the co-constitutive process that is interpretation. As understanding increased, the resulting decision trail for this research process was recorded here (HPR 3, 4, 7, 8, 15, 17).

The interpretive process. As noted previously, interpretation began with the conception of this study. I reflected upon the salient points of intrigue about the phenomenon of interest, and how I might explore them as I sought answers to my questions. Using Conroy's methodological plan to underpin the next section, I will now discuss the application of the six aspects of the interpretive process in this research project (2003).

Aspect 1. Upon receipt of ethical permission of the required approving bodies (school, ethics, etc.), I engaged with participants in this first phase of the journey to understanding. The goal of these dialogic efforts was to make visible the values, beliefs and assumptions of both the participant and myself (Conroy, 2003). I approached each conversation openly and authentically. I maintained a questioning stance to encourage a full description of the phenomenon. Being fully engaged in the process encouraged simultaneous interpretive efforts on my part, helping to assure shared understanding while assisting the participant to tell her story completely. Interpretation as framed by my vantage point was shared, to clarify understanding and ensure a 'fusion of horizon' between myself and each participant (Conroy, 2003; Koch, 1996). A written document outlining my interpretation (as constituted by journal entries and recorded conversation) of the participants' lived experience was shared with each participant via email to validate our shared interpretation. As previously noted, two participants agreed to a

second meeting, one participant provided electronic feedback, and two did not respond. Any further thoughts and comments were then incorporated into the overall interpretive process.

Aspect 2. Conversations with participants were recorded as verbal exchanges and as written narratives. After each conversation, I recorded my initial thoughts and feelings in my journal. As conversations were replayed, and written narratives reviewed, I recorded further reflections I encountered. As required, review of this auditable record (by myself and my thesis supervisors) was helpful in tracking understanding, misunderstandings, and decisions made along the journey. (Conroy, 2003).

I read each narrative many times, adopting a different interpretive gaze each time. By adopting an overall vigilant stance, I was watchful for Heideggerian themes of historicity, temporality, mood, authenticity, and significance (Dreyfus, 1991). Assuming the role of interpreter, I carefully reviewed initial conversations, listening for personal commonalities and differences of the experience of the storyteller. Concurrently, I continued with my reflective journaling, noting such instances. I noted any questions remaining or any new questions that surfaced, as well as implications for future procedural decisions.

I conducted a second review favoring the perspective of the narrator. I attended to the self – the I - in the story, while recording significant thoughts, feelings, and insights rendered by this activity, and making notes as I listened. I conducted a third reading, attending to the relational world of the participant, and seeking significance in the web of relations wherein the participant dwelled. My fourth reading highlighted choices made

by the participant (Brown et al., 1991). Again, I made notes accompanying all aspects of this narrative review.

I wrote interpretive summaries for each participant's conversation. These summaries were shared via email with participants for feedback as to the validity of interpretation. This activity further helped to increase my understanding as I made visible individual and contextual commonalities and differences (Brown et al., 1991; Wojnar & Swanson, 2007). Worksheets were developed to track this summary work (Conroy, 2003).

Aspect 3. Bi-weekly, then weekly meetings with my 'interpretive team' (my research supervisors) were held to review the synthesis of knowledge. Members of the team were provided with written narratives, researcher summary worksheets, and information of Heideggerian principles to guide their own interpretive review. By opening the research to the greater community (my research supervisors), it is contextualized further as community has influence upon the taken-for-grantedness of both participants and myself (Conroy, 2003). Their feedback often aligned with my work, or provided opportunity for clarification for redirection as their lack of personal stake in research outcomes allowed them to do. In this way, this work was audited as part of the process ensuring trustworthiness of the overall research project (Lincoln & Guba, 1986).

Aspect 4. The identification of a paradigm shift indicates experience of a hermeneutic turn (Hoy, 2006). As thematic development ensued, a change in initial values, beliefs and assumptions held by the participants and myself were interpreted as a paradigm shift. Experiencing a positive shift, or turn, indicated a solidification of

commitment to authentic behavior, rooted in those same values, beliefs and assumptions. A negative shift, or engagement of inauthentic modes of behavior indicated an inability to stand up for one's beliefs and values, thereby negating responsibility for one's own existence (Conroy, 2003). Such paradigm shifts were demonstrated by participants in this study and are discussed within the findings.

Aspect 5. Exemplar development was helpful to make visible usefulness of the research findings. I have used the study participant's words to create exemplars that help to illustrate the meaning discovered within their experiences. Creating a case that exemplifies "consistency in concerns, meanings, knowledge, and skills common to a participant's experiencing of the world" (Conroy, 2003, p. 55) aided in recognition of transferability for other readers.

Rigour in Research

Rigour in qualitative research is deemed necessary as a testament to the need to provide legitimacy to research work (Koch, 1996). Born of past requirements to demonstrate reliability and validity in quantitative work, this legacy is reframed in qualitative studies as trustworthiness and authenticity. This study will be deemed trustworthy using criteria of credibility, transferability, confirmability, and dependability (Koch, 1994; Lincoln & Guba, 1986; Munhall, 1994). I will seek resonancy (signalled by the 'phenomenological nod') amongst listeners when sharing my findings in future arenas (Munhall, 1994).

Credibility of this study has been achieved and demonstrated in various ways. The use and maintenance of a reflective journal to record personal reflections about the research process was one way I demonstrated credibility about this research. As well, I

have used data from many sources (maternal and researcher journals, conversations, readings) to synthesize an interpretation of the phenomenon. By involving my participants in reviewing their own narrative accounts for accuracy of our conversations and my interpretation of the same, I enhanced this process (Koch, 1994; Lincoln & Guba, 1986; Munhall, 1994).

Transferability or fittingness is measured by the usefulness of the data. Research is deemed transferable (demonstrates a good fit) when application of all or part of the findings is possible in settings outside the study context. Dependability is achieved in the audibility of the research process. The ability of an external auditor to follow, or recreate the decision trail used in the research process is important. By engaging second readers (my research supervisors), I have ensured data from all my study participants received the benefit of this same process (Conroy, 2003; Koch, 1994; Lincoln & Guba, 1986).

Strengths and Challenges

Interpretive phenomenology provides an opportunity to understand the reality of the lived experience of the phenomenon of interest – in this case, maternal decision making about infant feeding choices. Contextually significant stories have been relayed as they were known and lived by the participants. By adopting an open and engaged stance, and actively listening to their stories, I as the researcher, sought nuances of significance, and moments of anxiety, all the while supporting the participants to tell their stories, in their way and in their time. Embodied intelligence was evident during dialogic events, as personal and professional intuition guided prompts for clarification, and enabled ‘reading between the lines’, supporting my questioning attitude. Participants

experienced positivity regarding the research process as they engaged with me in a shared search for mutual understanding (Conroy, 2003; Koch, 1999).

Challenges of interpretive phenomenology include the time commitment required for all project participants (investigator, participants, and interpretive team). The time required obtaining the complete story of the participant, the interpretive process of synthesizing the data, and the writing commitments are all facets of interpretive phenomenology thought to be very time consuming. However, immersion in the project resulted in greater understanding of the phenomenon rendered visible in the words of all of the participants (Conroy, 2003; Koch, 1999).

Some Final Words

Sensitivity to the needs of clients is increased as nurses learn about human experience (Van der Zalm & Bergum, 2000). Nurses employing a phenomenological approach to practice in an interpretive fashion can achieve a deep understanding and meaning for clients by uncovering commonalities and differences through use of dialogue. “Engagement between persons within the healthcare relationship, whether they are practitioners or people coming for care, requires conversation,” (Bergum & Dosseter, 2005, p. 126). Taking time to fully engage in narrative experiences with clients, as an embodied practitioner, will in turn provide a level of understanding for self, and meaning often missing in the hurried health care practices of today (Bergum, 2004). To successfully use phenomenology in practice is to accurately interpret experience in terms recognizable to those experiencing it (Benner, 1994; Leonard, 1994; Thomas, 2005).

Completion of this research project has provided a greater level of understanding about how women experience decision-making, particularly around breastfeeding. As a

practitioner that values the art and science of breastfeeding as a source of nutrition, love, and relational human development for infants and women, I believe that this exercise affords me knowledge that can aid in the enhancement of breastfeeding outcomes in future.

As I prepared to embark upon this study, I reviewed my reasons for using Heidegger's phenomenology to explore the lived experience of decision making regarding infant feeding. By choosing to underpin my research with Heidegger's philosophy, I committed to an ontological approach, seeking an understanding of the meaning of the lived experience for my participants, not what can be known (Mackey, 2005). I recognized that the use of Heideggerian phraseology to demonstrate application of theory leading to interpretation of experience may instill feelings of discomfort around language used to describe participant experiences. However use of a Heideggerian lens has provided a comprehensive understanding from the stories of these participants in the fullness of their situated breastfeeding experiences.

A woman, as a human *be-ing* situated *in-the-world*, engages in decision-making processes about infant feeding that are grounded in all the Heideggerian structures discussed in Chapter 3 – temporality and historicity, world, embodiment, authenticity and mood. As persons born into diverse cultures (bordered by time, location, language), women are thrown into situations that value particular ways of being over others. Infant feeding, and in particular breastfeeding, is an activity that reflects historical and cultural influence. As an embodied experience, these women had an understanding specific to their own situatedness reflected in their decision (or not) to breastfeed. Exploration of authenticity and mood has enhanced understanding of decision-making processes.

“Heidegger emphasizes that Dasein must always be seen as being-in-the-world, concerned with things and caring for others, standing in the clearing for the sake of what concerns it and what it encounters” (Dahlstrom, 2013, p. 37).

CHAPTER 5

The Participants

Breastfeeding is a particular kind of maternal practice that means using the mother's body as a source of nourishment, comfort, even medicine, for the infant. Its meanings are produced in the particular socio-historical context within which the breastfeeding occurs, but the mother's own experience of breastfeeding and thus the personal meanings she attaches to it as a practice are unique and unpredictable. (Hausman, 2004, p. 279)

Introduction

I was privileged to engage five women eager to share their story of their infant feeding experiences. All participants expressed their intention to breastfeed their infants upon delivery; all were still exclusively breastfeeding at the time of our conversations. Conversations with each participant made visible varied journeys to one similar outcome – that of successful nourishment of their infants. However, the experiences of feeding their infants were so very different for each woman. As I introduce these women, I have used their words to impart a sense of who they were, and who they have become as they, along with their infants, families and communities co-constitute a new way of being within a world that provides context and understanding to knowing themselves as breastfeeding women. As all women referred to their marital partners as ‘husband’, I too use this designation within this thesis, when writing of their experiences.

Although my role in this project was primarily that of researcher, my engagement in each of these relationships was foreshadowed by my own *forestructure* of knowledge grounded in and through clinical practice within the perinatal setting. Listening to the stories these women chose to share was always interesting, albeit difficult at times. Some stories inspired feelings of pleasure and awe as women described their realized capacity of their own bodies in childbirth and breastfeeding. More negative emotion such as

sadness and anger was provoked as I listened to other stories describing unsupportive relationships and substandard healthcare (my perception). However, this new role of researcher provided a different lens through which to see and hear stories already deeply familiar to my being (Jardine, 1997). Remaining true to the application of the interpretive process as outlined by Conroy (2003) ensured my ability to simultaneously acknowledge my emotional reactions while still making sense of the experiences shared by all of these women. Engagement in this process has deepened my understanding of this phenomena – maternal decision-making about infant feeding choices.

Piper: Preparation and Commitment

“Because when I meet other moms [of my culture], like the same age as my mother, they would always ask, ‘Are you breastfeeding?’ and I was like, ‘Yeah.’ ‘Oh, that’s good.’ So I guess they don’t expect anything other than breastfeeding.”

My first encounter with Piper left me with a strong impression of a woman whose *forestructure* of understanding was socially and culturally constituted by strong influences of shared experiences of her husband, family and social community. As a result of these influences, she was passionately *attuned* to the notion of exclusively breastfeeding this infant, her first, upon delivery. As a woman whose cultural background values the breastfeeding process as the primary mode of infant feeding, she had prevailed upon her extensive expertise of technological resources to inform herself of the most current knowledge about this method of infant feeding. I did note that use of familial advice in her decision making about infant care, including feeding, was tempered with information garnered from ‘expert opinion’ as she availed herself of professional resources to ensure the validity of her acquired knowledge – “I wouldn’t know all of these

things and there would be petty things that I would be worried about that I shouldn't be worried about. But until I get to speak with a health professional then, you know, I wouldn't be pacified.”

At our first meeting prior to her birth experience, I was struck by Piper’s contagious vivacity and air of self-assuredness. Pragmatic regarding her life and her relationships, she was positively disposed toward her pending experience of birth and welcoming her infant into her family. However, our second meeting in her home at six and one-half weeks post-birth demonstrated a striking difference in Piper’s demeanour. Trust in her socioculturally influenced understanding of taken-for-granted background practices was shaky in light of her breastfeeding experiences. The activity of breastfeeding, previously experienced as an observer as *ready-to-hand* had, with new learning and experience, produced an *unready-to-hand* mode of being. What was believed to be an easy and natural progression of the childbearing experience was in fact much more rigorous, creating a dissonance in the *embodied trust* in her body she had previously enjoyed. The *facticity* of her *situatedness* – she was the only *Being* able to breastfeed her daughter – gave her pause as she pondered the meaning of this experience. Her dependence upon others during this time was accentuated as she spoke of the support derived from her husband and other healthcare professionals as she learned how to breastfeed her daughter.

But like what I've said, my husband is also an advocate of breastfeeding. And I couldn't be any happier with that because it's just... you know, like a part of the research that I was like reading, is that both of you have to be on the same page because it's not easy. (Piper)

While recounting her birth experience, I was provided insight into the personal strength she possesses and was using as she continued upon her journey of exclusive breastfeeding. Her commitment to the process was strong, enabling her to overcome any and all perceived obstacles in her journey. “I’m not saying that I would have given up but it might have been harder for me to continue breastfeeding because it’s really challenging.”

Our third encounter at five and one-half months post-birth, again in her home, provided me with a view of a woman returned to firmer footing within her *world*. Piper had successfully bridged the experiences and knowledge of her past with the *facticity* of her present regarding the breastfeeding process. Over time, persistence in breastfeeding efforts had reconstituted breastfeeding as a *ready-to-hand* activity; her *embodied trust* in this activity was rejuvenated. Confidence in herself and her capacity for mothering appeared restored.

Alex – It’s My Job

“It means something to me that I have a healthy baby that I’m able to feed and that, you know, I know she’s going to do well because of what I’m doing for her.”

My first encounter with Alex provided me a glimpse of a much focused woman, with little time for social banalities. Our initial meeting highlighted Alex’s employment as a healthcare provider and her belief in the importance of research in health care, resulting in her desire to participate in this study. Close to the end of her pregnancy, she was happily anticipating the birth of her first child, and taking on the mantle of ‘mother’.

As a health care provider, past work experiences provided Alex strong motivation to breastfeed her infant. Her professional experiences, along with her social and familial

situatedness certainly influenced her *forestructure* of understanding of the breastfeeding process. However, our second meeting at six weeks post-delivery in her home revealed that her reality in no way resembled any of her previously held expectations for feeding her infant. Due to a medical complication the breastfeeding process had become a laborious chore requiring much personal suffering and forbearance.

My dad asked me [if I like breastfeeding] one day when I was sitting at their house. And I was nursing her and he said, ‘Oh, don’t you enjoy this time when you get to breastfeed?’ I said, ‘No, I don’t, Dad. Actually it hurts a lot. It’s not fun.’ He was surprised I said that. (Alex)

Frustration about her breastfeeding experience was palpable during this meeting. Although some joy was expressed regarding the facticity of her daughter, a pervasive negative tension was evident in her description of her experiences. “[My daughter]’s gaining. [My daughter]’s beautiful and she’s doing great, but I’m not.” Alex expressed frustration with her own physical limitations – her body had let her down, diminishing her sense of *embodied trust*. Tension was mounting as reliance upon her body to nourish her baby was realized only as bodily betrayal in her pain and discomfort throughout the feeding process. A lack of treatment options was certainly disappointing, as was the notion that appeasement of her physical discomfort would not be guaranteed with cessation of breastfeeding. Supported in varying degrees by her husband, family, and healthcare providers, Alex persevered in her breastfeeding efforts out of a strong need to ‘do the right thing’ as she strived to provide nourishment while strengthening the relational connection with her baby. “So yeah, it’s just that I’m doing what I’m supposed to do and how I’m supposed to care for her. ... So yeah, I think it’s just my

responsibility. ... But anyway, it's my job." Interestingly, my invitation to meet again with Alex went unanswered.

Suzanne – Embodied Wonder

“Well obviously we're bonding when I'm breastfeeding her. But also it's nice, it's quiet. Sometimes we'll just, it's just, we'll sit here in complete silence while she nurses.”

My first impression while speaking with Suzanne indicated an air of serenity. After some initial reproductive issues, she was now pregnant with her first child. She expressed an intention to breastfeed her infant and that participation in my study would be interesting. Having worked in the world of business technology (albeit now unemployed as a result of corporate downsizing), much of her knowledge of breastfeeding (*forestructure* of understanding) was influenced by family, friends, and some reading. Although not really sure what to expect, she expressed a ‘wait and see’ attitude about breastfeeding her infant. “So it seemed like the normal, natural...like it seemed like that was the right thing to do.”

Our second meeting at nine weeks post-birth in her home confirmed these notions. As Suzanne described her experiences of childbirth and post-delivery care, I realized she was a woman of great inner strength. She takes everything in stride, dealing with each experience as it unfolds. “I thought it would be more weird before, like before she was born, I thought it would be kind of, you know, weird. It's kind of a weird...I don't know, I just thought it would be a weird feeling. But it seems so natural once you start doing it.” As she described the temporally influenced highlights of her breastfeeding experiences (a challenging birth experience, infant tongue-tie, very sore nipples), I was able to observe that for her, breastfeeding had now become a truly embodied activity.

The peace she exuded as she fed her baby while we spoke was evident in her facial expression and her overall bodily relaxation and aura of comfort. She had embraced this new role of mother with a sense of wonder and quiet joy; she was in love with her infant. She took great pleasure in being able to provide all the nourishment her infant required. “And she, you know, that’s all she needs to eat, is what my body produces.”

A third meeting at four and one-half months post-birth again in her home strengthened my initial impressions. She was better able to articulate her initial thoughts about breastfeeding – “Because you worry about those little things, the small chance that it might not work maybe. ... I don’t know, it’s like when you’re at the amusement park and that rollercoaster looks really amazing but you don’t really know how amazing it is until you get on it.” Suzanne’s quiet determination to succeed while engaged in the breastfeeding process has provided the impetus to continue a journey that was occasionally arduous, but has produced so much joy and fulfillment. “Yes I enjoy it now. It’s great.”

Tasha – Just Stop the Noise!

“Well, stopping listening to everyone’s comments really helped. I think that saved me. Stopping obsessing over like how many...like when I should sleep train and what I should do. Like just stopping the noise...”

Tasha, pregnant with her first child, enrolled in this study as an opportunity to discuss her infant feeding journey. Influences from immediate family (husband, mother and sister are healthcare providers) certainly swayed her decision to contact me about participation in this study. Prior to having this baby, she was unsure where this journey would take her, but was open to ‘trying on’ the breastfeeding experience. Attendance at

an initial prenatal class influenced and encouraged her to adopt a ‘wait and see’ attitude about decision making regarding infant feeding. Feelings of dismay were evoked upon listening to the presenter vilify the use of formula for infant feeding. “I’m sitting in this room and like I’m glad that I’m old enough and educated enough, and I guess confident enough to know that if I cannot breastfeed that my baby is still going to be fine and still going to be healthy.” Interestingly, her overall disappointment with this presenter ultimately influenced her decision to stop attending further prenatal classes.

Meeting Tasha seven weeks post-birth revealed that breastfeeding was going well for her. I was unable to meet her infant as we connected at an out-of-home venue to coincide with a medical appointment; she had left her infant with her husband. Although the birth experience was challenging, the resulting sequelae of an extended hospital stay provided her much nursing support, a fact she equated to her continued success with the breastfeeding process. “Which was kind of a blessing of the c-section in a way when I look back because if I had had a vaginal birth, I probably would have been released the next day, and I wouldn’t have had the RN who I had.” As an avowed ‘hands-on learner’, engaging in the breastfeeding process provided an opportunity for *embodied learning*, cementing her conviction that she had made the right choice for her and her baby. “No, I figured anything I read... Like this is my brain... That’s not how I will learn. I have to...like I can learn by reading but it will make more sense when I’m doing it.”

At the time of our meeting, she described commonalities shared with the other participants regarding her breastfeeding experience – sore nipples, latch assessment issues, feeding cue identification, and feeding time commitment. However much of Tasha’s reflections about her breastfeeding experiences were nestled within the

overriding normalization process of the parenting experience. Tasha's *ready-to-hand* experience of engaging with the world had changed to an *unready-to-hand* mode of existence, requiring navigation of a new journey that was inclusive of her breastfeeding experience. Being the recipient of unsolicited but well-meaning advice from friends about how to incorporate her baby into her life had created a firm resolve to parent her infant in ways amenable to her and her husbands' beliefs and lifestyle.

It's hard. But like my friend said to me...and she just said, you know, don't listen to anyone. Our society is in such a rush for you to be selfish. Like after you have a baby, they're in such a rush for you to get your life back. But you know, that's not what the baby needs right now. And it's probably the same with breastfeeding....Maybe that's being a parent. (Tasha)

An invitation to meet again was declined, however a brief email conversation at four months post-birth revealed that breastfeeding continued successfully at this time and that 'all was well'.

Nicole – An Exploration of Difference

I found with [my son], like at the beginning it was almost like it was, I don't know if a chore is the right word but kind of. Yeah, like it was just like I was so tired and so exhausted and in pain, and it was just like [my son] needed to feed. I mean intellectually I knew [my son] needed to, and I did it obviously. But it was hard. And this time it didn't feel hard like that. It just felt like, okay, [my daughter] needs to eat so I'm going to feed her. (Nicole)

Meeting Nicole during her pregnancy revealed an engaging, friendly young woman eagerly anticipating the birth of her second child. She had breastfed her first

infant, and was anticipating doing so again. Although scheduled for an operative birth, or Caesarian section, due to her previous birth experience, she was hoping that this appointment would not be required, and that she would deliver vaginally.

I met with Nicole six weeks post-birth in her home. Her sunny disposition and eagerness to tell her story was uplifting. Much of her energy was directed to reflecting upon the differences between her two childbirth and breastfeeding experiences. Observations and feelings about this experience were presented as reflected within Nicole's *historicity*. Beginning with her birth events, she elaborated upon the experience of difference. As she did not require a caesarian section this time, difference regarding her own physical recovery process following the birth of her daughter enhanced the enjoyment of the breastfeeding process. Difference in emotional experience was realized after the birth of her daughter as she did not seem to encounter the same extreme mood swings this time. Difference of behaviors exhibited by her two children was a source of anxiety when Nicole was discussing feeding styles. "I think [my son would] pretty much eat whenever. This one though, no man. [My daughter] is not eating unless she's hungry. Which is not a bad thing either I guess."

Prior to the arrival of her daughter, breastfeeding was an activity experienced as *ready-to-hand*. However, the differences noted between these experiences aided in the creation of a *present-to-hand* mode of existence, requiring conscious deliberation on her part to navigate a new way of being as she learned to breastfeed *this* baby. Situated within a family with strong beliefs supporting the breastfeeding process, Nicole spoke of still requiring a strong personal commitment to feeding her infant this way. "And I think

that that's a big part of it. It's kind of if you just kind of say I'm going to try, if you're just going to try, you're probably not going to do. I think it's part of how you go into it.”

Setting the Mood

As I began to make sense of the breastfeeding stories of these women, I reflected upon my application of the theoretical lens I had chosen to interpret these shared experiences. Reading and reflecting upon the conversations held with each woman, I was transported to Heidegger's thoughts regarding *mood*. Heidegger writes, “A mood makes manifest ‘how one is, and how one is faring’. In this ‘how one is’, having a mood brings Being to its ‘there’ ” (1927/1962, p. 173). *Mood* discloses significance in our world, making it possible to direct the self (*Dasein*) to something that matters – ‘*being-there*’ (Dreyfus, 1991; Heidegger, 1927/1962; Ratcliffe, 2013). *Mood* influences how we see the world as it is presented to us. *Mood* is not a subjective experience; ontologically, *mood* constitutes a sense of being part of a *world* (Ratcliffe, 2013, p. 157). *Mood* is a primordial phenomenon essential to *being-in-the-world* (Freeman, 2014). *Mood* determines how we encounter our world and its inherent possibilities; we are *always in a mood*.

My ruminations about *mood* progressed to Heidegger's portrayal of anxiety as a mood. I choose anxiety as many mothers experience this, as I will explain. *Dasein* derives meaning from her *world* only as a result of her own *thrownness*. Should her previously taken-for-granted *world* begin to obtrude (such as with the advent of a pregnancy, or a new baby), whereby everyday familiarity is diminished or changed, she experiences anxiety. Heidegger writes, “In anxiety one feels ‘*uncanny*’” (1962, p. 233). Dreyfus' translation of ‘*uncanny*’ to ‘*unsettled*’ (1991, p. 179) clarifies Heidegger's

meaning in this instance. *Dasein*'s experience of anxiety results in a withdrawal of the world as she understands it, disclosing the solipsistic nature of *Dasein* as she stands alone. Thus it is disclosed to *Dasein* that she is not the source of meaning for self-understanding. She can choose to return to her unchanged world without resolving her anxiety and remain unsettled. Alternatively, she can accept her anxiety and re-enter the world, resolutely identifying and accepting the possibilities offered by her world.

One's anxious gropings in the darkness encounter something that answers to them. Singular chances, singular potentialities of a singular reality that answer to and beckon to one's singular forces. One finds, in the dissolution of the general lines of the public world, unnamed possibilities. (Lingis, 1991, p. 122)

Dasein copes with anxiety through *projection*. "Coping with the available proceeds by pressing into possibilities. Such coping always has a point" (Dreyfus, 1991, p. 186). *Dasein* takes a stand on herself and projects herself into possibilities that make sense within her world. *Dasein*, by virtue of her *thrownness*, is circumspect in her knowledge of the range of possibilities available to her, providing room to maneuver. *Dasein*'s *mood* of anxiety induces her to reflect upon those available possibilities that make sense in her specific situation, resulting in understanding.

A woman becomes pregnant for the first time; self-interpretation allows that she is now defined by the possibility of being a mother. Readiness to cope is facilitated by a *mood* (anxiety) enhanced ability to discover socioculturally accepted possibilities as she projects herself as being a pregnant, soon-to-be mother. Inability to cope would see her remain unsettled and inhibited in her navigation of pregnancy. This might be the case for a woman experiencing an unwanted pregnancy.

Before I move on in my discussion, I must also explore authenticity in *mood*. “*Dasein* can be itself only in the context of its thrownness” (Braman, 2008, p. 14). *Mood* grounds the experience of authenticity. Ontologically, *mood* makes visible our world as we are thrown into it, enabling our reaction to it (Broome & Carel, 2009; Ratcliffe, 2013). As we are always in relation with the world, *mood* allows us to attend to the ontic – the world of factual and lived relations (Conroy & Dobson, 2005, p. 978). In instances, such as pregnancy, where our mode of existence changes from a *ready-to-hand* or taken-for-granted stance, to one that is *unready-to-hand* or unfamiliar, *mood* illuminates (attunes us to) things that must be attended to in our changed world. How we attend to them is related to authenticity. As pregnant women develop relationships with their unborn babies, they adopt a *present-at-hand*, or objective stance and begin to attend to the available choices for infant feeding.

Heidegger and Rubin – A Small Degree of Separation

Reflecting upon Heidegger’s work leads me to draw parallels to Rubin’s seminal work of the maternal tasks of pregnancy and maternal role attainment (1967a, 1967b, 1975, 1984). Becoming a mother is a transitional process common to most women experiencing pregnancy and childbirth. Rubin wrote, “from onset to its destination, childbearing requires an exchange of a known self in a known world for an unknown self in an unknown world” (1984, p. 52). Grounding her work in psychology, Rubin described the cognitive work most women engage in as they move through pregnancy and postpartum.

Women often describe feeling worried about the childbearing process (Lothian, 2008). They describe feelings of concern about the growing fetus, fear about the labor

and delivery process, and apprehension about their ability to be a good mother to this baby (Nelson, 2003). Such descriptions can be equated to feelings of anxiety. If anxiety experienced by childbearing women can be understood as an ontological *mood* as per Heidegger's writing, it is reasonable to understand the maternal tasks of pregnancy and processes of postpartum maternal role attainment as a way of coping with this anxiety.

Women manage anxiety as they engage in *seeking safe passage* for both themselves and their unborn babies. Enduring lifestyle change (e.g., nutrition changes, smoking cessation, etc.) and seeking professional pregnancy care are actions taken to mitigate concern for pregnancy outcomes. Anxiety is managed as women seek to *gain acceptance of the child* by significant others. Anxiety about the pregnancy might delay *binding-in* as a result of prenatal test results, ultrasounds, and/or previous losses.

Activities that enable to the seeking of safe passage for baby can help to lessen this anxiety. The postpartum stages of *taking-in* might incorporate anxiety borne of the fatigue and physical discomfort common post-birth. Anxiety is common for mothers as they move to *taking-hold* and begin to focus upon their baby, and realization of the responsibility inherent in becoming a mother. (Ament, 1990; Lothian, 2008; Martell, 2001; Mercer, 2004; Nelson, 2003; Rogan, Schmied, Barclay, Everitt & Wyllie, 1997; Rubin, 1975, 1984; Solchaney, 2001).

Heidegger writes of fundamental moods (of which the mood of anxiety is one) from which other moods might flow (Staehler, 2007). Past nursing research, personal, and professional experiences reinforce my notion that the decision to breastfeed is often a source of anxiety for many women. Influenced by the writing of Heidegger, I believe the resulting themes found in this thesis – embodiment, relational support, and the mood of

commitment - flow from a mood of anxiety about pregnancy, childbirth, and the taking on of the maternal role.

The women participating in this study shared their feeding experiences willingly with me. All that was observed, heard, felt and shared during each conversation (Schuster, 2013) has been interpreted phenomenologically to reveal an experiential tapestry for each woman. Although this interpretation has revealed a distillation of common threads, or themes linking the participant's experiences, each tapestry is woven in a unique fashion, demonstrating the subtleties of difference in each woman's experience of infant feeding. I use the following chapters to discuss these themes in depth, beginning with the theme of embodiment in Chapter 6. In Chapter 7, experiences of the mood of commitment as a theme are recounted. In Chapter 8 I explore the importance of relationships in support of breastfeeding efforts for mothers. In Chapter 9, I end this thesis with discussion of the interrelatedness of the preceding themes and offer some final words about this research project.

CHAPTER 6

Breastfeeding: An Embodied Process

The actual practice of breastfeeding forced me to recognize the embodied dimension of this maternal practice. I do not regret breastfeeding; in fact, I think my relationships to my son and to my own body were deeply shaped by the practice of breastfeeding. It was more labour-intensive and it was more child-centered. It showed me a form of motherhood and personhood that was not autonomous or atomistic but one that was interdependent and that had a profound impact on my body. (McCaughey, 2010, p. 96)

Phenomenological Embodiment

Heidegger writes that *Dasein* is an embodied being. “All the being-as-it-is which this entity possesses is primarily being. So when we designate this entity with the term *Dasein*, we are expressing not its ‘what’ (as if it were a table, house, or tree) but its ‘being’” (Heidegger, 1927/1962, p. 67). Heidegger did not imbue *Dasein* with a corporeal body. Aho suggests that, “For Heidegger, *Dasein* is not to be understood in terms of everyday human existence or embodied agency but...as an unfolding historical horizon or space of meaning that is already ‘there’ prior to the emergence of the human body and its various capacities” (2009, p. 3). As a result of her *thrownness*, *Dasein* interprets her own existence within a meaningful web of relations realized by socialization into a shared socio-historical context revealed within and by our *mood*. Meaning is a function of temporality. “As embodied agents, we already ‘stretch along’ forward and backward in a disclosive temporal horizon” (Aho, 2009, p. 27). Roles, relationships and equipment (or tools) are made meaningful as reflected within *Dasein*’s situatedness in her world (Aho, 2009, 2013).

But what happens to the corporeal body in the process of embodiment? Contrary to the Cartesian duality of body and soul as separate entities, embodiment is the ability to

achieve meaning by living and experiencing our world in and through our bodies (Goldberg, 2002; Wilde, 1999). The bodily nature of *Dasein* is not to be understood as something *present-at-hand* (a mere thing or object, without context and incapable of significant action) or *ready-to-hand* (an item of equipment, or tool, that is taken-for-granted, and used non-reflectively). Instead, the bodily nature of *Dasein* is one of capacity, able to engage in meaningful action through comportment within her situated world (Cerbone, 2000; Dreyfus, 1991; Heidegger, 1927/1962; Marshall, 1996). It is a lived-body, “stretching beyond its own skin, actively directed and interwoven with the world” (Aho, 2009, p. 37). The lived-body is limited by encountering a horizon constituted by perception (Heidegger, 1927/1962; Merleau-Ponty, 1962). “...the here of *Dasein*’s current factual situation never signifies a position in space, but signifies rather the leeway of the range of that equipmental whole with which it is most closely concerned...” (Heidegger, 1927/1962, p. 420). Heidegger writes that *Dasein* ‘stands outside’ of herself, not as a quantifiable mass of flesh and bone taking up space, but as *being-in-the-world* through interpretive encounters within her world. Concrete involvement in this world provides spatial orientation; as *Dasein* becomes familiar with her lived-space, she ‘knows’ her way around (Aho, 2009). Intelligibility, or meaning emerges pre-reflectively due to situated embodiment.

Well known for his philosophy of perception, Merleau-Ponty (1962) wrote of tacit body knowledge as ‘*etre-au-monde*’ – *being-towards-the-world*. For him, the body was inseparable from the world, as the body is central to intelligibility of the world through perception. Heidegger refuted this sentiment in that embodied perception is infused with meaning derived through the *a priori* horizon of temporality, and so before the bodily

nature of *Dasein*. He referred to intentionality of the body as ‘bodying forth’ (Heidegger, 2001). “Bodily intentionality as it is lived is our ability to apprehend and take up meaning at a perceptual-motor level” (Maclaren, 2009, p. 29). The subjective experience of an object (person, tool, task) occurs without pre-reflective thought as a result of our *situatedness*. Without thinking, I remove a pair of socks from my sock drawer and put them on. The donning of socks is a *ready-to-hand* activity, an activity taken-for-granted in its everydayness. A perception of roughness and extreme roominess elicited through my feet indicate something is wrong. I look at the socks (objectively, as they are now *present-at-hand*), realizing I have mistakenly put on my husband’s socks. In this way, my own embodied knowledge allows me to know I have made an error, prompting a need for correction.

Breastfeeding is an embodied process that is learned over time. Although breastmilk production usually occurs as a result of the ‘normal’ physiological process of pregnancy and childbirth, breastfeeding is most often a learned activity influenced by lived experience (Bartlett, 2002). The physicality of breastfeeding contributes much to this learning process, but the embodiment of breastfeeding encompasses much more. “An embodied perspective on breastfeeding centers the [understanding] on the doing of breastfeeding: how mothers go about and think about breastfeeding within the immediate social context and structural constraints of their lives” (Stearns, 2013, p. 361).

Lucky are women who enjoy the physicality of breastfeeding, while experiencing increased feelings of self-confidence in the maternal role resulting from the successful bodily and relational nourishment of their baby (Schmied & Barclay, 1999). Unfortunately, perceived societal expectation and pressure to engage in breastfeeding can

result in an atmosphere of embodied tension as women persist in a feeding method they do not enjoy in an effort to be seen as ‘good mothers’ providing socio-culturally approved sustenance (Dykes, 2005; Knaak, 2010; Nelson, 2012). These women provided many examples of embodiment while sharing their stories, spinning one of the threads to be woven into this tapestry of breastfeeding experience.

Heidegger and Technology

A filament included within the thread of embodiment is that of technology. Existence as an embodied being is strongly influenced by the technological advancements of the modern age. Heidegger expressed concern with society’s growing reliance upon technology in the everyday experience. In his study of *Be-ing*, Heidegger contemplated the essence of modern technology and its impact upon human beings (1977). Heidegger equated technology in past history as a means to an end, a *bringing-forth*, in that which was previously concealed is now revealed; for example a silversmith creates and reveals a chalice previously hidden within raw metal. He wrote that modern technology was to be understood as a form of truth in its quality of revealing, as it is not a means to an end (as in past times) but a way of disclosing (Burch, 1986; Heidegger, 1977). Modern technology, as a human activity, “strives to order, confine, control, and then to ‘challenge’ nature to produce” (Klawiter, 1990, p. 71). The potential within nature is regulated and secured in the form of *standing-reserve* (as something to be manipulated or controlled), a process referred to as *enframing* (contained by humans solely to serve the instrumental needs of humans) (Carnevale, 2005; Heidegger, 1977; Thomson, 2011). In this way, a stand of pristine forest is revealed as a load of logs, destined for a sawmill. “The *standing-reserve* is grounded in an inclusive rubric that

orders everything into a storehouse of potential use wherein nothing has autonomous status or individual meaning” (Klawiter, 1990, p. 72). That which is deemed *standing-reserve* experiences objectlessness, achieving significance only as property of the subject (Waddington, 2005). The landowner who visualizes his forest as logs demonstrates this concept.

What happens to the essence of *Be-ing* in the face of technological advancement? “Modern technology too is a means to an end. That is why the instrumental conception of technology conditions every attempt to bring man into the right relation to technology. Everything depends on our manipulating technology in the proper manner as a means” (Heidegger, 1977, p. 5). As *beings* come to understand their world in and through that which is revealed by technology, other ways of understanding are concealed. By seeing only logs to be harvested, the landowner fails to realize the above-mentioned forest as a home for wildlife, a barrier to natural disaster such as flooding and landslides, or as a place of peace and tranquility for those choosing to spend time amongst the trees. As technology is increasingly embraced (for making life measurable, easier, faster), *Beings* are re-presented through the process of enframing as *present-at-hand* objects, demonstrating nihilism as they concern themselves with the presentation of facts and concepts, without thought for the history, value or usefulness of *Others* (Aho, 2009; Burch, 1986; Heidegger, 1977; Thomson, 2011).

Meaning and self-interpretation are discerned in and through *being-in-the-world*. *Dasein*'s relational capacity is threatened by her *thrownness* into a world that embraces technology as, heavily influenced by Others, *Dasein* takes on the modern assumptions, prejudices and social fads of her shared world (Aho, 2009). As a result, *Dasein* as *being-*

in-the-world becomes relationally impoverished. Dasein, as an embodied being, is threatened as technology is increasingly understood as the sole truth.

Heidegger's concern with technology was "the human distress caused by the technological understanding of being" (Dreyfus, 2006, p. 360). He believed that such a condition could be balanced with thought influenced by the ontological state that is *being-in-the-world* as relational beings. Heidegger believed that maintaining openness to all ways of understanding would allow technology to be useful without enslaving ourselves to it (Dreyfus, 2006). "Technology does not need to be overcome or abandoned altogether in order to dwell in embodied thankfulness" (Aho, 2009, p. 150).

Technology and the birth experience. Today, the hospital birth experience employs an increasing amount of technology. The use of fetal heart monitors, ultrasound, and pharmacotherapy as commonplace has changed how birth is allowed to occur. Birth is planned, scheduled and directed through the use of technology. Relational support is often diminished as caregivers focus care upon instrumental knowledge, ignoring the embodied knowledge of the birthing woman (Davis-Floyd, Barclay, Daviss & Tritten, 2009). Women, relegated to *standing reserve* in the birthing process, are denied the opportunity to build trust in the capacity of their own bodies (Thomson, 2011). Sadly, the sacredness inherent in birth is potentially lost when the focus becomes 'getting the baby out' in a timely fashion (Crowther, Smythe & Spence, 2014).

A Breastfeeding Prelude

Conversations with all women began with a sharing of their recent birthing experience as a natural starting point to their breastfeeding story. The birth-day of their child(ren) is one that remains unforgettable for many women, as they transition from

‘pregnant woman’ to ‘mother-with-child’. Researchers have provided much evidence that the events surrounding birth can have an impact upon the breastfeeding experience for a woman (Barclay et al., 2012; Burns et al., 2010; Earle, 2000). Recognizing the focus of this thesis is not the experience of birth, I employ twofold reasoning for the inclusion of these stories. First, participating in the birth process can provide personal insight into a body’s capabilities. When trust in the birthing body is rewarded, the feelings of self-confidence that often result can buoy the breastfeeding experiences of the early postpartum, especially if mother and baby are asynchronous in their beginning breastfeeding efforts. All five women followed through with their prenatal intention to breastfeed their babies. Their experiences of this activity were unique, possibly influenced in some way by their birthing experiences.

Second, I highlight these stories to make visible the impact of birthing technology. Reliance upon technology to inform caregivers about the progress of labour and birth can reduce a woman’s opportunity for learning about her own bodily capacity. Trust in bodily capacity can be diminished when the maternal body is deemed unable to birth in the expected physiologic manner (Thomson, 2011). This lack of trust can, in turn, have an impact upon the breastfeeding process.

Just focus – you can do it. Both Piper and Nicole experienced non-medicated, vaginal deliveries. Piper and her husband had prepared a detailed birth plan (common practice in North America) for delivery with the input and support of a doula. Piper was committed to the notion of a non-medicated ‘natural’ birth experience. From the onset of her labour, Piper’s determination was bolstered through support of her husband, her sister, her doula, the attending nurse and obstetrician. Piper’s trust in her body to achieve

birth stumbled as she endured a perceived slow progress during the labour process. However, her trust was bolstered by the meaningful supportive words of her doula as Piper discovered her own well of inner strength to withstand the furor of labour, listen to her body, and achieve her goals for this birth experience.

So I was just like, "What? All that pain and all that effort just for 1 cm!" But my doula was really good and reminding me to not be caught up with the numbers. ...And if she hadn't told me that, I probably would have, like, gone crazy already. But then I was just, like, okay, don't get caught up with the numbers. It won't mean anything. Just focus. (Piper)

Nicole, having experienced a caesarean section delivery with her first child, was firm in her resolve to do everything in her power to achieve a vaginal delivery with this pregnancy. To provide the support she desired, she engaged a doula with experience in VBAC (vaginal birth after caesarean) deliveries. Embarking upon this labour experience with firm commitment to the process, and a trust in the incredible capacity of her body to birth this baby vaginally, she focused upon the support offered by her doula.

I had the support of the doula, which I think was really helpful. Just having her say, you know, like you're doing so well, you're working with your body, like, it's just words of encouragement really. But for me that helped, you know, keep me going and keep me kind of set on my resolve. But that was the other part, is I had resolved kind of going into it. It wasn't like, oh, I'll see what happens. I mean it was to the extent of you don't know what's going to happen. So if something had happened that obviously I had to have a section, I couldn't plan for obviously... You don't know. But assuming everything was okay, then my intention was

definitely to do it without. And I had really made that decision. And I think, you know, that was the only way that was going to happen. (Nicole)

Recounting their experiences made visible both Piper and Nicole's strength of intent in their resolve to deliver their babies in the manner they desired. The trusting relationship each woman enjoyed with their respective doula resulted in enhanced self-trust of the capacity for their own birthing bodies to deliver their babies, as highlighted by Nicole, "But that's all right, [my baby] came when she was ready." Attuned to the rigours of labour endured within this embodied process, they realized support in the physical presence and spoken words of their doulas. In turn, both women achieved meaning and pride in their bodily ability to deliver their babies with minimal medical intervention. This embodied trust was extended to their postpartum experience, contributing to a mood of commitment to their breastfeeding journey, as will be explored in Chapter 7.

For the sake of the baby. Suzanne and Tasha endured protracted and troublesome labour experiences, resulting in operative deliveries via caesarean section. Suzanne shared her story.

[I was dilated] 8 cm. I just got an epidural...and then [labour] just stopped....they gave me Pitocin to dilate my cervix. And then they were giving me more epidural and Pitocin; it was like the cycle. For hours, I didn't progress at all. [The baby] didn't move any further down, and the more Pitocin they were giving me, the more I guess her heart rate was dropping. So she was getting distressed. So they like would up my Pitocin and then her heart rate would just plummet. And so they would flush [the pitocin] out and then they'd do it again, and they'd slowly

increase the Pitocin. So they did that twice. And then they were going to try the third time and they were, like, well, if it doesn't work, we're going to have to go C-section. And so I was just like, well, let's just do it now. Like, why take the risk? So, I had a section. And then I haemorrhaged...after [the baby] came out, the placenta caused me to haemorrhage, I guess. (Suzanne)

A mood of anxiety gave way to one of fear as concern for the outcome for her baby mounted. Suzanne was able to voice this concern, and call a halt to the repeated interventions being performed. The fear she was experiencing illuminated what was important for her at that time – the safe delivery of her baby. Her lack of expressed fear regarding major surgery as the mode of delivery speaks to her seeming acceptance of medicalized birth. Thrown into a world where surgical delivery was the experience of many of her friends, her own embodied experiences of labour reinforced a notion that she too required medical assistance to birth this baby as concern for her baby's welfare overtook concern for self.

Although joyful about the safe birth of her baby at the time of our conversation, she described her immediate experience post-delivery as one of surrealism. The embodied sensations of the caesarean section were compounded by those of the sequelae of postpartum haemorrhage, and the effects of multiple medications used to ensure her own physical stability post-delivery. As a result, initial encounters of her baby, and initial breastfeeding efforts were hazy.

It's kind of a blur though because I had so many drugs in me. It was not a very good experience....I was just so tired and everything was so surreal. And I remember just shaking, but thinking like I'm not cold but I was shaking as if I was

cold. I remember thinking I just can't wait to sober up and just be 'normal' again.
(Suzanne)

Tasha experienced similarities to Suzanne's birth experience as the number of required medical interventions increased during her labour.

[It was] really scary. I wanted to try to do it as naturally as possible and I ended up needing a C-section. So it was like the total opposite of what I had envisioned. But I was glad that I told myself not to really have a set plan, to just be flexible, because it was easier to accept it. But it was scary just because in labour, the baby's heartbeat was a concern. And so my family doctor called the obstetrician and they had to test the baby's pH to make sure she was okay. And they didn't like the reading. So [I] got a C-section right away. And it just all of a sudden was this situation. You know, like a scary situation. But everything ended up being fine. She was fine. (Tasha)

Attuned to the birth process, Tasha was enveloped in a mood of anxiety as she endured her labour. Her plan to 'just be flexible' whatever transpired indicated that she too was situated within a world where the medicalization of birth is normalized. Tasha denied her own embodied knowledge as she allowed others (physician, nurse, and husband) to decide the course of action during her labour experience. As her labour progressed, her anxiety also gave way to fear about the safety of her baby. This overwhelming mood of fear highlighted the importance of quick delivery to keep her baby safe, and so Tasha unreservedly consented to a caesarean section. Upon safe delivery of her baby, her fear dissipated, giving way to a mood of joy at the outcome.

Alex's uneventful labour that seemed to promise a 'normal' vaginal delivery, still ended with a surprise operative delivery via caesarean section. She states, "So when the duty doc came to break my water, [the doctor] came out with meconium, and found out [my baby] was breech. So nobody knew....so at 9 ½ cm, the whole team was rushing in. And they were really calm though. They were fantastic." Alex's seeming calm acceptance of her birth experience alludes to her assent of medicalised birth. Even though her labour progressed well, her birthing body was judged by others to be unable to complete the process of birth on its own and so medical technology was used to aid the effort of parturition. Alex's *situatedness* in a world where birth is a medical event often requiring intervention was realized as Alex praised the medical personnel for their role in this process.

Take-away messages. What happens to the embodied knowledge acquired through birth experiences that rely heavily upon technological assistance? Alex did not share thoughts of future birth plans during our conversation. Suzanne and Tasha were more forthcoming. Embodied knowledge acquired by both of these women speaks again to the growing normalization of medicalized birth for women. Somehow, trust in their own bodily capacity to birth was diminished for both women, as illustrated in these following statements.

People ask are you going to have a second one?...Like, I know that a vaginal birth is better. I understand that there's benefits to that. But the thought that I can opt for a scheduled C-section! And I have friends that have done that too, and, you know, they told me how easy it is. You have an appointment Wednesday at 8:00 am and you casually go in at your own leisure, and you just...And it's very

routine and very...so I think that, the thought that if I chose to do that, that will be very easy. (Suzanne)

Tasha echoed this notion as she shared her thoughts about her own future labor and delivery experiences.

If we have another one, maybe I would...maybe it [a vaginal delivery] would be quicker even. But now that I've had a C-section, I'm like I don't... If I have another one, I want another C-section because because now I know what that is. Do you know what I mean? Like it's not unknown. (Tasha)

Dwelling in a world that embraces technology, Alex, Suzanne and Tasha were grateful for the happy outcome inherent in the delivery of healthy babies. All were accepting of the technology used in their birth experiences. All appropriated a level of understanding of their own bodily capacity during these birth experiences. It remains to be seen what will transpire in the event of future pregnancies.

Piper and Nicole experienced heightened embodied trust and self-confidence through their birthing experiences, possibly setting the stage for successful breastfeeding experiences. Although Nicole was enjoying her breastfeeding experience, I wondered if this was due to her previous breastfeeding experiences, or the manner of this birth experience (she did allude to the notion that both of these facts contributed to her current state of happiness). As I reflected upon the birth experiences of Alex, Suzanne and Tasha, I pondered the effect of surgical deliveries on breastfeeding experiences for these women. Would their experiences detract from an existing embodied trust, resulting in negative repercussions for their breastfeeding experiences? All women had declared a prenatal intention to breastfeed; all women were breastfeeding at the time of our

conversations. As breastfeeding was a new experience for Piper, Alex, Suzanne and Tasha, I am unable to draw meaningful conclusions about the effect of birth experience upon their ensuing breastfeeding exploits.

Breastfeeding as an Embodied Activity

Given the myriad of possibilities of experiences of breasts for women within their life journeys, the breastfeeding process may be viewed as an *unready-to-hand*, or unfamiliar activity by women with little or no exposure to breastfeeding, or with past personal negative breastfeeding and/or breastfed experiences. For a woman with no past exposure to breastfeeding, childbirth provides experience of her breasts in a new and unfamiliar state – that of the lactating breast, rendering breastfeeding as an *unready-to-hand* activity until physical dexterity of the process is achieved. Mothers soon learn that both they and their babies must learn how to breastfeed, as breastfeeding is not a ‘naturally’ occurring activity for mother or baby (McCaughey, 2010; Oosterhoff, Hutter & Haisma, 2014). Untoward events such as fatigue, pain from sore nipples and engorgement, prolonged reliance upon others, such as lactation consultants for the management of breastfeeding, or repeated use of technology, such as breast pumps, nipple shields, and pharmacotherapy can extend this *unready-to-hand* mode of engagement. Embodied knowledge in the breastfeeding process is denied as trust in the capacity of the body lessens when breastfeeding remains problematic (trust issues with body) (Grassley & Nelms, 2008; McBride-Henry, White & Benn, 2009).

As a woman gains confidence in her breastfeeding abilities, she moves to a *ready-to-hand* mode of engagement, adopting an air of *taken-for-grantedness* as she feeds her baby. Past experience (personal or situational) may have already endowed her with an

embodied knowledge of breastfeeding, hastening her move to this mode of engagement.

A woman may adopt a *present-at-hand* mode of engagement with breastfeeding as she becomes more secure in her embodied knowledge of the total process of lactation.

Breasts, as the equipment of breastfeeding, become transparent as breastfeeding is now viewed ontologically. Breastfeeding breasts are seen as a source of comfort, and a source of nutrition enabling growth and development, resulting in opportunity for relationship development with the baby (McBride et al., 2009).

Breasts as objects. The primary physiological function of a woman's breasts is to provide nutrition for babies. Secondary to this, "for many women, if not all, breasts are an important component of body self-image; a woman may love them or dislike them, but she is rarely neutral" (Young, 2005, p. 76). The experience of breasts is influenced by a woman's *situatedness* in her world. This was demonstrated in the observations offered by Suzanne, Nicole and Piper about their breasts, and how they now viewed them in a new way. Smiling, Suzanne expressed quizzical consternation as she stated, "Just the fact... The act of doing it and the fact that my body is making milk like a cow, you know. And it's coming out of my nipples...it's just kind of bizarre." Although happy to be able to provide the nourishment and closeness her baby required, she now regarded her breasts as objects to be tolerated until her baby was weaned.

Nicole referred to the ease of breastfeeding in this manner, "Like I just have to whip it out. It's so much easier." Piper also referred to her breasts in an offhand manner, "So my husband would hold her until I get my boobs out and then he would help us latch as well." I highlight these quotes as these women indicate a sense of detachment from, or

objectification of their breasts, in their breastfeeding experience. Their breasts were now simply shared objects or tools used to provide nourishment to their infants.

The following quote makes visible one woman's (not a study participant) experience of her own breasts over time, demonstrating the *forestructure of knowledge* that influenced her thinking and emotional lability about her breasts – breasts are beautiful, breasts are sexy, breasts attract a partner, breasts provide nutrition, breasts are uncomfortable, breasts unveil a woman's bovinely qualities, breasts are ugly – all thoughts relating to self-image, and potentially, self-confidence.

Before becoming pregnant, I had a pair of beautiful C-cups that leaned over a bar nicely and, I'm certain, played a part in attracting my daughter's father. When I became pregnant they turned into voluptuous D-cups. Man, did I love those hormone-enraged breasts! I had never felt sexier or more beautiful than when I had those things on me. When my milk came in 20 hours after the birth of my daughter, they became udders. The milk-filled veins throbbed across my breasts just the same as when the cows came down from the fields to our barn ready to be milked, their engorged bags squirting the aisle full of milk all the way to their stanchions. I was a cow, and that made me feel ugly. (Lynn, 2013, p.56)

Well, this is different. Piper, Alex, Suzanne and Tasha were breastfeeding for the first time. Prenatal preparatory efforts, including prenatal classes, selected reading, internet resources, and/or advice sought from health care professionals, family, and friends, did not fully equip them for the reality of breastfeeding their babies. All four experienced discomfort in the first few days after delivery due to latch issues. Alex stated, “[My baby] definitely destroyed my nipples quickly, and they were very raw and

very rough right from the start.” Using different descriptors, Suzanne echoed this experience as she shared, “And then my nipples started getting really chafed sometime within 24 hours after [delivery]....She was probably feeding every hour or two....Yeah, and then my nipples got really chafed.” Tasha expressed her discomfort in this way, “I just kept working on her latch...it was really painful at first. Like your nipples get all sore and dry.” Although somewhat prepared for this, the longer the discomfort persisted, the more strained the sense of commitment to breastfeeding became.

As nipple discomfort stemmed from latch issues for all women, the breastfeeding process remained *unready-to-hand* until embodied knowledge of latching technique could render it *ready-to-hand* with a lessening of experienced pain. The women focussed upon physically positioning their babies for optimum latch comfort when breastfeeding. Sensory knowledge was gained by observing the breast and nipple for tactile and visual cues; the women learned what constituted a ‘good’ latch. Issues regarding sore nipples were resolved by the end of two weeks for all women except Alex.

Nicole, free from the experience of sore nipples while feeding this baby, instead experienced engorgement, similar to her previous experience of breastfeeding. Interestingly, none of the other women experienced engorgement.

I don't know if it was quite a week, maybe a little bit less than a week, but when my milk first came in, as it does, my boobs were ginormous. Ginormous! And they're not small to start with....But I feel like they were almost bigger longer this time. I don't know why or if that's just my perception of it. (Nicole)

Although prepared for this occurrence, this experience was still different from that of her past breastfeeding journey as she also experienced an overproduction of breast

milk. Nicole states, “It did make it a little bit hard for her to eat too because when she'd start, it would just come out. And you could tell she was like choking because there's too much coming out.” Having read that use of a breast pump might remedy the overabundance of milk, Nicole decided to allow her own body to regulate her milk supply. “And I did debate on, like, should I pump, should I...But I didn't want to pump yet because I was like I would rather just have it regulate properly. Because if I pump, all that's going to do is produce more. So that's probably not the best thing to do.”

Embodied trust in her own bodily abilities was rewarded as milk production levelled and she could once again enjoy the breastfeeding experience as a *ready-to-hand* activity.

Piper experienced a similar scenario, “I would see that she would be feeding and then like the milk would pool around her...Like she would be swallowing but then there will still be milk pooling around her mouth...because sometimes she would choke [made choking sound], she would do that.” Piper did not own a breast pump during this period, so did not indulge in mechanical relief, a suggestion offered by healthcare professionals and information obtained through media resources. Although still experiencing an ‘overactive letdown’ whereby milk is ejected from the breast faster than the baby can swallow it at the time of our first conversation, she was coping without using a breast pump. By our second conversation this issue was resolved.

Tasha spoke of the messiness inherent in the bodily sensations of breastfeeding. She stated, “I just got a shower and I step out and there's milk dripping on me. Like that's why I just got a shower – to feel clean again. But then you get kind of used to breast pads and whatever else you need. Everything eventually becomes fine, you know.” Over time, such leakage became part of her situated everydayness, a *ready-to-hand* experience that

the use of breast pads solved. Humour could be found in such leaky incidents, as Nicole laughingly expressed, “So I'm leaking more, and like, just squirting more. Like sometimes...if [the baby] comes off, it's like I'm squirting. I'm spraying her all over the face.” Nicole accepted such instances as the natural outcome of breastfeeding.

At the time of conversations with Piper, Suzanne, Tasha and Nicole, their engagement in breastfeeding activity was realized as *ready-to-hand*. Suzanne corroborated this as she stated, “Yeah, it's like second nature now. You know, I've definitely got the hang of it. And so has [my baby].” This was not the case for Alex.

So I have [sic] infections through both my breasts, and I'm in huge amounts of pain all the time. So although [my baby] continues to do really, really well, I'm on a lot of medications and not getting any better for about four weeks now...they prescribed me the Newman's all-purpose cream. And so I've been using that ever since, and have healed immensely in my nipples. But now I have this shooting pain all through my breasts at all times. And that's the [infection]. (Alex)

Alex was mired in an *unready-to-hand* mode of engagement. Her extreme physical discomfort strongly influenced her regard of her breasts as objects that required professional management by her physician. Although rational knowledge of breastfeeding continued to support her commitment to breastfeeding, her embodied knowledge of pain with breastfeeding was subtly influencing her to contemplate alternative feeding methods.

The sensory experiences of all of these women were often unexpected as they entered the breastfeeding relationship with their baby. They were unprepared for the discomfort of sore nipples, seemingly unstoppable leaking from breasts, the increase in

size of breasts, and the need to learn the techniques required for successful breastfeeding. Although touted as a natural activity, breastfeeding did not feel natural for Piper, Alex, Suzanne and Tasha in the early days of their experience. Over time, with the exception of Alex, the knowledge gained through this embodied activity enhanced their confidence in their breastfeeding abilities to become an activity that did feel very natural.

This is MY baby. Women initiate relationships with their unborn infant through the embodiment of the pregnancy – feelings and sensations of the unborn baby are imbued with intention and personality. As the mother comes to know her unborn baby, the relationship deepens (Wynn, 2002). A new phase of this relationship is begun with delivery of the baby, as mothers use all senses to gain knowledge of their babies. Seeing the baby for the first time makes the fantasy baby real (Rubin, 1984). Olfactory sensations are new as the mother begins to know her baby by how she smells. Touch relays notions of skin texture, bodily contours, and reflexes. Auditory information allows the mother to know her baby’s noises. Reciprocity is realized as the baby learns and recognizes her mother’s smell, voice, and touch. This relationship continues to grow in and through embodied activities, such as breastfeeding in the first few weeks after delivery (Rubin, 1984; Wynn, 1997).

All study mothers were able to have skin-to-skin contact with their babies immediately after delivery, a behaviour well supported by researchers (Burke-Aaronson, 2015). Piper stated, “It was part of my birth plan to have her as soon as I could have her on my chest for the breast crawl. So yeah, so she was there. And then she was kind of like looking for [my nipple].” Both Suzanne and Tasha expressed wonder at the innate ability of their baby’s to initiate feeding instinctively. Tasha said, “On my chest, yeah,

and she latched on in the recovery room too. She just...I held her and she just did it. She just knew what to do.” Suzanne described a similar experience, “They put her on my chest. And yeah, you know, I don't know how long it was, not very long before she...I kind of coaxed her a little bit but she found my nipple and she started sucking immediately. So that was good.” Nicole, the only mother with previous breastfeeding experience stated, “And this time it didn't feel hard like [my other baby]. It just felt like, okay, she needs to eat so I'm going to feed her.” This embodied experience facilitated learning for both the mothers and their baby's in and through this process. These mothers began to appreciate the innate abilities of babies to seek out their nipples and begin the suckling process. Trust in their own bodily ability to feed their baby's was initiated at this time.

Alex, too, was able to experience skin-to-skin contact with her baby immediately after birth. Alex shared, “...and they put [my baby] right to the breast at Recovery, and she did well. I mean it hurt but she did well.” Her immediate recollection of pain at this time belies the notion that trust in her breastfeeding abilities was initiated in this moment.

As these mothers came to know their babies more, they grew more confident in their ability to ascribe meaning to baby behaviors. Learning to recognize her baby's cues indicating a need to eat was very meaningful for Tasha. Tasha embraced the improved ease of breastfeeding effort she experienced with her newfound knowledge.

I can tell now when she's getting...before she has to squawk for it, then I pick her up and feed her. Then she doesn't get to that level. I think she can fall asleep easier because she's not all freaked out. Because if she does get upset then it's harder to get her...she'll get distracted. So it's right in front of her but she just can't latch and

she's sticking her hand in her mouth instead. And you're trying to pull her hand away, that kind of stuff. So if you can get her before she's really upset then she's just a breeze. And now, she latches on easily when she wants to eat. She eats until she's full. She just... I don't know, it just seems to be going so smoothly. (Tasha)

These mothers came to recognize the calming effects of breastfeeding not attributable to nutritional needs. Suzanne said, “Well, she could be fussy, and it could make her calm down.” Piper elaborated on this notion. The embodied experience of breastfeeding influenced Piper to allow her baby to use her breasts for non-nutritive sucking. However her self-confidence (and bodily trust) around this behaviour was less than optimal, so she relied on ‘expert’ advice and knowledge obtained through media resources to justify her behaviour long after the birth of her baby.

And she does comfort sucking too. Which I've read that it's not bad at all. Because like especially in the first 0 to 6 months anyway, you're not going to spoil them because they don't... Well, that's what the book said too. They don't have wants; they just have needs. So if she needs to suck and she wants my boob, well. (Piper)

Piper did express occasional discomfort with her baby's need for comforting, as if the weight of responsibility of being a mother became too much at times, “Although it does feel uncomfortable at some point. Like the days that she's like just too clingy. But yeah, it's all good, I guess.” Piper correlated this sentiment with personal fatigue and periods of infant growth spurts. The positive reciprocity engendered between mother and baby within these burgeoning relationships did much to bolster confidence and trust in embodied knowledge of the breastfeeding process. Over time and as the mothers began to adopt a *ready-to-hand* mode of engagement with breastfeeding, they were able to

realize another level of relationship with their babies. Nicole, breastfeeding a second baby, appreciated the relationship she was developing with her baby as she stated, "...it's a bonding thing, for sure. And I think you feel close to your baby because you do that. Yeah, I really like it." It was only during our second conversations that Piper and Suzanne addressed the realization of the importance of the emotional relationship facilitated in and through breastfeeding their babies. Piper said, "I guess it's more what I'm finding is if you're a breastfeeding mom, like there is that connection between you and the baby." Suzanne reiterated this feeling with, "It's like... Well, obviously we're bonding when I'm breastfeeding her."

Unfortunately, this was not the case for Alex. Pain was a central tenet of her breastfeeding experience. Painful feeding sessions were a constant for Alex, beginning with her baby's very first feeding efforts. Alex spoke of the sucking strength of her baby as it related to her current physical breastfeeding discomfort.

And she was a gulper and just really going at it, and continues to be... Oh, this girl, I'm telling you, she has quite the suck. [speaking to her baby] You are, you're quite the little sucker. You are.... But I think part of that is because she's a really good sucker. So I feel like some of it is to do with that. (Alex)

During our conversation I was intrigued by Alex's interactions with her baby. Alex's physical issues did not extend to feeling comfortable enough to allow her baby to engage in non-nutritive sucking of her breasts; instead a soother was used for such purposes. When fussy, Alex soothed her baby by offering the soother, or rubbing her limbs and forehead. Alex always placed her baby beside her on the couch; she did not hold her baby unless she was breastfeeding.

Already noted earlier in this chapter, Alex makes reference to her baby's role in their breastfeeding relationship – that the baby had “destroyed my nipples”. Upon further reflection, I am left wondering if this comment might indicate a more deeply rooted feeling of unease about the breastfeeding process that she was unable or unwilling to acknowledge. Experiencing no relief from the constant pain in her breasts, perhaps Alex was feeling betrayed not only by her body, but also by her baby, hence the demonstration of infant care behaviours as described above.

Maintaining an *unready-to-hand* mode of engagement, Alex's breastfeeding experience remained one of duty, forbearance and much ambiguity as she states, “And I kind of think, well, at least I'm able to do this. It might hurt but I'm... You know, she can still drink my milk and she's healthy and happy, and that kind of thing.”

Enabling skin-to-skin contact immediately after birth encourages mothers and babies to initiate the breastfeeding relationship. Current research provides evidence supporting the encouragement of early breastfeeding and skin-to-skin contact as improving rates of sustained breastfeeding exclusivity (Dalbye, Calais & Berg, 2011; Phillips, 2013; Ruxer et al., 2013). With the exception of Alex, the many sensory experiences of breastfeeding contributed to these mothers expanding embodied knowledge base, thereby increasing the level of trust they held in their bodily abilities to provide nourishment and comfort to their babies. With increased confidence in breastfeeding activities, these mothers came to know and recognize their baby's behavioural and emotional cues, signalling infant wants and needs. In this way, the dyadic relationship was strengthened in the reciprocity of the breastfeeding interaction.

As trust in this new knowledge grew, so did the mother's enjoyment and valuing of the overall process.

Why breastfeed? Conversations with these women provided much insight into the meaning of the breastfeeding experience for each of them. Each mother began her breastfeeding journey situated within a socio-cultural background that strongly encouraged this mode of feeding. For many of the reasons already laid out earlier in the literature review, each of these mothers followed through on their prenatal intention to breastfeed their baby. Over time they experienced clarity about what it meant to them to breastfeed their babies.

I like breastfeeding. Suzanne, Tasha and Nicole clearly proclaimed their enjoyment found in breastfeeding their babies. Nicole stated, "But yeah, I enjoy it. I think it's a really nice, for me anyway." Suzanne and Tasha used similar words to describe their experiences. All women spoke of the closeness they felt while breastfeeding their babies, however none elaborated on what closeness meant to them. The knowledge that they were providing a superior nutritional food buoyed their satisfaction with this feeding choice. Alex was the lone dissenter as she revealed in this passage, "I don't mind saying I don't like it. It hurts and it takes a lot of time. It doesn't bother me to say I don't like it." Remaining in an *unready-to-hand* mode of engagement, Alex experienced breastfeeding as a painful but necessary activity.

I AM a good mother. The social construction of the 'good mother' is detailed throughout professional literature (Arendell, 2000; Boyd, 2010; Hausman, 2004; Wall, 2001), some of which has been used in this thesis preparation. These women ruminated on their role as mothers to their baby's as they sought meaning of their breastfeeding

experience. Embedded within a socio-cultural environment that often equates breastfeeding with ‘good’ mothering, their own thought processes were reflective of this background – that they ‘ought’ to breastfeed their babies.

I don't know, I think it just means I'm doing what I'm supposed to do as a mother.

You know, it just feels like that's what everyone's expectation is. And even though I sort of know that if I don't do it, nobody I know is going to judge me for it, I kind of feel like that's the expectation. So yeah, it's just that I'm doing what I'm supposed to do and how I'm supposed to care for [my baby]. (Alex)

Even though each feeding session was physically painful for Alex, she continued to breastfeed in the face of perceived societal influence, equating her efforts as ‘good mothering’. Expressly avowing her dislike for breastfeeding, her dedication to this method of feeding was beginning to waiver at the time of our conversation as a result of her continuous discomfort, as noted in this exchange.

I don't know, I don't think so much about sort of the good stuff I'm giving her because I do... I think that there's a lot of formula fed babies who do just fine as well. So I'm not sure that... I realize the research says one thing but I think that there's pros and cons of both. (Alex)

Unfortunately, no further contact with Alex leaves me without knowledge of her resolution of her breastfeeding issues. Reflection upon our conversation leads me to wonder if I represented a healthcare professional who could not, or would not, provide the support Alex was seeking. I do believe she was seeking permission to end her breastfeeding efforts, but as the researcher, that was not my role.

Although her experience began painfully, Suzanne continued to breastfeed. Feeling the weight of responsibility to provide breast milk for her baby, she explained her motivation to continue breastfeeding in these words.

But like you do it anyway. You continue breastfeeding anyway because you have to feed her. Like it's that motherly instinct. It's like no matter how much this is going to hurt and like bring tears to my eyes, I have to do it.... And I think in my mind too, formula wasn't an option. I eat very healthy myself. I try to eat all organic. I drink organic. I spend twice as much on the organic milk at the grocery store. Like I try to put good... Don't get me wrong, I like to go to McDonalds once in a while. But I try to put as much good stuff in my body as I can. And especially when I was pregnant, even more so. And then so, I don't know, I just... It was all about giving her what was the most healthy. And formula just can't be even close to as good for her. So yeah, it wasn't an option. I was going to be breastfeeding.

(Suzanne)

As noted previously, Suzanne did move to a *ready-at-hand* mode of engagement with breastfeeding as in time she began to appreciate and enjoy the loving relationship she had co-constituted with her baby. The interdependency she enjoyed in her relationship with her baby enhanced her confidence that she was a good mother as she provided nutrition and comfort to her growing child.

Tasha had spent some time thinking about the meaning of the breastfeeding process in relation to her baby and herself. She questioned what makes a 'good mother' as she recounted her thoughts.

I've thought about this a little bit because, like, a good friend of mine couldn't breastfeed. She wasn't producing enough milk. And to say it makes me feel like a good mother, that's like saying she's a bad mother. And, like, I don't really like that, like, good/bad. But it does make me feel good that I can provide that to [my baby]. But I know that that's through no conscious action of my own...So I feel lucky, I guess. But it does make me feel like I'm giving her the best, which makes me feel good. You know, it makes me feel confident of what she's getting...makes me feel more relaxed. So it means, like peace of mind because I know myself and I know if I was having to feed her formula, I'd be wondering, oh my gosh, like, what's this doing to her flora, you know, her digestion, or is there a recall? Like, I just have no worries now. So it does make me feel good. And like a good mom that I'm doing it. (Tasha)

Trust in her innate bodily ability to provide optimal nutrition boosted Tasha's confidence in her mothering abilities. The knowledge that her baby was growing and developing because of her breastfeeding efforts enhanced the growing relationship with her baby, as she, too, moved to a *ready-at-hand* mode of engagement with breastfeeding.

Nicole expressed a similar sentiment as she spoke these words, "And you feel like you're, I don't know, like right now the reason she's, you know, living is because I am giving her milk. Like that's pretty cool that it comes from me." As a mother with previous experience of breastfeeding, Nicole was aware of the potential joy in the relationship that could develop between mother and baby. She did not question her status as a good mother, as she believed she was providing the best care and nutrition for this baby.

All of these women expressed desire to breastfeed their babies. All wanted to be good mothers to their babies – I believe Alex was pushing forward with her breastfeeding efforts to ensure she maintained this status, at great cost to herself. With the exception of Alex, the knowledge and authentic enjoyment realized over time in and through the embodied relationship these mothers held with their babies resulted in pride in the maternal role and increased self-confidence.

Technology and breastfeeding. Women contemplating breastfeeding as their choice for infant feeding very often engage in preparatory information gathering prior to delivery of their baby. Books, web-based resources, and videos are some tools used as sources of information. Women situated within environments where breastfeeding is encountered or socially promoted, may seek knowledge and advice of others (mothers, sisters, friends, healthcare professionals) with practical experience of breastfeeding (McCaughey, 2010; Oosterhoff et al., 2014). Breast milk is usually promoted as the best, most natural food for infants; breastfeeding is encouraged as a natural motherly activity (Stearns, 2013). Procurement of tools thought to be necessary or useful as adjuncts to the breastfeeding process (breast pumps, bottles, formula) may be undertaken as a result of information received or when breastfeeding is not going well (Hausman, 2007).

Upon delivery of the baby, notions of their participation in the gratifying, ‘natural’ breastfeeding process are often erased within the first attempts to breastfeed their baby (Hauck & Irurita, 2003). McCaughey writes, “...these representations of breastfeeding fail to show the complex amount of physical and emotional energy that breastfeeding takes, and the social support women need in order to accomplish it” (2010, p. 84). These

same women are vulnerable to embodied disillusionment as the breastfeeding experience depicted in their prenatal preparatory efforts is not their reality.

Breastfeeding is an embodied, dyadic activity, requiring both mother and baby's full engagement in the process. Breastfeeding takes time. Breastfeeding is work (Stearns, 2009, 2013). Doubt is cast upon a mothers' embodied ability when solutions to breastfeeding issues are offered that interfere with the developing mother-baby breastfeeding relationship. Others (family, friends, and healthcare professionals) might offer formula in the face of perceived nutritional deficits, maternal fatigue, or from a sincere desire to 'help out' and give the mother 'a break'. The breast pump is offered to encourage breast stimulation when the mother's milk supply and/or baby's sucking efforts are deemed inadequate. The breast pump is used to empty overfull breasts, denying the maternal body the opportunity to regulate supply and demand. The breast pump is deemed necessary to obtain breast milk to be fed to the baby by others when the mother is absent, encouraging separation of mother and baby (Hausman, 2007).

Although there are times when technology is necessary to ensure the health and safety of a mother and baby when breastfeeding efforts go awry, too often it is used to create efficiency of the breastfeeding process. Heidegger questioned the notion of technology as a way of understanding the world. Formula, developed as a substitute for breast milk, is measurable and can be fed by others. Breast pumps are used to manage milk supply. Mothers are in danger of being deemed *standing-reserve*, objectified in the face of the use of infant feeding technology. The production of breast milk becomes a disembodied activity, something apart from the embodied, relational practice of

breastfeeding as breast milk production becomes something to be controlled and managed (Hausman, 2007; Stearns, 2013; Thomson, 2011).

Trusting my efforts. Piper was well prepared for her breastfeeding experience. She had read and researched extensively about breastfeeding. Situated within a cultural background that strongly encouraged breastfeeding, Piper resolved to breastfeed her daughter. However, her strong belief in the capacity of her birthing body did not appear to translate easily to an embodied trust of the breastfeeding process. Piper relied extensively upon written and web-based information to support her breastfeeding efforts as she says, “And, like, what the book said, always just trust your milk. Whatever you have there is enough. You don't need anything else for the first 6 months. Trust that your milk is the perfect food that your baby needs. It's the right temperature every time.” In addition, Piper made weekly visits to the public health nurse to have her baby weighed, “I'm going every week. So like what I've said, the nurse was saying you don't need to stress yourself weekly trying to watch her weight because of course as long as she's happy, gaining, not sick, weight is just a number.” Although her baby was achieving the expected growth and development milestones, Piper was unable to adopt a *present-at-hand* mode of existence about her breastfeeding effort, as she was unable to trust that she was providing adequate nourishment to her baby. However, as her baby grew, Piper was beginning to realize and appreciate the value of the relationship she now enjoyed with her baby, observed in her efforts to extend her maternity leave.

Adventures in pumping. Piper, Suzanne, Tasha and Nicole all spoke about breast pumps. Nicole was lackadaisical about her view of pumping as she stated, “Like I haven't pumped yet but I will. You know, just so that someone can feed her now and

then or whatever.” Having already experienced the joy of a breastfeeding relationship with her first child, she was in no hurry to allow someone else to replace her in this capacity with this new baby.

Piper, Suzanne and Tasha were using a pump for specific purposes. Piper’s plan to return to work at three months post-birth was her prime motivation. Although her return to paid employment was deferred, she did begin regular pumping to ensure an adequate supply of frozen breast milk for future needs. She was adamant her baby would ingest breast milk until one year of age, although other foods would be introduced at six months. Family pressure about pumping created inner conflict between her desire to maintain proximity to her baby and wanting to please her family as indicated by her attempt at humorous disassociation with her breast.

My aunt who's like my mom here, every time we visit...they just live down the road, right. So every time she's like, "Oh, every time you need to go somewhere, like you could, of course, leave [the baby] here." And I'm, like, if I could leave my boob too...so she's like, "Well, you better start pumping." And I'm like I know, I know, everyone is...everyone is, I think, encouraging me to start pumping because they want to spend time with her. Which is good. (Piper)

Adamant about her refusal to offer formula to her baby, Suzanne began pumping four weeks post-birth to ensure an on-hand supply in case of emergency. She was also making preparation to return to class at the time of our conversation.

I have pumped milk as well. So I just started that a couple of weeks ago. I have some in the freezer in freezer bags in case, you know, I don't know, anything could happen. I'm going to be going...actually I'm taking some courses in the fall. So

I'm going to have to be away from [the baby] for 3 hours. But just in case that she needs to eat while I'm gone. (Suzanne)

Suzanne demonstrated confidence in her decision to use the pump to ensure a continuous supply of breast milk for her baby on the occasion of her absence. Tasha's experience of pumping was very different.

I had this...thing of...not wanting to start pumping. Like I think [of] losing that control over feeding and worrying if she's going to not take the bottle or if it's going to mess up her latch or anything like that. But I had...I was kind of like pushed into it because I had a wedding that I wanted to go to for 2 hours, and I didn't want to leave her without food. So I had to do it...because it's also very scary to pump. Like the first time that I pumped for her, then I was terrified that she was going to wake up from her nap and be hungry, and I wouldn't have any milk for her. Like it was just really scary to take the milk out and put it somewhere else because I thought what if she's hungry and I have nothing for her? I'd say pumping was scarier than breastfeeding, for sure. (Tasha)

Although a lack of knowledge about the physiologic process of breast milk production contributed to her fear about pumping, Tasha embodies a strong connection to her baby in this passage, as she feared not being able to provide the food her baby required when needed. These four women accepted pumping technology as something that was potentially useful in their breastfeeding efforts.

Battle of the bottle. Nicole was the sole participant who had not contemplated the use of formula for infant feeding, and only considered the use of bottles with expressed breast milk as something for future consideration. Her past breastfeeding experience

provided her the embodied knowledge that she would be able to provide adequate nutrition for her baby in all instances. She enjoyed breastfeeding.

Piper withstood family pressure to feed her baby formula, as she remained firm in her resolve to provide breast milk to her baby. However, she was trying to encourage her baby to take breast milk from other containers, as she prepared to re-enter the workforce. She and her husband collaborated on the choice of container, seeking one with breast-like qualities.

We had to buy the special, like the Dr. Brown glass bottle because that's what my husband wanted. He doesn't want the plastic ones. And we had to change the nipple to the latex one because I think it's softer. It's more, like, nipple-like. So yeah, that's how. But then right now I'm starting to train her to...like, we have a kiddy cup, the Wow cup. (Piper)

Piper experienced difficulties persuading her baby to use a nipple replacement, hence the use of a cup for feeding, as noted here, “She doesn't take a soother...and she doesn't take the bottle. She does but it's not her favourite.” Future planning for a solution to her perceived dilemma was explained in this statement, “The only thing that I would probably change would be pump earlier...so at least I'll be more flexible and then the baby will be more trained to take the bottle.” Piper's engagement with breastfeeding was *ready-to-hand*, however her apparent need for some distance in her breastfeeding relationship, and her husband's encouragement to offer expressed breast milk to their baby seems to indicate her *being-in-the-world* as *standing-reserve*.

Both Suzanne and Tasha were adamant that their babies would not be offered formula. However that did not deter them from offering breast milk in bottles when they

were physically unavailable to feed. Both Suzanne and Tasha recognized that their babies would only accept bottle-feeding by others, such as friends or husbands. Both women also recognized their need to be absent as their babies would not bottle-feed in the presence of their mothers, a strong illustration of the interdependent relationship they enjoyed with their babies. Suzanne explained, “We just stuck with it, and [the baby] fought it. We had to swaddle her and hold her tight....And I would kind of walk away and just let [my husband] do it. Yes, it was very hard. She caved eventually.” Suzanne expressed some pleasure in the fact her husband was able to feed the baby in her absence while she attended class.

Tasha expressed a similar sentiment, “She's not going to take a bottle from mommy, I don't think. She's going to be like, "What are you trying to...No!" However Tasha was very happy to continue breastfeeding due to the ease of delivery, “It's easy because you don't have to heat up formula, you don't have to wonder what you're giving your baby...you don't have to clean bottles.” The added labour of bottle feeding was enough of a deterrent to keep Tasha on her breastfeeding journey, a similar thought held by Alex. As a result of the constant discomfort Alex was experiencing, she did contemplate the provision of formula to her baby. However, her uncertainty about formula created a barrier to acting upon this thought.

I think one of the biggest things that's keeping me going is I don't know what else to do. I wouldn't know where to start with formula to be honest. Like I don't even know what to buy or what to get, what to...how much to feed her. So it's a bit of, okay, I'd have to learn a completely new way of doing things. And I don't know if I

have the energy to do that to be honest. So a lot of it is lack of knowledge. I think the other part is I do think it's easier to be able to have a breastfed baby. (Alex)

These women live in worlds surrounded by easily accessible technology thought to enhance the breastfeeding experience. The *situatedness* of modern day living encourages women to plan, manage and control the breastfeeding experience as much as possible, while availing themselves of technological resources (Avishai, 2007). By more frequently ascribing to technological solutions, women can lose sight of the embodied nature of breastfeeding, remaking themselves as *standing reserve*.

Ending the Relationship

A little discussed fact about the breastfeeding relationship is its end.

Breastfeeding activity ends for many reasons, initiated by both mother and baby. Situated within their socio-cultural environment, women contemplate the end of the relationship. They may be saddened to think of ending this activity as they enjoy the experience of breastfeeding. Some women may be happy to end this phase of childrearing as they have fulfilled the requirement of 'good mothering'. Perhaps the baby will end the experience through self-weaning. Women may feel pressure to end the relationship. A return to paid employment, or personal/familial/social dissonance about breastfeeding older infants and children, create a need to defend their continued engagement with breastfeeding. "A mother who achieves recognition for providing 'liquid gold' through breastfeeding may soon be subject to negative evaluation for breastfeeding 'too long'" (Stearns, 2011, p. 551).

Piper expressed her intention to continue breastfeeding, even in the face of pressure to offer expressed breast milk and/or formula to accommodate familial wishes,

“I want to continue on until she weans herself.” As her relationship with her baby has become more embodied, and she has begun to think about a return to work, she reflects more upon what that might mean to her as she shared, “But when it's like 3 hours that I'm away, when I come back, I'd be like, "Ah, baby!" I don't know when mommy goes back to work.”

Suzanne, enjoying the embodied reality of her breastfeeding relationship, said this, “And I'm already thinking about when she won't be breastfeeding anymore, and how that will be sad.” Nicole was anticipating a negative emotional impact as she thought about the end of her breastfeeding relationship with her baby. Having been able to defer emotional fallout (grieving the loss of the breastfeeding relationship) when her first baby self-weaned as she was pregnant with this baby, she acknowledges that weaning this time might be more difficult as she said, “But I think because I was pregnant, I was like, well, I'm going to be starting again soon anyway. So it's not such a big deal. I guess I get a little break in between. But yeah, I might be a little more traumatized when she stops.”

Alex continuously contemplated ending her breastfeeding relationship with her baby as a result of her painful breast issues. However, she explained why she was continuing – for now – as she shared these words.

This isn't going to go away if I stop breastfeeding. The [issue] is still going to be present. So [my physician] don't know kind of ‘if you stop, how long are you still doing to have these symptoms and all this pain?’ So that's kind of part of it. Like why bother stopping if I'm in this much pain now? It's going to continue. Why not just continue.

These women had reflected at some point upon the end of the breastfeeding relationship and what it would mean to them. Alex contemplated weaning her baby solely for personal comfort purposes; if cessation of breastfeeding equated to the end of her chronic discomfort, she would not hesitate to wean her baby. Piper, Suzanne and Nicole were saddened to contemplate the loss of what was currently a valued embodied relationship with their babies. Breastfeeding had become a *ready-to-hand* activity, resulting in much personal satisfaction in this pleasurable activity as they provided nutrition, love, and comfort to their baby. Their breastfeeding journeys had provided much learning about their bodies, themselves as women, and their babies. Confidence in the knowledge of their own bodily ability enhanced their self-confidence.

In Closing

The women in this study provided many anecdotes about the breastfeeding experiences leading to a sense of embodiment of the process. Interestingly these mothers spoke sparingly of any strong emotional connection realized with their babies resulting from their breastfeeding efforts. As mothers were asked about their experiences of breastfeeding, so the conversations remained focused upon their experiences to date, eliciting feelings about the physical and emotional processes that they had experienced around their breastfeeding activities. For some, but not all, the breastfeeding relationship was enjoyed as an ontologically embodied experience. Breastfeeding technology was a facet in all their lives. Some women incorporated it into their everyday lives, while others chose to distance themselves while remaining aware of its availability.

The embodied experience of breastfeeding is filled with moments of both pain and pleasure, as has been illustrated throughout this chapter. It was unfortunate that for

one woman, the embodiment of breastfeeding was equated with pain. Although pain was experienced in the initial days of breastfeeding, the other women were able to sustain their breastfeeding journeys. In later conversations, Piper and Suzanne provided non-verbal behaviours interpreted as a realization of joy, satisfaction, and self-confidence that resulted in and through the development of embodied relationships with their babies. However, achieving confidence in their abilities was not solely due to embodiment. All women spoke of the need for commitment to the breastfeeding process, and relational support to prop them up on their journeys. I will discuss commitment in Chapter 7, with a discussion of support to follow in Chapter 8. I close this chapter about embodiment with a passage encouraging mindfulness of the power of the embodied experience that is breastfeeding.

I miss it. But I'm not nostalgic, exactly. I'm grateful. I'm grateful that my body could be of such profound usefulness to another. But I'm also grateful for the renewed energy my body has experienced post-lactation. I know my body differently, now. I know that it has astonishing capabilities and strengths, but I also know that it has limitations that are quite beyond my thinking mind. My body continues to remind me, quietly, that it can nourish life in other ways, feed and comfort and protect and honour. For this time, here on earth, my body is lit with spirit. It is a home: and everyone must leave home in one way or another, perhaps many times during the span of a life. (Snyder, 2013, p. 126)

CHAPTER 7

“It Just Seemed Natural” – Breastfeeding and Commitment

When I was pregnant, I always assumed I would breastfeed, never contemplating that it would be challenging or downright difficult sometimes. Breastfeeding seemed like the natural, obvious and logical choice one makes as a mother to start her child off right. (Braff, 2013)

As an experienced practitioner, I held the expectation that if a mother declares an intention to breastfeed before delivery, she would be committed to the process of breastfeeding her infant, as prenatal intention to breastfeed has been demonstrated to be a strong precursor of postnatal commitment (Meedy, Fahy & Kable, 2010; Tully & Ball, 2013). However, on hearing and reflecting upon the words of the mothers in this study, the realization is made that what was not initially understood was the complexity and meaning of such commitment, as experienced by these mothers after the birth of the baby. Use of an interpretive phenomenological lens reveals/allows that their words can enrich and improve [our] understanding of new mothers' relationships with their newborns and the significance of breastfeeding as their infant-feeding choice.

Theoretical Musings about Commitment

In the process known as maternal role attainment (outlined in Chapter 2 of this thesis), all women encounter developmental and psychological tasks as researched and described by Rubin (1984). In and through completion of these tasks – seeking safe passage, binding-in, ensuring acceptance, and learning to give of self - a woman assumes the identity of mother concurrently as she develops a relationship with her baby. Commitment to the baby's welfare, and also to breastfeeding, is borne within and through this process.

Commitment, in this thesis, will be defined as an ontological *mood*, resulting in a *state-of-mind* or *attunement*. Overlaying the embodied, chiasmic relationship that develops between mother and baby during pregnancy (Wynn, 2002) as described in Chapter 6, a *mood* of commitment is realized. As such, the mother's resulting *state-of-mind* as she reflects upon the meaning of her pregnancy and baby-to-be, *attunes* her to significant possibilities not previously encountered in her *ready-to-hand*, or taken-for-granted world. Now residing within a new *present-at-hand* world, she reflects upon what is disclosed, as *mood* illuminates that which now begins to matter. As the baby gains significance, so is significance realized in the choice of infant-feeding. The *mood* of commitment might render significant the choice to breastfeed. If this feeding choice is significant to this mother, as she is situated in her world, she would declare her commitment to breastfeeding her baby.

Enrollment of all mothers was predicated upon the premise that all women expressed a prenatal intention to breastfeed their newborn infants. How does a woman arrive at such a decision? Heidegger explains that historicity “encompasses the ‘context of living,’ extending from birth to death” (Dahlstrom, 2013, p. 97), thereby informing the present and future actions of *Dasein* (in this case, each mother). As this is so, all women's declaration of intention, signaling an early level of commitment, arises from their *facticity* - an *a priori*, *ready-to-hand* world context into which they have been *thrown* (Braman, 2008; Dreyfus, 1991). As such, all participants were *situated* as pregnant women (then newly-delivered mothers) within a *world* not of their own making, engaging in relationships defined within and through taken-for-granted customs and practices. Interpreting their *world* as they knew and understood it, all study mothers

made the decision to breastfeed their babies by incorporating values, beliefs and knowledge that were founded within a world shaped and influenced by meaning derived from the views, opinions, and experiences of self, husbands, family, friends, community, healthcare providers, and/or media resources.

How might the mothers of this study understand or experience commitment? Such a *state-of-mind*, or *attunement* to baby might bring out feelings of obligation, underpinned with emotional and moral nuances. Personal rumination about the maternal experience of commitment brings to mind these thoughts: commitment might be equated to love for the baby. Commitment might be experienced as relational motivation to provide the best care possible for the baby. Commitment might be felt as a moral obligation to place the needs of the baby ahead of all others, including herself. Commitment might not be well understood so is modeled upon shared thoughts and behaviors gleaned from significant relationships of the world inhabited by the mother.

As women thrown into *worlds* not of their own making, they rely upon themselves and the meaningful relationships of their world to mentor and guide them to make decisions about infant feeding. The choice to breastfeed is rendered upon consideration of, and within a world informed by personal, social, and professional experience, information, and opinion. Such a choice can be deemed authentic when, for example, mothers genuinely believe and accept this way of feeding as one that is significant to them. Commitment becomes authentically resolute only as each mother reflects upon the meaning of her breastfeeding experience, recognizing the power of Self in relation with the Other [her baby] (Macmurray, 1961) and assuming the responsibility inherent in this relationship within the context of the world she inhabits (Braman, 2008).

Authenticity of commitment is realized when mothers are true to their own values and beliefs in choosing to breastfeed, or not, even if such choice is unsupported within the world they dwell. Commitment to breastfeed might be deemed inauthentic when choice is made solely upon public influence and is not reflective of the mother's true desires or relational values. Women engaged in breastfeeding in an exclusively unreflective or passive manner experience undifferentiated commitment (Braman, 2008; Conroy & Dobson, 2005; Nelson, 1982). Although this study demonstrated a collective wavering between instances of authentic and inauthentic commitment to breastfeeding, these women still continued on their chosen journeys.

I DO Intend to Breastfeed

Initial encounters with mothers during the enrollment process revealed perceived committed anticipation as they authentically decided prenatally that they would breastfeed their newborn infants, a decision influenced by personal, cultural, familial and/or social understanding. Piper spoke of personal desire and strong cultural heritage giving rise to her decision to breastfeed her infant. Alex and Suzanne articulated feelings of responsibility to provide the best food for their babies. Tasha stated that breastfeeding was the most natural way to feed her baby, as did Nicole. Nicole also expressed her desire to repeat, for this second baby, the success of breastfeeding her firstborn.

As first-time mothers, Piper, Alex, Suzanne and Tasha all anticipated some level of change, adopting a *present-at-hand* stance, or ontological understanding, as they future-gazed to the heretofore unknown experience of breastfeeding their babies while contemplating the vagaries of this feeding activity (Dreyfus, 1991; Johnson, 2000). In contrast, Nicole expressed a level of 'taken-for-grantedness' about breastfeeding as a

second-time mother, indicating her willingness to engage in this perceived *ready-to-hand* activity once again.

As a group, they were committed to the *idea* of breastfeeding, as understood through their *situatedness* within their *world*. To this end, some women actively sought opportunities to expand their rational knowledge base about breastfeeding prior to the birth of their baby. Some women had researched the topic of infant feeding extensively to inform their decision-making. Some conferred with family and friends to explore thoughts and feelings about breastfeeding, placing their trust in the advice and wisdom of their supporters, mainly family and healthcare providers. All anticipated some level of support from family to assist their breastfeeding efforts. Interestingly, none relayed any indication that breastfeeding would result in enhanced emotional relationships with their babies.

After the delivery of their babies, all mothers resided within an *unready-to-hand* world as they discovered that breastfeeding *this* baby was not the activity they had perceived it to be, an experience shared in current literature (McCaughey, 2010). Collectively, they ‘woke up to the world’ and attempted to derive meaning from the reality of daily, intense parenting that their current breastfeeding experience evoked. Over time the significance of the breastfeeding relationship they had embarked upon with their babies pressed all mothers to reflect upon, reaffirm, or let go of previously held thoughts, beliefs and values about this kind of feeding experience as opposed to bottle (or formula) feeding. One such item of reflection was the notion of commitment to exclusive breastfeeding. The overriding *mood* of commitment grounded the significance of breastfeeding for these women, inducing them to persist on a journey that incorporated

experiences of joy, pain, fatigue, and even occasionally, despair, albeit not always in an authentic sense of existing.

After listening to, reading, and reflecting upon the conversations held with each mother in this study, it became evident that commonalities existed within their experiences of commitment, contributing to the weaving of an experiential tapestry of breastfeeding experience. However, the personal intricacies of these experiences were often unique and different for each mother. As this was so, the individual nuances or strands of experiential difference and complexity of commitment that combined to create this thread or theme, contributed to the texture and pattern of each woman's contribution to this tapestry as they moved through their journey of breastfeeding their infants.

Committed to Doing *My Best for My Baby*

These mothers were united in their desire to excel in caring for their infants. A component of providing excellent care was their choice of food and its delivery. Current evidence-based knowledge informed the choice of breastfeeding at an ontological level (realized as *mood*) for Suzanne and Tasha. Suzanne stated, "It was all about giving her what was the most healthy. And formula just can't be even close to as good for her. So yeah, it wasn't an option. I was going to be breastfeeding." Tasha stated,

Because you just learn that it's supposed to be healthier and easier for the baby to digest. Like all the benefits for the baby is really why I really wanted to do it and was really hoping I'd be able to. And that's why I'll keep going too. That's really the main deciding factor. (Tasha)

Piper echoed these sentiments of commitment in her words, "And this is what I know is best for my baby. So this is what we're doing." All women had reflected upon

the benefits of breast milk over formula as a source of nutrition for their infants. Nicole expressed wonder and personal satisfaction about breast milk production, “So it's just, you know, like when it's time to feed her, it's like oh, good, it's time to do that again. And plus, you kind of want to.”

Although quality nutrition was the primary focus for all women, Alex expressed verbal support for breastfeeding as a tool for infant emotional development: “And I [breastfeed], too, from an attachment standpoint because I work in mental health. So I feel like it is really important that she gets that time with me and gets all those nutrients and that sort of thing.” Suzanne expressed a similar sentiment, “I just bring her with me everywhere. Yeah, it makes me feel like she needs me. Which I like.” Although breastfeeding is not correlated with higher degrees of mother-baby attachment (Wolf, 2007), both mothers felt this was an important component influencing them to continue breastfeeding.

Minor lifestyle changes were enacted to ensure success in their breastfeeding efforts such as bringing the infant into the same room when sleeping, or co-sleeping with their infants in the same bed. Piper and her husband agreed to sleep in separate beds when he was working to ensure a good quality of rest for him while ensuring minimal disruption of the breastfeeding process for their infant. Although not this couple's preferred sleeping arrangement, Piper made visible her commitment as she expressed a strong yearning to ensure exclusive breastfeeding success that overrode personal comfort in her words, “So we want her to be independent in her crib. But like I've said, because co-sleeping is the one that works better for breastfeeding then we, kind of, have no choice right now.”

Committing to doing the best they could for their babies demonstrated a level of authenticity of desire for all these mothers. All mothers were desirous of the opportunity to breastfeed their babies. All were well informed of the nutritional benefits of breast milk; some were knowledgeable of perceived additional developmental benefits, referring to notions of bonding, attachment and infant development. Professing continued belief that breastfeeding was optimal for *their* babies, these mothers persevered in their feeding efforts while residing within an *unready-to-hand* world because of the unfamiliarity of the experience to ensure success in their breastfeeding journey.

I Can't Do This Without You

Support of husbands, family, friends and healthcare providers proved to be an important strand contributing to the thread, or theme of commitment within the tapestry of experience for these women. All mothers described support they had received that impacted their commitment to breastfeeding.

Piper, Tasha and Suzanne spoke of their husbands' involvement in their breastfeeding journeys. Piper stated, "My husband is also, like I mentioned before, he's also an advocate of breastfeeding. And we really want [is] to [be] completely exclusively breastfeeding for 6 months." Tasha echoed this sentiment, "I'm so thankful I have a really supportive husband who is awesome and so helpful ... I've seen friends struggle where they have husbands who just don't help." Suzanne alluded to less well-defined support but support still appreciated as she smiled contentedly, "[My husband] was really good. He knew I **really, really** wanted to... I don't know, I think he's proud of me for sticking with it." As support received from their husbands was perceived as

genuine, these mothers were better able to maintain a strong sense of commitment to breastfeeding.

This was not the experience of Alex. Leaning on her mother for support, Alex signalled appreciation for the enhanced understanding of her mother for the breastfeeding process as she stated, “So I think she's been really supportive. My husband has been... You know, he's been supportive but I don't think he understands as much as my mom does.” Alex described supportive efforts from her husband in this way, “I call my husband to give me moral support every time [my baby] has to latch when he's home. And he comes and just tells me, ‘You can do this. Don't worry, the pain goes away,’ because it does when she's feeding and it really helps.” Alex’s facial expression and somber tone of voice while sharing this statement denoted a lack of enthusiasm that was incongruous with her words. As I wondered about the quality of support in these words, I attempted to explore what I thought might be a trivialization of her discomfort. However, my attempt was rebuffed, as she reiterated that this was his way of providing support. I was left to wonder if her commitment to the breastfeeding process was being diminished by these interactions.

Mixed messages were again received as Alex verbally expressed an overall feeling of satisfaction with care provided by the public health nurses, while again demonstrating non-verbal behaviors that would indicate otherwise (lack of eye contact and heavy sighing while speaking). Later in our conversation, Alex unveiled a less appreciative stance of the deeper emotional in-home public-health support as she described her struggles to find a solution for her breast pain.

But yeah, we've had a lot of support from Public Health. So that's been really good...But, I'm starting grapefruit seed extract because that's Dr. Newman's protocol. But that really hasn't helped. I'm on 50 billion probiotics a day, again not a lot of help. And I'm on naproxen 500 twice a day just to try to get through. And that's not part of Dr. Newman's protocol but that's my protocol to make it through the day. So that's what's being done now. (Alex)

The relationships developed with her caregivers were not enough to overcome the disappointment and frustration in this perceived lack of response to treatment. When asked to expound upon her feelings about this, Alex expressed frustration with her current physical state, and that it was her problem to overcome. The inability to overcome her chronic breast pain and a perceived lack of support for validation of her personal distress appeared to contribute to a perceived lack of authenticity in her commitment to breastfeeding. The lack of congruity between words and non-verbal activity could lead to this conclusion.

This perceived lack of adequate, genuine support from significant others over time appeared to contribute to a perceived mood shift for Alex. As the required (or desired) level of support was not genuinely available, her overall mood appeared to be changing, and affecting her level of commitment to breastfeeding. However, her *forestructure* of beliefs and values continued to sustain her commitment to breastfeeding at the time of our conversation.

Nicole was ambivalent in her description of support from her husband, stating, “Well, certainly my husband is keen on it, I guess. So there's that.” As a second-time breastfeeding mother, it may be that she experienced his support as undifferentiated or in

a taken-for-granted manner. His support, however experienced, did not detract from Nicole's overall mood of commitment to breastfeeding. Nicole expressed more enthusiasm for support received in the form of the general camaraderie of friends that helped to normalize her breastfeeding experience, enabling that experience to become part of her taken-for granted, or *ready-to-hand* world. She stated, "We get together and we usually do some sort of potluck lunch...everybody was breastfeeding...You know, it's what you do. So it's good. It's very accepted. Which is good." Nicole was attuned to breastfeeding her baby within the social world around her. In *being-with* others that shared similar embodied knowledge and experiences, her sense of commitment to breastfeeding was strengthened in and through the relationships she enjoyed with her friends.

Other sources of support bolstering commitment to breastfeeding for these women included that of mothers, friends, and healthcare providers. All mothers of these women had breastfed their children, although not all the mothers in this study could recall actual memories of this activity. However, encouragement and advice from their mothers was helpful to maintain their overall sense of commitment; their mothers were perceived to understand what it was to be a breastfeeding mother. Suzanne, Alex, Tasha and Piper described in-hospital nursing care during the early postpartum period as supportive overall in the form of theoretical education and physical teaching, in turn strengthening their early commitment to their breastfeeding journeys.

Significant relationships within the mother's worlds impacted their ability to authentically commit to breastfeeding. When support was deemed to be the sort that was offered from a place of respect for Other, these women could share their true thoughts

and feelings, knowing they would not be judged or belittled. Mothers aligned themselves with their genuine supporters, and often distanced themselves from those offering support perceived to be insincere, or incongruent with their own values and beliefs. As they continued their feeding efforts, the offer of genuine support received as being-cared-for maintained, and even strengthened the overall mood of commitment to breastfeeding for these mothers.

Committed time

A discussion in this thesis of the impact of time upon commitment must necessarily begin with Heidegger and temporality. In temporality, Heidegger equates *being* with time, as humans move from one moment of significance, or meaningful instance, to another. Such moments are realized when *Dasein* is wrenched from a non-reflective, taken-for-granted, or *ready-to-hand* stance within the everyday world, requiring stopping, reflecting, and ascribing meaning to events of significance (Dreyfus, 1991; Fisher, 2009; Johnson, 2000). Mothers in this study contemplated significance within the breastfeeding experience, such as the first time breastfeeding occurred, the first successful latch, and absence of pain while breastfeeding, all the while future-gazing to the natural end of the breastfeeding relationship.

It's very overwhelming. Piper, Alex, Suzanne and Tasha grappled with the temporal stretching of a perceived relentless, never-ending state of necessary immediacy when caring for their infants, describing their feelings as 'being overwhelmed' with the task. Tasha describes her perception of inhabiting an *unready-to-hand* world as she reflects upon the never-before-experienced sense of responsibility inherent in becoming a mother to her baby. Tasha's mode of existence fluctuated between authentic and

undifferentiated as she developed her relationship with her baby. Tasha remained authentically committed to breastfeeding her baby, while providing infant care prescribed in recommended routines and advice provided by her supporters, all the while searching for ways that fit her own beliefs and values.

But it's that constant demand that's very overwhelming. It's, like, the constant, somebody -needs -you that's totally different from how you've ever operated. And you care so much that you're doing things properly for that... That's what I found overwhelming and what overwhelmed me a few times. (Tasha)

Upon the advice and support of a friend known to have similar approaches to breastfeeding (and therefore deemed trustworthy by Tasha), Tasha discovered that by allowing her infant to self-schedule breastfeeding sessions, life became a little easier, “Whenever she wants to sleep, she can sleep. Whenever she wants to wake up, she can wake up. Whenever she wants to eat, she can eat. We **just** [paused] **stopped** [paused] **listening** to everyone.” In this statement, Tasha’s engagement stance within her *unready-to-hand* world is one of *absorbed coping*. “[She] finds [herself] in a situation and is interwoven with it, encompassed by it, indeed just ‘absorbed’ into it” (Gurwitsch, 1979, p. 67). Proceeding on her breastfeeding journey circumspectly, *absorbed coping* as a way of being took precedence until she was able to ignore others’ comments about how and when she should feed her baby and she was able to reaffirm her authentic commitment to the breastfeeding process.

Piper, also feeling overwhelmed with this newly appreciated sense of responsibility, found interesting ways to manage her feelings of pressure, negotiating personally manageable, temporal targets to maintain her goal of exclusive breastfeeding.

As a mother who invested much trust and reliance upon the knowledge and advice of healthcare professionals, Piper exhibited an authentic/undifferentiated commitment to breastfeeding her baby. Although she continued to engage in an exclusive breastfeeding relationship, her experience of commitment was grounded in the beliefs and values of public sentiment, not necessarily her own. Should the breastfeeding relationship break down after six months for whatever reason, she took comfort in the knowledge that she would have provided her daughter the professionally recommended allotment of time and breast milk, as outlined by the public health nurse, as per Nova Scotia provincial guidelines (NSDHW, 2011).

We tried to divide it into chunks of months so I won't be overwhelmed. So zero to three [months], yeah, that's kind of like at least, if something happens, at least we've already given her a good start. Now that we're closing to six months, then that's the exclusive breastfeeding cut-off. I'm kind of like, ahh...But at least, like what I've said, just so I'm not overwhelmed. I'm just like thinking about six months, six months, six months. (Piper)

Commitment to breastfeeding was strained by the perceived lack of personal freedom for all women. For example, Suzanne stated, "And...so on the flip side, ...I can't be away from her for more than three hours right now. So that's...I don't have a lot of freedom. But I just bring her with me everywhere." As her experience of nipple pain diminished, Piper focused upon the perceived time constraints imposed in caring for her newborn infant, "So I think the only hurdle right now would be the round-the-clock feeding." As Alex reflected upon her choice of feeding and the resulting time constraints, she stated, "Yes. I think of all things I need to get done and I'm like, oh, but I need to feed

her. So I have to sit and do this instead. If I could just give her a bottle and it would take, I don't know if it would take less time.”

As a second-time mother, Nicole was somewhat prepared for both the clock-time commitment required of mothers during the breastfeeding process, as well as the temporal significance of the overall journey. Experience had taught her that there was a logical end to the breastfeeding phase of a child. Therefore, the commitment to breastfeed was not as daunting this time, as it had been with her first baby. Her commitment to the breastfeeding process for this baby remained authentically grounded in this knowledge. As such, she presented a more philosophical approach to the time demands of the breastfeeding experience.

I mean, of course, there are times where it would be nice to sleep through the night or, you know, that kind of thing. But I really can't complain with [my baby]. And, you know, in the end, I guess the one thing I learned from my first is that it's such a short time in the grand scheme of things really. Like at the beginning with him, certainly it felt like a long time because it's hard, you're tired, you're sore, you're all that stuff. But ultimately, [2 second pause] ultimately, it goes by **so** fast. (Nicole)

Women and their supporters generally under appreciate the time requirements of infant care (Dykes, 2005). As they embark upon their first adventures in motherhood, they find themselves dwelling within an *unready-to-hand*, or unfamiliar mode of existence, as they strive to derive understanding and meaning in their heretofore *ready-to-hand*, or *taken-for-granted* world. In the midst of such activities as feeding, washing, diapering and clothing, many mothers will reflect upon ways to improve their situation. The *facticity* of their *situatedness* is that as women, they alone can provide breast milk.

In keeping pace with life as lived in the face of all of its current technological advancements, women may naturally wonder if there is another (better, faster, easier) way of providing nourishment to their infants, especially when feeling overwhelmed by pain, fatigue and isolation. Authenticity of commitment is tested as these women discovered the temporal significance of living with a new baby.

The Juxtaposition of Commitment and Discomfort

As these women moved through the trajectory that was their breastfeeding experience, all experienced times of duress when they vacillated between authentic and inauthentic commitment to breastfeeding. Regardless of such vacillating tendencies, commitment to the breastfeeding process was maintained. As noted previously, initiation of the breastfeeding process triggered an unfamiliar move to an *unready-to-hand* mode of existence for the mothers as they confronted their new way of being. The reality of a breastfeeding process that included fatigue, pain, and feelings of an overwhelming responsibility for their babies resulted in a level of uncertainty within their previously known and understood world. The prevailing mood of commitment was tested as these women attempted to discern meaning from this experience and navigate a return to a *ready-to-hand* or *taken-for-granted* mode of existence.

Fatigue, an inability to feel clean, emotional discomfort, and physical pain were foci of our conversations. Commitment to breastfeeding was continuously assessed as mothers navigated a new mode of existence. All mothers described being fatigued, especially during the early days after the delivery of their babies. A desire for more sleep in the face of round-the-clock feeding activities often disrupted the desire to breastfeed. Piper credits her husband for bridging her inauthentic commitment to the breastfeeding

process as she describes her husband's actions in the face of her own experience of fatigue.

And I'm just like, oh, I'm really tired...And so he was the one who would, you know, like help the baby latch. And then if we needed to change sides, he would be the one to...like, "Can you grab the baby and turn her on the other side?" So yeah, he played a big part too. (Piper)

Piper's husband was described as being instrumental in the maintenance of an exclusive breastfeeding relationship to ensure successful breastfeeding for their daughter even when Piper was exhausted, something that brings her satisfaction upon further reflection.

Awaiting physiological regulation of milk production provided instances of embodied discomfort for some women, best described in Tasha's words.

Like when I first started breastfeeding, ...it's kind of like almost you feel...there's sometimes milk dripping all over you. ...it's kind of like I got sick of feeling dirty. I'm like, oh my god, I just got a shower and I step out and there's milk dripping on me, ...that's why I just got a shower – to feel clean again. (Tasha)

Breastfeeding experiences within the public forum were identified as a possible source of emotional discomfort. Tasha expressed pleasure in a newfound confidence discovered while breastfeeding in public.

I just can't imagine not breastfeeding. I think it's easier. I think it's easier for me too because I can be shy, and I thought I'd have...qualms about breastfeeding in public. But I realize I don't care. ...I've breastfed her in restaurants...I don't care.

So that helps. I think if you had anxiety about that, it would be very difficult. But I don't. (Tasha)

Nicole expressed some emotional discord as she lamented the lack of public facilities available to breastfeeding women, creating perceived barriers to her ability to feed her baby while outside her home. “It is hard though...when you go out to maybe find a place that you can breastfeed. You know, that's still challenging. It's kind of nice at the mall, the maternity stores will provide you a spot.” Commitment to breastfeeding was tested for Nicole as she felt constrained in her ability to travel outside her home with her breastfed baby. Support for commitment is negated for women *thrown* into *worlds* that privately endorse breastfeeding as the superior choice for infant feeding yet prefer to hide this embodied activity from the public context (Hausman, 2004; Shaw, 2004; Stearns, 2013).

Oooh, it’s going to hurt. Nipple pain due to damage sustained while learning latching techniques figured prominently for four of the women in the first few weeks after their infants were delivered, sorely testing their commitment to the breastfeeding process. Alex questioned her commitment to the breastfeeding process as she reflected daily upon the overall meaning of her breastfeeding experience. Her experience of physical pain extended beyond the first few weeks and has figured prominently throughout her overall experience. Her authenticity of commitment to breastfeeding was in question, as her breastfeeding efforts were being sustained by values not completely her own but those of her husband and family.

Breastfeeding has been a big, big struggle for me right from kind of that first week

home. I had to really psych myself up every single time [my baby] goes to the breast. And it's been tears, it's been I can't do this, I don't want to do this. But [my baby] continues to do fine so I just kind of push through it and make myself do it.

(Alex)

As she evaluated the many components of breastfeeding affecting both herself and her baby, she considered the notion of offering formula to her infant, the sole participant to do so. Her words are indicative of the beginning of a possible mood shift – a shift from commitment to breastfeeding to commitment to the provision of another suitable nutritional source, not necessarily breastmilk. Although hope was fading for a pain-free existence, Alex's sustained confidence in the *forestructure* of her understanding (her previously held beliefs, values and knowledge) of the benefits of breastfeeding her infant was still strong enough to maintain her resolve to remain committed to this method of feeding at the time of our single conversation, “The other part that I think of in the middle of the night is that they don't know... This isn't going to go away if I stop breastfeeding. The [cause] is still going to be present.”

Tasha, Suzanne and Piper all experienced nipple pain that eventually subsided after the first few weeks. Until the pain was gone, Tasha described a reluctance to begin feeding her baby as she said, “Because there were times where...she'd want to eat and I'd be...oh, no, she wants to eat, that's going to hurt. But...at the two- week mark, ...[my nipples] were better.”

Suzanne described using a coping mechanism of counting to help her to begin what she knew would be a painful experience as she stated, “And I don't know if that was just in my head or not, but I'd literally count down from fifteen. And after...the fifteen

seconds, it just kind of...the pain went away after the initial latch.” All three women were pain free within three weeks of delivery, as noted in Piper’s words, “I’ve said, we’re already at least past the hurdle of the good latch. So that’s taken care of.”

The authenticity of their commitment was severely tested during these painful sessions; however for these three women, breastfeeding continued. Maintaining their commitment to the breastfeeding process, Piper, Suzanne and Tasha continued to breastfeed through their tears and their physical pain. Their hope that the pain would end soon in the face of such strong embodied experiences proved to be a sustaining facet of their commitment to breastfeeding.

It never really was an option for me to go open up one of the containers [of formula] and feed [my baby] from that. So even when my nipples were cracked and bleeding and it hurt to shower because the water that runs on your nipples when - **OOOOOH**, it was so painful. But even at the height of all of that, I still...it was just a matter of getting through it. And like, you know, how many more days is it going to be before this feels better? Yeah. (Suzanne)

Nipple pain notwithstanding, Piper was particularly distressed by uterine pain in the early weeks of her breastfeeding experience. Childbirth planning had left her ill-prepared for the somewhat common postpartum experience of after-pains (postpartum uterine contractile discomfort), compounding her *unready-to-hand* or unfamiliar mode of existence as she questioned the newfound familiarity of her world as wrought by both the breastfeeding process, and this unexpected physical discomfort. As anxiety increased about Piper’s own personal wellbeing, her reliance upon others increased. Although medical and nursing professionals offered explanations, Piper remained dissatisfied with

perceived attempts by both healthcare providers and husband to minimize her complaints. However, she persevered in her breastfeeding efforts throughout her discomfort. As her understanding of this common postpartum issue increased and her pain diminished, Piper was able to move forward in her breastfeeding experience, “So yeah, that's why I was like, okay, so it's probably worth it. Like the pain, every pain was worth it. Other than of course she's breastfed, so it's really worth it.”

The reality of the breastfeeding experience necessitated a move to an *unready-to-hand* or unfamiliar mode of existence for these mothers. Experiences of pain, fatigue, physical and emotional discomfort, all facets of the breastfeeding experience as revealed in the words of these mothers, required a conscious reflection upon, and exploration of the meaning of commitment to the breastfeeding process for each woman.

Digging Deeper

The previous sections of this chapter provide illustration of the experience of commitment for the mothers of this study. However, it is the ontological experience of mood, namely that of commitment, that is the source of meaning for these mothers. As the experience of mood illuminated the things that mattered to these mothers, in particular breastfeeding, they then committed themselves to the breastfeeding process. Commitment created attunement to the significance of the breastfeeding process; however, commitment vacillated among authentic, inauthentic, and undifferentiated modes of existence at any given moment. As these women embarked on this journey, they discovered many things that tested their sense of commitment to the process.

It's not easy. Breastfeeding is not easy. Nicole stated, “And I don't know if that's...I think that might be part of it. It's kind of how you go into it. Because, you

know, it is, I would argue, obviously a very natural thing to do. That doesn't make it an easy thing to do.” Piper echoes this sentiment in her words as she speaks about the determination required to continue breastfeeding over the long term, “And I think [determination is] very important in breastfeeding because it's really... [Breastfeeding is] easy but not really.”

I need to do this for my baby. Choosing to breastfeed means often placing the needs of the baby ahead of others, including Self. All mothers reiterated this sentiment in their descriptions of placing the needs of their baby ahead of their own needs as a function of strong determination and focus to be ‘good mothers’. Suzanne stated, “It's, like, no matter how much this is going to hurt and, like, bring tears to my eyes, I have to do it.” Nicole echoes this sentiment, “I think, you know, part of it is really I think really believing that that is what you need to do for your baby and being solid that that is what you want to do, and persisting through...seriously adverse situations.” Piper purposefully placed her baby’s needs ahead of her own, as made visible in this sentiment, “...the choices that we make, it's kind of ... the harder choice for the mom. But, I mean, it's all good, I guess.” Her sense of commitment might be seen to waiver here, as she questions if in fact making such choices is really ‘all good’. Successful breastfeeding experiences are enhanced by positive self-talk according to Nicole.

You could get really upset because your baby is crying, and they need to eat. And what are you going to do? And I remember in the hospital, the nurse saying to me at one point, "You know, you're very calm about this." But I was just like, well, yeah, but there's nothing...me being upset is not going to help the situation.

(Nicole)

Although her experience had been disheartening, Alex was able to demonstrate a strong sense of determined commitment in the face of disequilibrium regarding her physical limitations.

I don't know if this is what you're looking for or not but one of the things that I can say to myself when it really hurts and in the middle of the night is that...or when she's having a really bad day, is that... So I used to work with babies with disabilities. So I used to have... I kind of say to myself, you know, think of perspective, think of at least I can feed her, at least she's not, you know, in the hospital, at least she doesn't have an NG tube, at least she doesn't have all this sort of thing. So you know, it means something to me that I have a healthy baby that I'm able to feed and that, you know, I know she's going to do well because of what I'm doing for her. (Alex)

As I reflect upon the conversations held with each mother, Piper, Suzanne, Tasha and Nicole expressed an overall affirmation of a mood or sense of commitment. Alex alone denoted a mood beset with frustration, anger, sadness and occasionally despair. A world repeatedly encountered in a mood that is persistently negative might result in a mood shift, as appeared to be occurring with Alex at the time of our conversation. Alex appeared to demonstrate the beginning of a paradigm shift in her thinking: she had wanted (perhaps inauthentically) to breast feed but indicated she was now contemplating a switch to commercial formula in an effort to manage her pain.

Some Final Words

In closing, all mothers in this study experienced an ontological mood of commitment. As such, all mothers were attuned to the value of the breastfeeding process

for their babies. Attunement is not grounded in emotion; attunement is how we are pre-disposed to encounter our world. Being attuned to our world allows us to find meaning in the things that matter to us (DeLancey, 2014; Dreyfus, 1991). The mothers with the exception of Alex, dwelling within their worlds as *situated thrownness*, were attuned to the notion of breastfeeding their babies and as such, their attunement to this activity shaped or augmented their sense of commitment. As mothers build and develop meaningful relationships with their babies, perhaps it is this mood of commitment and subsequent attunement to the process that enables them to endure their breastfeeding journeys as they return once more to their *ready-to-hand* or taken-for-granted world. I move now to a discussion of relational support as the last theme of this study.

CHAPTER 8

Being-With Me: The Importance of Relational Support

Breastfeeding is not necessarily easy and requires strong resolve and much support. My favorite part of the job is facilitating the Breastfeeding Support Groups at the Pump Station and Nurtury. Here, moms come together with their young babies to ask questions and “hang out” with others who are in the same place in life. It is today’s ‘kaffeklatsch’ and it’s wonderful. There are always tears from the exhausted and overwhelmed, encouragement from everyone, and lots and lots of laughter. The tough, embarrassing and funny situations these new mothers share help everyone leave feeling renewed and ready to carry on for another week. (Harvey & Haldeman, 2013, p. 4)

In the previous chapters, I discussed the themes of embodiment and commitment, thematic threads of this tapestry of breastfeeding experience. In this chapter, I discuss the theme of support, a theme made visible within the stories shared by the mothers. Support is intricately interwoven with embodiment and commitment to provide texture to this experience. As these mothers experienced the embodied process of breastfeeding, so they sought support that would enable their resolve, or commitment, to continue upon this chosen journey of breastfeeding their babies. Although the notion of support is intertwined in the theme of commitment as discussed in Chapter 7, it is, in itself, an important stand-alone theme that enhances and strengthens the creative weaving of their breastfeeding tapestry.

The concept of support for breastfeeding women is well documented in the literature as being vital to the success of their breastfeeding efforts, especially in the early days after the birth of the baby (Demirtas, 2012; Dykes, 2010; Phillips, 2010; Schmied et al., 2011). Researchers write that women often seek support that will build personal confidence while providing encouragement, mentorship, and physical help as required on their breastfeeding journey (Grassley & Nelms, 2008). In their search for support, these

mothers looked to healthcare providers, husbands, mothers and other family members, and friends to provide all of these things. An exploration of the personal experience of support offered proved more enlightening.

These mothers valued the ability and willingness of supporters to be present and available. Negotiation was a factor of support, as an achievement of balance was sought between support offered by the supporters and support desired by the mothers. The support of past breastfeeding experiences (knowledge or *forestructure*), whether their own (this was Nicole's second time breastfeeding) or their mothers, proved to be a factor in building trust for the embodied experience of breastfeeding for all women.

Support was sought by the mothers in this study between intervals of significance as denoted by momentary pauses within their sense of commitment to the breastfeeding process. Alex looked for support before every feed as the anticipation of a very painful activity was undermining her desire to continue breastfeeding. Suzanne and Tasha described seeking daily support while awaiting healing of their very painful nipples. Piper described searching for support weekly from public health nurses to ensure her success of meeting her goal of exclusive breastfeeding. Nicole found support in weekly potluck lunches with friends, an event similar in intent to the informal *kaffeeklatsch*, as expressed in the opening quote. However, the meaning of these various supports were different for each woman, creating difference in their perception and reception of support.

Heidegger, Mood and Being-with

Dasein's world is disclosed to her through her *mood* and that of those around her in her world. *Moods* attune *Dasein* to elements of significance in her world previously not revealed (DeLancey, 2006; Freeman, 2014). If commitment is to be understood as an

ontological mood, it follows that *Dasein* will be predisposed to seek out significant elements in her world that will help her to sustain her commitment; in this case her commitment to breastfeeding. One such element is the seeking-out and establishment-of supportive relationships with *Others* that share *Dasein*'s values and beliefs about breastfeeding.

Heidegger writes that the essence of *Dasein* is relational, equating *being-in-the-world* as *being-with-others* (Braman, 2008; Heidegger, 1927/1962). "*Dasein* as *Being-with* lets the *Dasein* of *Others* be encountered in its world" (Heidegger, 1927/1962, p. 157) and therefore enter into relation with them. Women are already situated within their world of relations, such as they are, when relationship building commences with their baby during the prenatal or gestational period (Wynn, 2002). With growing embodied knowledge of their still-to-be-born baby, a sense of commitment to this baby is realized. This prescient *mood* makes visible things that matter which were previously unheralded. If existing *mood* allows that breastfeeding is something that matters, researchers tell us that relational support is a strong factor correlated with breastfeeding success (Meedya et al., 2010; Rempel, 2004).

Clarity around beliefs and values regarding breastfeeding may be further augmented by ontological occurrences experienced during the time of birth and early postpartum. Rodemeyer writes that at the time of birth, pregnant *Dasein* experiences a *moment of vision*: an authentic moment whereby time stands still as *Dasein*'s embodied state demands focus simultaneously upon *Self* and *Other* (her baby), and her present extends into both past and future, so that time is seen as whole while still directed forward (1998, p. 82). Staehler complements this notion by allowing that the

phenomenal *mood* at this time is wonder; a mood of birth and beginning, unique in the fact it attunes *Dasein* to authenticity as she stands in awe of this *Other's ability-to-begin* (Stahler, 2007). As such, *Dasein* encounters authentic intelligibility of beliefs and values regarding her choice of infant feeding. Being attuned in this way, *Dasein* is revealed in her *thrownness*, as *Dasein's* world is revealed. Attunement discloses *Dasein* as *being-in-the-world* with others, as a relational being. Attunement contributes to the context of significance (breastfeeding) for *Dasein* in her world as it is now revealed (Freeman, 2014).

Heidegger writes of fundamental moods (of which the *mood* of wonder is one) from which other *moods* might flow (Stahler, 2007); I suggest that the aforementioned *mood* of commitment to breastfeeding is strengthened in and through a mood of wonder as *Dasein* becomes authentically attuned to her present situatedness. As *Dasein* gazes in wonder upon the newborn *Other*, the experience of attunement to authenticity illuminates her world, highlighting beliefs and values previously not realized, such as the wonder of a new life in her arms, her responsibility for that life, and her feeding choices for the baby.

Heidegger denotes *Dasein* as *being-in-the-world*, equating this with *being-with-others*. As a thrown entity, *Dasein* is always in relation with others (1927/1962). As a woman now situated as a breastfeeding mother, the meaning of her breastfeeding experience is explored and made apparent to her. In strengthening (or giving in) to a *mood* of commitment to breastfeeding, the context of significance shifts, and possibilities for meaningful support that in turn will fortify her commitment to this choice for infant feeding become visible in *Dasein's* world.

Being-with and Being-there - Presence in Support

Healthcare providers: For these mothers, the physical presence of healthcare providers (primarily nurses) was significant to the breastfeeding experience at the time of delivery. Although no relational significance of birth-unit nursing support was described by any of these mothers, they were appreciative of the physical help and instructional support provided as they embarked on their breastfeeding journey. This journey began in the delivery room as attending nurses placed the newly delivered baby upon each woman's chest providing opportunity for continuation of relationship building for mother and baby through skin-to-skin contact, and to encourage early breastfeeding. In each instance, these nurses remained in close proximity to aid each mother in her efforts to breastfeed her baby. Physical presence, tactical support, verbal encouragement and teaching were highlights of each experience with the delivery room nurse.

Suzanne recounts her initial encounter with her baby immediately after delivery with delight and wonder. As she spoke, her face softened, her eyes widened, and a small smile played about her mouth. This profoundly embodied experience was meaningful as she described the ease with which the baby fed, and the awe she experienced at the ability of her body/breast to provide adequate nourishment. "...they put her on my chest. And yeah, you know, I don't know how long it was, not very long before she...found my [breast], [actually] the nipple and she started sucking immediately."

Commitment to breastfeeding as a phenomenal mood influenced these mothers to seek all manner of healthcare provider (mainly nursing) support available to them round the clock while staying on the postpartum unit. The knowledge that professional support soon would be more difficult to access due to early discharge heightened anxiety borne of

lack of knowledge about the breastfeeding process for Piper, Alex, Suzanne and Tasha. Although equipped with a *forestructure* of knowledge about breastfeeding rooted within their sociocultural situatedness, the circumstances of early, embodied experiences of breastfeeding created a need to know more. To augment their rational knowledge, the mothers sought any and all physical (positioning for feedings, latch) and informational (professional advice, written materials) support in an effort to learn as much as they could about breastfeeding prior to discharge. These mothers were genuine (authentic) in their desire to obtain as much knowledge as possible while access to the nursing staff was easy, so were accepting of all that was offered. Suzanne was appreciative of the helpfulness and enthusiasm of the nursing staff, tracking all advice received with pad and paper for later review at home when alone with her baby.

They were very helpful, they were very eager to make sure that I was breastfeeding properly. So I got a lot of advice. They were a little bit inconsistent with the advice but it was all generally the same sort of thing. And I was tracking it on the pad of paper and everything. I knew in theory what needed to be done. But the nurses did add like another layer of advice. (Suzanne)

Suzanne also spoke of in-hospital physician support that helped her to endure her nipple pain: “So [the doctor] said, ‘Just, you know, stick with it.’ I had no intentions of stopping. I had heard from a lot of people that just stick it out, it will get better, [your nipples will] toughen up. And so she said the same thing.”

Piper engaged in seeking physical and informational help during her stay on the postpartum nursing unit in an *unready-to-hand* manner. As anxiety about being a mother to this baby strengthened her authentic commitment to her baby, Piper denied her own

embodied intelligence about breastfeeding, favoring rationalistic information from professional sources to inform her journey. Maintaining an *occurrent* (objective) stance, she sought information and reassurance whenever possible that she was doing everything she could to facilitate exclusive breastfeeding at every opportunity.

Plus the nurses were very helpful. And we were asking them for information, not just like, "Nah, we're okay," right. So we were asking how to... One nurse taught us how to hand express so the colostrum would be on the nipple so she would smell it and then she would latch better. And then at some point, another nurse taught us how to ... do the hand-express technique if, you know, I would need to hand-express. And then what else? I was asking them about the positions that I could...the way I could hold her. (Piper)

Piper maintained an *authentic/undifferentiated* mode of existence through her seeking of professional advice and support from public-health nurses by attending a local drop-in center long after her baby's arrival. Still genuine in her commitment to breastfeeding her baby, she continued to deny her own embodied intelligence about breastfeeding. Instead, Piper habitually relied upon the knowledge of others by following a weekly visit routine to ensure validation of continued success of her exclusive breastfeeding as *situatedness* within her world privileged the rational knowledge of professionals. "So we go there every week so she could be weighed. And then if I do have questions to the public nurse, they're able to answer it."

Although Tasha was very appreciative of the supportive physical presence of all the nursing staff, one nurse in particular was instrumental in building confidence while she learned to breastfeed her baby. This nurse (a midwife and RN) made herself available to

Tasha during feedings, sitting with her while providing emotional, physical and informational support. Tasha was emphatic as she stated, “And she was really helpful too because she said next time the baby feeds, call the nursing station and I'll come down and help you with the latch. So it wasn't ... Like, she was **really, really** helpful.” Tasha was the sole participant to correlate the educational level of the nurse to the quality of support received.

Because we had an LPN the first two days, and they didn't really teach me. And then I had the RN, and she taught me. Like this is what the latch looks like, this is what you should do, this is how you break the latch, this is...And so that made a huge difference...I think it was a mix of like luck that [my baby] caught onto it and that I had the RN that I did. She was an RN but also a midwife.....But she was **so** helpful. And I just followed her advice crazily. (Tasha)

Heidegger writes that Dasein, as Being-with-Others, engages in relationships built upon shared elements of significance or care (1927/1962). Researchers write that the incorporation of care and trust within these relationships, as in being authentically present, is vital to support breastfeeding mothers (Barclay et al., 2012; Schmied et al., 2011). van Manen writes that in caring for the *Other*, we must honor the *Other's* uniqueness and individuality (2000, 2002). In this instance for Tasha, it was not the credentials per se, but the previously unrealized, experiential knowledge (clinical phronesis) and authentic presence of the nurse that was most meaningful to Tasha's experience, enabling Tasha to advance her own embodied learning. This one nurse provided a relational connection to Tasha by making herself present and available when Tasha required her, providing care and support on many levels for she and Tasha's shared

concern – breastfeeding Tasha’s baby. This nurse’s actions were effective in building Tasha’s confidence in her own ability to breastfeed her baby. This being said, the possibility does exist that credentialing of nurses can play a small part in the level and type of support offered between nurses working in the same care team

Other healthcare providers imparting support for these mothers included doulas and public-health nurses. Nicole was authentically engaged in a postpartum visit that included breastfeeding support provided by the doula involved in her birth experience. The caring relationship established firstly during her pregnancy and then the birth experience, and made more meaningful by the doula’s clinical phronesis, created a level of mutual trust and respect that carried over to the postnatal scenario as Nicole was able to reminisce and reflect upon her experiences of birth and postpartum with another who had shared this time and space.

Yes, she came for kind of like a little postpartum visit. Which is nice, as well. It was kind of, we could reflect on things and talk about things, about how things are going now. She specialized in VBAC [vaginal birth after caesarean section], so that was very helpful as well. Because she just knew how it all works, you know.
(Nicole)

Aston et al. (2015) provide research support for the importance of relationship building by public-health nurses with their clients. Engaging in purposeful, supportive and non-judgmental interactions with mothers can result in the experience of positive health outcomes and increased maternal confidence. Upon their return home, Piper and Suzanne both availed themselves of available public health nursing resources, expressing satisfaction with the informational support received. Suzanne felt particularly supported

by the presence and availability of the public-health nurse providing in-home care. Although initially undifferentiated in her reception of this home visit, it became something much more as Suzanne engaged with the public-health nurse. The advice offered by this nurse resonated with Suzanne as the nurse created a mutually satisfying relational space where Suzanne and her baby were the primary focus; the public-health nurse was authentically available to both of them during the breastfeeding process.

The public health nurse came one day about a week later. She called me and she wanted to know if I wanted a visit. And I said, I guess I'm just sitting around here, why not get some expert advice. So she kind of watched me, watched what I did, how I did it or how we did it. And she gave me some tips that were helpful as well, just on positioning. And she said the same thing. She was like '**don't settle**'...

You know, unlatch her and just keep doing it until it's the right [way, for you and your baby]. (Suzanne)

As Alex shared her story, she wondered if the quality of nursing support during her postpartum tenure in hospital contributed to the painful sequelae she endured at home with each breastfeeding session. Although veracity of this perceived notion could never be corroborated, it may also be true that Alex's *forestructure* of knowledge did not adequately prepare her for the reality of the breastfeeding experience.

I don't know if it's a contributing factor, but it was a long weekend that she was born. And I don't feel like nursing staff was maybe as attentive as they could have been for me. So I didn't get... So in the recovery room, I had lots of support, and that was lovely, but I didn't then have a really great nursing support until kind of the second half of the second day that I was there in terms of helping me with

breastfeeding. So I didn't have that experience of, you know, when it hurts, take her off. I just kind of kept going because I didn't know any different because I didn't really know that that's what they were saying. (Alex)

Alex expressed her disappointment in the nursing support available to her during her time in hospital on the postpartum unit. Although her perceptions about timing (being in hospital on a long weekend) and seeming lack of nursing staff providing care may have been a reality, it may also be that the nurses working on these days were not ontologically available to the potential client-nurse relationship. A seeming failure on the part of the nurses to successfully communicate effective latching technique resulted in Alex feeling unsupported by nursing staff. As Alex struggled in her efforts to latch her baby to her breast, this perceived lack of nursing presence compounded Alex's lack of confidence in her own bodily knowledge – pain is often indicative of a problem. Rationalizing that any breastfeeding is good for mother and baby, Alex endured painful experiences with each feeding with little apparent assistance while in hospital. As noted in Chapter 6, this ongoing experience of painful feedings appeared to be affecting the developing relationship between Alex and her baby, negating such rationalization about the breastfeeding experience.

Healthcare providers – nurses, physicians, doulas - are positioned to provide meaningful, caring support to breastfeeding women. Similar to the scholarly writing of Hartrick (1997), these mothers valued moments with healthcare providers (primarily nurses) that were authentic, caring and trustworthy. These mothers felt most supported when their own ideas, beliefs and values were reflexively received, and considered within the context of the relational space. Relationally synchronous encounters that honoured

mutuality of purpose were celebrated, even if breastfeeding problems persisted such as sore nipples.

‘He helped me’ – Husbands and support. In his efforts to provide physical support to Piper after the delivery of their baby, Piper’s husband was instrumental in helping Piper to overcome fear of handling her baby. Piper had very little experience with baby care (this was her husband’s second child), so was happy to share this responsibility with her husband. During her hospital stay, she often deferred to her husband when physical handling of their baby was required, “When we were at the hospital, he was the one who would get the baby because I was really afraid because she’s so tiny and she’s so fragile. And my husband has a seven-year old already. So I was just like, ‘Can you grab the baby?’”

Fear is a derivative of the fundamental mood of anxiety. Staehler writes “anxiety is the more disturbing and unsettling mood, whereas fear can be countered by dealing with or removing the object that causes it” (2007, p. 418). Fear is described by Heidegger as an ‘everyday’ or, inauthentic mood. *Fearing as such* allows something that matters to become something fearsome. As fear discloses what matters, so it can determine the response. As a mother’s fear discloses something that matters (the baby), she may become inhibited, or even paralyzed in her behavior towards it (Heidegger, 1927/1962; Macmurray, 1961). Fear can result in the mother turning away from authentic attunement borne of the birth experience, to adopt an inauthentic comportment that allows the Self to be lost in her *undifferentiated* world.

Although Piper disclosed no overt anxiety in our conversations, hints of anxious moments were certainly noted. The fear that Piper disclosed was perhaps derived from

her own lack of self-confidence in the early days of postpartum as she contemplated the responsibility now facing her. Certainly her acceptance of feeding support from her husband while in hospital might indicate a predilection for *undifferentiation* on her part, as she shared this passage.

I could also attribute the success to my husband because he'd be like... He was so good in waiting for the cues that she's hungry. So she won't reach a point in which she would cry. So my husband would notice it and then he would...latch the baby. And I'm just like, oh, I'm really tired, I'm like tired. But he was just like...you know. So he would latch and latch. (Piper)

Piper praised the efforts of her husband to ensure successful breastfeeding in the early days as a sign of care and concern for her and her baby. Heidegger might see such behavior in a different way. For Heidegger, *Dasein* as *being-in-the-world*, is care. He builds upon this idea as he writes of solicitude, a way that *Dasein*, as *being-in-the-world*, encounters the *being-with* of Others (with care and concern). He presents two modes of solicitude for *Dasein* – *leaping-in* (*Dasein* creates a dominated and dependent state by taking over for the *Other*), and *leaping ahead* (the provision of authentic care enables the possibility for the *Other* to become resolute and an authentic self) (Freeman, 2009; Heidegger, 1927/1962). Professing care and concern for the wife, a husband may be inclined to ‘*leap-in*’ and take over care of the baby, basing his action upon his wife’s fatigue, infirmity or lack of knowledge. He may or may not be aware that his actions can negate the wife’s embodied and intellectual knowledge of her baby. She is effectively denied the opportunity to engage authentically with him, or more importantly, with her baby. As she relies more upon rationalistic knowledge and less upon her growing

embodied knowledge, she becomes dependent upon her husband for guidance regarding baby care, withdrawing further into an objective, or *present-at-hand* world as the possibility for selfhood is denied.

Piper, already situated in a world illuminated by fear, accepted her husband's ministrations of help in the early postpartum period. She relied upon him to recognize infant cues indicating hunger and satiation. She relied upon him to 'latch' the baby. Encouragement was not forthcoming from him for her to use her own intellectual and bodily knowledge in caring for her baby. Perhaps this is why she remained authentically committed to breastfeeding yet undifferentiated as she continued to rely upon the expertise of others (healthcare providers, media resources) for confirmation of breastfeeding success.

However, the physical support provided by the husbands of some mothers was well appreciated in the early days after delivery as a factor contributing to breastfeeding success. Fatigue and physical discomfort due to surgical deliveries proved to be problematic for some, so having a husband willing and available to aid in both personal and infant care was welcomed. Tasha described her ability to maintain her commitment to breastfeeding because of the physical support provided by her husband. His caring actions may indicate his own mood of commitment to their relationship, and now that of their baby.

Because after the C-section, I couldn't get up very easily, I couldn't pick up the baby. It was like really overwhelming. Because you picture having the baby and being able to do these things, and then suddenly you can't do them. And he would, you know, pick up the baby and bring her to me, and set up pillows so I was

comfortable. Like, get me food when I was feeding. Feed me if he had to. Like just really supportive. And I think that helped me to keep going with breastfeeding when it was difficult those first couple of weeks for sure. (Tasha)

Tasha was most expressive regarding the relational quality of support provided by her husband as she reflected upon the experiences of some of her friends. She believed her husband to genuinely support her commitment to the breastfeeding process.

I think it would be harder to have a partner that didn't help than to have [no partner] at all. Because to see them not helping you when they're there, I think it would be so hard. It would be easier to just be a single parent than to be with someone who was not supportive. (Tasha)

Authentically supportive behaviour by her husband has favourably contributed to Suzanne's breastfeeding journey. Occasionally relying upon written materials to procure information, Suzanne's husband shared this knowledge in a caring manner. However he deferred to Suzanne's growing embodied knowledge to guide her in her journey. Perhaps this is an instance of what Heidegger defines as 'leaping-ahead', as her husband enabled space for Suzanne to recognize and embrace her growing embodied knowledge of her own breastfeeding abilities. For Suzanne, knowing her husband was present, available and trying to help when she was unsure about what she was doing was noted by her to be very supportive.

So he just kept telling me, like, you know... He was very, I don't know, enthusiastic about, you know, encouraging me to stick with it and it will be okay. He even helped with her latch even. Like he'd sit there and go, "Well..." and he'd

kind of try to critique. Because he read the same pamphlets I read and everything else. (Suzanne)

The support of family. Reid, Schmied and Beale provide research findings alluding to the value of grandmothers within the support network of breastfeeding mothers. Positive, supportive relationships between grandmother and new mother can contribute to the feelings of competence and confidence about the new mother's breastfeeding abilities (2010). The supportive presence of her mother in the early days after delivery contributed to easing a less-than-satisfactory breastfeeding experience for Alex. As her physical discomfort during feeding sessions increased, she relied more and more upon her mother's supportive presence and attention to detail (running errands, performing internet research regarding current medical treatments that may be useful) as Alex worked through her breastfeeding problems. She stated,

And my mom has been really, really supportive. Because when I first came home, I couldn't drive. So my mom's been here a lot. She lives in the city. And she's been really, really helpful in looking things up for me and trying to do research for me and that sort of thing. And to ensure that we're getting all the treatment that we need to try to get rid of this. So I think she's been really supportive....I'd say my mom has been the biggest support to me. (Alex)

The remaining participants referred to maternal support (their own mothers) as important, but it was not their experience that this was the primary source of supportive presence for these women. Other family members such as husbands, aunts or sisters, and close friends provided equitable supportive presence to each of these participants.

Support of Past Experience

I remember this. With the exception of Nicole, no participant had previous personal experience with breastfeeding. Nicole was able to use her previous experience to guide this new experience of breastfeeding this baby. As she embarked upon the early feedings for this baby, her embodied learning of past experience was recalled, awakening memories of those previous experiences of breastfeeding. Such remembrances were welcomed as helpful to explain what was currently happening, and what she might expect of her experience breastfeeding this baby. She was able to use her previous breastfeeding experiences to navigate events of this experience, for example when her milk came in.

And [my breasts] were rock hard. It was very uncomfortable. And I remembered that from last time. Like I remember that happening last time because I remember when it came in, I was like shocked. I was like oh my god, is this what it's going to be like the whole time because I can't handle this. [laughs] But of course it's not. It eases and it regulates, and then it's okay.” (Nicole)

Nicole experienced her own embodied knowledge in her ability to use these past experiences to engage in, and find meaning in her current feeding experience. Feeling confident about her breastfeeding efforts, her focus for support requirements changed to her new baby, as she experienced stress generated in the experience of difference between her two babies. In this instance she sought emotional and knowledge support from others such as her husband and mother.

“She knew what I was going through”. As Dasein is thrown into her world, so she must navigate the relationships that make up her world. As a new mother learning to breastfeed her infant, she looks for support for her feeding efforts within these

relationships. One source of support is those with practical knowledge of breastfeeding. The past breastfeeding experiences of friends and family members provided support to all these women. Suzanne felt hope with the knowledge that a close friend's similar experience with very sore nipples had eventually resolved, helping Suzanne to persevere in her own breastfeeding efforts, "and my friend, one of my friends, she told me... Because she had...her nipples were really bad too. And she said, "Just count to, you know, 10 or 15 and then the pain will go away."

Nicole similarly leaned upon her friends for support on her breastfeeding journey, "I certainly have a lot of friends who breastfed as well. We'd do it at someone's house, and everybody was breastfeeding...You know, it's what you [did]. So it [was] good, very accepted." Spending time with her friends provided a weekly forum to discuss breastfeeding stories with other women experiencing similar journeys. Dwelling within a like-minded community that shared her values and beliefs about breastfeeding, Nicole was able to reach out for support while in turn supporting other women. Through this association with her friends, Nicole experienced enhanced confidence and enjoyment in her own breastfeeding efforts.

Although all participants reported having mothers with breastfeeding experience, most of the participants had little recollection of watching their own mothers' breastfeed. Suzanne reported, "Yeah, my mom breastfed me and my...I'm the oldest of four. So I grew up as a kid seeing my mom breastfeed my siblings." Suzanne was able to draw upon this experience as a starting point for herself. As a result of having observed her mother feed her siblings, she translated this memory into her own breastfeeding behaviors, such as how to hold her baby during a feed. Conversations about

breastfeeding with her mother revealed her mother's breastfeeding experience to be underpinned by dated research support. However, knowing her mother had realized similar feelings and activities enabled Suzanne to value and draw support from her mother's own embodied knowledge and experiences of breastfeeding as shared with Suzanne as she embarked upon her own breastfeeding journey. This was a notion expressed by all participants. Tasha trusted in the breastfeeding and educational experiences of family members to provide support as she revealed,

My mom...formula fed my sister but she breastfed me...my sister breastfed her kids and all my friends have breastfed or at least tried. So I didn't do the breastfeeding class, and I didn't read anything. I just thought I have...my sister is a nurse, and my mom is a nurse, and she's [my mother] going to be around for a while. My husband is a nurse. I have a lot of friends that have babies. Like I'm going to be able to get the resources that I need. And I was. (Tasha)

However, already anxious about her new role as a breastfeeding mother, Tasha discovered she was unable to cope with the abundance of advice being offered by family, friends, and healthcare professionals about breastfeeding and parenting, resulting in her engagement with her world in an *unready-to-hand* manner. To resolve her unsettledness, Tasha sought a new way of coping by consciously involving a friend with whom she shared a close relationship and similar views to solicit support about her breastfeeding efforts, "But like my friend said to me...I went to a specific friend that I knew would agree with me because that would be supportive, so I really respect [her]." Feeling overwhelmed with the informational overload she was experiencing, Tasha required a meaningful Other to provide unconditional support (and possibly a level of protection

from others with less relational integrity) as she processed all this information within her own time and space. By soliciting such support, Tasha was able to persist in her feeding efforts, while enhancing her self-confidence in her breastfeeding and parenting abilities.

Will You Give Me the Support I Need?

As *Dasein* is thrown into a world not of her own making, the strength and availability of support for breastfeeding is dependent upon the esteem held for breastfeeding between relational beings. Should the existing relationships with Others within *Dasein*'s world share her values and beliefs about breastfeeding, support might be more freely given. However, if her world did not hold breastfeeding as significant, or favour this method of infant feeding, then support for breastfeeding would be less available to *Dasein*.

The women initially described an overall satisfaction with the level of support received from their husbands, family and healthcare providers. However, as each conversation became more deeply reflexive of their thoughts and feelings, it became apparent that some support was obtained through negotiation. Some women indicated instances when support was not freely given, requiring reflection on their part to discern the meaning of their breastfeeding experience, and subsequent engagement in a cost/benefit analysis for seeking such support. Therefore, support realized in significant relationships (particularly that of husbands) was occasionally but purposefully negotiated. The support desired by these women was balanced by the need to maintain harmony within the marital relationship, as well as other relationships of equal or similar importance. Negotiation proceeded upon reflection and prioritization of the needs and desires of self, babies, husbands and others.

My initial encounter with Piper revealed a relational world that valued economic viability as she revealed repeatedly, “like, what my husband said, bills don’t stop coming when you have a baby, right.” Piper maintained an authentic commitment to breastfeeding her baby in spite of this. However she remained undifferentiated in many of her relationships throughout. Although she and her husband’s original plan was that she would return to paid employment when her baby was three-months old, circumstances required a negotiation for her husband’s continued support when she did not return to paid employment as planned due to scheduling conflicts with infant care provision and employer expectations. As Piper realized a stronger commitment through her growing embodied relationship with her baby, she realized a greater need to negotiate a later return to paid employment. Yielding to the economic pressures of her world, Piper described employing cost cutting measures such as switching to cloth diapers and using her ‘time off’ to initiate baby-care regimens such as infant-led weaning and elimination communication to ensure being seen by her husband as ‘doing her part’. Piper maintained her commitment to breastfeeding, while adopting a passive (undifferentiated) stance in taking on all extra baby care work to ensure her ability to stay at home with her baby.

And I was like, well, I'll just not feel bad because, you know, I'm taking care of my daughter. But then since I'm already off for like a long time, and we're in our like debt ratio right now, I'd rather maximize and do the hard core stuff for **your** daughter...and I'm like the choices that we [women] make, it's kind of like the harder choice for the mom. (Piper)

Piper also described negotiating healthcare provider support. Socio-cultural influences in Piper's background favour unconditional respect for professional bodies. When worries about herself and her baby became overwhelming, she maintained an undifferentiated stance as she passively accepted all responses to her queries to ensure her healthcare providers continued support of her breastfeeding efforts. Seeking assurance that she was not ill when experiencing after-pains (postpartum uterine contractions), her response was muted about the perceived denial by her physician and public health nurses of her embodied experiences. Upon learning about the physiological basis of after-pains, Piper was quick to rationalize the healthcare provider responses to her anxiety, as breastfeeding was continuing successfully, "And I'm like it's probably because you don't feel the pain, that's why you're all happy for me." Receiving an unprofessional response in her quest for reassurance about her baby's growth pattern, she again maintained an undifferentiated stance. She accepted this response, and looking to the bigger picture of overall support for her breastfeeding efforts, carried on.

So there came a point that I asked the nurse, is there such a thing as obese newborns? And then she laughed at me. She was just like, "No." Okay. Because if you said the average is 4 to 7 [ounces], and [my baby is] gaining 8 [ounces], I'm like going to be worried about that. (Piper)

Piper recognized the importance of maintaining family support in the face of advice offered but not taken. Although her mother-in-law was supportive of Piper's breastfeeding efforts, her support appeared to be waning over time. Her own daughter (Piper's sister-in-law) had switched her baby to formula at three months of age, so she was encouraging Piper to do the same. Unhappy about her mother-in-law's lack of

understanding about Piper's desire to exclusively breastfeed for a much longer period of time, Piper redirected the conversation to a safer topic in that moment.

My mother-in-law actually asked, "So when are you going to start weaning her from breast milk? When you go back to work?" And I was just smiling, right, because we [Piper and her husband] know that we want to do 2 years and beyond...I was like it feels as if [her husband's mom] is convincing us to switch at some point. (Piper)

In an attempt to maintain her mother-in-law's support, she involved her mother-in-law in a workshop about infant-led weaning, "I did take my mother-in-law with me. I really heard good things about it. And I did bring my mother-in-law with me when I attended the workshop just so at least we'd be on the same page." By including her mother-in-law, Piper hoped this opportunity would increase her mother-in-law's understanding of this process, but also achieve an understanding of Piper's values and beliefs about feeding her baby, and, in turn, be a support to Piper in future.

Some of these women realized a sense of pressure as they compared their own thoughts and feelings about the breastfeeding experience with those perceived by their husbands and families. Piper spoke of culturally influenced familial expectations that she would breastfeed. Tasha revealed an awareness of her husband's wish that she breastfeed this baby. As Alex struggled with a painful breastfeeding experience, her thoughts wandered to those thoughts she perceived her husband to hold, "I feel some pressure from my husband to continue too, just because I think he really feels breastfeeding is important."

Was this a true sentiment of her husband, or did this sense of pressure originate within Alex? Throughout her unique breastfeeding experience, Alex has contemplated the quality of her network of support, in that she did not always feel fully supported in her experience. Alex continued to breastfeed her baby but her endurance of a very painful condition was making her commitment to breastfeeding less justifiable within herself as she struggled to continue her breastfeeding journey. Her overall somber demeanour signified a woman conflicted about this aspect of her life.

It just feels like that's what everyone's expectation is. And even though I sort of know that if I don't do it, nobody I know is going to judge me for it, I kind of feel like that's the expectation. So yeah, it's just that I'm doing what I'm **supposed** to do and how I'm **supposed** to care for [my baby]. (Alex)

Alex felt the current support she received from her husband might diminish should she choose to end her breastfeeding experience. Is breastfeeding what Alex was 'supposed' to do? Alex persisted in providing an affirmative answer to herself. Reflecting upon her stated feelings, it appeared that Alex was maintaining an *inauthentic* mode of existence as a breastfeeding mother. She exhibited distress about her breastfeeding experience as she spoke of what she was 'supposed' to be doing. As she struggled to cope within her world, she highlighted the perceived relational expectations of her husband and Others purportedly requiring her to continue on this path. However, when given an opportunity to explore these statements further during our conversation, she was unable to provide validation that she had explored her true feelings within these relationships (her husband, her mother, her healthcare provider).

Alex appeared to favour rational knowledge of breastfeeding while denying her own recently gained embodied experience and knowledge. She deflected her own anxiety about breastfeeding as a very painful process, affirming the perceived conviction of Others that this was her problem alone. Her affirmation of this conviction only served to silence her further in her quest to find authentic support to help her process her true thoughts and feelings about what was happening to her.

And everyone just keeps on saying it's frustrating because like [my baby's] latch is fine, [my baby] is doing great. And that's the really frustrating part because I know that and she is doing really great. And it seems like her latch is fine because everyone says it is. But then it's the problem with me or it seems to be my problem with all the pain and all the agony. (Alex)

She appeared to be untrue to herself – her physical experience of pain was resulting in an apparent paradigm shift in her mood of commitment to breastfeeding. For Alex, a vital question remained unasked – would her husband/mother/healthcare providers be supportive of a decision to end her breastfeeding efforts? Alex described the conversation she wished to have but felt unable to initiate with anyone, as she stated, “No one has ever kind of supported me on that in terms of Public Health or my doctor or anybody. Nobody's said, "Okay, well, do you want to switch to formula? This is what you should get." Nobody's really said that to me.”

Alex became inhibited within her relationships, persisting in her *inauthentic* mode of existence. Experiencing an inability to open a negotiation about infant feeding (as noted above), she continued to accept what support was freely offered to lessen her burden, “But [my husband] does feed [our dog] so I can't complain about that.” As she

stated this, I noted a half smile, but she made no eye contact with me. When I attempted to clarify her feelings about this, she grimaced and moved on to speak about her baby.

Our conversation revealed that Alex wanted to be seen as a good mother; for her, good mothers breastfed their babies. Her sense of responsibility to her baby and to being a good mother provided the motivation to continue to breastfeed while disliking the process and postponing conversations she feared. She stated, “I don't like [breastfeeding] at all. It's fine, it's my responsibility, it's my expectation. I didn't like pregnancy either. I love [my baby]. It doesn't change what I feel about her.”

Conversation with Tasha revealed an *undifferentiated* attitude to the idea of breastfeeding as she began her breastfeeding journey. Influenced by her husband, sister and mother, and various friends, and committed to providing the best care for her baby, Tasha decided to try breastfeeding her baby. She stated, “...for this decision, the baby was the biggest consideration but also my husband [and] you know, medical advice.” Her response when asked if she liked breastfeeding was delightfully stated, “I actually do.” Having breastfed her baby for several weeks prior to our conversation now afforded Tasha the experience of knowing that breastfeeding was a good choice for her and her baby, one to which she was now authentically committed. Situated within a relationship where both partners currently agreed that breastfeeding was the preferred method of feeding for their baby, Tasha now expressed relief about this fact. Although happy overall with her breastfeeding experience, Tasha contemplated the support she would receive from her husband if she had chosen to formula feed her baby.

You know, if I said I wanted to formula feed, and I was capable of breastfeeding, I don't think [my husband] would like that. You know? I'd say it's a good thing I

just agreed with my husband. But I'd say it wasn't an autonomous choice because if I disagreed, if I'd chose formula, I think we'd have to discuss it. It wouldn't be autonomous; it would be a joint discussion because I know that he would want the baby to be breastfed. But it's lucky we agree on these things. So it's just easier.

(Tasha)

Interestingly, this response followed a request within our conversation by Tasha to quickly remind her about why this study was being conducted. I had used the word 'autonomy' in my description of possible findings. Tasha questioned her choice to breastfeed as being 'truly autonomous' given her original undifferentiated attitude where acquiescing to her husband's wishes would not be a desired solution to the resulting discord should their views have differed. Tasha readily identified the need to negotiate an agreeable decision about infant feeding within a meaningful significant relationship, such as the one she held with her husband.

All women recognized the need for support to continue their breastfeeding journeys, even when such support was difficult to elicit. Support from those closest to these women was perceived to be available, however not always as desired. Piper's *situatedness* within a world valuing economic viability, early weaning, and professional knowledge required her to develop negotiation skills that enabled her to create conditions of support for her breastfeeding efforts. Alex used the support she received to maintain her inauthentic commitment to the breastfeeding process. Tasha questioned if she would have the same level of support if she had chosen to feed her baby formula.

Summing Up

Support for the women of this study was garnered from many sources. Situated within their worlds, these women sought relationships with others that shared similar values and beliefs about breastfeeding. Support was provided through physical, emotional, and informational means. An authentic commitment to the baby initiated the search for genuine support for breastfeeding efforts. Strength of commitment was maintained in and through these supportive relationships, especially when the authenticity of commitment waivered due to episodes of fatigue or pain.

These women became more selective of the support they valued as their embodied experience and knowledge of breastfeeding grew. Developing or honouring relational connections that exhibited respect for the woman's individuality and experience was vital to the provision and acceptance of support. The support of others was best valued within authentic relationships, whereby the supporter was available and present to the experience and possessed an aura of care that promoted and enabled personal growth, embodied knowledge and autonomous behaviour.

CHAPTER 9

Conclusion: A Weaver's Reflections and Final Thoughts

As I begin the final chapter of my thesis, I reflect once more upon the stories of the women who participated in this study. Although their stories reflected diversity within their worlds, I was able to discern and make visible threads of commonality woven throughout their breastfeeding experiences that have deepened my own understanding and knowledge of the process of decision-making around infant feeding. I open this chapter with a summation of the experience of each woman. I then reiterate the linkages noted in the themes previously described as I complete my weaving process of this tapestry of experience. I discuss the notion of autonomy and a newfound appreciation for this concept. I close with discussion about the strengths and limitations of this study, the transferability of the findings, and some future recommendations for the nursing profession.

Where They Are

Piper. Piper began her breastfeeding journey as a culturally and societally approved opportunity to provide her baby with the best source of nutrition, with little appreciation for the bond that could develop between she and her baby. Piper's situatedness within her world, imbued with a cultural and societal pressure to breastfeed her baby, fuelled her prenatal intention and original feelings of commitment. While the pride and bodily confidence borne of this birth experience did not influence her ability to fully trust her own embodied knowledge of the breastfeeding process, her commitment to this feeding method was sustained by the joy she discovered in the relationship (noted in my observation of non-verbal behaviours such as a relaxed countenance, smiling, an aura

of confidence when) she had developed with her baby throughout her breastfeeding experiences. Her expressed intention to quickly return to paid employment was revised over time as she came to embrace the embodied relationship realised in and through her breastfeeding efforts that she now enjoyed. Ensnared in a world configured by familial responsibility and economic restraint, she repeatedly negotiated with her husband and family support for her decision to continue breastfeeding and to remain at home with her baby.

Alex. Alex did not enjoy the embodied confidence of Piper and the other women; she experienced a bodily betrayal that perpetuated a reality of dissonance surrounding her breastfeeding experience. Yet, Alex, too, dwells in a world that values breastfeeding as the best source of nutrition for babies. Maintaining an authentic commitment to doing the best for her baby, Alex's espousal of the values around breastfeeding was sorely tested each day her breast pain remained unabated, and central to her feeding experience. With no options available for effective alleviation of her pain, her breastfeeding journey appeared to result in a paradigm shift when her mood of commitment for breastfeeding began to realign with the desire for provision of formula to her baby. As she sought support and perhaps, permission, to explore ending her breastfeeding activities, Alex continued to demonstrate an inauthentic mode of existence in the face of her continued breastfeeding efforts.

Suzanne. Suzanne expressed a strong prenatal intention to breastfeed her baby. Situatedness within her world provided ambiguous support for this method of feeding – she was supported to ultimately engage in a feeding method that made her happy. However, Suzanne's attunement to her belief in the value of breastfeeding for her baby

committed her to the journey throughout all of its highs and lows. As her initial difficulties resolved, Suzanne experienced great pleasure in breastfeeding her baby. Her realization of the joy inherent in the relationship she developed with her baby strengthened her commitment to the breastfeeding process. At our last conversation together, Suzanne exuded authenticity in her role as mother, made visible in her relaxed, embodied confidence in her ability to breastfeed her baby.

Tasha. Situated in a world strongly supporting breastfeeding as the method of choice for infant feeding, Tasha maintained an authentic yet undifferentiated mode of existence in her declaration of prenatal intent to breastfeed her baby. Tasha maintained her authentic/undifferentiated stance about the breastfeeding process, as it became more of a *ready-to-hand* activity. She valued breastfeeding as a superior nutritional source for her baby; breastfeeding suited her *situatedness* as *being-in-the-world*. However the meaning of her breastfeeding journey was subsumed within her search for meaning about the overall parenting experience. Breastfeeding was part of the overall process of parenting and Tasha had spent little time reflecting upon breastfeeding as an isolated activity – it was just how she fed her baby.

Nicole. Breastfeeding her second baby made visible the respect Nicole held for the breastfeeding process. Acknowledging the lack of visibility afforded the labour of breastfeeding activities for women, Nicole reiterated the strength of the maternal commitment required to endure, and then enjoy the journey. Recognizing and appreciating the differences within her two babies as breast-feeders, increased her own insight into the breastfeeding relationship she had developed with her new baby. Nicole was authentic in her embodied enjoyment of the breastfeeding process.

Weaving It All Together

Embodiment, relational support and commitment have been identified as the main themes of the breastfeeding experiences of these women. All women experienced some degree of difficulty with breastfeeding in the very early postpartum period, shaping their experience of these themes. As these three themes are woven together to create a tapestry of experience, variation in warp and weft while working on life's loom creates distinction in thickness and color that enhances the subtleties of difference in each woman's experience.

As noted in Chapter 6, breastfeeding is an embodied experience. The process of embodiment begins with the very first feeding and evolves as the breastfeeding journey unfolds. Each woman was unique in her experience of this embodied activity. The knowledge and confidence resulting for most from this embodied activity was only realized over time as the developing embodied relationship with the baby deepened. Joy in breastfeeding their babies was expressed as a result of these embodied processes (McBride-Henry et al., 2009). However, in order to reach this point in the journey, commitment and relational support were required.

The notion of commitment to the breastfeeding process was vital to the success of these women. Commitment was borne of the original intention to breastfeed. Situated knowledge of the nutritional excellence of breast milk as promoted within their world fuelled each mother's feelings of commitment. The desire to be good mothers, again as understood within their *situatedness* in their worlds, also contributed to feelings of commitment to breastfeeding. Commitment was sustained in and through supportive relationships that valued breastfeeding as a feeding choice. Acceptance of the reality that

is breastfeeding – breastfeeding can be hard – and strong personal determination was required to maintain commitment to the process.

Genuine support for a woman’s breastfeeding efforts was invaluable to the overall experience. Upon the birth of their babies, all women immediately sought support for breastfeeding from their healthcare providers – the nurses, doulas, and physicians involved in their care. Early efforts at learning how to breastfeed were made easier when healthcare providers expressed a perceived sincere interest in helping these women. Sincerity was denoted by taking the time to listen to the woman’s story, respecting her experience, observing her breastfeeding activities and portraying empathy for her situation. Relationships perceived to be founded in sincerity (perceived as caring) were highly valued by these women.

Upon returning to their homes, these women turned primarily to family and friends for support of their breastfeeding efforts. When expected sources of support (e.g., husbands, healthcare providers) were perceived as not forthcoming or insincere, trusted sources of support were sought elsewhere. These mothers engaged significant others to provide support borne of experience. As women with previous breastfeeding experience, the stories and advice of mothers and select women friends were judged to be helpful and supportive in the face of physical discomfort (e.g., sore nipples) and prolonged fatigue. When sincere support was realised, the breastfeeding journey was made easier (Barclay et al., 2012).

As the initial experiences of fatigue and nipple pain diminished and breastfeeding became easier and more enjoyable, the embodied experiences of breastfeeding culminated over time in varying degrees of bodily knowledge and self-confidence borne

of this process. Supportive relationships with significant others, and a strong sense of commitment enabled most of these women to realize some joy in the embodied relationship that had developed over time with their baby.

Unfortunately, this was not Alex's experience. The experience of continuous breast pain proved to be a barrier for Alex to find joy in the embodied aspects of her breastfeeding experience. Relational support for her breastfeeding efforts was not enough to authentically maintain her sense of commitment to breastfeeding due to her extreme physical discomfort. Her experience of pain induced a paradigm shift as she contemplated a switch to formula for her baby.

Back to the Beginning – Making the Choice to Breastfeed

I met someone at school actually who just had a baby, and she said...I don't know how it came up but I said something about breastfeeding. And I said, oh, are you breastfeeding? And she said, "Well, yeah, you kind of have to these days, don't you, or else you're ridiculed." So she almost felt like society now is making her breastfeed. So she's doing it, but reluctantly. (Suzanne)

Women are *thrown* into worlds not of their own making. The prevailing public *mood* surrounding choice and infant feeding sees government and healthcare providers promoting breastfeeding as the best way to feed babies in North America (AWHONN, 2015; NSDHW, 2011). Scientific evidence supports breast milk provision for babies, preferably through breastfeeding (Burns et al., 2012; Newton, 2004). Highlighted in the selected quote above, moral pressure by society and by significant *others* is exerted on women to breastfeed their babies as 'good' mothers breastfeed (Schmied & Lupton, 2001; Wall, 2001). Women are inundated with advice and information from family,

friends, healthcare professionals, and media resources about breastfeeding activities for their babies (Barclay et al., 2012; Wolf, 2007). As this is so, is the choice to breastfeed truly their own?

Recognizing the role of *mood* in decision-making. Sustaining the choice to breastfeed is accomplished in and through a woman's commitment to the process. A woman's commitment is strengthened in and through supportive relationships perceived to be sincere and caring. As was discussed in Chapter 2, many women choose to breastfeed; far fewer sustain this choice for the recommended time frame of at least six months (Gionet, 2013). Completion of this research has made visible the notion of *mood* as espoused by Heidegger as having a role in the sustainment of breastfeeding as a feeding choice.

As women transition to the role of mother, they experience a *mood* of anxiety as they move through the maternal tasks of pregnancy (Rubin, 1975), a notion introduced in Chapter 5. Within a world espousing the ideal of the 'good mother', their experience of anxiety as a collective *mood* attunes them to this ideal, thereby influencing their decision-making regarding feeding their babies (Sutherland, 2010). Women will choose to engage in baby-care practices supported within their worlds, irrespective of their own mode of existence. The choice to breastfeed may originate from a stance that is authentic, inauthentic or undifferentiated; if *situatedness* in the woman's world supports this choice of infant feeding, then many women will declare their intention to feed their babies this way in order to *be* the 'good mother'.

A *mood* of commitment begins to flow from this *mood* of anxiety as mothers engage in caring for their newborn babies. Attunement to the provision of care extends to

feeding choices, as understood within the situatedness of the mother. A *mood* of commitment to a feeding choice is strengthened as mothers engage in feeding activities and they begin to live their choice of infant feeding. Although not always an authentic mode of existence, these study mothers collectively demonstrated a *mood* of commitment to breastfeeding their babies.

Relational *mood*. All of these women described relationships grounded in sincerity and caring as invaluable to sustainment of their commitment to the breastfeeding process. In the early days following birth, healthcare professionals exhibiting these qualities were valued for their presence and knowledge. Although some husbands were lauded for their supportive involvement at the time immediately following birth, most were appreciated simply for their everyday, undifferentiated support.

Equally valued, sometimes more, were relationships with other women endowed with breastfeeding knowledge and experience – mothers, sisters, and friends. Although knowledge of breastfeeding acquired through reading and other resources can be of value to women, better still is the expertise of those with breastfeeding experience. The woman-to-woman mentoring that occurred within these relationships provided strength and support as these women struggled to maintain their commitment for this choice of feeding. Knowing other women had travelled similar roads provided some assurance that they too could come to a place of comfort and satisfaction with their breastfeeding efforts, a notion well supported in the literature (Bartlett, 2002; Barclay et al., 2012; Stearns, 2013). With this support, the *mood* of commitment was sustained.

Embodied *mood*. All these women expressed knowledge of how they were ‘supposed’ to feed their babies, a belief fully embraced within their lived worlds. As

their pregnancies progressed, they reflected upon the choices open to them for infant feeding, before expressing their intent to breastfeed their babies. All were attuned to the nutritional benefits of breastfeeding. They did reflect, albeit fleetingly, upon what breastfeeding would mean to them – how they would feel about breastfeeding, and how it might impact their life. As only Nicole had previous breastfeeding experience, she was the only one whose expectations for breastfeeding were grounded in reality for this second baby. Although the other mothers had prepared for this experience, none were truly ready for the actuality that was their experience. Committing to the breastfeeding experience entailed the learning of new psychomotor skills to enable handling a newborn while breastfeeding, disorganized feeding episodes, the endurance of physical discomfort while feeding, and extreme fatigue, all while recovering from the birth experience. Commitment to breastfeeding was seen to wane when physical discomfort persisted, especially if support was less than desired or requested, resulting in a paradigm shift within one woman's world.

I reiterate here – breastfeeding is an embodied process. For those mothers authentically supported in their breastfeeding efforts whose commitment did not falter, the embodied activity of breastfeeding grew to be something more. Only when the physical recovery from the birthing and early breastfeeding experiences was complete did mothers engage in reflection upon the breastfeeding process, now experienced as a *ready-to-hand* activity, leading to a deeper exploration of meaning in and of the experience. For Piper and Suzanne, this reflective process led to a deeper appreciation of the embodied relationship they now enjoyed with the baby. Engaged in this *ready-at-hand* activity, these mothers could reflect upon the comfort they provided to their infants while

watching them grow and develop (Conroy, 2003; McBride-Henry et al., 2009). For these mothers, breastfeeding had moved from the realm of a feeding activity embraced within their *situatedness*, to one integral to the healthy growth and development of their baby, providing much personal joy and satisfaction with their own participation in their breastfeeding journeys.

Sustaining the *mood*. Throughout this thesis, I introduced the notion of authentic, inauthentic and undifferentiated ways of being to interpret the stories shared by these women. Each mother experienced instances of authentic, inauthentic and undifferentiated modes of existence throughout her breastfeeding journey, often dependent upon her physical experiences of this activity. However, each woman remained committed to her chosen path for feeding her baby, regardless of the mode of existence she inhabited while on her journey. Meaningful relational support was significant to the sustainment of this commitment as these women spiralled between moments of enjoying a feeding choice grounded in authenticity and one that was not. As physical discomforts lessened and familiarity of breastfeeding technique was realized, breastfeeding was more often enjoyed as an embodied, *ready-at-hand* activity. Authentic resoluteness of choice (and commitment) was realised by some of these mothers; some mothers continued to maintain an authentic/undifferentiated stance about their choice to breastfeed. When breastfeeding was associated with chronic pain as was the case for Alex, choice remained rooted in inauthenticity.

Enhancing the *mood of understanding*. So, what meaning emanates from this research? As a nurse, mother, and woman, I believe that breastfeeding is best for babies and mothers, whenever possible. However, as only women can breastfeed babies, I

believe it is the right of any woman to choose how she will feed her baby. Understanding the Heideggerian notion of *mood*, as reflected in the experience of women in the postpartum phase, affords me a greater appreciation of the process of choosing a method of infant feeding. *Mood* attunes mothers to make choices for infant feeding that reflect commitment to providing the best care for their baby, as understood in and through the worlds in which they dwell. Commitment to a feeding method may be authentic, inauthentic or undifferentiated. However, it is only over time that such commitment will reveal itself to be truly authentic or not, as reflection upon the feeding journey reveals the true meaning inherent to the experience.

With the completion of this study I have validated my own understanding that the full impact of the embodiment of breastfeeding is only realized with ‘hands-on’ engagement by mothers, over time. As this is so, the authenticity of a mothers’ commitment to the breastfeeding process in the early days of the postpartum may wax and wane, an inevitable response to physical experiences such as fatigue and nipple pain. The greater realization of this work is the importance of relational support for women as they commit to breastfeeding their babies. Such support is necessary for women to sustain their mood of commitment to breastfeeding until they build confidence and trust in their bodily capacity to nourish their babies. Support along their breastfeeding journey can enable women to reach a point whereby they might enjoy breastfeeding as an embodied, *ready-at-hand* activity that can result in strong embodied relationships with their infants through breastfeeding.

Women who remain inauthentically committed to breastfeeding require increased support to explore and acknowledge their feelings such as unresolved conflict about the

process, or a dislike for breastfeeding. Such support might be hard to access within their situated existence (Schmied, Sheehan & Barclay, 2001). Should their world support breastfeeding as the best choice for infant feeding, it becomes difficult to reverse this decision as many mothers, often at great cost to themselves, desire to be seen as a ‘good mother’, a designation often equated with breastfeeding in personal and societal expectations (Lee, 2012; Nelson, 2012; Rossman & Ayoola, 2012; Schmied et al., 2011; Sheehan et al., 2003; Sheehan et al., 2009, 2013; Wolf, 2007

Caring for women in the childbearing phase of their lives requires an exploration of their location within their world. As women begin the infant-feeding decision-making process, it is important to me, as a nurse, to understand their experiences of and about this topic. How do women feel about breastfeeding, or formula feeding? How do women understand the role of mother? How does the role of mother fit with other roles women might inhabit? What makes women feel good about being a mother? To what are women attuned (what is important to them) as they make this feeding decision? What significant (or not) relationships influence this feeding decision? How best can I support women throughout this process? How can I help women to maintain and enhance their sense of Self throughout this process? This final question brings me to the topic of autonomy, a topic founding this research project.

So, what about autonomy?

I reflected once more upon Goering’s questions around the possibility of autonomous behaviour during the postpartum period of the childbearing experience (2009). Given what I had heard and understood of the experiences of these mothers, I believe there is a modicum of truth in Goering’s proposition – that the physical and

emotional stress inherent to the immediate postpartum experience negates the possibility for autonomous capacity. How can women make ‘good’ decisions that will impact their baby, and themselves, in the face of the uncertainty that can be found in the postpartum experience? Further reflection encourages me to write that this is not a word well suited to the experience of women during this time period, especially in relation to breastfeeding. The benefits and limitations of traditional theoretical constructs of autonomy are questionable with the realization that the findings of this study have contributed to the uncovering of many more questions and reflections on the nature of autonomy and authentic resoluteness, especially for this population of women.

As previously discussed in Chapters 2 and 5, Heidegger wrote of authentic resoluteness in lieu of autonomy. *Dasein* exists in a world of situated *thrownness*. As such, she comes to understand the ways of her world in and through the interdependence and interconnection of her relational engagement. Heidegger writes that a resolute *Dasein*, while being true to herself, does not pull away from her world to do so, but engages solicitously in relational activity to address concerns of import. Authentic resoluteness is only achieved in relation with Others (Blattner, 2013; Dahlstrom, 2013; Dreyfus, 1991). As has been demonstrated in the stories shared, authentic resoluteness was achieved in and through the embodied relationship developed with the infant; this achievement was a relational process. As the joy and value of this relationship was realized, these mothers became resolute in the authenticity of their commitment to their babies – breastfeeding was indeed the best choice for them.

Such thinking resonates with the concept of relational autonomy. With the birth of a child, a woman is immediately in relation as part of a dyad, simultaneously situated

within a web of relations that constitutes her world as “...the degree to which one is able to be autonomous depends on one’s past and present relations to others” (Brison, 2000, p. 285). Situated within this world, women make decisions taking into account the wants and needs of significant others. Maier writes, “The concept of individual autonomy is too narrow to ensure ethical decision-making” (2014, p. 47). With the birth of a child, women will reflect upon the best choices for caring for her infant, as reflected within her world, embedding her expression of autonomy within the web of relations that surround her.

In launching this study, I expressed a desire to explicate the experience of autonomy for women within the process of decision-making around infant feeding. I was asked how I might ‘know’ autonomy should I be able to do this. In truth, I really did not know. However, as I complete this work, I believe I have been privileged to witness instances of maternal autonomy that is relational in nature. I recognize that such instances are relevant only to this study – autonomous behaviour may look quite different elsewhere. However, I believe autonomy was visible in the expression of joy in the embodied relationship mothers’ shared with their infant. It was visible in the sense of thriving of baby and maternal persona. It was visible in the increased sense of trust in bodily ability realized of the breastfeeding success, as measured by a growing, satiated, happy baby. It was visible in the maternal aura of enhanced self-confidence. As witness to the experiences of these mothers, I now more fully understand Brison as she writes of the increased autonomy constituted in and through the embodied relationship she enjoyed with her son (1997).

Study Strengths and Limitations

The strength of this study resonates in the application of Heidegger's phenomenology to explore and interpret the experience of maternal decision-making around infant feeding. As a philosophy grounded in relational being, it is well matched to the exploration of experiences involving mothers, babies and the worlds where they dwell. Using a hermeneutic process, meaning of this experience was derived by the shared engagement and reflection upon each woman's experience of *being-in-the-world*. Heideggerian concepts of *embodiment*, *being-with*, and *mood*, were applied to interpret the stories shared by these women (Aho, 2009; Delancey, 2006, 2014; Freeman, 2009, 2014; Heidegger, 1927/1962). Each concept was used as a lens through which to better understand and interpret commonality within the uniqueness of the individual experiences of each woman. In this way, the notion of commitment as *mood* emerged from their stories. Through integration of theory with shared experiences, a deeper understanding of the experience of maternal choice around feeding has been elucidated.

Although the study was advertised widely in areas providing care to pregnant women, the numbers seeking information and then agreeing to participate were small. It must be noted that other studies recruiting from this same population were advertised simultaneously. However, I believe that for many women, breastfeeding is a topic heavily laden with emotion and much potential for judgment. In a world that is supportive of breastfeeding as the optimal choice for feeding babies, women may be guarded in their desire to discuss their thoughts and desires about breastfeeding, hence their hesitation to participate in this study.

In keeping with this qualitative form of research, the findings recorded here are not generalizable to larger populations, however they certainly should be considered when caring for women in similar situations. Findings in this project do support those described in similar research (Schmied & Barclay, 1999; Sheehan et al., 2013), however the use of a Heideggerian lens to appraise this research has provided nuances of experience not previously seen in past work. Exploration of the Heideggerian concept of *mood* has been demonstrated to be of value in understanding a mother's experience of breastfeeding. Embodiment of the breastfeeding process, invaluable to sustainment of long-term breastfeeding, occurs over time. Sustainment of the mood of commitment for breastfeeding to enable embodiment is demonstrated to be stronger with the provision of adequate relational support. With successful breastfeeding embodiment, it is possible for a mother to realize a sense of autonomy.

So What? Recommendations for Nursing

With the birth of a baby, women transition to the role of mother. The meaning inherent in this role is greatly influenced by the world into which she has been thrown, or her *situatedness*. She will know this role and all of its possibilities as a reflection of the web of relations that constitute this world. Choices around birthing scenarios, caregivers, and feeding options are all reflections of knowledge appropriated within her world. Although *mood* will attune her to issues of significance, choice will still be strongly influenced by the relational situatedness of her world.

National initiatives supporting global mother and child health do not extend within our own country (Government of Canada, 2014). In Nova Scotia, economic realities of the healthcare system and normalization of childbirth contributes to shorter stays in

hospital, resulting in decreased access to nurses and other healthcare professionals in the immediate postpartum phase. These same economic pressures have resulted in a streamlining of community healthcare resources, often limiting nursing care provision for women in the early postpartum phase to screening triage by telephone. Should a woman meet the criteria for more involved nursing support, a nurse will be assigned to make a home visit. However, support for breastfeeding mothers is often found wanting in this scenario.

Breastfeeding is hard. For many women, especially those choosing this method of feeding for the first time, breastfeeding is not a natural activity. As a physiologic progression inherent to the childbearing process, the enactment of successful breastfeeding is often imbued with difficulty in the early weeks, as has been made visible in this study. As mothers want to do the best for their babies (e.g., breastfeed), so are they willing to endure much in the first weeks after the birth. As an embodied process requiring strength of commitment and relational support vital to sustain the journey, breastfeeding mothers need nurses to be providers of information, teachers of technique, cheerleaders, and to maintain a meaningful presence as they embark on this journey. Researchers support the impact of quality ‘one-to-one’ nursing support upon long-term sustainment of breastfeeding (Barclay et al., 2012; Brown et al., 2011; Manganaro et al., 2008; Rossman & Ayoola, 2012; Schmied et al., 2011). However, nursing workloads of those caring for mothers and babies in hospital and community are such that meaningful relationship development can be difficult. Barclay et al. (2012) suggest that:

this might be related to losing sight of the embodied nature of breastfeeding and the relationships that must exist between the mother and baby, the knowledge and skills

women quickly develop, and a loss of woman to woman support. Replacing this with institutional regulations and limiting opportunities to develop authentic presence and facilitative relationships between caregivers, family and friends exacerbate this loss of recognition of breastfeeding as a social/emotional/emodied practice (p. 289).

The findings of this research reiterate the relational quality required of nurse-client interactions. Authenticity of support from nurses is valued as mothers negotiate the breastfeeding process. Given time pressures on very busy nursing units, nurses should be afforded opportunity to facilitate the development of meaningful relationships with their clients as a priority to meeting goals for breastfeeding.

As a complex phenomenon that is often engaged with much uncertainty and trepidation, breastfeeding is a unique experience for all women (Barclay et al., 2011; Schmied et al., 2001). In light of increasing health promotion campaigns pressuring women to choose breastfeeding for infants, women need and deserve a level of support commensurate to their experience to fulfill this collective goal. Nursing has a moral and ethical responsibility to provide care that engages women in a meaningful manner, demonstrating respect for them as they are situated within their worlds. Meeting clients ‘where they are’ and being present in the moment enables nurses to develop relationships with women grounded in openness, trust and respect (Aston et al., 2015; Austin, 2007; Bergum, 2004; Evans et al., 2004; Goldberg, 2005). In doing so, nurses can enable women to meet goals they have set, such as exclusive breastfeeding, that are grounded in the reality of their own environments.

Time is of the essence in relationship development, a component frequently undervalued in current workload measurement scales. Nurses require time to engage in information gathering, the building of trust, and the sharing of knowledge. In the face of current nursing environments, how do nurses make changes that accept the value of relationship building to support health promotion ideals?

This research provides evidential support to the collective nursing voice calling for recognition and revision required for nursing support to meet the needs of new mothers as they embark upon the challenges of caring for their infants. Women in this study have demonstrated the importance of relational support to sustain their commitment to their chosen path of exclusive breastfeeding. By asking the questions previously outlined, we can meet women where they dwell –we can *be-with* women – and our understanding of their situatedness is enhanced.

Implications for Future Research

This study has focused upon the maternal experience of breastfeeding as a choice for infant-feeding. As research often creates questions to enhance further explication of phenomena, so too does this project. As the embodiment of breastfeeding is understood as a process, a more-involved and longer study could enhance insight into the evolution of the process of embodiment as it relates to the maternal-infant relationship. What emotions are prevalent in mothers as this relationship grows? Do mothers who breastfeed their babies experience an enhanced maternal-infant relationship when compared to mothers who feed their infants formula? I have made visible themes affecting the process of decision-making around infant-feeding, however I believe more study is required to enhance understanding about the experience of authentic

resoluteness, autonomy, and decision-making in times of physical and emotional distress resulting in changing priorities.

My Final Thoughts

This study has provided me with much insight into the maternal experience of choosing, and maintaining a commitment to breastfeed. The use of Heideggerian phenomenology to appropriate this knowledge has proved illuminating. The ontological nature of this philosophy has provided an interpretation that is revelatory of the infant feeding experiences of women, and of the questions about the experience of autonomy in the postpartum still to be explored. I close with this quote.

Motherhood is challenging, to say the least. The responsibilities can be overwhelming. ... Experienced mothers have much to share with new women just beginning to take on this role, and amusing stories are a wonderful way to endear us to one another. ... The neophyte struggling with her new role as mother can find tremendous comfort in learning about the trials other women have dealt with and won. (Harvey & Haldeman, 2013, p. 4)

References

- Ahluwalia, I., Morrow, B. & Hsia, J. (2005). Why do women stop breastfeeding? Findings from the pregnancy risk assessment and monitoring system. *Pediatrics*, *116* (6), 1408-1412.
- Aho, K. (2009). *Heidegger's neglect of the body*. Albany, NY: State University of New York.
- Aho, K. (2013). The body. In F. Raffoul and E. Nelson (Eds.), *The Bloomsbury companion to Heidegger* (pp. 269-274). New York, NY: Bloomsbury Press.
- Aktan, N. (2007). Functional status after childbirth: A review of the literature. *Clinical Nursing Research*, *16* (3), 195-211.
- Allen, M. & Jensen, L. (1990). Hermeneutical inquiry: Meaning and scope. *Western Journal of Nursing Research*, *12*, 241-253.
- Ament, L. (1990). Maternal tasks of the puerperium re-identified. *Journal of Gynecologic, Obstetrical and Neonatal Nursing*, *19* (4), 330-335.
- Anderson, J. (1991). The phenomenological perspective. In J. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 25-38). Newbury Park, CA: Sage Publications.
- Anells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, *23*, 705-713.
- Archabald, K., Lundsberg, L., Triche, E., Norwitz, E. & Illuzzi, J. (2011). Women's prenatal concerns regarding breastfeeding: Are they being addressed? *Journal of Midwifery and Women's Health*, *56*, 2-7.
- Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and the Family*, *62*, 1192-1207.
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). (2015). AWHONN position statement: Breastfeeding. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, *44* (1), 145-150.
- Aston, M. (2002). Learning to be a normal mother: Empowerment and pedagogy in postpartum classes. *Public Health Nursing*, *19* (4), 284-293.
- Aston, M. (2008). Public health nurses as social mediators navigating discourses with new mothers. *Nursing Inquiry*, *15* (4), 280-288.

- Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C. et al. (2015). The power of relationships: Exploring how public health nurses support mothers and families during postpartum home visits. *Journal of Family Nursing*, 21 (1), 11-34.
- Aston, M., Saulnier, C. & Robb, K. (2010). Not just another delivery: Women's maternity care experiences of provider client relationships. *Women's Health and Urban Life*, 9 (1), 32-49.
- Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science*, 30, 81-88.
- Avishai, O. (2007). Managing the lactating body: The breast-feeding project and privileged motherhood. *Qualitative Sociology*, 30, 135-152.
doi:10.1007/s11133-006-9054-5
- Badinter, E. (2011). *The conflict: How modern motherhood undermines the status of women*. (translated by A. Hunter). Toronto, ON: HarperCollins Publishers Ltd.
- Baier, A. (1981). Cartesian persons. *Philosophia: Philosophical Quarterly of Israel*, 10, 169-188.
- Bambach, C. (2011). Review essays: The time of the self and the time of the other. *History and Theory*, 50, 254-269.
- Banks, A. (2011). Developing the capacity to connect. *Zygon: Journal of Religion and Science*, 46 (1), 168-182.
- Barclay, L. (2000). Autonomy and the social self. In C. MacKenzie & N. Stoljar (Eds.), *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self* (pp. 52-71). New York, NY: Oxford University Press.
- Barclay, L., Longman, J., Schmied, V., Sheehan, A., Rolfe, M., Burns, E. & Fenwick, J. (2012). The professionalizing of breast feeding – where are we a decade on? *Midwifery*, 28, 281-290.
- Bartlett, A. (2002). Breastfeeding as headwork: Corporeal feminism and meanings for breastfeeding. *Women's Studies International Forum*, 25 (3), 373-382.
- Baumslag, N. & Michels, D. (1995). *Milk, money, and madness: The culture and politics of breastfeeding*. Westport, CT: Bergin and Garvey.
- Baylis, F. (2012). The self in situ: A relational account of personal identity. In J. Downie & J. Llewellyn (Eds.), *Being relational: Reflections on relational theory and health law* (pp. 109-131). Vancouver, BC: UBC Press.

- Beauchamp, T. & Childress, J. (1994). *Principles of biomedical ethics (4th ed.)*. New York, NY: Oxford University Press, Inc.
- Beck, C. (2002). Theoretical perspectives of postpartum depression and their treatment implications. *MCN: The American Journal of Maternal/Child Nursing*, 27 (4), 282-287.
- Ben-Ari, A. & Weinberg-Kurnik, G. (2007). The dialectics between the personal and the interpersonal in the experiences of adoptive single mothers by choice. *Sex Roles*, 56, 823-833.
- Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring and ethics in health and illness* (pp. 99-127). Thousand Oaks, CA: Sage Publications, Inc.
- Benner, P. (2000). The roles of embodiment, emotion and lifeworld for rationality and agency in nursing practice. *Nursing Philosophy*, 1, 5-19.
- Benner, P. & Wrubel, J. (1989). *The primacy of caring*. Menlo Park, CA: Addison-Wesley Publishing Co.
- Bergum, V. (2003). Relational pedagogy. Embodiment, improvisation, and interdependence. *Nursing Philosophy*, 4, 121-128.
- Bergum, V. (2004). Relational ethics in nursing. In J. Storch, P. Rodney & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 485-503). Toronto, ON: Prentice Hall.
- Bergum, V. & Dossetor, J. (2005). *Relational ethics: The full meaning of respect*. Hagerstown, MD: University Publishing Group, Inc.
- Bessant, K. (2010). Authenticity, community, and modernity. *Journal for the Theory of Social Behavior*, 41 (1), 2-32.
- Bishop, A. & Scudder, J. (1997). A phenomenological interpretation of holistic nursing. *Journal of Holistic Nursing*, 13 (2), 103-111.
- Blackburn, S. (2007). *Maternal, fetal and neonatal physiology (3rd ed.)*. St. Louis, MO: Saunders, Elsevier, Inc.
- Blattner, W. (2013). Authenticity and resoluteness. In M. Wrathall (Ed.), *The Cambridge companion to Heidegger's 'Being and Time'* (pp. 320-337). New York, NY: Cambridge University Press.

- Blyth, R., Creedy, D., Dennis, C., Moyle, W., Pratt, J. & De Vries, S. (2002). Effect of maternal confidence on breastfeeding duration: An application of breastfeeding self-efficacy theory. *Birth*, 29 (4), 278-284.
- Boland, M. (2005). Exclusive breastfeeding should continue to six months. *Paediatrics and Child Health*, 10 (3), 148. Retrieved from : <http://www.cps.ca/english/statements/n/breastfeedingmar05.htm>
- Bollnow, O. (1961). Lived-space. *Philosophy Today*, 5, 31-39.
- Borrett, D., Kelly, S. & Kwan, H. (2000). Bridging embodied cognition and brain function: The role of phenomenology. *Philosophical Psychology*, 13 (2), 261-266.
- Bottorff, J. (1990). Persistence in breastfeeding: A phenomenological investigation. *Journal of Advanced Nursing*, 15, 201-209.
- Boyd, E. (2005). Mothers at home: Oppressed or oppressors or victims of false dichotomies? In A. O'Reilly, M. Porter & P. Short (Eds.), *Motherhood: Power and oppression* (pp. 195-203). Toronto, ON: Canadian Scholars' Press Inc.
- Boyd, S. (2010). Autonomy for mothers? Relational theory and parenting apart. *Feminist Legal Studies*, 18, 137-158. doi:10.1007/s10691-010-9152-3
- Braff, A. (2013). Breastfeeding boot camp. In R. Epp Buller (Ed.), *Have milk, will travel: Adventures in breastfeeding* (pp. 68-71). Bradford, ON: Demeter Press.
- Braman (2008) *Meaning and authenticity*. Toronto, ON: University of Toronto Press.
- Brison, S. (1997). Outliving oneself: Trauma, memory, and personal identity. In D. T. Meyers (Ed.), *Feminists rethink the self* (pp. 12-39). Boulder, CO: Westview Press, Inc.
- Brison, S. (2000). Relational autonomy and freedom of expression. In C. Mackenzie & N. Stoljar (Eds.), *Relational Autonomy* (pp. 280-299). New York, NY: Oxford University Press.
- Broome, M. & Carel, H. (2009). The ubiquity of moods. *Philosophy, Psychiatry and Psychology*, 16 (3), 267-271. doi:10.1353/ppp.0.0246
- Brown, A., Raynor, P. & Lee, M. (2011). Healthcare professionals' and mothers' perception of factors that influence decisions to breastfeed or formula feed infants: A comparative study. *Journal of Advanced Nursing*, 67 (9), 1993-2003.

- Brown, C., Dodds, L., Attenborough, R., Bryanton, J., Rose, A., Flowerdew, G., Langille, D., Lauzon, L. & Semenic, S. (2013). Rates and determinants of exclusive breastfeeding in fir six months among women in Nova Scotia: A population-based cohort study. *CMAJ Open* 2013, E9-E17. doi:10.9778/cmajo.20120011
- Brown, L., Debold, E., Tappan, M. & Gilligan, C. (1991). Reading narratives of conflict and choice for self and moral voices: A relational method. In W. Kurtines & J. Gewirtz (Eds.), *Handbook of moral behavior and development, Volume 2: Research* (pp. 25-61). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Brown, S., Small, R. & Lumley, J. (1997). Being a 'good mother'. *Journal of Reproductive and Infant Psychology*, 15 (2), 185.
- Browne, A., Doane, G., MacLeod, M. & McLellan, E. (2010). Public health nursing practice with 'high priority' families: The significance of contextualizing 'risk'. *Nursing Inquiry*, 17 (1), 27-38.
- Buber, M. (1970). *I and thou*. (W. Kaufmann, Trans.). New York, NY: Charles Scribner's Sons. (Original work published 1934).
- Burch, R. (1986). Confronting technophobia: A topology. *Phenomenology and Pedagogy*, 4 (2), 3-21.
- Burke-Aaronson, A. (2015). Skin-to-skin care and breastfeeding in the perioperative suite. *The American Journal of Maternal/Child Nursing*, 40 (2), 105-109.
- Burns, E., Schmied, V., Fenwick, J. & Sheehan, A. (2012). Liquid gold from the milk bar: Constructions of breastmilk and breastfeeding women in the language and practices of midwives. *Social Science and Medicine*, 75, 1737-1745.
- Burns, E., Schmied, V., Sheehan, A. & Fenwick, J. (2010). A meta-ethnographic synthesis of women's experience of breastfeeding. *Maternal and Child Nutrition*, 6, 201-219.
- Butler, J. (2007). Performative acts and gender constitution: An essay in phenomenology and feminist theory. In H. Bial (Ed.), *The performance studies reader* (2nd ed.). New York, NY: Routledge.
- Cameron, B. (2004). Ethical moments in practice: The nursing 'how are you' revisited. *Nursing Ethics*, 11 (1), 53-62.
- Campbell, J. & Gilmore, L. (2007). Intergenerational continuities and discontinuities in parenting styles. *Australian Journal of Psychology*, 59, 140-150.
- Cancellaro, C. (2001). *Pregnancy stories*. Oakland, CA: New Harbinger Publications, Inc.

- Carman, T. (2005). Authenticity. In H. Dreyfus & M. Wrathall (Eds.), *A companion to Heidegger* (pp. 285-296). Cornwall, UK: Blackwell Publishing Ltd.
- Carnevale, F. (2005). The palliation of dying: A Heideggerian analysis of the 'technologization' of death. *The Indo-Pacific Journal of Phenomenology*, 5 (1), 1-12. Retrieved from: <http://www.ajol.info/index.php/ipjp/article/view/65612>
- Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1 (1), 13-23.
- Carson, G. (2012). *Encountering the other in nurse-patient pedagogic relationships: Becoming we*. (Unpublished doctoral thesis). University of Alberta, Edmonton, AB. Available from ProQuest Dissertations and Theses database. (UMI No. NR89549)
- Carter, S. & Little, M. (2007). Justifying knowledge, justifying method, taking action: epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, 17 (10), 1316-1328.
- Chalmers, B. (2013). Breastfeeding unfriendly in Canada? *Canadian Medical Association Journal*, 185 (5), 375-376.
- Chalmers, B., Levitt, C., Heaman, M., O'Brien, B., Sauve, R. & Kaczorowski, J. (2009). Breastfeeding rates and hospital breastfeeding practices in Canada: A national survey of women. *Birth*, 36 (2), 122-132.
- Chan, G., Brykczynski, K., Malone, R. & Benner, P. (2010). *Interpretive phenomenology in health care research*. Indianapolis, IN: Sigma Theta Tau International.
- Chanter, T. (2001). The problematic normative assumptions of Heidegger's ontology. In N. Holland & P. Huntington (Eds.), *Feminist interpretations of Martin Heidegger* (pp. 73-108). University Park, PA: The Pennsylvania State University Press.
- Christie, J., Poulton, B. & Bunting, B. (2007). An integrated mid-range theory of postpartum family development: A guide for research and practice. *Journal of Advanced Nursing*, 61 (1), 38-50.
- Code, L. (2000). The perversion of autonomy and the subjection of women. In C. MacKenzie & N. Stoljar (Eds.), *Relational autonomy* (pp. 181-209). New York, NY: Oxford University Press.
- Cody, W. (2003). Paternalism in nursing and healthcare: Central issues and their relation to theory. *Nursing Science Quarterly*, 16 (4), 288-296.
doi:10.1177/0894318403257170

- Cohen, M. (1987). A historical overview of the phenomenologic movement. *Image: Journal of Nursing Scholarship*, 19 (1), 31-34.
- Conroy, S. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods*, 2 (3), 36-62.
- Conroy, S. & Dobson, S. (2005). Mood and narrative entwinement: Some implications for educational practice. *Qualitative Health Research*, 15 (7), 975-900.
- Creswell, J. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Cricco-Lizza, R. (2004). Infant-feeding beliefs and experiences of Black women enrolled in WIC in the New York metropolitan area. *Qualitative Health Research*, 14 (9), 1197-1210.
- Crowther, S., Smythe, L. & Spence, D. (2014). Mood and birth experience. *Women and Birth*, 27, 21-25.
- Dahlstrom, D. (2013). *The Heidegger dictionary*. New York, NY: Bloomsbury Academic.
- Dalbye, R., Calais, E. & Berg, M. (2011). Mothers' experiences of skin-to-skin care of healthy full-term newborns – A phenomenology study. *Sexual and Reproductive Healthcare*, 2, 107-111.
- Dali, S. (1975). *Gaia nude looking out to sea*. Fundació Gala-Salvador Dalí, Figueres, Spain.
- Dally, A. (1982). *Inventing motherhood: The consequences of an ideal*. London, UK: Burnett Books Ltd.
- Davis, S., Stichler, J. & Poeltler, D. (2012). Increasing exclusive breastfeeding rates in the well-baby population. *Nursing for Women's Health*, 16 (6), 460-470.
- Davis-Floyd, R. (2003). *Birth as an American rite of passage* (2nd ed.). Berkeley, CA: University of California Press.
- Davis-Floyd, R., Barclay, L., Daviss, B. & Tritten, J. (2009). Introduction. In R. Davis-Floyd, L. Barclay, B. Daviss & J. Tritten (Eds.), *Birth models that work* (pp. 1-27). Los Angeles, CA: University of California Press.
- DeLancey, C. (2006). Basic moods. *Philosophical Psychology*, 19 (4), 527-538.
- DeLancey, C. (2014). Commitment and attunement. *Phenomenological Cognitive Science*, 13, 579-594.

- Demirtas, B. (2012). Strategies to support breastfeeding: A review. *International Nursing Review*, 59 (4), 474–481.
- de Montigny, F. & Lacharite, C. (2004). Fathers' perceptions of the immediate postpartal period. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33, 328-339.
- de Montigny, F. & Lacharite, C. (2005). Perceived parental efficacy: Concept analysis. *Journal of Advanced Nursing*, 49, 387-396.
- de Montigny, F. & Lacharite, C. (2008). Modeling parents and nurses' relationships. *Western Journal of Nursing Research*, 30, 743-758.
- de Montigny, F., Lacharite, C. & Amyot, E. (2006). Becoming a parent: A model of parents' post-partum experience. *Paideia*, 16 (33), 25-36.
- Dennis, C. (2002). Breastfeeding initiation and duration: A 1990-2000 literature review. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 31 (1), 12-32.
- Doane, G. & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in Nursing Science*, 30 (3), 192-205. doi:10.1111/j.1365-2648.2011.05647.x
- Donchin, A. (2001). Understanding autonomy relationally: Toward a reconfiguration of bioethical principles. *Journal of Medicine and Philosophy*, 26 (4), 365-386.
- Dowling, M. From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44, 131-142.
- Dreyfus, H. (1991). *Being-in-the-world: A commentary on Heidegger's Being and Time*. Boston, MA: Massachusetts Institute of Technology.
- Dreyfus, H. (2004). Heidegger and Foucault on the subject, agency and practices. Lecture notes. The Department of Philosophy, University of California, Berkeley, CA. Retrieved from:
http://socrates.berkeley.edu/%7Ehdreyfus/html/paper_heidandfoucault.html
- Dreyfus, H. (2006). Heidegger on the connection between nihilism, art, technology, and politics. In C. Guignon (Ed.), *The Cambridge companion to Heidegger* (2nd ed.) (pp. 345-372). New York, NY: Cambridge University Press.
- Dreyfus, H. & Wrathall, M. (2005). Martin Heidegger: An introduction to his thought, work, and life. In H. Dreyfus & M. Wrathall (Eds.), *A companion to Heidegger* (pp. 1-16). Cornwall, UK: Blackwell Publishing Ltd.
- Driscoll, J. (1990). Maternal parenthood and the grief process. *Journal of Perinatal and Neonatal Nursing*, 4 (2), 1-10.

- Dubois, L. & Girard, M. (2003). Social determinants of initiation, duration and exclusivity of breastfeeding at the population level. *Canadian Journal of Public Health*, 94 (4), 300-305.
- Dykes, F. (2005). 'Supply' and 'demand': Breastfeeding as labour. *Social Science and Medicine*, 60, 2283-2293.
- Dykes, F. (2010) Encouraging breastfeeding: A relational perspective. *Early Human Development*, 86, 733-736.
- Earle, S. (2000). Why some women do not breastfeed: Bottle feeding and father's role. *Midwifery*, 16, 323-330.
- Earle, S. (2002). Factors affecting the initiation of breastfeeding: Implications for breastfeeding promotion. *Health Promotion International*, 17 (3), 205-214.
- Earle, V. (2010). Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy*, 11, 286-296.
- Emirbayer, M. & Mische, A. (1998). What is agency? *American Journal of Sociology*, 103 (4), 962-1023.
- Esfeld, M. (2001). What can Heidegger's *Being and Time* tell today's analytic philosophy? *Philosophical Explorations*, 1, 46-62.
- Evans, M., Bergum, V., Bamforth, S. & MacPhail, S. (2004). Relational ethics and genetic counseling. *Nursing Ethics*, 11, 459-471.
- Feldman, P. & Frati, F. (2008). *Evidence-based benefits of breastfeeding for the breastfeeding committee for Canada: An annotated bibliography*. Retrieved from Breastfeeding Committee for Canada: http://www.breastfeedingcanada.ca/documents/BCC%20Annotated%20Bibliography_Revised%20Aug%202007_corrected%2010%20March%202008.pdf
- Figes, K. (1998). *Life after birth*. Toronto, ON: Penguin Books Ltd.
- Fingeld-Connett, D. (2008). Concept synthesis of the art of nursing. *Journal of Advanced Nursing*, 62 (3), 381-388.
- Fish, D. (1998). *Appreciating practice in the caring professions*. Woburn, MA: Butterworth-Heinemann.
- Fisher, L. (2000). Feminist phenomenology. In L. Fisher and L. Embree (Eds.), *Feminist Phenomenology* (pp. 1-15). Dordecht, NL: Kluwer Academic Publishers.

- Fisher, T. (2009). Heidegger's generative thesis. *European Journal of Philosophy*, 18 (3), 363-384. Doi:10.1111/j.1468-0378.2009.00354.x
- Flacking, R., Lehtonen, L., Thomson, G., Axelin, A., Ahlqvist, S., Moran, V., Ewald, U., Dykes, F. & The SCENE Group. (2012). Closeness and separation in neonatal intensive care. *Acta Paediatrica*, 101, 1032-1037.
- Forbat, L. & Henderson, J. (2005). Theoretical and practical reflections on sharing transcripts with participants. *Qualitative Health Research*, 15 (8), 1114-1128.
- Frank, A. (2005). What is dialogical research, and why should we do it? *Qualitative Health Research*, 15 (7), 964-974.
- Freeman, L. (2009). Recognition reconsidered: A re-reading of Heidegger's Being and Time §26. *Philosophy Today*, 53 (1), 85-99.
- Freeman, L. (2011). Reconsidering relational autonomy: A feminist approach to selfhood and the other in the thinking of Martin Heidegger. *Inquiry*, 54 (4), 361-383.
- Freeman, L. (2014). Toward a phenomenology of mood. *The Southern Journal of Philosophy*, 52 (4), 445-476.
- Freeman, M. (2007). Performing the event of understanding in hermeneutic conversations with narrative texts. *Qualitative Inquiry*, 13 (7), 925-944. Doi:10.1177/1077800407304463
- Friedman, M. (1997). Autonomy and social relationships: Rethinking the feminist critique. In D. T. Meyers (Ed.), *Feminists rethink the self* (pp. 40-61). Boulder, CO: Westview Press, Inc.
- Friedman, M. (2003). *Autonomy, gender, politics*. New York, NY: Oxford University Press, Inc.
- Friedman, M. (2009). For whom is breast best? *Journal of the Association for Research on Mothering*, 11 (1), 26-35.
- Gadamer, H. (1989). *Truth and method* (Rev. ed.) (J. Weinsheimer & D. Marshall, Trans). New York, NY: Continuum Publishing Group.
- Gadamer, H. (2000). Subjectivity and intersubjectivity, subject and person. *Continental Philosophy Review*, 33, 275-287.
- Gadamer, H. (2006). Classical and philosophical hermeneutics. *Theory, Culture and Society*, 23 (1), 29-56.

- Gadow, S. (1995). Narrative and exploration: Toward a poetics of knowledge in nursing. *Nursing Inquiry*, 2, 211-214.
- Gadow, S. (1999). Relational narrative: The postmodern turn in nursing ethics. *Scholarly Inquiry for Nursing Practice: An International Journal*, 13 (1), 57-70.
- Gadow, S. (2000). I felt an island rising: Interpretive inquiry as motet. *Nursing Inquiry*, 7, 209-214.
- Gage, H., Williams, P., Von Rosen-Von Hoewel, J., Laitinen, K., Jakobik, V., Martin-Bautista, E. ...Raats, M. (2012). Influences on infant feeding decisions of first-time mothers in five European countries. *European Journal of Clinical Nutrition*, 66, 914-919. doi:10.1038/ecjn.2012.56
- Gagnon, A., & Bryanton, J. (2009). Postnatal parental education for optimizing infant general health and parent-infant relationships. *Cochrane Database of Systematic Reviews*, 1. Art. No.: CD004068. doi:10.1002/14651858.CD004068.pub2. Retrieved from: <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004068/frame.html>.
- Gannon, S. & Muller-Rockstroh, B. (2005). Narrating breasts: Constructions of contemporary motherhood(s) in women's breastfeeding stories. In A. O'Reilly, M. Porter & P. Short (Eds.), *Motherhood: Power and oppression* (pp. 41-55). Toronto, ON: Canadian Scholars' Press Inc.
- Geanellos, R. (1996). Storytelling: A teaching-learning technique. *Contemporary Nurse*, 5, 28-35.
- Geanellos, R. (1998a). Hermeneutic philosophy. Part I: implications of its use as methodology in interpretive nursing research. *Nursing Inquiry*, 5, 154-163.
- Geanellos, R. (1998b). Hermeneutic philosophy. Part II: A nursing research example of the hermeneutic imperative to address forestructures/pre-understandings. *Nursing Inquiry*, 5, 238-247.
- George, L. (2005). Lack of preparedness: Experiences of first-time mothers. *MCN: The American Journal of Maternal/Child Nursing*, 30 (4), 251-255.
- Gergen, K. (2009). *Relational being: Beyond self and community*. New York, NY: Oxford University Press.
- Gilligan, C. (1986). Remapping the moral domain: New images of the self in relationship. In T. Heller, M. Sosna & D. Wellbery (Eds), *Reconstructing individualism: Autonomy, individuality, and the self in western thought* (pp. 237-252). Stanford, CA: Stanford University Press.

- Gilligan, C. (1993). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Gionet, L. (2013). *Health at a glance: Breastfeeding trends in Canada*. (Statistics Canada Publication, Catalogue no. 82-624X). Retrieved from: www.statcan.gc.ca/pub/82-624-x/2013001/article/11879-eng.pdf
- Glazebrook, T. (2005). Gynocentric eco-logics. *Ethics and the Environment*, 10 (2), 75-99.
- Goering, S. (2009). Postnatal reproductive autonomy: Promoting relational autonomy and self-trust in new parents. *Bioethics*, 23, 9-19. doi:10.1111/j.1467-8519.2008.00678.x
- Goksen, F. (2002). Normative vs. attitudinal considerations in breastfeeding behavior: Multifaceted social influences in a developing country context. *Social Science and Medicine*, 54, 1743-1753.
- Goldberg, L. (2002). Rethinking the birthing body: Cartesian dualism and perinatal nursing. *Journal of Advanced Nursing*, 37 (5), 446-451.
- Goldberg, L. (2003). In the company of women: Enacting autonomy within the perinatal nursing relationship. *Nursing Ethics*, 10, 581-588.
- Goldberg, L. (2005). Introductory engagement within the perinatal nursing relationship. *Nursing Ethics*, 12, 401-413.
- Government of Canada. (2014). Saving every woman, every child: Within arm's reach summit. Retrieved from: <http://mnch.international.gc.ca/en/summit/index.html>
- Grassley, J. & Nelms, T. (2008). Understanding maternal breastfeeding confidence: A Gadamerian hermeneutic analysis of women's stories. *Health Care for Women International*, 29, 841-862.
- Greenhaigh, R., Slade, P. & Spiby, H. (2000). Fathers' coping style, antenatal preparation, and experiences of labor and the postpartum. *Birth*, 27 (3), 177-184.
- Gurwitsch, A. (1979). *Human encounters in the social world*. Pittsburgh, PA: Duquesne University Press.
- Guttman, H. (1983). Autonomy and motherhood. *Psychiatry*, 46, 230-235.
- Hamlett, L., Wagner, T. & Brevard, P. (2004). Reasons for breastfeeding cessation by WIC participants in a Virginia health district (Poster presentation). *Journal of the American Dietetic Association*, 104, Supp 2, 61. Retrieved from: <http://dx.doi.org/10.1016/j.jada.2004.05.184>

- Hannon, P., Willis, S., Bishop-Townsend, V., Martinez, I. & Scrimshaw, S. (2000). African-American and Latina adolescent mothers' infant feeding decisions and breastfeeding practices: A qualitative study. *Society for Adolescent Medicine, 26*, 399-407.
- Hartrick, G. (1997). Relational capacity: The foundation for interpersonal nursing practice. *Journal of Advanced Nursing, 26*, 523-528.
- Harvey, C. & Haldeman, W. (2013). Forewords: A tale of two lactation consultants. In R. Epp Buller (Ed.), *Have milk, will travel: Adventures in breastfeeding* (pp. 1-6). Toronto, ON: Demeter Press.
- Harwood, K., McLean, N. & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology, 43* (1), 1-12.
- Hauck, Y. & Irurita, V. (2003). Incompatible expectations: The dilemma of breastfeeding mothers. *Health Care for Women International, 24*, 62-78.
- Hauck, Y., Fenwick, J., Dhaliwal, S., Butt, J. & Schmied, V. (2011). The association between women's perceptions of professional support and problems experienced on breastfeeding cessation: A western Australian study. *Journal of Human Lactation, 27* (1), 49-57.
- Hausman, B. (2004). The feminist politics of breastfeeding. *Australian Feminist Studies, 19* (45), 273-285.
- Hausman, B. (2007). Things (not) to do with breasts in public: Maternal embodiment and the biocultural politics of infant feeding. *New Literary History, 38* (3), 479-504.
- Healey-Ogden, M. & Austin, W. (2011). Uncovering the lived experience of well-being. *Qualitative Health Research, 21* (1), 85-96.
- Health Canada. (2000). *Family-centered maternity and newborn care*. Ottawa: Minister of Public Works and Government Services.
- Health Canada. (2012a). *Canadian Community Health Survey*. Retrieved from: <http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/prenatal/overview-apercu-eng.php>
- Health Canada. (2012b). *Infant nutrition*. Retrieved from: <http://www.healthycanadians.gc.ca/init/kids-enfants/care-soins/nutrition-alimentation/index-eng.php>

- Heidegger, M (1962). *Being and Time* (J. Macquarrie & E. Robinson, Trans.). New York, NY: Harper and Row. (Original work published 1927).
- Heidegger, M. (1977). The question concerning technology. In M. Heidegger (W. Lovitt, Trans.) *The question concerning technology and other essays* (pp. 3-35). New York, NY: Harper and Row, Publishers, Inc.
- Heidegger, M. (1998). *Pathmarks*. (W. McNeill, Ed.). Cambridge, NY: Cambridge University Press.
- Heidegger, M. (2001). *Zollikon Seminars*. (F. Mayr & R. Askay, Trans.) Evanston, IL: Northwestern University Press. (Original work published 1987).
- Hedberg, I. (2013). Barriers to breastfeeding in the WIC population. *MCN, The American Journal of Maternal/Child Nursing*, 38 (4), 244-249.
- Hertzman, C. & Power, C. (2004). Child development as a determinant of health across the life course. *Current Paediatrics*, 14, 438-443.
- Ho, A. (2008). The individualist model of autonomy and the challenge of disability. *Bioethical Inquiry*, 5, 193-207.
- Horwitz, E. & Long, B. (2005). Mothering and stress discourses: A deconstruction of the interrelationship of discourses on mothering and stress. In A. O'Reilly, M. Porter & P. Short (Eds.), *Motherhood: Power and oppression* (pp. 97-110). Toronto, ON: Canadian Scholars' Press Inc.
- Hoy, D. (2006). Heidegger and the hermeneutic turn. In C. Guignon (Ed.), *The Cambridge companion to Heidegger* (2nd ed.) (pp. 177-201). Cambridge, MA: Cambridge University Press.
- Husserl, E. (1960). *Cartesian meditations: An introduction to phenomenology*. (D. Cairns, Trans.). The Hague: Martinus Nijhoff Publishers. Retrieved from: [https://umdrive.memphis.edu/basmyth/public/PHIL%208051%20--%20Patočka%20and%20Merleau-Ponty/1b.%20Husserl%20--%20Cartesian%20Meditations%20\(Introduction,%20Meditation%201\).pdf](https://umdrive.memphis.edu/basmyth/public/PHIL%208051%20--%20Patočka%20and%20Merleau-Ponty/1b.%20Husserl%20--%20Cartesian%20Meditations%20(Introduction,%20Meditation%201).pdf) (Original work published in 1931)
- Ingram, J., Johnson, D. & Hamid, N. (2003). South Asian grandmothers' influence on breastfeeding in Bristol. *Midwifery*, 19, 318-327.
- Inwood, M. (2005). Dasein. In T. Honderich (Ed.), *The Oxford companion to philosophy* (2nd ed.) (p. 189). New York, NY: The Oxford University Press Inc.
- Jansen, J., de Weerth, C. & Riksen-Walraven, J. (2008). Breastfeeding and the mother-infant relationship: A review. *Developmental Review*, 28, 503-521.

- Jardine, D. (1992). The fecundity of the individual case: Considerations of the pedagogic heart of interpretive work. *Journal of Philosophy of Education*, 26 (1), 51-61.
- Jardine, D. (1997). "Their bodies swelling with messy secrets". In T. Carson & D. Sumara (Eds.), *Action research as a living practice* (pp. 161-166). New York, NY: Peter Lang Publishing, Inc.
- Johnson, M. (2000). Heidegger and meaning: Implications for phenomenological research. *Nursing Philosophy*, 1, 134-146.
- Kaitz, M. (2007). Maternal concerns during early parenthood. *Child: Care, Health and Development*, 33, 720-727.
- Keith, K. (1997). Infant feeding choice among first-time mothers. *Scholarly Inquiry for Nursing Practice: An International Journal*, 11 (3), 199-224.
- Kendrick, K. & Robinson, S. (2002). 'Tender loving care' as a relational ethic in nursing practice. *Nursing Ethics*, 9, 291-300.
- Kennedy, H. (1995). The essence of nurse-midwifery care. The woman's story. *Journal of Nurse-Midwifery*, 40 (5), 410-417.
- Kennedy, H. (2000). A model of exemplary midwifery practice: Results of a Delphi study. *Journal of Midwifery and Womens Health*, 45 (1), 4-19.
- Kennedy, H., Shannon, M., Chuahorm, U. & Kravetz, M. (2004). The landscape of caring for women: A narrative study of midwifery practice. *Journal of Midwifery and Women's Health*, 49 (1), 14-23.
- Knaak, S. (2005). Breast-feeding, bottle-feeding and Dr. Spock: The shifting context of choice. *The Canadian Review of Sociology and Anthropology*, 42 (2), 197-216.
- Knaak, S. (2010). Contextualising risk, constructing choice: Breastfeeding and good mothering in risk society. *Health, Risk and Society*, 12 (4), 345-355.
- Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 19, 976-986.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21, 827-836.
- Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing*, 24, 174-184.

- Koch, T. (1999). An interpretive research process: Revisiting phenomenological and hermeneutical approaches. *Nurse Researcher*, 6 (3), 20-34.
- Koestner, R. (2008). Reaching one's personal goals: A motivational perspective focused on autonomy. *Canadian Psychology*, 49 (1), 60-67.
- Koggel, C. (1998). *Perspectives on equality: constructing a relational theory*. Lanham, MD: Rowman and Littlefield Publishers, Inc.
- Koggel, C. (2012). A relational approach to equality: New developments and applications. In J. Downie & J. Llewellyn (Eds.), *Being relational: Reflections on relational theory and health law* (pp. 63-88). Vancouver, BC: UBC Press.
- Kools, E., Thijs, C., Kester, A. & de Vries, H. (2006). The motivational determinants of breast-feeding: Predictors for the continuation of breast-feeding. *Preventive Medicine*, 43, 394-401.
- Kukla, R. (2006). Ethics and ideology in breastfeeding advocacy campaigns. *Hypatia*, 21 (1), 157-180.
- Kukla, R., Kupperman, M., Little, M., Lyerly, A., Mitchell, L., Armstrong, E. & Harris, L. (2009). Finding autonomy in birth. *Bioethics*, 23 (1), 1-8.
- Leahy-Warren, P. (2007). Social support for first-time mothers. *MCN, The American Journal of Maternal/Child Nursing*, 32, 368-374.
- Lee, R. (2012). Breastfeeding and constraints on mothers' agency. *Journal of the Motherhood Initiative for Research and Community Involvement*, 3 (2), 93-102.
- Leonard, V. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring and ethics in health and illness* (pp. 43-63). Thousand Oaks, CA: Sage Publications, Inc.
- Levesque-Lopman, L. (2000). Listen, and you will hear: Reflections on interviewing from a feminist phenomenological perspective. In L. Fisher and L. Embree (Eds.), *Feminist Phenomenology* (pp. 103-132). Dordrecht, NL: Kluwer Academic Publishers.
- Lilley, S. & Price, P. (2003). *Home visiting to support young families in Nova Scotia*. Halifax, NS: Nova Scotia Department of Health.
- Lincoln, Y. & Guba, E. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, 1986 (30), 73-84. DOI:10.1002/ev.1427

- Lingis, A. (1991). We mortals. *Philosophy Today*, 35 (2), 119-126.
- Llewellyn, J. & Downie, J. (2012). Introduction. In J. Downie & J. Llewellyn (Eds.), *Being relational: Reflections on relational theory and health law* (pp. 1-10). Vancouver, BC: UBC Press.
- Lopez, K. & Willis, D. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14 (5), 726-735.
- Lothian, J. (1994). The decision to breastfeed. *Journal of Perinatal Education*, 3 (4), 39-45.
- Lothian, J. (2008). The journey of becoming a mother. *Journal of Perinatal Education*, 17 (4), 43-47.
- Lothian, J. (2010). How do women who plan home birth prepare for childbirth? *The Journal of Perinatal Education*, 19 (3), 62-67. doi:10.1624/105812410X514459
- Lowe, E. (2005). Ontology. In T. Honderich (Ed.), *The Oxford companion to philosophy* (2nd ed.) (p. 670-671). New York, NY: The Oxford University Press Inc.
- Luborsky, M. & Rubinstein, R. (1995). Sampling in qualitative research: Rationale, issues, and methods. *Research on Aging*, 17 (1), 89-113.
- Ludlow, V., Newhook, L., Newhook, J., Bonia, K., Goodridge, J. & Twells, L. (2012). How formula feeding mothers balance risks and define themselves as 'good mothers'. *Health, Risk and Society*, 14 (3), 291-306. Retrieved from: <http://dx.doi.org/10.1080/13698575.2012.662635>
- MacKenzie, C. & Stoljar, N., Eds. (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*. New York, NY: Oxford University Press.
- Mackey, S. (2005). Phenomenological nursing research: Methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies*, 42, 179-186. doi:10.1016/j.ijnurstu.2004.06.011
- Maclaren, K. (2009). Emotional metamorphoses: The role of others in becoming a subject. In S. Campbell, L. Meynell and S. Sherwin (Eds.), *Embodiment and agency* (pp. 25-45). University Park, PA: Pennsylvania State University Press.
- Macmurray, J. (1961). *Persons in relation*. Atlantic Highlands, NJ: Humanity Books.

- Magri, E. & Hylton-McGuire, K. (2013). Transforming a care delivery model to increase breastfeeding. *MCN: The American Journal of Maternal/Child Nursing*, 38 (3), 177-182.
- Maier, B. (2014). Is the narrow concept of individual autonomy compatible with or in conflict with evidence-based medicine in obstetric practice? *Woman – Psychosomatic Gynaecology and Obstetrics*, 1, 40-49.
- Manganaro, R., Marseglia, L., Mami, C., Paolata, S., Gargano, R., Mondello, M., Puliafito, A. & Gemelli, M. (2008). Effects of hospital policies and practices on initiation and duration of breastfeeding. *Child: Care, Health and Development*, 35 (1), 106-111.
- Marshall, H. (1996). Our bodies ourselves: Why we should add old fashioned empirical phenomenology to the new theories of the body. *Women's Studies International Forum*, 19 (3), 253-265.
- Marshall, J., Godfrey, M. & Renfrew, M. (2007). Being a 'good mother': Managing breastfeeding and merging identities. *Social Science and Medicine*, 65, 2147-2159.
- Martell, L. (2001). Heading toward the new normal: A contemporary postpartum experience. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 30 (5), 496-506.
- McBride-Henry, K., White, G. & Benn, C. (2009). Inherited understandings: The breast as object. *Nursing Inquiry*, 16 (1), 33-42.
- McCaffrey, G., Raffin-Bouchal, S. & Moules, N. (2012). Hermeneutics as research approach: A reappraisal. *International Journal of Qualitative Methods*, 11 (3), 214-229.
- McCarter-Spaulding, D. (2008). Is breastfeeding fair? Tensions in feminist perspectives on breastfeeding and the family. *Journal of Human Lactation*, 24 (2), 206-212. doi:10.1177/0890334408316076
- McClellan, H., Hepworth, A., Garbin, C., Rowan, M., Deacon, J., Hartmann, P. & Geddes, D. (2012). Nipple pain during breastfeeding with or without visible trauma. *Journal of Human Lactation*, 28 (4), 511-521.
- McConnell-Henry, T., Chapman, Y. & Francis, K. (2009a). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice*, 15, 7-15. doi:10.1111/j.1440-172X.2008.01724.x
- McConnell-Henry, T., Chapman, Y. & Francis, K. (2009b). Unpacking Heideggerian phenomenology. *Southern Online Journal of Nursing Research*, 9 (1). Retrieved

from: <http://web.ebscohost.com/ehost/detail?sid=0d41fbfa-b6f4-4990-8bd9-4c8b896ea421%40sessionmgr115&vid=2&hid=113&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=c8h&AN=2010235015>

- McIntyre, M. (2003). Cultivating a worldly repose: the contribution of Sally Gadow's work to interpretive inquiry. *Nursing Philosophy*, 4, 111-120.
- McLeod, C. (2002). *Self-trust and reproductive autonomy*. Cambridge, MS: MIT Press.
- McLeod, C. (2009). Editorial: Rich discussion about reproductive autonomy. *Bioethics*, 23 (1), ii-iii.
- McLeod, C. & Sherwin, S. (2000). Relational autonomy, self-trust, and health care for patients who are oppressed. In C. MacKenzie & N. Stoljar (Eds.), *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self* (pp. 259-279). New York, NY: Oxford University Press.
- McMullin, I. (2009). Sharing the 'now': Heidegger and the temporal co-constitution of world. *Continental Philosophy Review*, 42 (2), 201-220. Doi:10.1007/s11007-009-9103-3
- McNiesh, S. (2010). A fusion of horizons: Meaning and understanding in becoming a nurse. In G. Chan, K. Brykczynski, R. Malone & P. Benner (Eds.), *Interpretive phenomenology in health care research* (pp. 23-40). Indianapolis, IN: Sigma Theta Tau International.
- McQuillan, J., Greil, A., Shreffler, K. & Tichenor, V. (2008). The importance of motherhood among women in the contemporary United States. *Gender & Society*, 22 (4), 477-496.
- Mead, G. (1934). *Mind self and society*. Chicago, IL: University of Chicago.
- Medina, S. & Magnuson, S. (2009). Motherhood in the 21st century: Implications for counselors. *Journal of Counseling and Development*, 87, 90-96.
- Meedya, S., Fahy, K. & Kable, A. (2010). Factors that positively influence breastfeeding duration to six months: A literature review. *Women and Birth*, 23, 135-145.
- Mercer, R. (1995). *Becoming a mother*. New York, NY: Springer Publishing Co., Ltd.
- Mercer, R. (2004). Becoming a mother versus maternal role attainment. *Image: Journal of Nursing Scholarship*, 36 (3), 226-232.
- Mercer, R. & Walker, L. (2006). A review of nursing interventions to foster becoming a mother. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 35, 568-582.

- Merkle Sorrell, J. & Redmond, G. (1995). Interviews in qualitative nursing research: Differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing*, 21, 1117-1122.
- Merleau-Ponty, M. (1956). What is phenomenology? *Cross Currents*, 6, 59-70.
- Merleau-Ponty, M. (1962). *Phenomenology of Perception* (C. Smith, Trans). New York, NY: Routledge.
- Merleau-Ponty, M. (1964). The child's relations with others (W. Cobb, Trans.). In M. Merleau-Ponty, *The Primacy of Perception* (pp. 96-155). Evanston, IL: Northwestern University Press.
- Meyers, D. T. (2003). The rush to motherhood: Pronatalist discourse and women's agency. In D. T. Meyers, *Gender in the mirror – Cultural imagery and women's agency* (pp. 30-58). Retrieved from: <http://www.oxfordscholarship.com.ezproxy.library.dal.ca/view/10.1093/0195140419.001.0001/acprof-9780195140415-chapter-2>
- Meynell, L. (2009). Introduction: Minding bodies. In S. Campbell, L. Meynell & S. Sherwin (Eds.), *Embodiment and agency* (pp. 1-21). University Park, PA: The Pennsylvania State University Press.
- Moules, N. & McCaffrey, G. (2015). Catching hermeneutics in the act. *Journal of Applied Hermeneutics*. Retrieved from: <http://jah.journalhosting.ucalgary.ca/jah/index.php/jah/article/view/73/pdf>
- Mullin, A. (2005). Trust, social norms, and motherhood. *Journal of Social Philosophy*, 36 (3), 316-330.
- Mumtaz, Z. & Salway, S. (2009). Understanding gendered influences on women's reproductive health in Pakistan: Moving beyond the autonomy paradigm. *Social Science and Medicine*, 68, 1349-1356.
- Munhall, P. (1994). *Revisioning phenomenology: Nursing and health science research*. New York, N.Y.: National League for Nursing Press.
- NCAST Publications. (1990). *Keys to Caregiving*. Seattle, WA: University of Washington.
- Nedelsky, J. (1988). The challenges of multiplicity. *Michigan Law Review*, 89, 1591-1609.
- Nedelsky, J. (1989). Reconceiving autonomy: Sources, thoughts and possibilities. *Yale Journal of Law and Feminism*, 1 (7), 7-36.

- Nedelsky, J. (1999). Dilemmas of passion, privilege and isolation: Reflections on mothering in a white, middle class nuclear family. In J. Hanigsberg & S. Ruddick (Eds.), *Mother troubles: Rethinking contemporary maternal dilemmas* (pp. 304-337). Boston, MA: Beacon Press.
- Nelson, A. (2003) Transition to motherhood. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 32 (4), 465-477.
- Nelson, A. (2006a). A metasynthesis of qualitative breastfeeding studies. *Journal of Midwifery and Women's Health*, 51 (2), 13-20. doi:10.1016/j.jmwh.2005.09.011
- Nelson, A. (2006b). Toward a situation-specific theory of breastfeeding. *Research and Theory for Nursing Practice: An International Journal*, 20 (1). 9-27.
- Nelson, A. (2007). Maternal-newborn nurses' experiences of inconsistent professional breastfeeding support. *Journal of Advanced Nursing*, 60 (1), 29-38. doi:10.1111/j.1365-2648.2007.04373.x
- Nelson, A. (2012). A metasynthesis related to infant feeding decision making. *MCN - The American Journal of Maternal/Child Nursing*, 37 (4), 247-252.
- Nelson, E. (2008). Interpreting practice: Dilthey, epistemology, and the hermeneutics of historical life. *Idealistic Studies*, 38 (1-2), 105-122.
- Nelson, F. (2009). *In the other room: Entering the culture of motherhood*. Black Point, NS: Fernwood Publishing Co.
- Nelson, M. (1982). Authenticity: Fabric of ethical nursing practice. *Topics in Clinical Nursing*, 4 (1), 1-6.
- Newton, E. (2004). Breastmilk: The gold standard. *Clinical Obstetrics and Gynecology*, 47 (3), 632-642.
- Noblit, G. & Hare, R. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage Publications, Inc.
- Nova Scotia Department of Health [NSDoH]. (2003). *Healthy babies, healthy families: Postpartum and postnatal guidelines*. Retrieved from: <http://www.gov.ns.ca/hpp/publications/PostpartnatalGuide.pdf>.
- Nova Scotia Department of Health and Wellness (NSDHW). (2011). Breastfeeding basics. Halifax, NS: Communications Nova Scotia. Retrieved from: http://www.gov.ns.ca/hpp/publications/05003_breastfeedingbasics_en.pdf
- Nova Scotia Department of Health. (2005). *Healthy beginnings: Enhanced home visiting initiative*. Halifax, NS: Communications NS.

- Nova Scotia Department of Health. (2008a). *Loving care: Birth to six months*. Retrieved from: http://www.gov.ns.ca/hpp/publications/09045_Loving%20CareBirth-6%20Months_May08_En.pdf.
- Nova Scotia Department of Health. (2008b). *Loving care: Parents and families*. Retrieved from: http://www.gov.ns.ca/hpp/publications/09048_Parents&Families_May08_En.pdf.
- Oakley, A. (1979). A case of maternity: Paradigms of women as maternity cases. *Signs: Journal of Women in Culture and Society*, 4 (4), 607-631.
- Ockenden, J. (2002). Antenatal education for parenting. In M. Nolan (Ed.) *Education and support for parenting*. (pp. 89-112). London, UK: Baillere Tindall.
- Odent, M. (1992). *The nature of birth and breastfeeding*. London, UK: Bergin and Garvey.
- Olesh, A. (2008). *Martin Buber's critique of Heidegger's Being-with: An exploration of a disagreement between two of the most significant thinkers of the 20th century*. Retrieved from: <http://organizations.oneonta.edu/philosc/papers08/olesh.pdf>
- Oosterhoff, A., Hutter, I. & Haisma, H. (2014). It takes a mother to practice breastfeeding: Women's perceptions of breastfeeding during the period of intention. *Women and Birth*, 27 (e43-e50). Retrieved from: <http://dx.doi.org/10.1016/j.wombi.2014.08.003>
- Orbanic, S. (1999). The Heideggerian view of person: A perspective conducive to the therapeutic encounter. *Archives of Psychiatric Nursing*, 13 (3), 137-144.
- Ortiz, M. (2009). Hermeneutics and nursing research: History, processes, and exemplar. *Southern Online Journal of Nursing Research*, 9 (1). Retrieved from: <http://web.ebscohost.com/ehost/detail?sid=4064fe62-83ec-4ecd-99d0-2dd861162bc1%40sessionmgr10&vid=1&hid=20&bdata=JnNpdGU9ZWVhc3QtbGl2ZQ%3d%3d#db=c8h&AN=2010235013>
- Oshana, M. (2007). Autonomy and the question of authenticity. *Social Theory and Practice*, 33 (3), 411-429.
- Parent Health Education Resource Working Group (PHERWG). (2008). *Loving care*. Halifax, NS: Nova Scotia Department of Health Promotion and Protection.
- Parsons, K. (2010). Exploring how Heideggerian philosophy underpins phenomenological research. *Nurse Researcher*, 17 (4), 60-69.

- Pask, E. (2003). Moral agency in nursing: Seeing value in the work and believing that I make a difference. *Nursing Ethics*, 10 (2), 165-174.
- Phillips, K. (2011). First-time breastfeeding mothers: Perceptions and lived experiences with breastfeeding. *International Journal of Childbirth Education*, 26 (3), 17-20.
- Phillips, R. (2013). The sacred hour: Uninterrupted skin-to-skin contact immediately after birth. *Newborn and Infant Nursing Reviews*, 13, 67-72.
- Phoenix, A. & Woollett, A. (1991). Motherhood: Social construction, politics and psychology. In A. Phoenix, A. Woollett & E. Lloyd (Eds.), *Motherhood: Meanings, practices and ideologies* (pp. 13-27). London, UK: Sage Publications Ltd.
- Plager, K. (1994). Hermeneutic phenomenology. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (pp. 65-83). Thousand Oaks, CA: Sage Publications, Inc.
- Priaulx, N. (2004). Joy to the world! A (healthy) child is born! Reconceptualizing 'harm' in wrongful conception. *Social and Legal Studies*, 13 (1), 5-26.
- Public Health Agency of Canada [PHAC]. (2008). *Canadian perinatal health report*. Retrieved from: <http://www.phac-aspc.gc.ca/publicat/2008/cphr-rspc/pdf/cphr-rspc08-eng.pdf>.
- Public Health Agency of Canada. (2009). *What mother's say: The Canadian maternity experiences survey*. Retrieved from: <http://www.phac-aspc.gc.ca/rhs-ssg/pdf/survey-eng.pdf>.
- Purdy, L. (2006). Women's reproductive autonomy: Medicalisation and beyond. *Journal of Medical Ethics*, 32, 287-291.
- Raphael, D. (Ed.). (2004). *Social determinants of health: Canadian perspectives*. Toronto: Canadian Scholar's Press, Inc.
- Ratcliffe, M. (2013). Why mood matters. In M. Wrathall (Ed.), *The Cambridge companion to Heidegger's Being and Time* (pp. 157-176). New York, NY: Cambridge University Press.
- Reich, S. (2005). What do mothers know? Maternal knowledge of child development. *Infant Mental Health Journal*, 26 (143-156).
- Reid, J., Schmied, V. & Beale, B. (2010). 'I only give advice if I am asked': Examining the grandmother's potential to influence infant feeding decisions and parenting practices of new mothers. *Women and Birth*, 23, 74-80.

- Rempel, L. (2004). Factors influencing the breastfeeding decisions of long-term breastfeeders. *Journal of Human Lactation*, 20 (3), 306-318.
- Rempel, L. & Rempel, J. (2004). Partner influence on health behavior decision-making: Increasing breastfeeding duration. *Journal of Social and Personal Relationships*, 21 (1), 92-111.
- Riordan, J. & Wambach, K. (2009). *Breastfeeding and human lactation* (4th ed.). Sudbury, MA: Jones and Bartlett Learning.
- Rodemeyer, L. (1998). Dasein gets pregnant. *Philosophy Today, suppl. Conflicts and Convergences*, 42, 76-84.
- Rossmann, C. & Ayoola, A. (2012). Promoting individualized breastfeeding experiences. *The American Journal of Maternal/Child Nursing*, 37 (3), 193-199.
- Rubin, R. (1967a). Attainment of the maternal role (1). *Nursing Research*, 16 (3), 237-245.
- Rubin, R. (1967b). Attainment of the maternal role (2). *Nursing Research*, 16 (4), 342-346.
- Rubin, R. (1975). Maternal tasks in pregnancy. *Maternal-Child Nursing Journal*, 4 (3), 143-153.
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York, NY: Springer Publishing Co., Ltd.
- Ruddick, S. (1995). *Maternal thinking: Toward a politics of peace*. Boston, MA: Beacon Press.
- Ruxer, D., Burkhardt, M., Brewer, T., Leakeas, T, Shay, M., Mateer, K. & Seipel, B. (2013). The impact of increased skin-to-skin contact on breastfeeding neonates on exclusive breastfeeding at 4 and 8 weeks postpartum. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 42 (s1), S85-S86. doi:10.1111/1552-6909.12176
- Sandberg, J. (2005). How do we justify knowledge produced within interpretive approaches? *Organizational Research Methods*, 8 (1), 41-68.
- Sandelowski, M. & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research*, 13 (7), 905-923.
- Schmied, V. & Barclay, L. (1999). Connection and pleasure, disruption and distress: Women's experience of breastfeeding. *Journal of Human Lactation*, 15 (4), 325-334.

- Schmied, V., Beake, S., Sheehan, A., McCourt, C. & Dykes, F. (2011). Women's perceptions and experiences of breastfeeding support: A metasynthesis. *Birth*, 38 (1), 49-60.
- Schmied, V. & Lupton, D. (2001). Blurring the boundaries: Breastfeeding and maternal subjectivity. *Sociology of Health and Illness*, 23 (2), 234-250.
- Schmied, V., Sheehan, A. & Barclay, L. (2001). Contemporary breast-feeding policy and practice: Implications for midwives. *Midwifery*, 17, 44-54.
- Schulze, P. & Carlisle, S. (2010). What research does and doesn't say about breastfeeding: A critical review. *Early Child Development and Care*, 180 (6), 703-718.
- Schuster, M. (2013). Hermeneutics as embodied existence. *International Journal of Qualitative Methods*, 12, 195-206.
- Shaw, R. (2004). Performing breastfeeding: Embodiment, ethics and the maternal subject. *Feminist Review*, 78, 99-116.
- Sheehan, A., Schmied, V. & Barclay, L. (2009). Complex decisions: Theorizing women's infant feeding decisions in the first six weeks after birth. *Journal of Advanced Nursing*, 66 (2), 371-380.
- Sheehan, A., Schmied, V. & Barclay, L. (2013). Exploring the process of women's infant feeding decisions in the early postbirth period. *Qualitative Health Research*, 23 (7), 989-998.
- Sheehan, A., Schmied, V. & Cooke, M. (2003). Australian women's stories of their baby-feeding decisions in pregnancy. *Midwifery*, 19, 259-266.
- Sheffer, C. (2000). *The lived experience of pregnancy for women with pre-existing insulin dependent diabetes* (Unpublished master's thesis). Dalhousie University, Halifax, NS. Available from ProQuest Dissertations and Theses database. (UMI No. MQ57261)
- Sherwin, S. (1992). *No longer patient: Feminist ethics and health care*. Philadelphia, PA: Temple University Press.
- Sherwin, S. (1998). A relational approach to autonomy in health care. In S. Sherwin (Ed.), *The politics of women's health: Exploring agency and autonomy* (pp. 19-47). Philadelphia: Temple University Press.
- Sherwin, S. (2012). Relational autonomy and global threats. In J. Downie & J. Llewellyn (Eds.), *Being relational: Reflections on relational theory and health law* (pp. 13-34). Vancouver, BC: UBC Press.

- Simmonds, A. (2008). Autonomy and advocacy in perinatal nursing practice. *Nursing Ethics, 15* (3), 360-370.
- Simms, E. (2001). Milk and flesh: A phenomenological reflection on infancy and coexistence. *Journal of Phenomenological Psychology, 32* (1), 22-40.
- Sittner, B., Hudson, D., & Defrain, J. (2007). Using the concept of family strengths to enhance nursing care. *MCN: The American Journal of Maternal/Child Nursing, 32*, 353-357.
- Sloan, S., Sneddon, H., Stewart, M. & Iwaniec, D. (2006). Breast is best? Reasons why mothers decide to breastfeed or bottlefeed their babies and factors influencing the duration of breastfeeding. *Child Care in Practice, 12* (3), 283-297.
doi:10.1080/13575270600761743
- Smith, J. (1999). Towards a relational self: Social engagement during pregnancy and psychological preparation for motherhood. *The British Journal of Social Psychology, 38*, 409-426.
- Smith, J., Flowers, P. & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method and research*. London: Sage Publications Ltd.
- Snyder, C. (2013). When a body feels a body: Reflections on breastfeeding. In R. Epp Buller (Ed.), *Have milk, will travel: Adventures in breastfeeding* (pp. 127-130). Bradford, ON: Demeter Press.
- Society of Obstetricians and Gynecologists of Canada [SOGC]. (2007, April). *Postpartum maternal and newborn discharge* (Policy Statement No. 190). Ottawa: Author.
- Solchany, J. (2001). *Promoting maternal mental health during pregnancy*. Seattle, WA: NCAST Publications.
- Sowaal, A. (2004). Cartesian bodies. *Canadian Journal of Philosophy, 34* (2), 217-240.
- Spatz, D. (2012). Innovations in the provision of human milk and breastfeeding for infants requiring intensive care. *Journal of Obstetric, Gynecologic and Neonatal Nursing, 41* (1), 138-143.
- Speier, D. (2001). Becoming a mother. *Journal of the Association for Research on Mothering, 3* (1), 7-18.
- Stainton, C., Harvey, S. & McNeil, D. (1995). *Understanding uncertain motherhood: A phenomenological study of women in high-risk perinatal situations*. Calgary, AB: Faculty of Nursing, University of Calgary.

- Stearns, C. (2009). The work of breastfeeding. *Women's Studies Quarterly*, 37 (3), 63-80.
- Stearns, C. (2011). Cautionary tales about extended breastfeeding and weaning. *Health Care for Women International*, 32, 538-554.
- Stearns, C. (2013). The embodied practices of breastfeeding: Implications for research and policy. *Journal of Women, Politics and Policy*, 34, 359-370.
- Stein, J. (Ed.). (1980). *The Random house college dictionary* (Rev. Ed.). New York, NY: Random House, Inc.
- Steube, A. (2009). The risks of not breastfeeding for mothers and infants. *Reviews in Obstetrics and Gynecology*, 2 (4), 222-231.
- Steube, A. & Schwarz, E. (2010). The risks and benefits of infant feeding practices for women and their children. *Journal of Perinatology*, 30, 155-162.
- Sutherland, J. (2010). Mothering, guilt and shame. *Sociology Compass*, 4 (5), 310-321.
- Tallon, A. (1973). Person and community: Buber's category of the between. *Philosophy Today*, 17 (1), 62-83.
- Taylor, C. (1991). *The ethics of authenticity*. Cambridge, MA: Harvard University Press.
- Taylor, C. (2006). Engaged agency and background in Heidegger. In C. Guignon (Ed.), *The Cambridge companion to Heidegger* (2nd ed.) (pp. 202-221). Cambridge, MA: Cambridge University Press.
- Taylor, E. & Wallace, L. (2011). For shame: Feminism, breastfeeding advocacy, and maternal guilt. *Hypatia*, 27 (1), 76-98. doi:10.1111/j.1527-2001.2011.01238.x
- Thomas, S. (2005). Through the lens of Merleau-Ponty: Advancing the phenomenological approach to nursing research. *Nursing Philosophy*, 6, 63-76.
- Thomasma, D. (1994). Toward a new medical ethics: Implications for ethics in nursing. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring and ethics in health and illness* (pp. 85-98). Thousand Oaks, CA: Sage Publications, Inc.
- Thompson, J. (1990). Hermeneutic inquiry. In L. Moody (Ed.), *Advancing nursing science through research, Vol. 2* (pp. 223-280). Newbury Park, CA.: Sage Publications Inc.

- Thomson, G. (2011). 'Abandonment of Being' in childbirth. In G. Thomson, F. Dykes & S. Downe (Eds.), *Qualitative research in midwifery and childbirth: Phenomenological approaches* (pp. 133-152). New York, NY: Routledge.
- Thurman, S. & Allen, P. (2008). Integrating lactation consultants into primary care services: Are lactation consultants affecting breastfeeding success? *Pediatric Nursing*, 34, 419-427.
- Tronto, J. (1998). "Truth" and advocacy: A feminist perspective. *Political Science and Politics*, 31 (4), 808-810.
- Tronto, J. (2003). Time's place. *Feminist Theory*, 4 (2), 119-138.
- Tully, K. & Ball, H. (2013). Trade-offs underlying maternal breastfeeding decisions: A conceptual model. *Maternal and Child Nutrition*, 9 (1), 90-98.
- UNICEF et al. (2005, November). Innocenti declaration 2005 on infant and young child feeding. 1990-2005: *Celebrating the Innocenti Declaration: Protection, promotion and support of breastfeeding*. Declaration developed at the conference in Florence, Italy. Retrieved from: http://www.unicef.org/nutrition/files/innocenti2005m_FINAL_ARTWORK_3_MAR.pdf
- Van der Zalm, J. & Bergum, V. (2000). Hermeneutic-phenomenology: Providing living knowledge for nursing practice. *Journal of Advanced Nursing*, 31, 211-218.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.
- van Manen, M. (2000). Moral language and pedagogical experience. *Journal of Curriculum Studies*, 32 (2), 315-327.
- van Manen, M. (2002). Care-as-worry, or "Don't worry, be happy". *Qualitative Health Research*, 12 (2), 262-278.
- Varcoe, C. & Doane, G. (2007). Mothering and women's health. In M. Morrow, O. Hankivsky & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 297-323). Toronto, ON: University of Toronto Press Inc.
- Vincent, C., Ball, S. & Braun, A. (2010). Between the estate and the state: Struggling to be a 'good' mother. *British Journal of Sociology of Education*, 31 (2), 123-128.
- Vonderheid, S., Norr, K. & Handler, A. (2007). Prenatal health promotion content and health behaviors. *Western Journal of Nursing Research*, 29 (3), 258-276. doi:10.1177/0193945906296568

- Walker, M. (2011). What's a feminist therapist to do? Engaging the relational paradox in a post-feminist culture. *Women and Therapy, 34*, 38-58.
- Walker, M. U. (1989). What does the different voice say? Gilligan's women and moral philosophy. *The Journal of Value Inquiry, 23*, 123-134.
- Wall, G. (2001). Moral constructions of motherhood in breastfeeding discourse. *Gender and Society, 15* (4), 592-610.
- Walters, A. (1995). The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing, 22*, 791-799.
- Wamback, K. & Koehn, M. (2004). Experiences of infant-feeding decision-making among urban economically disadvantaged pregnant adolescents. *Journal of Advanced Nursing, 48* (4), 361-370.
- Weaver, J., Statham, H. & Richards, M. (2007). Are there 'unnecessary' caesarean sections? Perceptions of women and obstetricians about caesarean sections for nonclinical indications. *Birth, 34* (1), 32-41.
- Wilde, M. (1999). Why embodiment now? *Advances in Nursing Science, 22* (2), 25-38.
- Williams, R. (1990). Aristotle, time, and temporality. *Journal of Theoretical and Philosophical Psychology, 10* (1), 13-21.
- Winson, N. (2003). Transition to motherhood. In C. Squire (Ed.), *The social context of birth* (pp. 137-151). Oxon, UK: Radcliffe Medical Press Ltd.
- Wojnar, D. & Swanson, K. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing, 25* (3), 172-180.
- Wolf, J. (2007). Is breast really best? Risk and total motherhood in the national breastfeeding awareness campaign. *Journal of Health Politics, Policy and Law, 32* (4), 595-636.
- World Health Organization. (2009). *Infant and young child feeding*. Geneva, SW: WHO Press. Retrieved from: http://www.who.int/maternal_child_adolescent/documents/9789241597494/en/
- World Health Organization [WHO]. (2013). The WHO global data bank on infant and young child feeding. Retrieved from: <http://www.who.int/nutrition/databases/infantfeeding/en/index.html>
- World Health Organization & Unicef. (2009). *Baby-friendly hospital initiative*. Retrieved from: <http://www.who.int/nutrition/publications/infantfeeding/9789241594950/en/print.html>

- Wynn, F. (1997). The embodied chiasmic relationship of mother and infant. *Human Studies*, 19, 253-270.
- Wynn, F. (2002). The early relationship of mother and pre-infant: Merleau-Ponty and pregnancy. *Nursing Philosophy*, 3, 4-14.
- Young, I. (2005). *On female body experience: Throwing like a girl and other essays*. New York, NY: Oxford University Press.
- Young, J. (2000). What is dwelling? The homelessness of modernity and the worlding of the world. In M. Wrathall & J. Malpas (Eds.), *Heidegger, authenticity, and modernity: Essays in honor of Hubert L. Dreyfus, Volume 1* (pp. 187-203). Cambridge, MA: MIT Press
- Zaborowski, H. (2011). Heidegger's hermeneutics: Towards a new practice of understanding. In: D. Dahlstrom (Ed.), *Interpreting Heidegger: Critical essays* (pp. 15-41). Cambridge, UK: Cambridge University Press.
- Zeiler, K. (2004). Reproductive autonomous choice – A cherished illusion? Reproductive autonomy examined in the context of preimplantation genetic diagnosis. *Medicine, Health Care and Philosophy*, 7, 175-183.

Appendix A

Hermeneutical Principles for Research (Conroy, 2003)	
1.	Seek understandings of the participants' world of significance through immersion in their world.
2.	Make explicit the shared world of understanding between the researcher and the researched.
3.	Immerse oneself in the hermeneutic circle throughout the research spiral.
4.	Make explicit the immersion of the researcher in the hermeneutic spiral.
5.	Draw out what is hidden within the narrative accounts and interpret them based on background understandings of the participants and the researcher.
6.	Enter into an active dialogue with the participants, the second readers, the narrative itself as spoken and written.
7.	Maintain a constantly questioning attitude in the search for misunderstandings, incomplete understandings, and deeper understandings.
8.	Move in a circular progress between parts and the whole, what is disclosed and hidden, the world of the participant and the world of the researcher.
9.	Engage the active participation of the participants in the research process: the implementation and the interpretation.
10.	Encourage self-reflective practice by the participants through participation in the research and through offering a narrative account of the researchers' understandings and interpretation.
11.	View every account as having an interpretation based on a person's Background.
12.	View any topic narrated by the participant as significant at some level to the participant.
13.	Deem every account as having its own internal logic; whatever is brought to an interview is significant to its bearer, consciously or not.
14.	Access and make explicit participant understandings through their own modes of existence, mode of engagement while being sensitive to one's own modes of existence and of engagement and foregrounding.
15.	Be aware of one's own use of coping tools in any of the modes of existing.
16.	Engage in the spiral task of hermeneutical interpretation along with the participants.
17.	Keep track of movements in understanding.
18.	Work with participants to see which points are salient.
19.	View interpretive phenomenology as an interpretation of participant's interpretation.
20.	Look beyond the participant's actions, events and behaviour to a larger Background context and its relationship to individual events.

Appendix B

Consent and Authorization Documents General Requirements – Minimal Risk

Research Title: Breastfeeding as Choice

Researchers: Catherine Sheffer RN PhD(c), Student, Dalhousie University, Principal Investigator
Dr. Megan Aston PhD RN, Dalhousie University, Doctoral Supervisor
Dr. Sherrill Conroy PhD RN, University of Alberta, Doctoral Co-Supervisor
Dr. Judy MacDonald PhD, Dalhousie University, Doctoral Committee Member, Reader
Dr. Christy Simpson PhD, Dalhousie University, Doctoral Committee Member, Reader

Funding: N/A

Introduction and Purpose:

You are being invited to participate in the research study named above. This form provides information about the study. Before you decide if you want to take part, it is important that you understand the purpose of the study, the risks and benefits associated with taking part, and what you will be asked to do. You do not have to take part in this study. Taking part is entirely voluntary (your choice). Informed consent (allowing you to take part) starts with the initial contact about the study and continues until the end of the study. As the principal investigator, I will be available to answer any questions you may have. You may decide not to take part and you may withdraw from the study at any time. This will not affect the care you or your family members receive from your health care provider in any way.

The purpose of this study is to explore how women, as mothers, experience the decision-making process in choosing (or not) to breastfeed their infant.

How will the researchers do the study?

This single-site study is being conducted to engage women in conversation about their experiences of maternal decision-making around breastfeeding. I would like to speak with you, along with eight or nine other women, to see what factors affect your decisions about how you choose to feed your baby. There are no right or wrong answers, as I will be looking at similarities and differences in what women in the study say. As I complete my report of my research, I will use exact words of some women to better illustrate their experiences. Participants from the IWK Perinatal Center will be invited to take part in this study. I hope to enroll eight to ten women who plan to breastfeed their infant after delivery. However, if you change your mind about breastfeeding your infant after you have enrolled in this study, I still want to speak with you. Data collection will be conducted from April, 2014 to September, 2014.

What will I be asked to do?

You may participate in the study if you are a woman over 18 years of age, you can speak, read, and understand English, you are having a singleton pregnancy (only one baby), and are planning to breastfeed your baby. If you are interested in participating, you may contact me (Cathy Sheffer) and I will clarify any questions you may have about the study.

Once a signed consent form has been received from you, I will await the safe delivery of your infant. I will then make an appointment with you to speak with me about your infant feeding experiences when your infant is four to eight weeks of age, at a time and place convenient for you. The interview will last approximately 90-120 minutes and will be recorded. I will ask you to describe your infant-feeding experiences (using breastmilk, formula or a combination of both) that you have had since the birth of your infant. Examples of the types of questions I might ask are “By sharing your experiences to date, I’d like you to help me understand your experience(s) of decision-making regarding your choice of feeding method for your baby.” Or “What influenced you the most in making your decision?”

You may refuse to answer any questions or you may stop the interview at any time. You may also withdraw from the study at any time. If you choose to receive the results of this study, I will send you a copy of the research summary when complete.

What are the burdens, harms and potential harms?

No harms are anticipated as part of participating in this study; however it is possible that reflecting on past experiences and situations may cause you to become upset. If you do become upset, you may stop the interview and you will be able to speak to your primary health care provider (your family doctor or nurse-practitioner) about your feelings.

What are the possible benefits?

There is no guarantee that you will benefit personally by taking part in this study. However, the information you provide may help improve hospital practices for women choosing to breastfeed by providing insight into the experience of infant feeding decision making in the first few weeks after the birth of their infants. This information can be shared with other health care professionals through workshops, conferences, and publications.

Can I withdraw from the study?

You may decide to withdraw from the study at any time. Withdrawing from the study will not affect the care you or your family receive from your health care providers. There are no risks involved with withdrawing from this study at any point. If you choose to withdraw from the study after we have met to speak of your experiences, your information will be removed and not be used in the study. If the study is changed in any way which could affect your decision to continue to participate, you will be told about the changes and you may be asked to sign a new consent form.

Will the study cost me anything an, if so, how will be reimbursed?

The study will cost you nothing. I am offering no reimbursement for your time.

What about possible profit from commercialization of the study results?

There is no profit from commercialization of the study results to be realized.

Are there any conflicts of interest?

I have no conflict of interest in pursuing this project.

How will my privacy be protected?

All attempts to maintain confidentiality will be taken. I will not be collecting any data from any health care records. I will have access to your name in the initial consent forms and interview files. Confidentiality will be further maintained by replacing your name with an identification number, as well as by removing the names of people, organizations, and agencies referred to in our conversation. You will not be identified by name in any reports or publications of this research. Data stored digitally will be encrypted and password protected. Digital transcriptions will be stored upon memory sticks. Data storage devices used, and all printed interview transcripts will be locked in secure filing cabinets located within my locked office in the School of Nursing. I alone will have access to files in the locked filing cabinet. Five years after this research has been published, this data will be destroyed. All studies conducted at the IWK Health Care Center are subject to a potential audit by the IWK Health Centre's Research Ethics Audit committee. Should an audit be conducted, your privacy will continue to be protected to the maximum extent allowable by the law.

What if I have study questions or problems?

Should you have any questions or concerns, you may contact me at any time - Cathy Sheffer (902-494-1975, (902) 880-9225, or csheffer@dal.ca).

What are my research rights?

Signing this form indicates that you have agreed to take part in this research and for your responses to be used. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. You are free to withdraw your authorization at any time without jeopardizing the health care that you are entitled to receive.

If any issues do arise as a result of your participation in this study, please feel free to contact me at any time –You may also contact the Research Office of the IWK Health Centre at (902) 470-8520, Monday to Friday between 9:00AM and 5:00PM if you have any questions at any time during or after the study about research in general.

Please note that, in accordance with provincial laws, in the rare event that we learn anything during the course of the study that would cause us to believe that a child was being harmed, we would be required to report this to a child protection agency.

How will I be informed of study results?

The final research report is anticipated to be completed by the end of August, 2015. If you would like to receive a summary of the overall study results, please provide your name and email or mailing address and I will send the summary to you.

Thank you,

Catherine Sheffer RN PhD(c)

Study Title: Breastfeeding as Choice

Participant Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time without affecting my care in any way. I agree to have my words from the interview used in reports, publications, and conferences. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: (Print) _____
Participant Signature: _____
Date: _____ Time: _____

Statement by person providing information on study

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study.

Name: (Print) _____
Signature: _____ Position: _____
Date: _____ Time: _____

Statement by person obtaining consent

I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating

Name (Print) _____
Signature: _____ Position: _____
Date: _____ Time: _____

How will I be informed of study results?

Would you like to receive a summary of the study results? Yes ____ No ____

If you indicated yes to this question, please provide your email and/or mailing address:

Appendix C

Information Letter to Potential Participants

I would like you to consider being part of a study about maternal decision-making processes around breastfeeding. It is called "Breastfeeding as Choice." I am a registered nurse with over 30 years experience in perinatal nursing. I am doing this study as part of my doctoral degree in nursing at Dalhousie University. The Research Ethics Board of the IWK Health Center, Halifax, NS, and the Faculty of Graduate Studies at Dalhousie University has approved this project.

Through the years, a lot has been learned about how women make decisions about feeding their babies. This study will explore more about the day-to-day experience of how mothers make the decision to breastfeed their baby (or not). By doing this study, health-care providers can gain a greater understanding of this experience and, in turn, be able to provide the best care possible for women such as yourself. If you agree, your contact information will be provided to me by your nurse. I will contact you within one week, and arrange a meeting with you to discuss this project and to obtain your consent.

If you agree to take part, one interview will be required. This interview will take place four to eight weeks after the delivery of your infant, and be about 90-120 minutes long. Interviews can be in a place of your choice - in your home, at Dalhousie University, at the IWK Health Center, or somewhere else that is private and free from distractions. I want to hear **your** story of **your** experiences of feeding your baby. After talking with you and other women in similar situations, I will begin to write a report that describes the stories that I have heard. I will contact you again after speaking with you so that I might ensure accuracy of the conversation we had. When all the interviews are finished, I will share this report with all of the women who were interviewed to make sure that I 'got it right'. This final contact will give you a chance to let me know if I am on the right track to understanding your day-to-day experience.

With your permission, all interviews will be tape-recorded from beginning to end. I may write notes while you are talking so that I do not forget important bits of information about your conversation.

Your privacy will be guaranteed throughout this project. Your name and that of the IWK Health Center will not be used in any report, publication, or presentation. Any use of possible identifying situations will be avoided as well. You may choose to not answer any questions. If you wish to withdraw at any time from this study for any reason, you may do so. Choosing to withdraw will not affect your medical care.

Thank you for your consideration,

Catherine Sheffer

Appendix D

List of Research Questions

1. By sharing your experiences to date, I'd like you to help me understand your experience(s) of decision-making regarding your choice of feeding method for your baby.
2. What influenced you the most in making your decision? The least? Who influenced you the most? The least?
3. Can you share with me your feeding experiences? What thoughts or emotions do you experience when you feed your baby?
4. What does it mean to you to feed your baby?
5. What is the most important thing to you about feeding your baby? The least important?

APPENDIX E

Recruitment Poster

Breastfeeding as Choice

- Are you **pregnant**, expecting to **deliver between April and July/2014**, and **hoping to breastfeed** your baby?
- If so, I would love to speak with you! I am **Cathy Sheffer**, a doctoral student in nursing. I am seeking women who are interested in speaking with me after delivery about their day-to-day experiences of feeding their baby.
- Ask your **nurse** for an **information letter**, or you can contact me directly about this study at: **(902) 494-1975**, **(902) 880-9225**, or **csheffer@dal.ca**

