THE LIVED EXPERIENCE OF BREASTFEEDING FOR WOMEN WITH PERINATAL DEPRESSION

by

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A Dissertation Submitted to the Faculty of

Christine E. Lynn College of Nursing

In Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

Florida Atlantic University

Boca Raton, FL

August 2017

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This dissertation was prepared under the supervision of the candidate's dissertation advisor, Dr. Joy Longo, the Christine E. Lynn College of Nursing, and has been approved by the members of her supervisory committee. It was submitted to the faculty of the Christine E. Lynn College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ACKNOWLEDGEMENTS

I wish to thank God for carrying me when I least felt able to continue. I wish to thank my family, Luigi, Kirra, Julian, Mom, Dad, and Ana Lucia, for remaining by my side through this process. It has been a long and arduous journey, and I could not have gotten to the other side of it without you all. I also wish to express gratitude to my church family for keeping me in prayer and being my spiritual support. I love you all.

I wish to express sincere gratitude to my dissertation committee members, Dr. Joy Longo, Dr. Shirley C. Gordon, and Dr. Nancy Aaron Jones, for continued guidance and support during this dissertation journey. Each of you has gifted me with your knowledge. Thank you, Dr. Longo, for upholding the virtues of confidence, dedication, and patience, which are keys to success. Thank you, Dr. Gordon, for introducing me to the intricacies of qualitative research and encouraging me to grow with the process. Thank you, Dr. Jones, for showing me that truly significant research comes from the passion within oneself.

I wish to express heartfelt thanks to the organizations that assisted with recruitment: the Christine E. Lynn College of Nursing, Dr. Lynn Lampert, the Florida Nurses' Association, Healthy Mothers Healthy Babies of Palm Beach County, and the momsTOmoms online support group. Most of all, I wholeheartedly thank all the amazing warrior mothers who bared their lives to me during the interview process. You are an inspiration to everyone, especially your children.

ABSTRACT

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Degree:	Doctor of Philosophy
Year:	2017

Exclusive breastfeeding for at least 6 months provides numerous infant and maternal benefits. Yet mothers with risk factors, such as lower education, lower socioeconomic status, younger maternal age, planned cesarean birth, and anxiety and depression, are more likely to stop breastfeeding in the early postpartum period. Few studies have focused on perinatal depression as a risk factor for breastfeeding cessation. To tailor effective interventions, nurses must first understand the lived experience of breastfeeding for mothers at risk for perinatal depression.

A descriptive phenomenological study was conducted to elucidate the experience of breastfeeding for mothers with perinatal depression. The study was grounded in Swanson's middle-range theory of caring. After university Institutional Review Board approval, a purposive sample of 10 women was recruited from various organizations. Participants completed a demographic questionnaire and the Edinburgh Postnatal Depression Scale, and semistructured, audiorecorded face-to-face or telephonic

interviews were conducted. The researcher transcribed the data which was transformed into constituents of the mothers' lived experience by utilizing Giorgi's descriptive phenomenological method.

Five constituents emerged: *choosing selflessness*, *harboring inadequacy*, *deliberate persevering*, *discerning meaning*, and *cherishing intimacy*. The constituents embodied the essence of the mothers' thoughts and feelings connected to breastfeeding. By daily *choosing selflessness,* mothers consciously decided to breastfeed despite physical or psychological struggles. They often were *harboring inadequacy* due to ongoing struggles which led to incessant thoughts of maternal incompetence. Yet they successfully breastfed for at least 2 weeks after birth by *deliberate persevering*. Through breastfeeding, they were *discerning meaning* to realize their value as mothers. Finally, they reveled in purposeful moments of togetherness with their babies through *cherishing intimacy*.

The study findings inform recommendations for nursing education, practice, research, and policy. Nursing education must include basic breastfeeding and perinatal mental health knowledge in prelicensure curricula and up-to-date lactation management techniques and perinatal mental health awareness training in continuing education. Practicing maternal-child nurses must provide education and support to mothers about advantages and difficulties of breastfeeding throughout the perinatal period. Future research includes determination of support needs for women with perinatal depression with subsequent development and evaluation of therapeutic actions to promote breastfeeding success.

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I. INTRODUCTION

Pregnancy is a delicate period of biological, physical, and social transitions, which affect both mother and infant. After birth, one of the most important decisions influencing these transitions is the way in which a mother will feed her infant. Breastfeeding is the normative standard for infant nutrition (American Academy of Pediatrics [AAP], 2012), and major health organizations recommend that a mother-infant dyad continue exclusive breastfeeding (EBF) up to the infant's 6th month of age to achieve optimal infant and maternal health benefits (AAP, 2012; American College of Obstetricians and Gynecologists [ACOG], 2013; World Health Organization [WHO], 2015). Benefits of EBF include a decrease in cases of otitis media and nonspecific gastroenteritis for infants and a decrease in the risk of breast and ovarian cancer for mothers (Ip et al., 2007).

The United States Department of Health and Human Services has been an advocate of breastfeeding due to maternal, infant, and economic benefits since the first *Healthy People* initiative was published in 1979 (U.S. Department of Health, Education and Welfare [DHEW], 1979). The *Healthy People 2020* (U.S. Department of Health and Human Services [DHHS], 2011a) target goals for Maternal Infant and Child Health are to increase the number of infants ever breastfed to 81.9% and to increase the number of infants EBF through 6 months to 25.5%. Currently the rate of ever breastfeeding (infants breastfed even if only a single time) is relatively high at 81.1%; however, the rate of infants who are EBF for 6 months as recommended was 22.3% in 2016. This percentage

was determined by cellular telephone sampling and the United States National Immunization Survey (Centers for Disease Control and Prevention [CDC], 2016).

The variables associated with breastfeeding cessation are social, demographic, biological, and psychological (Thulier & Mercer, 2009). One of the at-risk populations for breastfeeding cessation is women who are diagnosed with perinatal depression (Dunn, Davies, McCleary, Edwards, & Gaboury, 2006; Henderson, Evans, Straton, Priest, & Hagan, 2003; Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011). Longer duration of breastfeeding in this population, however, has the potential to encourage healthy maternal-infant bonding and decrease depressive symptoms (Jones, McFall, & Diego, 2004; Field et al., 2010; Hahn-Holbrook, Haselton, Schetter, & Glynn, 2013; Ystrom, 2012).

Many interventions have been produced to encourage breastfeeding in various populations at risk for breastfeeding cessation (McCarter-Spalding & Gore, 2009; Sauls & Grassley, 2011; Tenfelde, Finnegan, & Hill, 2011). Researchers have studied specific populations of women at risk for breastfeeding cessation, such as African American women (McCarter-Spalding & Gore, 2009), adolescents (Sauls & Grassley, 2011), and low-income women (Tenfelde et al., 2011) to determine factors affecting breastfeeding exclusivity for these populations. No studies, however, have focused solely on the perceived needs for breastfeeding support of women who have perinatal depression. To tailor future interventions for this population, researchers must focus on the firsthand experiences of these women. Therefore, in this study qualitative research methods were used to uncover and describe the breastfeeding experience as perceived by women who self-reported perinatal depressive symptoms. This chapter introduces the study

phenomenon of interest; the background and significance, including connection to caring science; the study purpose and research questions, and the researcher's perspective.

Phenomenon of Interest

Breast milk is the natural first food for the infant (WHO, 2015) and is considered the ideal form of infant feeding due to its numerous nutritional and non-nutritional benefits for infants and mothers (Ballard & Morrow, 2013). Ip, Chung, Raman, Trikalinos, and Lau (2009) performed a meta-analysis for the Agency for Healthcare Research and Quality (AHRQ) to evaluate and synthesize existing empirical evidence regarding the effects of breastfeeding on the health of infants and mothers. According to the meta-analysis, breastfeeding was associated with a reduction in the risk of acute otitis media, gastrointestinal infections, lower respiratory tract disorders, and Sudden Infant Death Syndrome (SIDS) in infants. Breastfeeding was also associated with decreased maternal risk of breast and ovarian cancers.

Other studies have demonstrated additional benefits for breastfeeding mothers. These include decreased stress hormone levels, enhanced sleep patterns (Tu, Lupien, & Walker, 2006), and increased cellular immunity (Groër & Morgan, 2007). Psychological benefits include positive changes in maternal sensitivity during early childhood (Papp, 2013), positive maternal-infant interactions (Jones et al., 2004; Field et al., 2010), and decreased maternal anxiety and depression (Ystrom, 2012).

Breastfeeding has considerable economic benefits as well. Utilizing breastfeeding data from the AHRQ and the CDC, Bartick and Reinhold (2010) performed a comprehensive pediatric cost analysis on breastfeeding in the United States including childhood outcomes, such as necrotizing enterocolitis, otitis media, gastroenteritis,

hospitalization for lower respiratory tract infections, atopic dermatitis, SIDS, childhood asthma, childhood leukemia, type 1 diabetes, and childhood obesity. The researchers calculated that the United States could save $13 billion dollars and prevent greater than 911 infant deaths annually with 90% compliance of exclusive breastfeeding for 6 months. Although exclusive breastfeeding rates for 6 months have increased in the United States from 13.3% in 2010 (Centers for Disease Control [CDC], 2010) to 22.3% in 2016 (CDC, 2016), Bartick and Reinhold (2010) suggested that health care providers continue to make a concerted effort to meet future breastfeeding goals.

Background and Significance

United States Breastfeeding Goals

The *Healthy People* initiative (DHEW, 1979) was the first public policy to establish the importance of breastfeeding in the United States. Five years later, the United States Surgeon General, C. Everett Koop, M.D., Sc.D., held the first workshop on breastfeeding and lactation with participants from major professional and voluntary associations (U.S. Breastfeeding Committee, 2017a). The participants reviewed the progress in breastfeeding promotion, assessed the factors that enhanced or inhibited breastfeeding, determined continuing challenges, and developed strategies to meet the *Healthy People* goals (U.S. Department of Health & Human Services [DHHS], 1984). Since then, three additional *Healthy People* initiatives were published, including the current *Healthy People 2020* initiative (U.S. Department of Health and Human Services [DHHS], 2011a).

Current target goals of *Healthy People 2020* include the challenge to increase the proportion of infants who are ever breastfed to 81.9% from 81.1% (CDC, 2016) and of

infants who are exclusively breastfed at 6 months from 22.3% (CDC, 2016) to 25.5%. Although 6-month EBF rates are higher in certain regions, such as Montana (33.6 %), the overall EBF rate in the United States remains decidedly lower than that in many developing countries. However, a steep decline in EBF is evident in breastfeeding during the first 4-6 weeks postpartum, resulting in low EBF rates at 6 months (Figueiredo, Canário, & Field, 2014). National health organizations (American Academy of Pediatrics [AAP], 2005; U.S. Department of Health and Human Services [DHHS], 2011b) encourage researchers to identify barriers to and support for populations at risk for breastfeeding cessation aimed at increasing duration of EBF.

Breastfeeding Support Interventions

A variety of community-based breastfeeding support interventions exist in the United States. Interventions may occur specifically during the antepartum period (Schlickau & Wilson, 2005), during the postpartum period (Hopkinson & Konefal Gallagher, 2009; Howell, Bodnar-Deren, Balbierz, Parides, & Bickell 2014; Pugh et al., 2010), or during the combined ante- and postpartum period (Anderson, Damio, Young, Chapman, & Perez-Escamilla, 2005; Bonuck, Trombley, Freeman, & McKee, 2005; Bonuck et al., 2014; Chapman et al., 2013; Gill, Reifsnider, & Lucke, 2007; Olson, Haider, Vangjel, Bolton, & Gold., 2010; Sandy, Anisfeld, & Ramirez, 2009). Generally, interventions utilize various methods of education and support provided by individuals with specialized training, such as nurses, hospital-based breastfeeding clinics, breastfeeding peer counselors, social workers, lactation consultants, prenatal care providers, or public health care professionals. All interventions include the goal of

increasing breastfeeding initiation and encouraging continuation of breastfeeding. Few interventions have concentrated on populations at risk for breastfeeding cessation.

The most studied at risk populations in interventional studies include women with low income (Pugh et al., 2010; Olson et al., 2010) or women from minority groups (Hopkinson & Konefal Gallagher, 2009; Howell et al., 2014; Lewallen & Street, 2010; McCarter-Spaulding, 2007; McCarter-Spaulding & Gore, 2009; Sandy et al., 2009; Schlickau & Wilson, 2005), or both (Anderson et al., 2005; Gill et al., 2007). Other populations, however, are at risk for breastfeeding cessation. Studies have found that young maternal age, maternal educational level, smoking (Chittleborough, Lawler, & Lynch, 2012), planned cesarean sections (Prior et al., 2012; Regan, Thompson, & DeFranco, 2013), and psychological distress, such as antenatal depression and anxiety (Lindau et al., 2015) are risk factors for breastfeeding cessation. This research study focused on women 18 years of age or older at the time of birth who were at-risk for breastfeeding cessation due to the presence of depressive symptoms in the perinatal period.

Populations At Risk for Breastfeeding Cessation

Perinatal depression. Research on breastfeeding has included women from minority populations (Anderson et al., 2005; Gill et al., 2007; Gore, 2009; Hopkinson & Konefal Gallagher, 2009; Howell et al., 2014; Lewallen & Street, 2010; McCarter-Spaulding, 2007; McCarter-Spaulding & Gore, 2009; Sandy et al., 2009; Schlickau & Wilson, 2005), women from lower socioeconomic classes (Olson et al., 2010; Pugh et al., 2010), and women with specific breastfeeding difficulties (Hauck, Langton, & Coyle, 2002; Hegney, Fallon, & O'Brien, 2008; Mauri, Zobbi, & Zannini, 2012; Palmér,

Carlsson, Mollberg, & Nyström, 2012). However, a paucity of breastfeeding research exists with the focus on the experiences of women who have a diagnosis of perinatal depression. Yet, approximately 1 in 7 new mothers develop depressive symptoms during pregnancy or after delivery each year (Wisner, Parry, & Piontek, 2002).

When depressive symptoms are present during the antenatal and/or postnatal period, negative consequences may result. These negative consequences include preterm delivery (Li, Liu, & Odouli, 2009), low birth weight (Iyengar et al., 2010), delay in cognitive, social-emotional, or behavioral development of infant (Earls, 2010), suicidal ideation (Wisner et al., 2013), and suicide attempts (Vaiva, Teissier, Cottencin, Thomas, & Goudemand, 1999). These incidents lead to decreased quality of life for both mother and infant, increased medical costs (Bartick & Reinhold, 2010), and discontinuation of breastfeeding (Lindau et al., 2015).

The psychological factors within depression influence the stress response. This response causes the body to react in many ways, including altered levels of anxiety, loss of cognitive and affective flexibility, and inhibition of sleep, sexual activity, and growth and reproductive endocrine pathways (Jolley, Elmore, Barnard, & Carr, 2007). Since the stress response undergoes adaptation during pregnancy and lactation (Brunton, Russell, & Douglas, 2008; Christian, 2012), individual pregnant women exhibit great variability in the magnitude of their reactions to stress (de Weerth & Buitelaar, 2005). However, pregnant women who experience antenatal depression likely demonstrate increased hormonal changes in contrast to pregnant women who do not experience antenatal depression (O'Keane et al., 2011).

In addition to changes in the stress response during pregnancy, mothers are physiologically influenced by lactogenic hormones. For mothers with perinatal depression, oxytocin and prolactin released during labor and breastfeeding appear to decrease depressive symptoms and reduce stress responsiveness (Walker et al., 2004). An increase in oxytocin levels in late pregnancy and early postpartum has been found to have a positive effect on maternal and infant bonding (Levine, Zagoory-Sharon, Feldman, & Weller, 2007). High prolactin levels also have played a significant role in early initiation and continuation of breastfeeding (Zanardo et al., 2012). It is possible that sustained maternal lactation and decreased maternal stress in the perinatal period protect maternal (Hahn-Holbrook et al., 2013) and infant health (Jones et al., 2004), and appropriate breastfeeding support interventions may be one method to increase the duration of breastfeeding and prolong the beneficial results.

Screening for perinatal depression. To improve strategies that encourage breastfeeding, it is important to understand the specific needs of populations at risk for breastfeeding cessation, such as women who have perinatal depression. Researchers posit that maternal screening for depressive symptoms during the antenatal and postnatal periods will enable health care practitioners to provide enhanced support for mental health and breastfeeding continuation (Chittleborough et al., 2012; Dennis & McQueen, 2007; Fairlie, Gillman, & Rich-Edwards, 2009; Figueiredo et al., 2014; Watkins et al., 2011). Early screening and intervention improves the odds of successful breastfeeding (Field, Hernandez-Reif, & Feijo, 2002).

However, women with perinatal depression may be reluctant to discuss their feelings and needs with their health care providers. Their hesitation may be due to

awareness of the deep-seated stigma of depression during pregnancy and after delivery of a healthy infant and fear of strained or lost relationships with family and friends (Williams & Hagerty, 2004). Thus, valuable dialogues between mothers and their health care providers may not take place. The new mothers may be less likely to seek assistance when beneficial maternal and infant behaviors such as breastfeeding become difficult and seem overwhelming.

To tailor interventions for women with perinatal depression, nurses must first listen to and understand the mother's perspectives regarding this intimate lived experience. Through the findings of descriptive qualitative research, nurses will gain a better understanding of the mothers' feelings connected to breastfeeding and perceived breastfeeding support needs. Health care providers will then be able to determine and develop appropriate interventions to support breastfeeding for women who have depression during pregnancy and the postpartum period.

Connection to Caring Science

Assumptions

The foundation of nursing is caring; as such, this descriptive phenomenological study was grounded in Swanson's (1991, 1993) middle-range theory of caring, developed during the study of pregnancy loss. Four assumptions underlie this caring theory: persons/clients, environment, health/well-being, and nurses and informed caring. Persons/clients are unique individuals who are growing to reach their "wholeness" through their genetic attributes, spiritual life, and power to exert free will (Swanson, 1993, p. 355).

The persons/clients are situated in an environment or a specific situation. The environment may influence the person, and the person may also influence the environment. Within this context, the person is able to encounter health/well-being in living the experience of wholeness by feeling integrated and engaged with living and dying. Nurses embody informed caring through the integration of science, self, concern for humanity, and caring to enhance the well-being of persons (Swanson, 1991, 1993).

Processes

Following from these assumptions of caring, Swanson (1991, 1993) developed a theory with five overlapping processes that aim to result in client well-being: *maintaining belief*, *knowing*, *being with*, *doing for*, and *enabling*. *Maintaining belief* forms the philosophical basis of nurse caring and incorporates nurses' commitment to believe in the ability of all patients to live through current situations and find meaning in future situations. *Knowing* becomes the anchor for the subsequent processes of nurse caring. Through empirical, ethical, and aesthetic knowledge of a range of human responses to health issues, nurses utilize *knowing* to understand a situation through the eyes of the client (Swanson, 1991, 1993).

When grounded in *maintaining belief* and *knowing*, the nurse is able to be emotionally present to the client. *Being with* communicates to clients that the nurse is emotionally available and able to appreciate their health situation. While *being with* the client, the nurse is able to enhance caring through the therapeutic actions of *doing for* and *enabling*. In *doing for*, the nurse assists clients by actions, such as anticipating their needs, to preserve their wholeness. *Enabling* is the process utilized by the nurse to facilitate clients' journey through current health situations with the goal of enhancing

their well-being. Enabling may involve actions such as coaching, supporting, guiding, or validating clients' experiences. Grounding of this descriptive phenomenological study in Swanson's (1991, 1993) theory of caring allowed the researcher to genuinely and effectively utilize nursing to support the clients to voice their experience and validate their reality.

Purpose of the Study

Insufficient information exists regarding barriers and solutions to successful breastfeeding for the vulnerable group of women with perinatal depression. Although approximately 18.4% of women are affected by depression in the prenatal period, which includes conception to birth (Gavin et al., 2005), many scholarly studies focus on postpartum depression. This qualitative research study encompassed all women who experience depression during and after pregnancy. The focus on this broader target population should help shape future interventions to improve current practices of breastfeeding promotion.

A descriptive qualitative phenomenological design with principles of caring theory was used to explore the breastfeeding experiences of women who self-reported perinatal depressive symptoms. Semistructured in-depth individual interviews were conducted to discover the experience of breastfeeding for women with self-reported depressive symptoms who have breastfed for various durations. A caring lens, which included an accepting attitude towards these participants and an informed understanding of breastfeeding and perinatal depression, allowed the researcher to examine how breastfeeding intersected with the day-to-day lived experiences of these mothers.

Research Questions

The participants in this study experienced self-reported depressive symptoms during the antepartum and postpartum period. They were asked to recall and share thoughts, feelings, and emotions experienced at any time during the process of breastfeeding. The following questions provided the structure of this study:

1. How do women who self-report perinatal depression describe their experience of breastfeeding?
2. How do women who self-report perinatal depression describe helpful breastfeeding advice?
3. How do women who self-report perinatal depression describe unhelpful breastfeeding advice?

Researcher's Perspective Including Conceptual Definitions

Researcher's Perspective

During nursing practice on the labor and delivery floor, the researcher encountered a client who had perinatal depression. The client had no treatment, and she was unable to perform simple acts, such as signing her name on the consent form. Since the researcher was a novice nurse, she was had a lack of understanding of the client's situation. Like other nurses on the unit, the researcher criticized this client's behavior and wondered why she would have a baby. As the researcher thought about the client, she imagined how the pregnancy and fetus's experience would have been different if the mother were treated for depression. Would the client have been more joyful to be a mother? Would the baby's physical or mental health be affected by the client's emotional state? Would the client be able to care for her child or breastfeed her child?

Years later, the researcher found herself in a similar position to this mother, dealing with postpartum depression and its devastation. Fortunately, the researcher was able to successfully care for and breastfeed her baby. Motherhood, the researcher believes, was and is the most important job she has ever had in her life.

During breastfeeding sessions, her child looked up at her with loving eyes. It was the closest bond the researcher has ever experienced with another human being. The act of breastfeeding helped the researcher through a very difficult time. Recall of this time and the feelings and events shaped the path that the researcher wishes to continue pursuing to help other mothers who have antenatal and postpartum depression with support for their breastfeeding.

Conceptual Definitions

Three of the most important concepts of this research are *breastfeeding, duration of breastfeeding, and perinatal depression*. These concepts are defined as follows:

Breastfeeding. This concept is defined for this study as the feeding of a mother's own breast milk to her infant for at least 2 weeks successively in duration. The feeding may occur by the infant suckling at the breasts or consuming pumped breast milk via bottle or other delivery systems. Breastfeeding also includes infants who receive breast milk in conjunction with nonhuman milk, formula, and solid-semisolid foods (World Health Organization [WHO], 2008).

Breastfeeding duration. This concept is defined as the length of time that a mother breastfeeds her infant. Duration begins the first time that a baby suckles at the mother's breast or when the mother begins pumping breast milk and providing it to her

infant. Duration ends with complete cessation of either the infant suckling at the breast or pumping breast milk for the infant (Noel-Weiss, Boersma, & Kujawa-Miles, 2012).

Perinatal depression. This concept is defined as incorporating major depressive symptoms occurring during pregnancy to within 6 months after delivery (Segre & Davis, 2013). Daily or nearly every day for at least 2 weeks, the mother reports a loss of interest or pleasure in most activities. This loss results in significant impairments in self-care and social or occupational functioning. In addition, the mother experiences other symptoms which may include feelings of worthlessness or guilt, excessive worry, inability to cope with everyday stress, decreased energy, difficulty sleeping, changes in appetite or weight, uncontrollable crying, and suicidal ideation (Segre & Davis, 2013).

Summary

Breastfeeding is the optimal form of infant feeding (AAP, 2012). Although 81.8% of women in the United States initiate breastfeeding (CDC, 2016), many discontinue breastfeeding by 2 weeks postpartum (Brand, Kothari, & Stark, 2011; Ertem, Votto, & Leventhal, 2001). Various client populations are at risk for breastfeeding cessation, including women with low income (Olson et al., 2010; Pugh et al., 2010), women from minority groups (Hopkinson & Konefal Gallagher, 2009; Howell et al., 2014; Lewallen & Street, 2010; McCarter-Spaulding, 2007; McCarter-Spaulding & Gore, 2009; Sandy et al., 2009; Schlickau & Wilson, 2005), women with educational level of high school or less (Chittleborough et al., 2012), women who have planned cesarean sections (Prior et al., 2012; Regan et al., 2013), and women who experience psychological distress, such as antenatal depression and anxiety (Lindau et al., 2015). This descriptive qualitative

phenomenological research study included the at-risk population of women who self-reported perinatal depressive symptoms.

Perinatal depression includes depression during pregnancy and after delivery. Little research has been conducted regarding the population of women with perinatal depression and their experiences of breastfeeding. However, breastfeeding encourages healthy maternal-infant bonding and may even be helpful in attenuating mothers' depressive symptoms (Walker et al., 2004). Descriptive qualitative research is necessary to determine the educational and psychological support needs for this population of women.

II. LITERATURE REVIEW

Introduction

This literature review presents a critical synthesis of theoretical and empirical evidence surrounding the maternal health benefits of breastfeeding, breastfeeding support interventions, and populations at risk for breastfeeding cessation. The review also includes analysis of the few studies related to breastfeeding and perinatal depression. Finally, the review considers the link of the study to caring science.

Critical Synthesis of Theoretical and Empirical Foundation

Breastfeeding and Maternal Health Benefits

Breastfeeding is an important infant feeding method that impacts maternal health; however, few studies have been conducted on maternal health benefits (Godfrey & Lawrence, 2010). Nevertheless, some studies have documented several advantages of breastfeeding for maternal health. These include decreased postpartum blood loss, increased child spacing, and reduction in breast and ovarian cancer with cumulative breastfeeding of greater than 12 months (AAP, 2012); decreased depressive symptoms (Groër, 2005; Hahn-Holbrook et al., 2013; Hatton et al., 2005); and increased emotional bonding (Kim et al., 2011).

Health care providers have the opportunity to provide life-changing client education regarding the maternal health benefits of breastfeeding. More women, especially those who are at risk for breastfeeding cessation, may decide to commit to exclusive breastfeeding for the recommended 6 months if they learn about these benefits

of lactation. Other factors play a role in breastfeeding intentions, initiation, and duration. Therefore, the literature regarding these factors is also examined.

Factors Affecting Breastfeeding Outcomes

Sociodemographic factors. The potentially stressful postpartum period is a time of transition for women, and successful lactation may be affected by a variety of personal, physical, and psychological factors (Groër, Davis, & Hemphill, 2002). Sociodemographic variables that have an impact on breastfeeding outcomes include maternal age, maternal education, and socioeconomic status (Callen & Pinelli, 2004). Young maternal age is a consistent variable associated with never breastfeeding (Chittleborough et al., 2012) and early breastfeeding cessation (Forster, McLachlan, & Lumley, 2006).

Studies vary on the maternal age that influences breastfeeding outcomes. However, most of the data demonstrate a maternal age less than 30 as a risk factor for breastfeeding cessation (Ayton, van der Mei, Wills, Hansen, & Nelson, 2015; Chittleborough et al., 2012; Forster et al., 2006; Schwartz et al., 2002; Vogel, Hutchison, & Mitchell, 1999). Several elements may influence young mothers with the decision to breastfeed, including various misperceptions. These include the notion that "breastfeeding leads to dependency," in which the mother believes breastfeeding makes it difficult for her to leave the baby with another individual (Nelson, 2009, p. 253). Another misconception is that of "privacy matters," referring to public breastfeeding and subsequent feelings of discomfort the mother may have in this situation (Nelson, 2009, p. 253). In addition, older mothers with more than one child may have more favorable

breastfeeding outcomes due to previous experience with breastfeeding and family support.

Another contributing factor affecting breastfeeding outcomes is maternal education. Each year, the Centers for Disease Control and Prevention (CDC, 2014) collects data from the National Immunization survey regarding several sociodemographic characteristics, including maternal education. The percentage of women with a high school diploma or less in the United States who exclusively breastfed for 6 months is lower than those with a college degree. Of 3,017 high school graduates, 8.9% exclusively breastfeed through 6 months; of 7,311 college graduates, 19.6% exclusively breastfeed through 6 months (CDC, 2014). A higher level of education, therefore, appears to be a protective factor for breastfeeding initiation and continuation (Ayton et al., 2015; Lindau et al., 2015; Schwartz et al., 2002). It is possible that women with a high school diploma or less are unaware of specific breastfeeding benefits, less familiar with techniques for breastfeeding, or lack strong family and social support (ACOG, 2013).

In some research studies, socioeconomic status has been shown to be another variable that impacts breastfeeding outcomes (Chittleborough et al., 2012; Lindau et al., 2015). Women in lower socioeconomic brackets generally return to work earlier than women in higher socioeconomic brackets. Women with lower socioeconomic status, therefore, are more likely to discontinue breastfeeding. These women also are employed in environments less conducive to breastfeeding practices than women with higher socioeconomic status (Shealy, Li, Benton-Davis, & Grummer-Strawn, 2005).

The United States Department of Labor has reformed workplace accommodations for breastfeeding by utilizing the Affordable Care Act to support an amendment to the

Fair Labor Standards Act (U.S. Department of Labor, 2010). In 2010, employers with a company of 50 or greater employees had a mandate to provide reasonable break time for lactating mothers to express breast milk during work hours for the infant's first year of life. A private place, other than the bathroom, was provided for this purpose (U.S. Breastfeeding Committee, 2017b). Small gains in labor laws might assist in the improvement of breastfeeding outcomes for all women, especially those of low socioeconomic status.

Psychological factors. In addition to the influence of sociodemographic variables, psychological factors can influence breastfeeding outcomes, specifically duration (de Jager, Skouteris, Broadbent, Amir, & Mellor, 2013). These psychological factors include breastfeeding intention and maternal confidence. O'Brien, Buikstra, and Hegney (2008) explored psychological characteristics of postpartum mothers ($N = 357$) to determine the influence on breastfeeding outcome. The researchers collected self-report questionnaires to determine sociodemographic characteristics and the psychological variables of breastfeeding intention, maternal confidence, and depression. After controlling for sociodemographic variables, O'Brien et al. (2008) determined that breastfeeding confidence and planned duration of breastfeeding were reliable unique predictors of breastfeeding duration. They found that participants who planned on breastfeeding for less than 6 months were more likely to discontinue breastfeeding earlier than their intended plan (*OR* 2.19, 95% CI [1.52, 3.16], $p < 0.001$).

Dunn et al. (2006) performed a secondary analysis of a prospective longitudinal telephone survey of mothers at 6 weeks postpartum to determine the relationship between maternal confidence, postpartum depression, formula supplementation, perceived

adequacy of support, and breastfeeding outcomes. The sample consisted of 526 women who initiated breastfeeding. Results of bivariate analysis demonstrated that women with less maternal breastfeeding confidence were more likely to discontinue breastfeeding at 6 weeks postpartum (*OR* 3.10, 95% CI [1.36, 7.07], $p = .01$). In addition, women with an Edinburgh Postnatal Depression Scale (EPDS) score of equal to or greater than 12, which is a score that indicates postpartum depressive symptoms, were more likely to discontinue breastfeeding by 6 weeks postpartum than women with an EPDS score of less than 12 after controlling for age (MH $\chi 2 = 5.93$; $p = .01$) and education (MH $\chi 2 = 6.13$; $p = .01$). The findings highlight the need to assess and provide services for mothers who have depressive symptoms and are at risk for breastfeeding cessation (Dunn et al., 2006).

To determine factors associated with breastfeeding duration of at least 6 months, Forster et al. (2006) performed a secondary analysis on data from three groups of participants in a randomized controlled trial that incorporated two mid-pregnancy educational interventions on breastfeeding outcomes. The findings from logistic regression analysis demonstrated that a strong desire to breastfeed (adjusted *OR* 2.18, 95% CI [1.45, 3.29]) was associated with longer durations of breastfeeding. In addition, Forster et al. (2006) reported an association between self-reported maternal depression and anxiety in the 6 months after birth (adjusted *OR* 0.64, 95% CI [1.35, 1.86]) and the duration of breastfeeding. The authors emphasized that future research must take into consideration interventions that promote breastfeeding in women at risk of early breastfeeding cessation, such as those with decreased desire to breastfeed for the recommended 6 months and those with depressive symptoms.

Perinatal depression. Although psychological factors that may affect breastfeeding outcome have been studied, few studies have focused on women with perinatal depression. Research has shown that depressive symptoms are strongly associated with breastfeeding duration (de Jager et al., 2013). Continuous breastfeeding has been shown to decrease depressive symptoms in the postpartum period (Dennis & McQueen, 2009; Hahn-Holbrook et al. 2013). This protection would appear to be governed by the neuroendocrinology associated with the natural and biologic behavior of postpartum lactating mothers (Groër et al., 2002). Researchers have begun to explore this psychoneuroimmunological relationship more closely to determine any association between depressive symptoms and breastfeeding.

Psychoneuroimmunological effects of breastfeeding. The studies on psychoneuroimmunology effects support the theory of a bidirectional pathway between depressive symptoms and breastfeeding. Hormonal secretions from breastfeeding affect mood, and depression influences serum and breast milk properties (Donaldson-Myles, 2012; Groër, 2005; Groër & Davis, 2006; Stuebe, Grewen, & Meltzer-Brody, 2013). The neuroendocrine responses to breastfeeding, therefore, may be an evolutionary protection against depressive symptoms (Figueiredo et al., 2014; Hahn-Holbrook et al., 2013; Stuebe et al., 2013).

Stress hormones, such as cortisol, are affected by pregnancy and lactation (Molitch, 2012). The hypothalamic-pituitary-adrenal (HPA) pathway is responsible for the release of corticotropin releasing hormone (CRH) signaling release of the adrenocorticotropic hormone (ACTH) and ultimately cortisol in response to stressful situations. Stress hormones are found to be higher in breastfeeding and formula-feeding

mothers than in nonpostpartum healthy women, perhaps due to differential regulation of the HPA axis during pregnancy and postpartum (Groër, 2005).

Iliadis et al. (2015) conducted a longitudinal study in Sweden to assess the levels of evening salivary cortisol and symptoms of postpartum depression. The researchers collected evening salivary samples for laboratory cortisol testing and responses to the EPDS from mothers at 36 weeks gestation (N = 265) and 6 weeks postpartum (N = 181). A higher evening salivary cortisol level was found in women who scored ≥ 10 on the EPDS compared to women who scored <10 on the EPDS at 6 weeks postpartum (median cortisol 1.19 nmol/L vs. 0.89 nmol/L, $p < 0.05$). In addition, the researchers determined that there was a positive association between evening cortisol levels and postpartum depression (*OR* 0.41, 95% CI [1.7, 9.7]). This association remained significant when a history of depression and breastfeeding were considered (adjusted *OR* 4.5, 95% CI [1.5, 14.1]).

Tu et al. (2006) measured the diurnal cortisol levels of postpartum primiparous and multiparous women who breastfed or bottle-fed their infants. The diurnal cortisol levels of multiparous women varied depending on feeding method. Specifically, multiparous women who bottle-fed had higher diurnal cortisol levels than those who breastfed. Primiparous women, however, did not exhibit any difference in diurnal cortisol levels regardless of infant feeding choice. Further studies are needed in populations of both primiparous and multiparous mothers to determine whether stress hormone results would decrease as a result of breastfeeding.

Hormones, such as oxytocin and prolactin, are also involved in the psychoneuroimmunological changes during pregnancy and lactation (Buhimschi, 2004).

Prolactin is a lactogenic hormone that increases during pregnancy and is released during breastfeeding. Prolactin stimulates milk production and suppresses production of estrogen, progesterone, and follicle-stimulating hormone. Prolactin has been found in higher amounts in the serum of women who breastfeed than women who bottle feed (Groër, 2005). Prolactin has also been found in higher amounts in women who breastfeed after a vaginal delivery than women who breastfeed after an elective cesarean delivery (Zanardo et al., 2012), causing a decrease in stress and depressed mood.

Oxytocin is a hormone stored in the posterior pituitary. Released during lactation, oxytocin causes uterine contractility and milk letdown and moderates stress responses (Jolley et al., 2007). Oxytocin levels of women who have severe breastfeeding problems show a decrease over time compared to women without breastfeeding problems (Jobst et al., 2016). Among mothers with postpartum depression who breastfeed for several weeks, higher EPDS scores were inversely correlated with lower oxytocin levels during and after feeding (Stuebe et al., 2013). Increased levels of oxytocin influence positive maternal-infant interactions and bonding (Levine et al., 2007**;** Mah, Van Ijzendoorn, Mith, & Bakermans-Kranenburg, 2013).

Lactation causes changes in stress hormones, lactogenic hormones, and neurological hormones. These changes positively influence maternal mood and behavior. Women with perinatal depression may benefit from the psychoneuroimmunological effects of breastfeeding. Therefore, it is important to identify these at-risk women.

Identification of perinatal depression. One of the most rapid methods to measure a mother's risk for development of perinatal depression is the use of self-report depression instruments, such as the Edinburgh Postnatal Depression Scale (EPDS). This

tool is easy and reliable to administer in the health care setting, takes approximately 5 minutes for the participant to complete. The EPDS tool has a sensitivity of 86%, a specificity of 78%, and a positive predictive value of 73%. A cut-off score of 9/10 may be used to ensure that actual cases of depression are not overlooked (Cox, Holden, & Sagovsky, 1987). Many studies have investigated the relationship between maternal depressive symptoms and breastfeeding outcomes with incorporation of the EPDS self-report instrument (Fairlie et al., 2009; Figueiredo et al., 2014; Hamdan & Tamim, 2012; Hatton et al., 2005; Henderson et al., 2003; Watkins et al., 2011). These studies have also suggested the need for identification of women with perinatal depression so that breastfeeding support may be provided.

Henderson et al. (2003) collected data from 1,745 women who delivered a healthy infant at 35 weeks gestation or greater and who were not initially under psychological care. The study purpose was to investigate the relationship between depressive symptoms and breastfeeding duration over a 12-month period. The researchers utilized the EPDS to screen for depressive symptoms at the 2, 6, and 12-month follow-up interviews. Based on a diagnostic interview between 2 to 12 months after delivery, Henderson et al. (2003) found that 18% of the participants ($N = 314$) developed depression. Postnatal depression was significantly associated with breastfeeding duration ($p = 0.025$). The risk of breastfeeding cessation was 1.25 times greater in the women who experienced postnatal depression than those who did not (95% CI [1.03, 1.52]). Moreover, breastfeeding cessation was preceded by the onset of depressive symptoms. Henderson et al. (2003) suggested that breastfeeding support should be included for women with depressive symptoms.

Infant feeding outcomes and postpartum depressive symptomatology at 1, 4, and 8 weeks postpartum were examined by Dennis and McQueen (2007) with a secondary analysis of a longitudinal study. Postpartum depressive symptoms were determined by an EPDS score of greater than or equal to 12. The researchers found that a significant number of mothers with an EPDS greater than or equal to 12 at 1-week postpartum discontinued breastfeeding by 8 weeks postpartum (*OR* 0.57, 95% CI [0.34, 0.95], $p = 0.01$). Dennis and McQueen (2007) emphasized that early identification of women with depressive symptoms would have the potential to reduce the negative health outcomes of postpartum depression and promote increased breastfeeding duration.

Akman et al. (2008) conducted a prospective, longitudinal study to explore the association between postpartum depression, maternal anxiety level, perceived social support, and maternal attachment styles and infant feeding practices. The researchers determined that mothers with an EPDS score of greater than or equal to 13 discontinued breastfeeding prior to 4 months postpartum. The EPDS scores of mothers who discontinued breastfeeding prior to 4 months postpartum was significantly higher than those who did not discontinue breastfeeding ($p = 0.002$). Akman et al. (2008) stressed the importance of health care providers' recognition of postpartum depressive symptoms to support women in continuation of breastfeeding.

The relationship between depression and breastfeeding was investigated by Hatton et al. (2005) with 377 participants who completed the EPDS at 6 weeks and 12 weeks postpartum. Analysis of covariance results demonstrated that women who were breastfeeding had fewer depressive symptoms at 6 weeks postpartum ($p < .05$) while controlling for age, income, education, and race than women who were not breastfeeding.

The researchers suggested that early symptoms of postpartum depression could affect lactation. Identification of depressive symptoms early in the postpartum period could be an important determinant of need for psychological and breastfeeding support in this vulnerable group of women.

Hamdan and Tamim (2012) also studied the relationship between breastfeeding and postpartum depression. The researchers conducted a prospective study with 137 women. Women who breastfed at 2 and 4 months postpartum had lower EPDS scores than those who did not (5.5 vs. 9.1; $p = 0.0037$; 4.5 vs. 8.1; $p < 0.0001$, respectively). The authors suggested that their results indicated that breastfeeding was an important protective factor against postpartum depression.

A secondary analysis of data from 2,586 participants was conducted by Watkins et al. (2011) to determine the association between early breastfeeding experiences and postpartum depression at 2 months postpartum. The researchers calculated that mothers with postpartum depressive symptoms, as evidenced by an EPDS score of greater than or equal to 12 (68.6%), were less likely to still be breastfeeding at 2 months postpartum compared to mothers without depressive symptoms (74.9%) ($p = .04$). Watkins et al. (2011) suggested that early screening for postpartum depressive symptoms might identify women at risk and promote health care providers' reduction of the morbidity associated with both postpartum depression and early breastfeeding cessation.

Current analysis on the effect of breastfeeding and maternal mental health by Borra, Iacovou, and Sevilla (2015) demonstrates the heterogenous effect of breastfeeding on postpartum depression. The researchers performed a secondary data analysis of the Avon longitudinal survey of parents and children (ALSPAC). This was a study of

approximately 14,000 children born in and around Bristol, England, in the 1990s (Golding, Pembrey, Jones, & the ALSPAC Study Team, 2001). In the ALSPAC study, questionnaires were collected from parents at various points during pregnancy and the postpartum period.

Borra et al. (2015) utilized parent responses collected during the ALSPAC survey, including breastfeeding intention, EPDS results at 8 weeks, 8, 21, and 33 months postpartum, and infant feeding method during the same time periods. The aim of the researchers was to determine whether a causal relationship existed between breastfeeding and postpartum depression. Results indicated that exclusive breastfeeding for 4 weeks or longer was significantly associated with lower EPDS scores (*OR* 0.81, 95% CI [0.68, 0.97], $p = 0.05$). Interestingly, the researchers also found that any effects of breastfeeding on postpartum depression were influenced by maternal intention to breastfeed and maternal mental health during pregnancy.

Breastfeeding, Perinatal Depression, and Qualitative Studies

Although some quantitative research studies have investigated correlations between breastfeeding and depressive symptomatology, little qualitative research has been conducted to understand how women with depression experience breastfeeding in their day-to-day lives. Increasing attention, however, has been placed on the link between breastfeeding and depressive symptoms (Olson & Bowen, 2014). Very few qualitative research studies have detailed women's experiences of depressive symptoms and breastfeeding. Therefore, more detailed information is necessary to promote breastfeeding duration in this population.

In one of the few qualitative studies, Fooladi (2006) interviewed nine women with depressive symptoms in relation to crying, breastfeeding, lactation suppression, and prior pregnancy loss. Focus groups included questions based on an ethnographic approach and the critical theory of participatory action based on Freire (Fooladi, 2006). Utilizing immediate debriefing, Fooladi (2006) discovered data themes through an exploratory, descriptive method. Women experienced improved postpartum mental health when they were able to cry and breastfeed. Participants in the study who breastfed for more than 6 weeks described themselves as "happy," "thrilled," "content," "lucky," "blessed," and "tired" (Fooladi, 2006, p. 209). Some participants even described breastfeeding as the deepest bond with another human being that they had ever encountered in their life. Fooladi suggested that a supportive environment from health care providers would assist vulnerable mothers to make an informed decision regarding infant feeding methods.

In another qualitative study, semistructured interviews were conducted by Haga, Lynne, Slinning, and Kraft (2012) with 12 first-time mothers. Nine of the mothers self-reported depressive symptoms. The goal of the research was to gain insight into the women's lived experience of the postpartum period. The participants' postpartum durations ranged from 8 weeks to 8 months. The researchers utilized thematic analysis to identify, report, and analyze patterns in the data and identified three themes that were attributed to depressive symptoms and overall well-being.

The themes revealed were personal approach to motherhood, social support, and breastfeeding. The women with depressive symptoms were more likely to practice a "controlled" personal approach, to have less social support, and to have difficulty managing breastfeeding (Haga et al., 2012, p. 462). The participants who struggled with

breastfeeding reported feeling like failures because they were not able to breastfeed with ease. Haga et al. (2012) concluded, however, that successful breastfeeding and adequate social support were important variables that improved depressive symptoms and the well-being of mothers during the early postpartum period.

These two qualitative studies provided initial results surrounding the mother's perceptions of the breastfeeding experience. Sound nursing practice, however, requires in-depth analysis of the experiences of women with perinatal depression who initiate and continue breastfeeding. Innovative qualitative research with this at-risk population may lead to suggestions for new strategies to promote and protect the practice of breastfeeding. Participants' insights will aid in nurses' ability to individualize support for women and their infants. Comprehensive research will provide pertinent information to support mental wellness in the antenatal and postnatal period to improve maternal, infant, and family mental and physical health outcomes.

Discussion of Gap in Knowledge Base and Link to Caring Science

For women with depressive symptoms, breastfeeding promotion may incorporate coaching for more optimal feeding interaction behaviors (Field et al., 2010), educating and supporting mothers to improve the mother-infant relationship (Tamminen & Salmelin, 1991) or teaching mothers to recognize and manage stress (Groër, 2005). In order to adequately support a population of women at risk for depressive symptoms and consequently early breastfeeding cessation, researchers must examine the type of breastfeeding support that is most effective in breastfeeding promotion among depressed mothers (Dennis & McQueen, 2009).

The first step is to describe breastfeeding for women who self-report perinatal depression. The most appropriate method to uncover the lived experience of breastfeeding for these women is conducting of a phenomenological study based on caring science (Wojnar & Swanson, 2007). Swanson's theory of caring (1991, 1993) provided the theoretical framework for this research.

Swanson's theory of caring (1991, 1993) evolved from three phenomenological studies based on women's experiences of miscarriage (Swanson-Kaufman, 1986), care providers' experience in the Newborn Intensive Care Unit (Swanson, 1990), and mothers' experiences of the nurse-client relationship during participation in a long-term intensive nursing intervention (Swanson, 1991). Since development of this theory, Swanson has continued testing it by incorporating the caring elements into a clinical research model and demonstrating the positive impact of caring on the amount of anger, depression, and overall disturbed moods experienced by women who had a miscarriage (Swanson, Chen, Graham, Wojnar, & Petras, 2009). Other studies also incorporated the theoretical components into practice settings and research studies, tested and validated the theory, related research findings to the theory, and developed measurements from the theory (Andershed & Olsson, 2009). Researchers have incorporated this theory into studies with perinatal contexts (Anderson, 2002; Coté-Arsenault & Marshall, 2000; Gergett & Gillan, 2014; Hutti et al., 2016; Kavanaugh et al., 2015; Mott, 2016) as well as medical-surgical contexts (Ahern, Corless, Davis, & Kwong, 2011; Beatty, 2004; Hines-Martin, Brown-Piper, & Malone, 2003; Roscigno, 2016).

The researcher grounded the current study in Swanson's (1991, 1993) theory of caring and applied its five processes during participant interviews and related the theory

to the findings and implications. The five processes that form the structure of nursing caring in Swanson's (1991, 1993) theory are *maintaining belief*, *knowing*, *being with*, *doing for*, and *enabling*. By *maintaining belief* in the participants, the researcher has faith in their ability to find personal meaning in breastfeeding. By *knowing*, the researcher seeks to understand the participants' personal breastfeeding experiences.

By *being with* the participants, the researcher is authentically present during the interviews and appreciates the mothers' realities when *doing for* by actively listening to the breastfeeding story. During the interview, the researcher is *enabling* by validating the participants' lived experience and creating spaces for the mothers to share their breastfeeding experiences. Through this framework, the researcher aims to understand how women with depressive symptoms experience breastfeeding and how they perceive breastfeeding support.

Summary

Breastfeeding and maternal health benefits were discussed in this chapter. Evidence from the literature suggests that these benefits, especially a decrease in depressive symptoms, are dependent upon breastfeeding duration (Hahn-Holbrook et al., 2013; Kramer & Kakuma, 2012; WHO, 2015)**.** Evidence in the literature that influences breastfeeding outcomes revealed that sociodemographic, psychological factors, such as breastfeeding intention, and psychoneuroimmunological effects have an influence on breastfeeding outcomes (Chittleborough et al., 2012; Dunn et al., 2006; Lindau et al., 2015; O'Brien et al., 2008). However, a gap in the literature regarding the in-depth exploration of the breastfeeding experiences of women with perinatal depression was uncovered.

Research is necessary that focuses on exploration of the breastfeeding experiences of women with perinatal depression, with the aim of discovering not only what factors affect breastfeeding duration but also how and why these factors affect breastfeeding duration. The results of this study will generate a description of how breastfeeding is incorporated into the everyday experiences of mothers who self-report perinatal depression. The findings may guide the development of therapeutic actions supporting breastfeeding among women with perinatal depression, with the goal of improving breastfeeding outcomes that may decrease depressive symptoms.

III. RESEARCH METHODOLOGY

Introduction

This chapter describes the research design of the study, with a focus on the underlying philosophy and methodology of the qualitative descriptive phenomenological approach. The sample, recruitment method, and setting for this study are presented in detail. Data generation, data analysis, study rigor, ethical considerations, and strengths and limitations of the study are also examined. In addition, a brief timeline of the research study is included.

Research Design Including Philosophical Foundations of the Method

A qualitative descriptive phenomenological research approach was used to explore the breastfeeding experience of women with perinatal depression. Descriptive phenomenology is a philosophical method of inquiry that aims to explore the human experience through open communication between the researcher and the participant (Wojnar & Swanson, 2007) and resolves to uncover the essences of the phenomenon studied (Giorgi, 2012**).** The paucity of research in breastfeeding for women with perinatal depression and the lack of conceptualization of the breastfeeding experience of women with perinatal depression led to the need for additional research. The most appropriate method to uncover patterns and similarities of this human experience is descriptive phenomenology.

For a better understanding of the evolution of the qualitative research perspective and the philosophical underpinnings of descriptive phenomenology, it is important to

review its history. The emergence of qualitative research began after Immanuel Kant refuted René Descartes' view of science and proposed that reality was not explainable by mere observation (Speziale & Carpenter, 2007). This idea led to a radically different view of science from the accepted empirical and objective data-gathering to a nonreductionist humanistic approach (Merleau-Ponty, 1945/2012).

During the first decade of the 20th century, Franz Brentano (1838-1917) paved the way for philosophy to uphold scientific rigor in the realm of psychology in the same manner as the natural sciences. Brentano introduced the idea of intentionality as a mental phenomenon, which contained an object intentionally within itself (Huemer, 2014). The next phase of phenomenology central to its development was generated by Brentano's student Edmund Husserl (1857-1938). The concept of intentionality as human "consciousness [being] always consciousness of something" (Husserl, 1931/2012, p. 63).

Husserl (1931/2012) advanced the philosophy of phenomenology through development of the concepts of essences, intuiting, and phenomenological reduction. Husserl defined essence (*eidos*) as the true meaning of a phenomenon. He theorized that "whatever belongs to the essence of an individual can also belong to another individual" (Husserl, 1931/2012, p. 11). Participants in phenomenological research would then be able to disclose the essential nature of a known experience and provide descriptive data to uncover its true essence that could be applied to a general category of individuals. To develop a common understanding of the phenomenon investigated, Husserl posited that intuiting reflected free imagination of data variation that ultimately revealed the essence of the phenomenon. Thus, intuiting was a necessary process in phenomenological research (Speziale & Carpenter, 2007).

Husserl (1931/2012) stressed the importance of researchers suspending their own view of the natural world in conducting descriptive phenomenological research. He labeled this process the "phenomenological reduction," which the researcher would undertake by constantly "bracketing" any personal theses or convictions related to the phenomenon of interest (pp. 56, 58). Husserl (1931/2012) described phenomenological reduction as a part of the research method "which bears on our own empirical existence as well as on that of other beings, forbidding us to introduce a proposition which contains, implicitly or explicitly, such references to the natural order" (p. 127). According to Husserl's philosophical stance, descriptive phenomenological researchers must suspend their own world knowledge and beliefs to observe and describe the essence of another's lived experience in its purest form.

Giorgi (2009) advanced Husserl's nonreductionistic phenomenological philosophy regarding life experiences of human beings by developing a rigorous and descriptive research method. The work of Giorgi stemmed from experimental psychology and the study of the structures of consciousness and life experiences presented to consciousness. Giorgi (2009, 2012) expanded the four essential components of Husserl's (1931/2012) phenomenological philosophy into a descriptive phenomenological research method. These components were comprised of phenomenological reduction, bracketing, intuiting, and describing.

As Giorgi (2009) indicates, the researcher must assume a human scientific phenomenological reduction, which would include acknowledging the raw data as the participants' experiences of a specific phenomenon. An integral part of phenomenological reduction is bracketing, which Giorgi defined as a suspension of past

knowledge to enable the researcher to elucidate the essences of the study phenomenon from only the raw data collected from participants. In this qualitative research method, Giorgi purported that intuiting would allow the researcher to indirectly experience the exact situation described by the participants. Through analysis of raw data, the researcher would then be able to describe the phenomenon's distinct structure. With these concepts and definitions, this method was chosen as most appropriate for comprehension of the breastfeeding experience for women who have perinatal depression. Details of Giorgi's (2009) method of analysis are discussed in the data analysis section.

Sample, Recruitment, and Setting

Sample

This descriptive phenomenological study took place in the United States with recruitment of a purposeful sample of 10 women. The following were the participant inclusion criteria:

- Self-report diagnosis of perinatal depression
- Delivery of singleton
- Breastfeed for at least 2 weeks after delivery
- No more than 1-year postdelivery
- 18 years of age or older at time of delivery
- English speaking

The following were the participant exclusion criteria:

- Preterm birth prior to 37 weeks gestation
- Infant or maternal complications resulting in physical separation of mother and baby that led to delay in initiation of breastfeeding

- Current pregnancy
- Medical conditions of the mother or infant that might affect breastfeeding. These complicating factors would most likely outweigh the overall experience of breastfeeding for women with perinatal depression.

Recruitment

To recruit this population, the researcher emailed an introduction letter (Appendix A), including a brief description of the proposal, request for placement of recruitment flyers, and participant inclusion criteria to the appropriate personnel at the Center for Postpartum Adjustment, area support groups of Postpartum Support International, Healthy Mothers Healthy Babies of Palm Beach County, and the Miami Maternity Center. Four organizations, including Healthy Mothers Healthy Babies of Palm Beach County, Dr. Lynn Lampert, momsTOmoms postpartum support group, and the Florida Nurses' Association, were interested in participation. The researcher then discussed the proposal in more detail with them.

When agreement was reached, signed letters of cooperation (Appendix B) were obtained. Upon Florida Atlantic University Institutional Review Board (FAU-IRB) approval on July 22, 2015 (Appendix C), recruitment flyers (Appendix D) were placed in the offices or online for the participating organizations. The flyer highlighted the study intent and eligibility criteria. A dedicated secure telephone number and email address for the researcher was provided on the flyer to facilitate participant contact.

Due to a small number of participants who responded, the researcher sent an amendment to the FAU-IRB in March 2016 to revise recruitment methods. The FAU-IRB approved changes to the protocol on March 21, 2016. The researcher submitted an

advertisement with South Florida Parenting Magazine (Appendix E), distributed the recruitment flyer via email to FAU College of Nursing students (Appendix F), and expanded participant recruitment from women who lived in Florida to women who lived in the United States. Additionally, the researcher updated the recruitment flyer (Appendix G).

Prior to FAU-IRB approval expiration on July 22, 2016, the researcher submitted a Continuing Review Report to request extension of the study due to low recruitment numbers. As of July 2016, the researcher interviewed a total of 7 participants. FAU-IRB approved extension of the study until July 22, 2017 (Appendix H) to include approval for enrollment of up to 13 more participants. FAU-IRB stamped the existing verbal and written consent forms, recruitment flyer, and recruitment email with the approved expiration date of July 22, 2017. When data saturation was reached, the researcher concluded recruitment on September 23, 2016, with a total of 10 participants.

Setting

Upon initial participant contact, the researcher determined whether the mother met inclusion criteria as previously outlined. If the participant met these criteria, the researcher explained the study in full. If the mother decided to participate, the researcher arranged an interview at the participant's choice of location, such as a restaurant, or a telephone interview via a dedicated research study telephone line. Each interview lasted up to 60 minutes. Upon completion of the interview, the participant was offered a $10 gift card to be sent via mail. If the participant consented, the researcher obtained a mailing address to be used only for this incentive. After mailing, addresses were immediately destroyed.

Data Generation

Grounding in Caring Theory

Generation of data for this research study required grounding in Swanson's (1991, 1993) middle-range theory of caring. The researcher began gathering data by *maintaining belief* in the participants through adoption of the philosophical attitude that mothers with a diagnosis of perinatal depression were fully capable of the breastfeeding process and would face difficulties of this infant feeding method with dignity. The researcher grounded *maintaining belief* in *knowing* by avoiding assumptions about these women, focusing on their experiences, assessing their personal realities, and engaging them in caring dialogues.

Swanson's (1991, 1993) *being with* followed the first two processes. When the researcher *maintained belief* and welcomed *knowing* the participants, she could engage in and emotionally *be with* the individuals during personal interactions. This empathic response encouraged participants to understand the importance of their lived experiences. The researcher then performed actions, *doing for,* on behalf of the participants' long-term well-being. *Doing for* included use of appropriate interpersonal communication skills as well as translation of the qualitative research into themes that might shape future breastfeeding promotion interventions for this at-risk population. The final process that led to the intended outcome was *enabling*. Nurse caring enabled others to practice self-care behaviors. The researcher supported the participants, allowed them to express their own lived experiences, and at the same time through acknowledgement and acceptance validated their voiced realities.

Interview Process

The researcher fully disclosed the purpose of the study and interview requirements with potential participants to obtain written (Appendix I) or verbal informed consent (Appendix J). The researcher collected one written informed consent from a face-to-face interview and nine verbal informed consents from telephone interviews. Participant interviews ranged from 11 to 36 minutes, although up to 1 hour was allotted. The participants initially completed written or verbalized answers to a demographic questionnaire (Labbok & Krasovec, 1990) (Appendix K) and the self-report Edinburgh Postpartum Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987; Appendix L). The purpose of the questionnaire and the EPDS was to provide an overall description of the participant group.

Before the interview, the researcher *bracketed* her own previous experiences and pre-existing ideas. With deliberate naiveté, as if she was unfamiliar with the breastfeeding experience of women who have perinatal depression**,** the researcher conducted semistructured interviews with the participants to gain insight regarding the mothers' lived experiences of breastfeeding. Through repeated readings of the interviews, the researcher elucidated the essences of the described phenomenon (Kvale & Brinkmann, 2009). One interview was conducted face-to-face in a private setting, and nine interviews were conducted via telephone on a dedicated research telephone line. With participants' permission, the interviews were audiorecorded. Nine of the participants agreed to be recorded and one did not. The researcher used a handheld digital recorder to audiorecord the conversations and then transcribed them verbatim for descriptive phenomenological analysis.

The interviews consisted of open-ended questions to encourage the participants to discuss specific aspects of their breastfeeding experience (Appendix M). The initial open-ended question was: “Describe your breastfeeding experience in as much detail as possible.” The researcher asked further probing questions to verify the responses and elicit detailed descriptions of the breastfeeding experience, as well as possible connections to perinatal depression. After completing 10 participant interviews, the researcher found that data saturation occurred when the participants’ information and references to recurring essences became repetitive (Guest, Bunce, & Johnson, 2006).

Data Analysis

Characteristics of the study population were examined by descriptive statistical analyses, including means and standard deviations. The participants’ characteristics included age, race, marital status, level of education, current employment, annual income, type of delivery, and category of breastfeeding. The EPDS (Cox et al., 1987), a self-report tool, was used to classify the participants’ depressive symptoms in the past week. Participants with an EPDS score of greater than or equal to 10 were considered to have a positive screen for possible perinatal depression.

The researcher analyzed the transcribed raw data as defined by Giorgi (2009). This method of data analysis involved several steps. The researcher first read the raw data for a sense of the entire phenomenon as described by the participants. Then the researcher determined the meaning units of the participants’ reports of the phenomenon. Lastly, the researcher transformed the meaning units into a phenomenologically and psychologically sensitive expression of the whole.

After transcription of raw data, the researcher assumed the phenomenological attitude by setting aside her theoretical, cultural, and experiential presuppositions. By doing so, the researcher examined data through a fresh lens. The transcriptions were then read again in their entirety to gain an overall sense of the participants' descriptions. During the initial reading, it was also important for the researcher to gain an overall understanding of the "intentional objects of the lifeworld description provided by the participant" (Giorgi, 2009, p. 129). However, the researcher did not separate the specific items that arose, such as breastfeeding difficulties and depressive symptoms, because they initially remained a part of the whole.

The next step involved delineation of meaning units. With subsequent readings, the researcher marked the points at which meaning shifts occurred during the interviews. Once again assuming a detached phenomenological and psychological attitude, the researcher remained aware of the phenomenon of interest to determine demarcation of the meaning units. After establishment of the meaning units, the researcher divided the raw data into smaller portions for subsequent analysis and reintegration into the phenomenological essences.

The final step in Giorgi's (2009) method incorporated iterative readings of meaning units to interpret ideas critically and properly. During this process, the researcher transformed the meaning units into psychologically sensitive statements of the participants' lived experience. The researcher elevated the phenomenon to an individuated, worldly, and personal level. The statements were re-expressed in the third-person while remaining faithful to the meanings expressed by the participants. From the

transformation of the meaning units, the researcher synthesized a general psychological structure of the experience based on the constituents of the experience.

Study Rigor: Credibility and Transferability

The researcher must establish trustworthiness during a qualitative inquiry (Lincoln & Guba, 1985). This trustworthiness may consist of credibility, transferability, dependability, and confirmability. Credibility allows researchers to have confidence in the accuracy and truthfulness of the findings (Lincoln & Guba, 1985). To establish credibility, in the current study the researcher utilized analyst triangulation by conferring with dissertation committee members to review the study findings.

Transferability demonstrates the applicability of research findings to other populations (Lincoln & Guba, 1985). In this dissertation, thick descriptions were an important part of the method utilized to demonstrate transferability. To facilitate thick description, the researcher wrote detailed field notes before and after each interview to account for the field experience and during data analysis to account for emergence of findings.

Study Rigor: Confirmability and Dependability

Confirmability ensured that researcher bias was not present in the findings. Confirmability was enhanced as the dissertation committee members reviewed the findings to determine whether they were shaped by the participants' descriptions and not solely by the researcher's bias or interest. For dependability of the study, the researcher developed an audit trail, which included raw data, data reduction and analysis products, data reconstruction and synthesis products, and process notes (Lincoln & Guba, 1985).

Ethical Considerations Including Protection of Human Subjects

This study included human subjects, and therefore the researcher's ethical decision-making was of the utmost importance. Prior to the interview, the researcher explained the study in detail to the participants, including risks and benefits, confidentiality, and their right to withdraw at any time. All participants' questions were answered prior to signing or agreeing to the informed consent. A copy of the signed consent form was kept by the researcher and another was given to the participant.

Minimal risk might be associated with any research project. However, the level of risk involved in participation and completion of this study's questionnaires and interview was not greater than situations ordinarily encountered in daily life. If participants were to demonstrate any signs of significant distress during the interview, such as anxiety, aggressiveness, or suicidal thoughts, the researcher would immediately stop the interview and provide emotional support. The researcher also would offer to end the interview and might refer the participant to her health care provider, a maternal mental health certified psychologist, a psychiatrist, or a Postpartum Support International local support group. During the interviews, none of the participants expressed significant distress.

The proper maintenance of data was another important aspect in the ethical management of this research study. The data and audiorecorded files were stored in a locked file cabinet and in a password-protected computer accessible only to the researcher and dissertation committee members. To maintain participant confidentiality, no identifying information was retained with the stored data.

Participants were assigned code numbers and given pseudonyms that were used with all related documents. The signed consent forms were kept separate from these data

because of the identifying information on the forms. Participants' names were not released without permission, unless disclosure was required by law. The researcher will not, and did not, include identifying information in any publications resulting from this research. The data will be retained for 5 years and then destroyed. The researcher adhered to these ethical standards throughout the span of this study.

Strengths and Limitations of Research Plan

Several strengths are evident in this descriptive phenomenological study. This type of research was useful for studying a limited number of cases with the goal of obtaining individual information that resulted in the description of a complex phenomenon. The participants were most comfortable disclosing personal information in a naturalistic setting of their choosing. Upon collection and evaluation of initial data, the researcher could determine whether a need existed to shift focus of the questions to collect more detailed descriptions.

The results of this study were useful as initial data to identify client care needs of woman who breastfeed and have perinatal depression. The study participants also gained a greater understanding of their own experience of breastfeeding as mothers who experienced perinatal depression. At the close of the interviews, the participants also voiced satisfaction about contributing to improvement of maternal and infant health care for others.

Several limitations are acknowledged for this study. The data collection and analysis phase of the study took a significant length of time, a significant amount of resources, and yielded few participants. The researcher conducted 10 interviews in a span of 14 months, and data analysis was ongoing throughout data collection and after data

collection completion. The inclusion criteria significantly narrowed the target population and had an impact on the length of time and resources to gain participant recruitment.

A lack of racial and ethnic diversity among participants was evident, even though the researcher attempted to recruit mothers from all backgrounds. Although the participants represented a range of income brackets and had varying levels of education, 90% (n = 9) were Caucasian (the demographic characteristics are described in Chapter IV). A broader perspective may have resulted in an ethnically and racially diverse group of participants. It was also assumed that the participants understood the demographic questionnaire and EPDS and responded to the instruments honestly. However, possibly the participants may have engaged in social desirability—skewing answers to gain approval from the researcher (Holtgraves, 2004).

Timeline

The proposal for this study was submitted to the FAU-IRB in July 2015. On acceptance and approval, the researcher distributed flyers by the end of the July 2015 and continued recruitment and data collection until data saturation occurred (Guest et al., 2006). The researcher began data collection on September 25, 2015, and completed on September 23, 2016. Recruitment and data collection took approximately 14 months, encompassing the Fall 2015, Spring 2016, and Summer 2016 semesters. Data analysis began during data collection and continued for approximately 4 months after the final interview.

Summary

This chapter outlined the study methodology, including design, philosophical foundations, sample, recruiting, and setting. Explanation for the utilization of the

descriptive phenomenological method was presented. The method of data collection and Giorgi's (2009) method of analysis were described in detail. Measures of study rigor were also specified. The chapter concluded with a clarification of ethical considerations in human subject research as well as the strengths and limitations of this research study.

IV. FINDINGS

Introduction

The purpose of this descriptive phenomenological study was to examine and define the experience of breastfeeding for women who self-reported as having perinatal depression. This chapter presents descriptive data of the participants, their narratives, and the results of the data analysis. Following Giorgi's (2009) descriptive phenomenological method of analysis, the participants' entire descriptions of the breastfeeding experience were analyzed and deconstructed into meaning units for deeper and more efficient evaluation. The meaning units were transformed into third-person re-expressions of psychologically sensitive meanings (Giorgi, 2009, p. 131)**,** and the essential elements were extracted to construct the structure of the lived experience of breastfeeding for participants in this study.

Interviews

Ten women who self-reported as having perinatal depression took part in this study. The participants answered open-ended questions to reveal rich detail regarding their lived experience of breastfeeding. One of the interviews took place in person, and the others took place by telephone. Basic sociodemographic data were collected to provide a general overview of the participant population. The descriptive data as well as anecdotal narratives are presented. The participant codes (P1-P10) and the corresponding pseudonyms are included in the narratives to ensure protection of participants' identities.

Descriptive Data

Women (n=10) who participated in this study ranged in age from 24 to 34 years old, with the mean age 29.75 years. Regarding race, there were 90% (*n* = 9) non-Hispanic Whites and 10% (*n* = 1) African American. In terms of marital status, 60% (*n* = 6) were married, 20% (*n* = 2) were living with a partner, and 20% (*n* = 2) were single. The educational level varied widely. A total of 10% (*n* = 1) had some college credit with no degree, 10% (*n* = 1) had trade/technical/vocational training, 20% (*n* = 2) had an associate degree, 20% (*n* = 2) had a bachelor's degree, 20% (*n* = 2) had a master's degree, and 20% (*n* = 2) had a doctorate degree.

The participants also had diverse types of employment status. A total of 30% (*n* = 3) were employed for wages, 50% (*n* = 5) were homemakers, 20% (n = 2) each were students or out of work. Their wages ranged from under $10,000 annually to between $75,000 to $99,999 annually. A total of 10% (*n* = 1) chose not to disclose earnings, 10% (*n*=1) earned under $10,000 annually, 10% (*n* = 1) earned between $20,000 to $29,999 annually, 50% (*n* = 5) earned between $50,000 to $74,999 annually, and 20% (*n* = 2) earned between $75,000 to $99,999 annually.

The participants all delivered full-term infants. A total of 50% (*n* = 5) had vaginal births, and 50% (*n* = 5) had cesarean births. At the time of the interview, their infants' ages ranged from 7 to 48 weeks, with an average age of 23.4 weeks. A total of 90% (*n* = 9) of the women were breastfeeding at the time of the interviews, and 10% (*n* = 1) stopped breastfeeding when her infant was 24 weeks old.

The participants reported different types of breastfeeding during the postpartum period, ranging from exclusive breastfeeding to partial breastfeeding. A total of 50% (*n* =

5) of the women were exclusively breastfeeding, defined as giving the infant no other liquid or solid from any other source. A total of 20% (n = 2) were almost exclusively breastfeeding, defined as allowing occasional tastes of other liquids, traditional foods, vitamins, or medicines. A total of 20% (n = 2) were full breast milk feeding, defined as the infant receiving expressed breast milk in addition to breastfeeding. A total of 10% (n = 1) was partial breastfeeding, defined as any feeding of expressed breast milk (Labbok & Krasovec, 1990).

The participants disclosed their experience of depressive symptoms in the perinatal period. At the time of interviews, they completed the Edinburgh Postnatal Depression Scale (EPDS) questionnaire (Appendix L), which self-reported presence of depressive symptoms in the last 7 days. A cut-off level of ≥10 was used to denote possible perinatal depression. The results of the EPDS ranged from 4 to 18. A total of 40% (n = 4) scored <10, and a total of 60% (n = 6) scored >10. Of the participants who scored <10, which indicated no presence of depression, 10% (n = 1) scored 4, 20% (n = 2) scored 5, and 10% (n = 1) scored 8. Out of the participants who scored >10, which indicated possible depression, a total of 10% (n = 1) scored 11, 10% (n = 1) scored 12, 10% (n = 1) scored 13, 10% (n = 1) scored 17, and 20% (n = 2) scored 18. The summaries of the descriptive characteristics with coded pseudonyms are displayed in Tables 1 and 2.

Table 1

Participants' Sociodemographic Data (N = 10)

Code	Pseudonym	Age	Race	Marital Status	Educational Level	Employment Status	Income
P1	Sara	33	African American	Single	Trade/Technical/ Vocational Training	Out of Work	<$10,000
P2	Lydia	31.5	Non-Hispanic White	Married	Master's Degree	Homemaker	$50,000-$74,999
P3	Priscilla	34	Non-Hispanic White	Married	Masters' Degree	Homemaker	$75,000-$99,999
P4	Julia	28	Non-Hispanic White	Married	Associate's Degree	Student	$50,000-$74,999
P5	Anna	31	Non-Hispanic White	Married	Bachelor's Degree	Homemaker	$50,000-$74,999
P6	Joanna	26	Non-Hispanic White	Single	Associate's Degree	Homemaker	$20,000-$29,999
P7	Tabitha	24	Non-Hispanic White	Living with Partner	Some College, No Degree	Homemaker	Did not answer
P8	Claudia	29	Non-Hispanic White	Married	Bachelor's Degree	Employed for Wages	$50,000-$74,999
P9	Susanna	28	Non-Hispanic White	Living with Partner	Doctoral Degree	Employed for Wages	$50,000-$74,999
P10	Martha	33	Non-Hispanic White	Married	Doctoral Degree	Employed for Wages	$75,000-$99,999

Table 2

Participants' Breastfeeding Data

Code	Pseudonym	Infant Age	Method of Birth	Type of Breastfeeding (BF)	EPDS Score
P1	Sara	7	Cesarean	Almost Exclusive BF	18
P2	Lydia	24	Vaginal	Exclusive BF	18
P3	Priscilla	18	Vaginal	Exclusive BF	5
P4	Julia	47	Vaginal	Full Breast Milk Feeding	17
P5	Anna	7	Vaginal	Exclusive BF	8
P6	Joanna	18	Cesarean	Exclusive BF	12
P7	Tabitha	10	Cesarean	Partial BF	4
P8	Claudia	28	Cesarean	Exclusive BF	5
P9	Susanna	48	Cesarean	Almost Exclusive BF	13
P10	Martha	27	Vaginal	Full Breast Milk Feeding	11

Descriptions of Participants

P1: Sara. Sara, the first participant, was the only mother who participated in a face-to-face interview. The researcher met with her in the morning at a fast food restaurant, and they sat together in a secluded area for privacy. When Sara entered the restaurant, she had just walked from the bus stop, and she was pushing her 7-week-old baby in a stroller. She wore her hair up and had on casual sportswear and flip flops.

After introductions, the researcher discussed the study and its purpose with Sara. She was given the consent form to read, and the researcher answered her specific questions about the study. Sara signed the consent form and agreed to have her interview audiorecorded. The researcher then gave her the demographic questionnaire and the EPDS to fill out before beginning the interview.

The researcher initially asked Sara to describe her breastfeeding experience from the beginning to present time. Sara had five children and had breastfed two of them. Before she gave birth, she truly had a deep desire to breastfeed this fifth child. However,

she had to have a cesarean birth, which caused significant postsurgical pain. Sara's desire to breastfeed her baby became dampened by the need to take pain medication, which she believed would harm her new daughter.

Sara deliberately searched for answers to ease her fears by seeking the advice of her nurse. She asked the nurse whether or not the medication would harm the baby, and the nurse told her that the medication was safe to take while Sara breastfed the baby. Once Sara found out that the medication would not negatively affect her baby, she was able to breastfeed with a clear conscience.

At various times, Sara had conflicting feelings about breastfeeding her child. She was in pain after the cesarean section and did not want to have her baby so close to her body all the time. She also knew that breastfeeding was a long-term commitment. Sara recognized that breastfeeding might make her feel good about providing for her baby; however, she often wanted to quit. Sara wrestled back and forth with her decision to breastfeed through much of the postpartum period, yet she ultimately chose her baby's needs before her own.

During Sara's pregnancy, she began to feel depressed. She described feeling "ugly," with an increasing desire to neglect her physical appearance. She was the sole supporter for five children, ages 1 to 8 years old, had to quit her job, and had little income to pay the bills. Sara struggled every day with household decisions, such as determining whether to pay the lights or the rent, do laundry, or buy diapers. During the pregnancy, she described crying in front of the obstetrician and asking what was wrong with her. The obstetrician told her that she had depression. Sara would cry for no apparent reason, and her family and friends could not understand what was wrong with her. Sara began to

isolate herself from everyone around her, and she felt that they misunderstood her. During pregnancy and the postpartum period, Sara continued to harbor unrelenting feelings of inadequacy as a mother.

Throughout her breastfeeding experience, Sara encountered many difficulties and increasing depressive symptoms. These symptoms influenced her desire to interact with others, including her baby. Her daughter had difficulty latching to the right breast, and Sara became frustrated and wanted to give up on breastfeeding, even though this was her original intention.

She felt pressure from her family and society regarding the best way to breastfeed and raise her baby. Sara described one of her most frustrating moments with the physical difficulty of breastfeeding and her encounter with the nurse:

> The nurse came in and I guess I was frustrated because I couldn't get her [the baby] to latch on to this boob. My right boob. And she was like, just keep tryin'. Just keep trying, keep trying. She's gonna latch on, just keep trying. And I was like, no, no, I wanna bottle feed, I don't wanna do this no more. She's like this is the point that she'd just told me she wanted me to keep trying. She pressured me to keep trying. Even though at the time, I was like, why the hell are you pressuring me? I just said I wanna bottle feed. I just think I was so . . . . I had so much on my mind and so much. I felt like even though I'm here and I'm resting. I'm sitting here and doing nothing, and I know there is so much I have to do. I'm like, lady; just get out of my face. Just give me a bottle. And the fact that she pursued me to keep trying, because she knew that I knew it would be best for her [the baby]. So it was the fact that she kept trying and kept pushin' me.

Although Sara had this difficulty, the nurse's continuous pushing her to breastfeed helped Sara deliberately persevere through the struggle.

Despite Sara's struggles and because of her ability to persevere, she was ultimately able to recognize the importance of her influence on the baby through breastfeeding. Sara acknowledged the role of her breastfeeding in enhancing the baby's

physical health: “She was more breastfed too, that they don't get sick. She don't get sick. Like my little ones catch colds quick. And I'm like, you're not sick? So I know it's good.” Sara also acknowledged her significant role as the baby’s advocate and protector. Although there were times Sara felt like the baby was a burden, she knew that she herself was the one who brought her baby into the world and the one who cared for the baby. Sara continued to breastfeed her baby and found comfort in doing so. Over time, Sara realized her importance as a mother through the experience of breastfeeding.

Once Sara recognized her importance in her daughter’s life, she enjoyed intermittent moments of breastfeeding with the baby. She described, “Sometimes when I breastfeed it feels like okay I get to that point where I can just, I know I'm calmed down. . . . . It gets me that relaxing feeling, like okay, everything stops for a minute.” Sara was alone with her baby, and no one else could invade their space. The rest of her world with all its stressors was suspended for a moment while she experienced an intimacy with her baby that others could not.

P2: Lydia. The second participant, Lydia, was interviewed via telephone. Lydia was soft-spoken. She had a quiet tiredness to her voice combined with raw determination to ensure that her breastfeeding experience helped other mothers “feel empowered to breastfeed.”

The researcher requested that Lydia describe her breastfeeding experience in detail. This was her first pregnancy, and her baby was 24 weeks old at the time of interview. Lydia emphasized the importance of her culture and its influence on breastfeeding as a normal and natural process for mothers and their babies. She believed

that she would have the same experience that every woman close to her had with birth and breastfeeding.

Although Lydia left the hospital with great confidence in her ability to breastfeed her baby, she found out quickly that her reality was much more difficult. She experienced excruciating pain while breastfeeding, which led to insomnia and anorexia. She ended up crying each time she put the baby to her breast. Her husband was extremely concerned and wanted her to formula feed so she would not be in agony. During these trying times, Lydia chose to breastfeed regardless of the circumstances. She continued to put the baby's needs before her own.

During the second postpartum week, Lydia quickly slid into a depression. She began to worry all the time and felt alone and unable to cope with her situation. Lydia often cried without reason and felt worthless. She explained that she was "rejecting her [daughter]. I could just leave her there, look at her. Worrying that she is not well, but not picking her up. And, you know, cradle her. Or give her any attention." When Lydia felt this way, she did not believe that she was a good mother for her baby. Her beliefs were confirmed by an interaction with a health care provider who advised her to formula feed her baby, because the baby was losing weight. The health care provider also stated that Lydia was incapable of providing nutrition to her baby. With such observations, it was difficult for Lydia to continue breastfeeding her baby as she intended because she felt incompetent.

Lydia not only had ongoing depression but her baby also had problems latching properly, which caused Lydia a great amount of pain while breastfeeding. Lydia felt that she did not receive appropriate assistance from health care providers, because they did

not assess the baby's latch for any problems. Yet, Lydia pressed on through these trials with support from her husband, family, friends, and support group mothers. Lydia found perseverance within by leaning on others to propel her forward into a successful breastfeeding experience with her baby.

While surmounting and overcoming the difficulties associated with breastfeeding, Lydia glimpsed her capability to be the mother she had dreamed of prior to delivery. She revealed, "The only moment I felt good about myself and being a competent mother was when I was breastfeeding her. Because I was there for her, and I was doing a good thing." Through breastfeeding, Lydia could discern her value as a mother and counter the deception of depressive symptoms.

Lydia found peace for herself and her baby through breastfeeding. She explained that "those moments when I was breastfeeding her, um, I don't know if it has something to do with serotonin or dopamine or something in the brain happening—I was happy for those moments she was at my breast." The intimacy shared between mother and child was a salve during her difficulties. Lydia sincerely cherished this closeness experienced during breastfeeding.

P3: Priscilla. The third participant, Priscilla, was interviewed via telephone. Priscilla was a talkative and energetic mother with three children. Her current baby was 18 weeks old, and she was excited to share their story.

Priscilla had breastfed one of her other two children, and she decided that she would breastfeed her current baby as well. After the birth, she had skin-to-skin contact with the baby, and her son was able to latch with relative ease. Priscilla explained that she had bacterial infections during the postpartum period, for which she had to take several

medications. It became more difficult for her to continue breastfeeding because of the increasingly severe nature of the infections. Despite her circumstances, Priscilla continued to choose breastfeeding as the best way to feed her baby.

As Priscilla's physical and psychological health continued to deteriorate, she became sicker and sicker until she was too weak to fight off several infections. She lost too much weight and "couldn't even lift the baby anymore." During this physical decline, Priscilla also encountered psychological struggles. She experienced depression and anxiety, which her doctor defined as rapid cycling bipolar disorder. She began to worry about sufficient milk supply and about the baby's ability to digest the breast milk appropriately. Priscilla ended up weaning the baby completely from breastfeeding to bottle feeding. Although Priscilla intentionally decided to breastfeed, her hopes had not gone as planned. She began to doubt her maternal competence, which fueled her anxiety and depression further.

During these ongoing trials, Priscilla made the decision to feed her child with donor breast milk instead of formula. She managed to fight through the physical illnesses and was determined to breastfeed her baby once again. Priscilla knew that the chances for relactation were low, but she actively sought out information from others and believed that relactation was possible. She was running out of donor milk and went to a local support group for assistance with relactation.

The lactation consultants gave her a supplemental nursing system, which was a feeding tube attached to a bottle. Through this setup, she breastfed her baby donor milk until her own breast milk returned. This process took her 3 weeks. Priscilla was thankful that there was a free support group at the local hospital that was open to all new mothers.

She credited her success with the relactation process to the trained lactation consultants who worked with this support group. She also credited these lactation consultants and the other mothers in the support group for her success and perseverance.

Priscilla found hidden inner strength to prevail over her physical and emotional hardships. She supplemented her mindful determination with the encouragement of family, friends, and lactation consultants. Through the success of relactation, she accepted her power as a mother to bring her and her baby "back to an exclusive breastfeeding scenario," which was their situation at the time of interview. Breastfeeding was an important aspect of Priscilla's maternal relationship with her baby.

Being close to her baby through breastfeeding engendered peace and comfort for Priscilla. She explained, "I just feel more bonded and closer to my baby when I'm breastfeeding." The intimacy with her baby was mutually beneficial. Her baby reaped the benefits of breastfeeding's emotional and physical bonding, and Priscilla felt less anxious and depressed when she was breastfeeding. Priscilla found joy in cultivating closeness with her baby during her lived experience of breastfeeding.

P4: Julia. Julia, the fourth participant, took part in a telephone interview. She was the mother of three children. Her first two children were not breastfed because of influences from her mother. Julia's mother told her that breastfeeding was strange and that she would get saggy breasts. The reason that Julia decided to breastfeed her third baby was to protect the baby's health.

Julia had suffered a miscarriage between her second and third living children due to an addiction to pain pills. Then she became pregnant with her current baby. Once she found out about the pregnancy, she began methadone therapy. Julia was advised by her

doctor to breastfeed the baby so that he would not go through withdrawals because of her addiction. This information weighed the most in her decision-making.

Julia emphasized the fact that she did not have a good support system for breastfeeding, and she had to choose daily to breastfeed for her baby's benefit. Many days she fought the urge to give up on breastfeeding. She said that she "wanted to stop so many times, but having all the knowledge of its benefits for my son made the little pain not a big deal." Julia readily chose her son's needs over her own.

Throughout the postpartum period, Julia often suffered in silence and felt extremely lonely. Many times, she believed that she was an inadequate mother. She felt that her past choices made it difficult for health care providers to treat her with dignity and respect. She became defensive whenever she spoke to nurses or doctors, because she found that they focused on her former addiction and not on the person she had become. Julia endured the stereotypes assumed by health care providers related to the stigma of drug addiction, and these stereotypes eroded her self-esteem and affected her maternal capability.

Julia also had a secret that added to her feelings of incompetence. Prior to having her current baby, Julia unknowingly was pregnant. She had been taking Oxycodone, and the health care provider prescribing the drug abruptly cut her off. She began to withdraw and started to bleed. Julia went to the hospital and was released two days later. However, she began bleeding again and had a miscarriage at 20 weeks gestation.

She felt extremely guilty about the loss of her son, which led to depression prior to her most recent pregnancy. When she had her third living child, Julia knew it was a blessing, but she felt guilty again about losing her baby less than a year earlier. Two

weeks after the baby's birth, she became depressed again. She stopped taking care of herself, wanted to be alone, had insomnia, ate poorly, forgot the tasks that she needed to accomplish, arrived late for every appointment, and cried for no apparent reason.

Julia was also embarrassed about the depression. She did not want to talk to anyone about her depressive symptoms, especially since she just had a baby. Her husband and family did not understand why she was having a challenging time, because she just had a baby. They did not think she should be bothered by anything. Julia kept to herself all her doubts and insecurities about being a capable mother.

The postpartum period was difficult for Julia. Yet she had a very strong desire to improve for the sake of her baby and the rest of her children. With lack of support from health care providers and family, Julia looked elsewhere for the guidance she needed to accomplish her desires to mother this baby. She felt no one but herself wanted this child.

The only support Julia received was from other friends in different states who also breastfed their babies. She did not even receive the appropriate support in the hospital. Julia pushed for help with proper latch technique and in healing blisters on her nipple. When the nurse came to her room, she merely asked Julia if she would rather bottle feed. Then the nurse left the room and came back with several bottles of formula, which she left in Julia's room. Although Julia felt tempted by the ease of bottle feeding, she asked the nurse about pumping on the breast with the nipple soreness. The nurse told her that she could do so and eventually brought her a breast pump.

Julia described the lack of support from her family and friends as well; "Everyone else was quick to say, 'Oh my God, I'd never do that!'" She also admitted that her husband did not really care how she fed the baby. She felt that her husband was more

than happy for her to breastfeed, because then he would not have the responsibility to bottle feed the child. Her mother kept laughing at her, because she believed that Julia would have sagging breasts as a consequence of breastfeeding. Julia was exhausted by the lack of support and said that "even though I did advocate for it, sometimes I do wish I could have let someone else feed him, too." Yet she deliberately persevered on her breastfeeding journey.

There were times that Julia could comprehend her importance as her baby's mother and the profound effect that she would have on his future. When she chose to breastfeed her child, she knew that she would be his comfort. She had experienced the pain of withdrawal from narcotics, and she passionately refused to let her baby go through this same type of pain. Through this decision, she understood her value as his mother. Julia also found her worth as a mother in the fact that her baby was born healthy and did not suffer through withdrawal. Everyone had suggested that Julia abort this baby because of her addiction, but Julia said, "I actually showed everyone, look, he is fine, he is perfect!" She discerned her maternal capability, which was revealed to her family and friends through the healthfulness of her baby.

Another important aspect of the lived experience of breastfeeding for Julia was the intimate time spent with the baby. She truly wanted to be as close as possible to this baby, because he would be her last child. She was employed and only able to bottle feed her other children, and she understood that breastfeeding provided intimate attachment between a mother and a child. Julia related that she "just stayed home and bonded with this child. He is my last baby, so I didn't want to miss anything with him like I did the other two because I worked."

She valued the time spent with her baby and savored the bonding brought about with breastfeeding. She abhorred having to use a blanket to breastfeed in public, because she and her baby could not see each other. They could not bask in the intimacy of their moments together. Through her lived experience of breastfeeding, Julia was determined to breastfeed her baby for his health. Even though she suffered from depression, Julia found the strength to fulfill her goals and create a space for herself and her baby to become lovingly connected to each other.

P5: Anna. The fifth participant, Anna, participated with a telephone interview. She had three children, and she breastfed all three. At the time of interview, she was tandem breastfeeding her middle child, who was almost 2 years old, and the baby, who was 7 weeks old.

While pregnant, Anna decided to breastfeed her baby. She had a history of depression, which continued during the entire pregnancy. Anna did not take any medication until the third trimester, when she started taking Zoloft again. At that point, her doctor felt the antidepressant was safe. Anna wanted to protect her baby from potential effects of this medication during pregnancy and while breastfeeding. She wanted to provide the best for her baby despite her circumstances.

As Anna described, during pregnancy she experienced depression, which continued during the postpartum period. She took many proactive measures to mediate the depressive symptoms, including taking antidepressant medication, going to individual therapy, and breastfeeding her baby. Anna, however, experienced many moments of incapability as a mother. She had symptoms of depression and anxiety which fueled irritability and rage. During these times, she felt like she was a horrible mother and wife.

In spite of her efforts to care for herself, Anna's insecurities rose to the surface and colored her maternal identity.

Anna was fortunate to have support from family, friends, and her health care provider. She described her husband as emotionally supportive and helpful with the children and household chores. She relied greatly on him to help her through the times of depression and anxiety. Due to Anna's realization of her psychological struggles, she could mindfully accept support from others and gather strength to fulfill her desire to breastfeed.

Anna had breastfed her two previous children, which increased her confidence in breastfeeding her current son. She knew that she provided an important part of her children's nutritional and psychological requirements. Even though she did not always feel like a good mother, Anna believed that breastfeeding provided the opportunity to be emotionally and physically connected to the baby. Through breastfeeding, Anna noted that she truly was a capable mother.

Anna found closeness with her baby through the moments of breastfeeding. During the darkness of her depressive symptoms, she did not feel very responsive, but when she experienced the physical touch of breastfeeding, she thankfully felt a connection to the baby. Anna's simple act of breastfeeding provided a moment of heartfelt togetherness with her baby.

P6: Joanna. Joanna, the sixth participant, was a first-time mother, who had a telephone interview. She revealed that she decided to breastfeed immediately upon learning that she was pregnant. This was her first child, and she wanted to ensure that her daughter would have the best source of nutrition. Although Joanna preferred a vaginal

birth, she consented to a cesarean birth. Despite a great deal of pain after birth, she was determined to breastfeed her baby. She suffered through this pain so that her baby would have enough breast milk to satiate hunger. Joanna made a conscious and sometimes difficult decision to breastfeed her baby, regardless of her own situation.

In the early postpartum period, Joanna was very disappointed in herself. She had expectations of a flawless vaginal birth and an easy transition to breastfeeding. However, she did not live up to her own expectations. Joanna was hard on herself for undergoing a cesarean birth, and she labeled herself a failure. Joanna put pressure on herself to overcome this disappointment by breastfeeding as she initially intended. Joanna's ability as a mother was connected to her success at birth and breastfeeding. She did not meet her own expectations, and thus Joanna believed that she was an inadequate mother until proven otherwise.

Joanna encountered several roadblocks during her experience of breastfeeding. Initially, she had pain from the cesarean delivery, which affected breastfeeding. She described her pain as extreme discomfort from the breasts to the surgical incision. Her baby was long, so she experienced pain when breastfeeding and could not find any suitable position. In addition to complications with positioning, the baby had problems latching well. One reason that Joanna could persevere through these struggles was the presence of the postpartum nurses, who "were pretty much a lifesaver." These trained lactation consultants helped Joanna identify the proper latch by the baby. Joanna believed that the nurses formed an indispensable support system, and she credited her breastfeeding success to them.

Joanna also experienced depression before and after pregnancy. Ten months prior to her pregnancy, she had an abortion. Her subsequent pregnancy brought up similar frustrations and anxieties. Although she knew she did not want another abortion, the reality of a pregnancy and birth of a baby affected her greatly and caused depressive symptoms. Joanna continued to have depressive symptoms after the birth of her baby, and she sought assistance to confront these issues. She saw a postpartum therapist weekly and also attended a support group for mothers who had depression.

With heartfelt emotion, Joanna stated,

> I can be honest. I go for me. A lot of mom's support groups are about baby. And this is the only support group that I can go to where I can talk about me without judgment. So it's a lifesaver. And I started going to that when my daughter was 3 weeks old.

Joanna did not hesitate to find the support that she needed within herself and through others to press on and overcome her trials.

Joanna was very frank in admitting that she was disappointed in herself about needing a cesarean birth. Because of this event, she did not feel like a good mother. Joanna compensated for her disappointment in the realization that she breastfed successfully, despite all her struggles. Her self-respect increased as she discovered her value as a competent and caring mother.

P7: Tabitha. The seventh participant, Tabitha, had a telephone interview. She recalled that she had decided during her pregnancy to breastfeed her baby. This was her first baby, and she understood the advantages of breastfeeding for the baby. She at least wanted to attempt to breastfeed. As Tabitha explored breastfeeding as her infant feeding choice, she determined that she would breastfeed for her son's benefit.

While Tabitha was in the hospital, she encountered struggles with breastfeeding. The baby had difficulty latching properly, and Tabitha did not know what to do. The hospital supplied little breastfeeding support, and no one helped her work out how to have the baby latch on appropriately. The baby's blood sugar began to drop, so the health care providers gave the baby formula, even though Tabitha wanted to breastfeed exclusively.

Finally, she agreed to partially breastfeed, but she felt very stressed with this decision. She blamed herself for her baby's low blood sugar and for her inability to breastfeed easily. Tabitha believed that she was not a capable mother because of her breastfeeding difficulties.

Although breastfeeding was not easy for Tabitha and the baby, she did not give up and intentionally sought out assistance in the days following the baby's birth. Tabitha and her fiancé returned to the hospital to see the lactation consultant who had not been available during the baby's birth, which took place on a weekend. The lactation consultant taught Tabitha how to enable her baby to latch on properly, and the baby breastfed for 1 hour. Armed with the appropriate information, Tabitha could now breastfeed her baby.

Several times during the postpartum period, Tabitha wanted to stop breastfeeding and simply give her baby a bottle. However, her mother and fiancé strongly encouraged her on the chosen path of breastfeeding. They knew that she would be extremely upset and disappointed in herself if she stopped breastfeeding. With her determination and others' support, Tabitha faced her struggles and overcame them.

During the periods of frustration and trial, Tabitha did not have a clear perception of her maternal capabilities, instead experiencing depressive symptoms of persistent sadness and fatigue. She could not understand why she felt so extremely sad, and she did not speak in depth about this experience of depression to anyone. Yet, Tabitha's outlook began to change ultimately because of breastfeeding success. After Tabitha and her baby mastered breastfeeding, she began to wean the baby from the bottle. Her sadness decreased and the confidence in her abilities clarified her sense of self as mother.

An important piece of breastfeeding for Tabitha was the ability to bond with her baby. When the breastfeeding did not proceed as planned, Tabitha became depressed. Once she and the baby had the breastfeeding technique worked out, though, Tabitha could enjoy the times of closeness. She lovingly noted that she felt captivated by her baby's affectionate demeanor when he looked up at her while breastfeeding. Tabitha experienced many moments of bliss through the intimacy of breastfeeding her baby.

P8: Claudia. Claudia, the eighth participant, took part in a telephone interview. She said that it was important for her to attempt to breastfeed her baby. She knew that there were many advantages for a breastfed baby, and she preferred to care for her baby in the most natural way possible. Claudia wanted to continue to provide the baby with nutrients for growth as she did when pregnant. Claudia purposefully made up her mind to breastfeed for her new daughter's benefit.

Claudia experienced depression during pregnancy, and she was concerned about difficulties in the postpartum period. She lamented that she was likely to have postpartum depression, and she "couldn't imagine feeling that way and having to take care of another human being." After the birth of her baby, Claudia breastfed, but the health care

providers told her that the baby was not getting enough milk. Her baby had a little jaundice, and the health care providers promoted use of formula. Claudia did not want to use formula, so she did what was purported to be best for her baby by breastfeeding and taking the baby outside in the sun for a few minutes a day. The baby, however, began to reject the breast. At that point, Claudia was afraid and frustrated by her inability to breastfeed as she intended.

However, through the persistent sadness and disappointment, Claudia found the inner strength needed to change her breastfeeding situation. She believed that the initial problem was most likely that the baby was not latching properly. Once the baby began to refuse the breast, Claudia conducted some research and found a breastfeeding-friendly resource. She contacted La Leche League, and the representative recommended that she feed her baby with a dropper to promote suckling at the breast.

Claudia found that the use of a dropper and the use of a nipple shield were helpful for proper latching. However, she continued to have some difficulty with breastfeeding and reached out to a lactation consultant for assistance. After a 2-hour session, she gained the necessary tools to improve the baby's latch. Claudia was also encouraged and supported by her doula, a woman who assists the mother before, during, and after childbirth ("Doula," n.d.), and her husband, who encouraged and pushed her to continue breastfeeding.

Claudia breastfed her baby with great determination and guidance from others. She noted the effect that breastfeeding had on her baby. Claudia was astonished because the baby doubled her weight by 6 months old and was developmentally on point purely from breastfeeding. Claudia was in awe of her ability to provide nutrition for her baby.

She came to recognize and understand her worth as a mother through the act of breastfeeding.

Through Claudia's lived experience of breastfeeding, she had several periods of fluctuation. She was frustrated by the health care providers' advice to supplement with formula, especially since her milk had not even come in yet. She experienced extreme sadness when not feeling that she would fulfill her intention to breastfeed. Between these times, she had moments of basking in the intimacy of breastfeeding. She described her emotions during breastfeeding as peace and contentment. Claudia authentically treasured these times of connection with her baby.

P9: Susanna. The ninth participant, Susanna, had a telephone interview. She began by describing her reason for choosing to breastfeed as the method of infant nutrition for her baby. She decided to breastfeed in the antepartum period, because she understood the health benefits for the baby. She also added that it was important to increase the bonding opportunities with her baby boy by utilizing a cost-effective infant feeding method.

Susanna had planned on a vaginal birth followed by skin-to-skin contact as soon as possible to promote breastfeeding and bonding. Her plan did not materialize, however, because she had a cesarean birth. Her baby was taken away for about 20 minutes until she moved to the recovery room. This removal was very "nerve-wracking" for Susanna, and she was disappointed about their separation because of the cesarean birth. In the first 2 months of breastfeeding, the baby ate constantly and did not sleep very much. Susanna explained, "It's easy as a new mom to question whether you are doing the right thing."

She often received advice from others regarding how to improve her infant's sleep habits by adding cereal or formula to breast milk. Susanna lamented that she could not possibly please everyone, yet she felt guilty when not complying with others' opinions. Throughout the postpartum period, Susanna experienced many periods of self-doubt regarding her maternal competence.

Susanna encountered various struggles during the postpartum period. Her baby developed jaundice, and she questioned whether she had a sufficient milk supply for the baby. She found information from her online support group for new mothers that helped her determine whether the baby received enough breast milk by counting the number of wet diapers per day. Since Susanna had a good milk supply, she breastfed the baby to decrease jaundice and even spent 15 minutes a day in the sun with him. She also had concerns about her baby's sleep pattern. Even though she received poor advice from others about adding cereal to the breast milk, including her pediatrician, she "never caved in." Susana was determined to carry out her intentions.

In addition to breastfeeding struggles, Susanna was stressed and had depressive symptoms. She believed that her "deep-rooted exhaustion" contributed to the depressive symptoms and noticed that increased stress and depression caused a decrease in her milk supply. She attempted to control her stress so the amount of her breast milk would not decrease.

When Susanna felt tense, she also felt frustrated with breastfeeding. She had conflicting emotions that angered her "in a good way and sometimes in a bad way." She observed that she had more stress when she needed to accomplish several tasks in the home. Yet she also knew that breastfeeding slowed her down, and she was forced to relax

for those several minutes. Susanna's conscious decision to continue breastfeeding the baby helped her persevere and succeed during the periods of stress and depression.

Susanna's initial disappointment in herself for undergoing a cesarean birth was counteracted by the initial ease of breastfeeding. She knew that she was fortunate that her baby did not have difficulty latching on. She acknowledged her ability to care for her baby through breastfeeding. When she was concerned that her baby did not have enough to eat, she sought assistance and learned how to determine whether he drank a sufficient amount of breast milk. When she found out that she could simply check the amount of diapers he used per day, she was relieved. Susanna's knowledge about breastfeeding helped her realize that she was providing the best for her baby.

Having developed the ability to distinguish the positive aspects of her mothering ability, Susanna experienced treasured breastfeeding sessions with her baby. She described breastfeeding as relaxing, calming, and purposeful moments for her. These were the intimate moments that she had hoped for and intended to have between herself and her baby.

P10: Martha. The final participant in this study, Martha, took part in a telephone interview. She made the decision to breastfeed her child while she was pregnant. She stated that she attended a childbirth class and decided to breastfeed "for his health, you know, for the ease of it, which is such a funny thing to say now that I actually breastfeed. It's not easy at all." Throughout the postpartum period, Martha continued to choose to breastfeed, even though she had times of doubt. She knew that the baby needed her, but she felt stressed, frightened, and extremely sad. At these times, she found it more difficult

to breastfeed. Her strongest desire was to put her baby son's well-being first, despite her struggles with breastfeeding and feelings of depression.

Martha touched on the difficulties she encountered during breastfeeding. Although her son latched well, she had nipple soreness for the first 2 weeks. She also breastfed on demand for a son who, she said, "wanted to literally eat for hours." Martha would breastfeed for extended periods and often fell asleep with her baby at the breast. She felt exhausted, and some people in her life suggested that Martha supplement with formula to increase the baby's sleep time. Although these people might not have meant to hurt Martha, she felt upset by their criticisms, which were damaging to her maternal identity. The unsuspecting comments also influenced her feelings, and she felt inadequate and like a failure. Martha developed depressive symptoms, and her feelings of self-doubt and maternal incompetence grew.

Martha's depression influenced her outlook; however, she had enough desire and strength to search deliberately for guidance through the more difficult periods. With intense passion, she was determined to successfully breastfeed. Her motivation came from knowledge of the biological benefits to the baby. She felt that breastfeeding was physically and mentally challenging. At times, Martha was not sure if she would be able to survive its emotional demands. Martha pushed herself to find information on natural products to combat nipple soreness and used lanolin, flaxseed oil, and expressed breast milk to decrease this pain.

Martha searched for local resources to determine whether her son's apparently immense appetite was normal. She even went back to the hospital in which she gave birth to ask for assistance. At the hospital latch clinic, the health care providers explained that

the frequent feedings were normal, because the baby needed to satiate his hunger to fall asleep. Martha also obtained information from La Leche League and a hospital-based mothers' group, receiving support and encouragement from other mothers. They encouraged her to continue breastfeeding and reassured her that as time went on it would become easier. Martha related that she felt it was important for her "to kind of be pushed along on this course." She faced her problems head on and overcame them with her own determination and others' support.

As Martha indicated, she initially believed that breastfeeding would be easy, but she encountered many trials during the experience. She did not feel prepared and recognized her feelings of inadequacy. Martha explained, "It's just much bigger. I think there's so much about this that no one can prepare you for, you can't imagine it, and then when you're in it, you're just like desperately trying to stay above water." But she also exclaimed that breastfeeding was an amazing experience that she would do over again. She felt that breastfeeding changed her life in a positive way. Despite her difficulties, or perhaps because of them, Martha slowly realized her importance as the baby's provider through the lived experience of breastfeeding.

Through the moments of trial, depression, stress, pain, and fatigue, Martha spent much time physically close to her son while breastfeeding. The intimacy of breastfeeding was beautiful, magical, and wonderful for her. She savored the moments when her son looked up at her and smiled, because she felt one with him. In these brief periods, Martha treasured the togetherness with her baby and kept them in her mind, as she said, to remember forever.

Data Analysis

The researcher utilized a descriptive phenomenological method to analyze the interviews obtained from the participants about their lived experience of breastfeeding. Giorgi (2009) modified the Husserlian approach to descriptive qualitative research by employing a five-step method of analysis. The researcher followed these steps: (a) assuming the phenomenological attitude; (b) reading the entire interview transcript to develop a sense of the whole; (c) delineating meaning units; (d) transforming meaning units into third- person, psychologically sensitive expressions of the participants' lived experience; and (e) determining the constituents of the transformed meaning units to develop a general structure of the lived experience, useful for future research endeavors.

Phenomenological Attitude

The participant interviews describing the lived experience of breastfeeding in the midst of perinatal depression were audiorecorded and transcribed in their entirety by the researcher. These empirical data formed the basis of this descriptive phenomenological research study. Prior to analysis of the descriptions given by others, the researcher assumed a phenomenological attitude. It was, therefore, important to distinguish the difference between a natural attitude and a phenomenological attitude.

Husserl (1931/2012) explained the natural attitude as "the world in which I find myself and which is also my world-about-me" (p. 53). A natural attitude would thus be considered the one in which a person lives daily. A person might imagine the natural attitude as encompassing daily activities; identification of objects, thoughts, and emotions about people or things; identification and recognition of objects; and experience of things that exist or could possibly exist in individuals' worlds (Sokolowski, 2000). The

participants gave descriptions consistent within their natural attitudes (Giorgi, 2009); they recounted their specific experiences as best they could as the lived-through events.

The researcher's phenomenological attitude, on the other hand, was necessary for proper analysis of the empirical data. The researcher had to shift to a different viewpoint that was more comprehensive than the natural attitude (Sokolowski, 2000). A researcher assuming the phenomenological attitude could be described as a spectator of the participant experience. Merleau-Ponty (1945/2012) revealed that a key role of the phenomenological attitude is to comprehend the natural attitude in a more complete way than the natural attitude itself. The participants, however, would preferably be unaware of the phenomenological process to decrease the possibility of changing their descriptions to please the researcher (as in social desirability [Holtgraves, 2004]) and to retain the complexity of their personal lived experiences (Giorgi, 2009).

As part of the phenomenological attitude, Husserl (1931/2012) described the concept of *epoché* or bracketing as setting aside the realities of the natural world to modify consciousness. This setting aside is necessary for the researcher to fully adopt a phenomenological attitude. Bracketing includes suspension of personal past experiences and knowledge and is one method to remove researcher bias. With this shift, the researcher focused on and contemplated the lived experience or "lifeworld" of the participants.

Read for Sense of Whole

For this study, assuming the phenomenological attitude, the researcher read through each transcript completely to gain an understanding of the overall sense of the description (Giorgi, 2009). The goal was to understand the lived experience from the

participant's point of view. The researcher had to remain present to the data and not critically read the description nor formulate a general description of the lived experience. At this point in the process, the researcher grasped the overall "feel" and "rhythm" of the description but did not perform any interpretations.

Delineate Meaning Units

After gaining a sense of each entire transcript, the researcher read it over several more times to determine meaning units. In phenomenological analysis, the empirical data must be separated into smaller parts for proper analysis (Creswell, 2012). Giorgi (2009) defined these parts as psychologically sensitive units of meaning. During the readings, the researcher differentiated changes in participants' tones and marked the areas with a forward slash (/). The researcher also indicated numerical values at the beginning of the meaning units, represented as MU1, MU2, MU3, and so forth.

The starting and stopping points in the transcripts were representative of significant shifts in the meanings of the descriptions. The initial designation of meaning units is not to be considered absolute (Giorgi, 2009). Rather, meaning units may change throughout data analysis.

Giorgi (2009) explained that meaning units might be considered somewhat arbitrary, and they simply make the data more manageable. If other researchers read the same descriptions, they might delineate different meaning units. Researchers bring their individual psychological sensitivities to the analysis, influencing the perceived changes in meaning units. However, differing meaning units do not mean that designations by other researchers are wrong.

In addition, the researcher might change the starting and stopping points of the meaning units throughout research for several reasons. These may include initial delineations that were too long or too short, or later descriptions adding information that could alter earlier meaning units. Assignment of meaning units is a self-correcting process determined by the researcher's continued immersion with the data.

Transform Meaning Units

The most significant part of the descriptive phenomenological method is the transformation of meaning units into psychologically sensitive descriptions (Giorgi, 2009). This step represents the first essential change to the empirical data. The researcher went back to the meaning units in each transcript and explored each one individually to uncover the most fitting words to articulate the psychological sensitivity of the description. The transformed meaning units were rewritten in the third person and remained true to the participants' meanings. The transformation process was lengthy and iterative, as the researcher continually dwelt with the data to extract the essences.

The researcher also utilized free imaginative variation to transform the meaning units. Husserl (1931/2012) introduced "eidetic variation" (p. 4) or free imaginative variation as a method by which the researcher extracts the essential meanings of a description. In this method, the researcher may add or take away from the meaning unit to determine which qualities are necessary for the description to remain the same or which qualities are not necessary.

For example, a table would remain a table with the essential elements of a flat surface on top of four legs. If one removed a leg of the table, it would no longer be a table. Yet if one removed the color of the table, it would remain a table. The leg of the

table would be considered an essential quality of the table, but the color would be considered an incidental quality of the table (Husserl, 1931/2012). The researcher's incorporation of free imaginative variation allowed for purposeful transformation of meaning units into psychologically sensitive descriptions for further analysis.

Once the meaning units were transformed and written in the third person, the researcher remained immersed in the data to determine the qualities expressed by it. Giorgi (2009) described this process as gleaning the essential psychological qualities hidden in the more concrete and complex descriptions of the lived experience. The psychological attitude or psychological sensitivity focused on the participants' individual human subjectivity as experienced in the phenomenon of interest, breastfeeding during perinatal depression. In addition, the transformed meaning units were generalized for easier integration of data from the 10 participants.

Develop Constituents and General Structure

It was necessary for the researcher to remember that "constituents" relate to the whole and must depend on each other (Giorgi, 2009, p. 102**)** to create the general structure of the phenomenon. This concept was grounded in the phenomenological idea of parts versus wholes, such that the value of the whole is greater than the sum of its parts. Parts can be broken down into elements and into constituents. Husserl (1970) defined dependent parts or elements as interconnected and unable to stand alone. The phenomenon in which elements and constituents live is context-dependent; the lifeworld cannot be carried out solely in a laboratory (Giorgi, 2009).

To develop constituents and obtain a general structure of the lived experience of breastfeeding, the researcher engaged in an iterative process to compare the participants'

transformed meaning units for derivation of constituents. Through free imaginative variation, the researcher applied descriptive phrases to the constituents. The applied descriptive phrases were subjected to through several iterations to identify the essential psychological meaning of the constituents.

The initial analysis resulted in nine constituents. The researcher, however, found through several versions that four of the proposed constituents could exist independently outside the experience of breastfeeding for women with perinatal depression. Throughout the process, the researcher returned to the data in the transformed meaning units to determine the essential constituents. The result of the iterations was a total of five constituents, which made up the general structure.

A distinction of Giorgi's (2009) descriptive phenomenological method from other forms of qualitative research is development of the constituent, which is not the same as development of a theme. According to M. Applebaum, Ph.D. who studied with Giorgi and is a professor in the Department of Psychology and Interdisciplinary Studies at Saybrook University, "A constituent is different from a theme, because a constituent has a part/whole relationship with the essential psychological structure. Themes are not necessarily part of a larger whole" (personal communication, February 5, 2017). In summary, in the data analysis phase, the phenomenological parts and whole were kept intact throughout the entire phase (Giorgi, 2009). The researcher read the naïve description, which composed the whole, in its entirety. The researcher also maintained the meaning units, which composed the parts, as complete data sets and examined them for interdependent constituents to the entire descriptions of participants' lived experiences of breastfeeding.

General structure. The general structure was composed of essential constituents of the phenomenon which related to each other in such a manner as to demonstrate the manifestation of the lived experience (Giorgi, 2009). The general structure of the lived experience of breastfeeding for women in this study who self-reported perinatal depression unfolded as follows: The experience of breastfeeding for the mother who has perinatal depression begins with making a conscious decision to breastfeed for the baby's benefit regardless of ever-present conflicting emotions. The mother who has perinatal depression, however, secretly harbors unrelenting feelings of her incompetence to care for baby. She also struggles with surmounting and ever-changing hardships, yet she successfully perseveres and overcomes them by deliberately looking for solutions and by relying on self and/or on other people in her life, such as family members, health care providers, and support groups. The mother ultimately discerns her value as mother through the act of breastfeeding and embraces this time spent intimately connected to her baby.

The description of the general structure was not as rich as the data from which it arose because it was a second-order description of participants' psychological understanding of the experience. The first order description was the participants' candid descriptions of the lived experience (Giorgi, 2009). According to Giorgi (2009), "an analysis such as this can never grasp the totality of the original experience and such limits have to be respected when it comes to interpreting the results of the study" (p. 200). The general structure also consisted of interrelated constituents that could not be extracted from the description. These constituents connected interdependently to maintain the

general structure. If any of the constituents were removed from the general structure, it would collapse.

Constituents. Descriptive phenomenological analysis utilizing Giorgi's (2009) method revealed that five constituents comprised the general structure of the lived experience of breastfeeding for women who have perinatal depression. Tables 3 and 4 depict the constituents of the description with supporting participant variations of empirical data. Each constituent is detailed to highlight the meaningfulness for the participants' lived experiences.

Each of the five constituents was represented by one or more of the participants. With representative illustrations from participants, the constituents are described next. The five are (a) choosing selflessness, (b) harboring inadequacy, (c) deliberate persevering, (d) discerning meaning, and (e) cherishing intimacy.

Choosing selflessness. The women in this study intended to breastfeed during their pregnancy. Most of them were aware of the purported infant health benefits for this method of infant feeding and wanted to give their baby any advantage that they could. They all began breastfeeding after delivery and then encountered difficult circumstances, both physical and psychological. They not only had to decide to breastfeed for the baby's benefit before pregnancy but also had to make this decision consciously many times throughout the day or the subsequent weeks and months.

Sara (P1) had breastfed two of her children, and she knew that she wanted to breastfeed her current infant. She had a cesarean section and suffered through postsurgical pain. Sara earnestly wanted to breastfeed, yet she "just didn't want nobody,

nothing on" her while she was in pain. She was also a single mother who had five children, with minimal assistance from others.

Sara experienced depression during and after pregnancy, so she was fatigued and became isolated. She explained that breastfeeding "was like a good feeling, but then like, no, I don't want to do this. But I know it was healthy for my child so I did it. I continue to do it." Sara disregarded her own desires for comfort and rest and purposefully breastfed her baby because she knew "it was healthy" for her child who "knows what's best for her tummy."

Lydia (P2) was a first-time mother who believed that birth and breastfeeding were "normal, natural, and nonmedicated." She knew that she wanted to breastfeed the moment that she found out she was pregnant. Breastfeeding appeared to be an easy choice for her, but she became depressed. She had insomnia, worried all the time, and was unable to eat. Eventually, her depression was so intense that she voluntarily checked into the emergency room.

Throughout this period, Lydia continued to breastfeed her baby. Her husband told her that he could not bear to see her crying all the time when she was breastfeeding and he wanted to buy formula to stop Lydia's agony. She ordered him not to buy formula. She passionately told her husband, "This is the only thing that I can do. I've been designed; my body was designed to do this." Lydia constantly made a conscious decision to put her baby's well-being before her own.

Table 3

Constituents of Participants 1 Through 5: Variations

Constituent	Sara (P1)	Lydia (P2)	Priscilla (P3)	Julia (P4)	Anna (P5)
Choosing Selflessness	So it was like a good feeling but then like no—I don't wanna do this. Bus I know it was healthy for my child so I did it. I continue to do it.	I said no I have this is the only thing that I can do. I've been designed; my body was designed to do this.	During that time, I had a bunch of physical illnesses. And I ended up having to go on some yucky medications . . . and nursed him through some of it.	I did want to stop so many times. But having all the knowledge of its benefits for my son made the little pain not a big deal.	I'm depressed to begin with so I didn't take anything for it 'til the third trimester. And my doctor put me back on Zoloft. She didn't feel safe with me taking anything else until that point.
Harboring inadequacy	My doctor was like okay I'm probably feeling depression coming on. And it's like at first like right before he induced me I was stressed and I just started crying. So everybody was like what's wrong? And I was, like man, just leave me alone. Leave me alone. I'm like, he's like, why are you crying? I'm, like, I don't know but just leave me alone. So it's like everything. She cries. I want to cry. Bills,	The part of not coping, feeling that I cannot cope with it. I do not want to stand up from bed. Being all alone. Thinking I cannot do it. Seeing that she's losing weight and the doctor tells me you know a lot of moms think they can breastfeed their babies—not a lot of them actually end up doing it.	Mine [psychological difficulties] definitely are more on the anxiety side of things, but I think they go hand and hand. I actually went into a rapid cycling bipolar disorder. So I had some of both, but it very much affected things, because I ended up weaning completely.	So I felt alone in my struggle and I knew talking to someone from all the other times I have been in treatment they throw pills down your throat and honestly you have to change the situation before it gets better. Being pregnant and having a pill problem when I got pregnant I feel like	For me, it's depression and anxiety. The anxiety part manifests itself in irritability and sometimes rage. And that can make you feel really bad about yourself. Like you're a crappy wife and mom and person.

	everything. Man if it isn't one thing it's another.			was a big factor, I felt like people really focused on that more than anything else and I found myself in defensive mode every time I spoke with a nurse or doctor.	
Persevere Deliberately	The nurse came in and I guess I was frustrated because I couldn't get her to latch on to this boob. My right boob. And she was like, just keep tryin'. Just keep trying, keep trying. She's gonna latch on, just keep trying. And I was like, no, no, I wanna bottle feed, I don't wanna do this no more. She's like this is the point that she'd just told me she wanted me to keep trying. She pressured me to keep trying. Even though at the time, I was like why the hell are you pressuring me? I just said I wanna bottle feed.	But they didn't tell me, let's see her latch, and let's see what the problem is. Uh those were the hardest two weeks with breastfeeding. Slowly, slowly I discovered, you know, I can add lanolin on. I found a support group over here with other moms. And that pushed me forward.	Well, I think the support group is amazing. I think if had it not been for the fact that it was free and I could walk in there with my baby and meet a bunch of other moms who either were or weren't you know having issues or whatnot and have two trained breastfeeding consultants right there who could sit down with me and help me with this relactation process, I don't think I would've even probably done it.	I don't think I really got much help from doctors or nurses, I think in the hospital after I had my baby when I was having a heck of a time getting him to latch on right, he had just gotten the nipple and was sucking blisters on me, when I was saying hey this is hurting, they just were like you want to bottle feed then? And then brought me a bunch of formula which was tempting but I said well I read about pumping should I just pump until this sore heals on this	He's [my husband's] very supportive both emotionally and just helping with things around the house and with the kids.

				one side and they were like you can.	
Discerning meaning	It [breastfeeding] affected it [depression] in a good way. It was just okay, I felt that wanting from her that cuddling like hey mommy I didn't ask to be here. I didn't ask to be a burden to you. 'Cause I felt like at that time everything was a burden. It didn't matter that she was a baby. And I knew that she was a baby, and I knew that she couldn't help it. So I felt like that breastfeeding gave me that time of comfort with her to realize hey this is a baby. This is a child. She didn't ask to be born into all this.	The only moment I felt good about myself and being a competent mother was when I was breastfeeding her. Because I was there for her, and I was doing a good thing.	-	After my baby, I think it took a few weeks [to feel depressed]. I was on a high after he was born, he was healthy and did not withdraw so I was thankful for that because everyone wanted him aborted due to my pill problem and getting on Methadone that I actually showed everyone-- "Look he is fine, he is perfect!"	I think it [breastfeeding] helps because even if I feel like I'm not, some days I'm not very connected emotionally, I know that at least I'm providing him, the baby, with physical touch and bonding and all that. Even if I'm not mentally 100% there. So I think it makes me feel better about myself as a mom.
Cherishing intimacy	And I guess sometimes when I breastfeed it feels like okay I get to that point where I can just, I know I'm calmed down, I'm .. It gets me that relaxing feeling, like okay, everything stops for a minute. It doesn't seem to bother me.	And those moments when I was breastfeeding her, um, I don't know if it has something to do with serotonin or dopamine or something in the brain happening, I was happy for those moments. She was at my breast.	So then once I medicated, my medication controlled my anxiety and I just feel more bonded and closer to my baby when I'm breastfeeding.	I just stayed home and bonded with this child. He is my last baby so I didn't want to miss anything with him like I did the other two because I worked.	It [Breastfeeding] does help you feel connected to the baby even if you are not mentally feeling that great.

Table 4

Constituents of Participants 6 Through 10: Variations

Constituent	Joanna (P6)	Tabitha (P7)	Claudia (P8)	Susanna (P9)	Martha (P10)
Choosing Selflessness	‘Cause my child was hungry and wanted my milk and the milk hadn’t fully come through yet. I suffered the pain as much as any good mom would and have been doing it ever since.	Before I was pregnant I knew that that was what I wanted to do. Just because I knew the benefit and I knew that I just wanted to give it a try.	I know that it is the best for the baby. I like to try to do things as natural as possible. So I would rather, if I can, make the milk and my body can continue to support her and have her grow like it did when she was inside of me. Then of course, I would want to continue doing that.	When I was pregnant [I decided to breastfeed]. Well there were a few reasons. Mostly because you know of the health benefits behind it for the baby.	I think it's [depression and anxiety] like hand in hand. I think it's him needing me so much was hard, and it was made harder, because I was really stressed and scared and terrified and sad and hormonal. Being sad and anxious and terrified made it harder to breastfeed sometimes.
Harboring inadequacy	It really, really no matter how much pain it was in the beginning, I really wanted to go the assurance route of being able to breastfeed my child. I looked at it as I failed at the one day labor process, but	Well I was sad, because I couldn't feed him the right way. I was sad because I wanted to breastfeed him. You know, it's a bonding moment and everything. I couldn't do that, like physically. So I had to rely on the bottle and it	I was nervous to have postpartum, because I had never been depressed before. So being depressed during pregnancy was really upsetting and then I couldn't imagine feeling that way and having to take care of another human being.	And just you know everybody always has advice to give. And it's tough to, you know, obviously it's tough to please everyone. So that kind of gives some guilt, too. You know because you're always doing something wrong, I think, according to somebody.	I just think that people don't realize that you're complicating my life and not solving it when you say that [I should supplement with formula] and it's hurtful and stressful to hear. Like you feel like you're a failure.

	feeding my child months long process, I wanted to accomplish.	was just, I was sad that it had to happen that way.			You feel inadequate. You feel all these things, and the person's not trying to do any of that to you.
Deliberate Persevering	The nurses, the postpartum nurses were pretty much a lifesaver. They were all trained lactation consultants. And they were amazing. I had, like I said, difficulty with positioning. Then getting my colostrum to come out. They really, really helped me distinguish a good latch with my baby. With my breasts also, because I also had engorgement really bad, so it was hard for her to latch to my huge breasts. They were a lifesaver. I don't think I would have been as successful with breastfeeding if it wasn't for them. I couldn't, I don't think I would have been able to	And at one point I was like you know what at this rate I'm just gonna give up and give him a bottle. But you know like my mom and my fiancé said this is what you wanted to do so you should do it. You know cause you're going to be upset if you don't go through with what you wanted to do.	She wouldn't take it from my breast without the nipple shield, so I went to a lactation consultant and she worked with me for probably two hours to show me how to pull my nipples out so it was easier for her to latch on. And push her head so she was staying latched on and not taking the easy way out.	He did have some jaundice, so we nursed through the jaundice and brought him out in the sun for at least 15 minutes a day for the first two weeks and that helped clear it up very quickly.	So [continuous breastfeeding] that was challenging and early on I definitely asked for help. Where I live, there's like a lot actually resources here. So I went back to the hospital I had him at. They have a latch clinic and they told me that you know that was a good thing. He wanted to fill up so he could sleep. Because he was actually sometimes sleeping pretty well at night.

		breastfeed if it wasn't for their help initially.				
	Discerning meaning	So that I really was hard on myself about that [cesarean delivery]. But then that little gold star to myself I give myself every day I continue to breastfeed.	Definitely once we got the hang of it and everything and you know I could actually feed him more and more and more and try to wean him off the bottle, the sadness has kind of disappeared.	I'm kind of amazed. I just started her on solids a couple of weeks ago. So six months of her life, she doubled in weight and has grown and reached all these developmental milestones solely from my milk. And I think that's the most incredible thing. It's kind of hard to comprehend.	I was very lucky that as soon as I was able to get to him [after the cesarean delivery] only about 20 minutes later, we nursed immediately and really without much trouble at all. He had a good latch from the beginning. He continued to keep that good latch all the way through the hospital.	It's just much bigger. I think there's so much about this that no one can prepare you for, you can't imagine it, and then when you're in it, you're just like desperately trying to stay above water. But it is amazing. It is something I would do again. It is just life changing. It changes who you are.
	Cherishing intimacy	-	He likes to look up at me. And he just learned how to smile, so it's [breastfeeding is] a bonding moment. Definitely. And it's like there's nothing else going on in the world. It's just me and him. So it's pretty good. Our little moment.	I kind of feel relaxed. It's relaxing for the both of us, I think. I mean I love her, so I love the closeness that we have when we're doing it.	It's a calming experience. You know it's [breastfeeding's] usually a relaxing and calming and purposeful experience for me.	Sometimes it's like you know beautiful, magical, wonderful, and you're cuddling and your baby is smiling at you and you get to just wrap yourself around him. And he's wrapped inside of you if you're lying down or sitting.

Harboring inadequacy. The women in this study suffered from perinatal depression. Some of them experienced depression in the antenatal period and some in the postpartum period, and others had depression throughout pregnancy and the postpartum period. New mothers often have moments of frustration and powerlessness when caring for their babies. These participants, however, experienced prolonged periods of helplessness to the point of feeling completely incompetent as mothers. These feelings persisted for days and even months. They were an ever-present shadow that cast darkness in the mothers' minds and daily lives.

Anna (P5) had three children whom she breastfed. At the time of the interview, she was tandem feeding her new baby and the next youngest child. Anna had a history of depression and knew that it would persist after pregnancy. She took medication for depression once she knew that it would be safe during pregnancy. Although she was aware of her depressive symptoms, it was still difficult for her at times to believe that she was a good mother. Some days she felt "numb" and "not very connected emotionally to the baby."

Anna's experience of depression included moments of irritability and rage. It was during these moments that she felt most inadequate to mother her baby. She emphasized that depression could "make you feel really bad about yourself. Like you're a crappy wife and mom and person." Although Anna realized that depression was not her defining characteristic, she often yielded to incessant thoughts of maternal incompetence.

Martha (P10) was a first-time mother who breastfed her baby for the health, emotional, and financial benefits. She initially experienced some pain during breastfeeding, but she felt better after 2 weeks. Her son, however, was a "high-demand

feeder," and she explained, "That was emotionally taxing at times." Martha also received much unsolicited advice from family and friends; they advised her to supplement her baby's feeding with formula so he would sleep longer and give her needed respite. She did not care for this advice, which was "hard to hear" and was "not the support I was looking for." Martha pointed out that she felt "like you're a failure. You feel inadequate. You feel all these things." She began to experience unrelenting feelings of maternal incompetence throughout the postpartum period.

Deliberate persevering. When struggles presented themselves to the participants, they did not give up. To do so would have been the easier route for them, especially because of their depressive symptoms and feelings of maternal incompetence. The mothers who participated in this study mindfully confronted and surmounted their shifting hardships. They researched information online, attended support groups, visited lactation consultants, asked for help from family and friends, and saw health care providers regarding depression. Their efforts took much energy and inner strength, which helped them continue to breastfeed their infants.

Priscilla (P3) had a history of depression and anxiety. When she gave birth to her third child, she had immediate skin-to-skin contact and successful breastfeeding. For 7 weeks, Priscilla breastfed her baby until she began to get physically ill. Priscilla developed several infections necessitating antibiotics, which were not suitable for breastfeeding. While Priscilla recovered, she fed her baby donor milk for 3 weeks. Running out of donor milk, Priscilla discovered that she could relactate and felt healthy enough to attempt relactation.

Priscilla sought information from a local support group that had two trained lactation consultants. They guided her on the relactation process and suggested she use a supplemental nursing system. Priscilla gave her baby donor milk through this system, took supplements to enhance her milk production, and successfully relactated. She credited the support group and lactation consultants and stated:

> I think if it had not been for the fact that it was free and I could walk in there with my baby and meet a bunch of other moms who either were or weren't, you know, having issues or whatnot and have two trained breastfeeding consultants right there who could sit down with me and help me with the relactation process, I don't think I would've even probably done it.

Priscilla deliberately gathered her own strength and was motivated by others, specifically the lactation consultants, to breastfeed her baby.

Julia (P4) had three children and did not breastfeed the first two children. She was addicted to pain medication when she became pregnant and carried a profound guilt about her addiction. Julia wanted to ensure that she gave her baby the best life possible. Her physician told her that she should breastfeed her baby so he would not go through withdrawal from her addiction. Armed with this information, Julia was determined to breastfeed regardless of her husband who "didn't care actually" and was happy that she "was the only one who could do feedings," rather than involving him. Julia also had to resist her mother's view and "got a good laugh out of what my boobs will look like after I did this."

Julia advocated for breastfeeding and sought information from the Internet to assist her. However, she had minimum support from health care professionals. When she developed blisters on her nipples and told the nurses that she had a lot of pain, they asked her if she wanted "to bottle feed then?" She related that they "brought a bunch of

formula, which was tempting, but I said, 'Well, I read about pumping. Should I just pump until this sore heals on this one side?' And they were, like, you can." Julia was her own advocate and overcame her struggles to continue breastfeeding her baby.

Discerning meaning. As time went on, all the mothers could breastfeed as they had intended. They also experienced moments of grasping the reality of their capability and value as the mother of their baby through the act of breastfeeding. Through their desperation and ultimate perseverance, the mothers' understanding unfolded to reveal themselves as competent mothers because of breastfeeding.

Joanna (P6) felt many fears, anxieties, and frustrations at the beginning of her pregnancy, having had a termination 10 months prior to her first baby's birth. She knew she wanted to have this baby, but she was afraid and depressed due to "the reality of going through with the pregnancy and birth." She had doubt about her maternal abilities, and these doubts were amplified when she had to have a cesarean birth. She felt "like a failure in the labor process" and criticized herself harshly about it.

Despite any pain she might experience, Joanna wanted "to go the assurance route of being able to breastfeed" her child. She saw herself as a failure in the "one-day labor process", because she underwent a cesarean birth. Joanna hoped to at least breastfeed her baby for many months. When Joanna successfully did breastfeed despite her struggles, she gave "a little gold star to myself every day I continue to breastfeed." She found her value as a mother through the act of breastfeeding.

Claudia (P8) was a first-time mother. She breastfed her baby in the hospital; however, her baby developed jaundice. The health care providers told Claudia that her baby was not getting enough milk, so, she explained, they "scared me into supplementing

with formula." She did not receive guidance on proper latch technique and thus felt incapable of proper breastfeeding. Her daughter even began to refuse her breast, so Claudia's frustration and self-doubt increased. To combat her feelings, she contacted the La Leche League and a lactation consultant to improve breastfeeding techniques. With guidance, her dedication and persistence helped her and the baby breastfeed correctly. Claudia expressed her amazement at her maternal capability to breastfeed:

> I just started her on solids a couple of weeks ago. So 6 months of her life, she doubled in weight and has grown and reached all these developmental milestones solely from my milk. And I think that's the most incredible thing. It's kind of hard to comprehend.

Claudia finally was able to acknowledge that she was a good mother as a result of breastfeeding.

Cherishing intimacy. One of the most challenging aspects of depression for a new mother is the inability to enjoy her life and time spent with baby. The participants in this study suffered from depressive symptoms, and they found the interactions with their babies at times frustrating and tiresome. By acknowledging their maternal capability, the mothers felt reprieve from depressive symptoms during these brief periods of togetherness with their babies. Instead of persistent negativity, they experienced heartfelt joy and began *cherishing intimacy* with baby at the breast.

Tabitha (P7), a first-time mother, began to breastfeed her baby in the hospital with the hope that she would continue to exclusively breastfeed for 2 years. She had latch issues in the hospital, and her baby had low blood sugar. The health care professionals did not assist her with the latch issues and encouraged her to use formula instead. The situation was very stressful to her, and she thought it was her fault for not knowing how to breastfeed. She became depressed when later she experienced nipple soreness and

bleeding, which affected breastfeeding. After Tabitha and her baby established a flowing breastfeeding rhythm, she was able to focus on her baby instead of the mechanics of breastfeeding. She described the experience. While breastfeeding, her baby

> likes to look up at me. And he just learned how to smile, so it's a bonding moment. Definitely. And it's like there's nothing else going on in the world. It's just me and him. So it's pretty good. Our little moment.

Tabitha had the ability to embrace and delight in these profound moments of togetherness with her baby.

Susanna (P9) was a first-time mother who planned to breastfeed her baby for at least 1 year. She had a cesarean birth, even though she preferred a more natural vaginal birth. She was nervous and frightened because she had to wait to see her baby until she was in the recovery room. Susanna developed depressive symptoms in the postpartum period and felt guilty when she could not please everyone around her, especially her mother. Once Susanna and her son overcame breastfeeding difficulties, she noticed a difference in her own mindset. She found satisfaction in the bonding taking place while breastfeeding because, as she said, "it's usually a relaxing and calming and purposeful experience for me."

Evaluation Criteria

Descriptive qualitative research studies, a type of naturalistic inquiry, must pass the scrutiny of critical peer evaluation. The major axioms of qualitative research include holistic and socially constructed realities, influence between the researcher and the participant, the possibility to produce general findings for specific contexts, the impossibility of separating causes from effects, and the value-bound nature of the inquiry

(Lincoln & Guba, 1985, pp. 35-37). These characteristics guide the criteria for determining trustworthiness of the qualitative inquiry.

Trustworthiness

The concept of trustworthiness as described by Lincoln and Guba (1985) is similar to the concept of rigor in quantitative research. Trustworthiness of research lends value and usefulness to study outcomes. The researcher in this study adhered to four aspects of trustworthiness to strengthen the findings: credibility, transferability, confirmability, and dependability.

Credibility. The criterion of credibility links to the truth value of the study (Lincoln & Guba, 1985). To increase confidence in the study and its findings, the researcher consulted with dissertation committee members for review and transformation of the data into constituents of the general structure of breastfeeding for women with perinatal depression. Several meetings took place over the course of the study which allowed for repeated questioning and examination of the data analysis products.

Transferability. The criterion of transferability refers to the ability to transfer or apply research findings to other settings (Lincoln & Guba, 1985). "Thick description," a written detailed account of the researcher's field experience (Geertz, 1973, p. 28), was an important method to present this research study in a thorough manner. Through "thick description" the researcher described the circumstances present during the participant interviews and the use of the descriptive phenomenological method. To obtain detailed descriptions of the breastfeeding experience, the researcher asked the participants open-ended questions with follow-up questions to ensure thorough discussion of the phenomenon (Amankwaa, 2016). The researcher also wrote detailed field notes before

and after each interview to recount the field experience and throughout the data analysis process to recount and analyze the emergence of findings.

Confirmability. The criterion of confirmability determines whether the results of the findings are or could be corroborated by other researchers (Lincoln & Guba, 1985). This process decreases the probability of researcher bias in the study findings. The current researcher enhanced confirmability by collaborating with the dissertation committee members, who reviewed the findings throughout data analysis. The committee members challenged the initial findings, which resulted in a further elaboration of the results. The committee also reviewed the transcripts in relation to the findings to determine whether they had been faithfully extracted from the participants' descriptions rather than created based on the researcher's bias or personal interest.

Dependability. The criterion of dependability refers to examination of the research process and its results (Lincoln & Guba, 1985). Dependability confirms that the findings are coherent, with the possibility of replication by other researchers. To this end, the researcher developed an audit trail, which included raw data, data analysis products, data reconstruction and synthesis products, and field notes. The audit trail may be examined to determine the reliability of the research findings.

Summary

This chapter provided an overview of the participants and their descriptions of their lived experience of breastfeeding. The sociodemographic characteristics of the sample were reported, as well as specifics regarding age of infant, type of birth, type of breastfeeding, and EPDS scores. The participants' lifeworld and experiences of breastfeeding were recounted. Giorgi's (2009) descriptive phenomenological method

utilized in this study was explained in detail. Further, the general structure of the lived experience of breastfeeding for women who have perinatal depression was revealed. The experience of breastfeeding for the mother who has perinatal depression begins with making a conscious decision to breastfeed for the baby's benefit regardless of ever-present conflicting emotions. The mother who has perinatal depression, however, secretly harbors unrelenting feelings of her incompetence to care for baby. She also struggles with surmounting and ever-changing hardships, yet she successfully perseveres and overcomes them by deliberately looking for solutions and by relying on self and/or on other people in her life, such as family members, health care providers, and support groups. The mother ultimately discerns her value as mother through the act of breastfeeding and embraces this time spent intimately connected to her baby.

The constituents derived from the participants' descriptions were also delineated: (a) choosing selflessness, (b) harboring inadequacy, (c) deliberate persevering, (d) discerning value, and (e) cherishing intimacy. Lastly, the evaluation criteria of this qualitative research study, which were based on trustworthiness, were discussed.

V. DISCUSSION

Introduction

The aim of this research was to describe the experience of breastfeeding for women with perinatal depression. Utilizing Giorgi's (2009) method of descriptive phenomenological analysis, the researcher identified the general structure and its essential constituents of the phenomenon experienced by the participants. This chapter presents the study findings and implications as related to the theoretical framework based on Swanson's (1991, 1993) theory of caring. The chapter further elaborates on the constituents of the general structure and connects them to relevant literature. Similarities between the study findings and those of previous research as well as the unique qualities of the study findings are examined. The chapter concludes with recommendations based on the research findings which shape future nursing practice, education, research, and policy.

Swanson's Theory of Caring

Swanson's theory of caring (1991, 1993) provided a framework for this study. The application of this theory to the interview process was discussed in Chapter III. The findings and implications as discussed in the following paragraphs were also framed by this caring theory.

The first caring process of Swanson's theory of caring (1991, 1993) is knowing. Following from this process, the study adds to the "knowing" of the lived experience of mothers with postpartum depression who breastfeed. The findings were also connected to

Swanson's theory of caring (1991, 1993) as demonstrated by the mothers in this study caring for self and baby during the lived experience of breastfeeding.

Each of the constituents that emerged in this study reflect one of Swanson's (1991, 1993) caring processes. *Choosing selflessness* involved Swanson's caring process of *maintaining belief*. As the mothers walked through the breastfeeding experience, they continuously believed that breastfeeding was the best form of infant feeding for their baby. This process was fundamental for these mothers to continue caring for the baby.

Through *harboring inadequacy*, the mothers in this study embarked on Swanson's caring process of *knowing*. They were confronted with depressive symptoms and physical difficulties during breastfeeding, and they began to acquire an informed understanding of both struggles. The mothers were able to move out of *harboring inadequacy* by *deliberate persevering* in the search for answers to their struggles and *discerning meaning* as mother through breastfeeding. Through their therapeutic actions, the mothers in this study incorporated Swanson's caring processes of *doing for* and *enabling*. The interconnected processes of Swanson's (1991, 1993) theory of caring led to the intended outcome for these participants of successful breastfeeding.

The implications of the study findings also aligned with the processes in Swanson's (1991, 1993) theory of caring. Recommendations for nursing education were grounded in Swanson's processes of *maintaining belief, knowing,* and *being with*. When nurses are given proper knowledge regarding breastfeeding in the midst of client depression, nurses are more likely to express an accepting attitude towards mothers with perinatal depression and provide them with informed care. The caring message conveyed

to these mothers created a space for them to welcome subsequent therapeutic actions to promote successful breastfeeding.

Recommendations for nursing practice, nursing research, and public policy were also grounded in Swanson's (1991, 1993) theory of caring. In practice, nurses must understand lactation management techniques and perinatal mental health for *maintaining belief*, *knowing*, and *being with* breastfeeding mothers who have perinatal depression. Nurses must then integrate therapeutic actions, such as honest and thorough sharing of breastfeeding information, while caring for these mothers. The therapeutic actions of *doing for* and *enabling* nurture *cherishing intimacy* and encourage mothers with perinatal depression to fulfill the intended outcome of successful breastfeeding.

Future nursing research must be guided by evidence-based therapeutic actions built on *maintaining belief*, *knowing*, *being with, doing for*, and *enabling.* Through informed caring, researchers must consistently preserve and convey an accepting and encouraging attitude towards breastfeeding mothers with perinatal depression. Then appropriate therapeutic actions based on caring will lead to clients' well-being and the intended positive outcomes of breastfeeding, despite the presence of perinatal depression.

A strong public health policy in support of breastfeeding should have the capacity to increase *maintaining belief, knowing*, and *being with* new mothers as they navigate in a society that has not yet fully accepted public breastfeeding. Public promotion of breastfeeding will give mothers with perinatal depression who intend to breastfeed a sense of respect as they face their future. Robust policies of acceptance will also encourage these women to reach their desired potential as mothers while remaining valued members of society.

Discussion of Constituents

Because of a gap in the clinical knowledge about breastfeeding for women with perinatal depression, the research method chosen for this study was descriptive phenomenology. This method considered the whole person and her way of interacting with the phenomenon of breastfeeding as experienced in her lifeworld. The data were transformed through the researcher's implementation of Giorgi's (2009) descriptive phenomenological method to reveal the general structure which described the overall experience of breastfeeding for all participants.

Within the general structure, five constituents formed moments or essential meanings of the entire lived experience: *choosing selflessness*, *harboring inadequacy*, *deliberate persevering*, *discerning meaning,* and *cherishing intimacy*. The constituents derived from this study are interpreted and described in this chapter in relation to extant research findings with an emphasis on new insights about the phenomenon of breastfeeding for women with perinatal depression.

Choosing Selflessness

The first constituent of the general structure of breastfeeding was *choosing selflessness,* demonstrated by the mothers in this study making a conscious decision to breastfeed for their baby's benefit. All participants made the initial decision to breastfeed in the antepartum period. Some intended to breastfeed for a couple of months, and others intended to breastfeed until the baby weaned on his or her own. During breastfeeding, the participants encountered physical struggles, such as nipple pain due to poor latch; or psychological struggles, such as depressive symptoms, which caused the mothers to question their decision to breastfeed. Yet the mothers found the resolve to breastfeed

because they believed it was the best infant feeding method they could provide to enhance their baby's emotional and physical well-being. Despite the mothers' struggles with pain or poor latch while breastfeeding or with depressive symptoms, such as feelings of persistent sadness, they continuously chose to put their baby's well-being before their own.

Choosing selflessness was a vital component of the mothers' successful breastfeeding experience. Many times, they could have abandoned breastfeeding. Their conscious decision regarding the chosen infant feeding method made during pregnancy and continued desire throughout the postpartum period to support their baby's well-being led to successful breastfeeding outcomes. Nine out of the 10 mothers breastfed for at least 7 weeks, and one mother breastfed for a total of 24 weeks.

Previous studies indicated that the intention to breastfeed during pregnancy was an important influence on breastfeeding initiation and maintenance. This intention was significant especially with the presence of early postpartum complications (Ahluwalia, Morrow, & Hsia, 2005; Borra et al., 2015; Kronberg & Vaeth, 2004). The choice to breastfeed by the current participants that was determined in the antepartum period contributed to their accomplishment of breastfeeding.

In addition to the conscious choice to breastfeed, for these mothers, this constituent involved their act of selflessness. They devoted themselves to the baby's welfare and not their own and repeatedly decided that they would continue breastfeeding despite struggles with the process or depressive symptoms. Although no existing studies concentrate on women with perinatal depression, qualitative studies on breastfeeding with women without perinatal depression have also demonstrated that the mothers who

intended to breastfeed were inclined to continue breastfeeding for baby's well-being when difficulties arose after hospital discharge (Bottorrf, 1990; Kronberg, Harder, & Hall, 2015; Phillips, 2011).

Choosing selflessness was significant, because several previous studies indicated that mothers with postpartum depression were likely to discontinue breastfeeding in the early postpartum period (Akman et al., 2008; Dunn et al., 2006; Forster et al., 2006; Henderson et al., 2003; Lindau et al., 2015). In contrast to the findings of previous studies, the mothers, all of whom had perinatal depression, in the current study fought long-term feelings of isolation and sadness with the desire to provide the best infant feeding choice for their baby. The mothers might have experienced feelings of sadness and anxiety for weeks or even months in the postpartum period; however, they demonstrated and acted on determination to fulfill their initial breastfeeding decision. When it would have been easy to give up, these mothers continually chose to be selfless and breastfeed.

Harboring Inadequacy

The second constituent of the general structure of breastfeeding was *harboring inadequacy.* This term meant that the mothers truly believed that they were not fit or capable of caring for their baby. They described experiencing prolonged periods of psychological turmoil originating from depressive symptoms. These symptoms were amplified for some participants when physical pain was present.

Some of the mothers distanced themselves from their babies and began to reject them. Other mothers felt inadequate because they had problems with breastfeeding, such as pain or incorrect latch, and the baby lost weight or weaned earlier than intended. Yet

some of the mothers felt overwhelming societal pressure from friends and family who gave breastfeeding advice, and the mothers felt inadequate if they did not follow this advice to please their friends or family. Because of these circumstances, the mothers experienced unrelenting feelings of maternal incompetence which affected their interactions with their baby.

Harboring inadequacy was consistent with findings from a qualitative discourse analysis of Internet posts written by women with postpartum depression (Kantrowitz-Gordon, 2013). In those posts, the mothers felt disconnected from their babies due to depressive symptoms, and this disconnection shattered their hopes of being good mothers. The participants in the current study, however, had feelings of inadequacy resulting not only from depressive symptoms but also from breastfeeding difficulties.

In a study of women who had severe breastfeeding difficulties but not postpartum depression, Palmér et al. (2012) found comparable results. They determined that the women who had severe mastitis and latch dysfunction ended up weaning their baby and experienced feelings of failure, uselessness, and decreased sense of self-worth. Therefore, in the current study it was significant to find that the mothers with perinatal depression were *harboring inadequacy* not only from the influence of depressive symptoms but also from the difficulties experienced with the breastfeeding process. These mothers dealt with dual burdens that undermined their maternal capability and required a greater amount of support in the postpartum period than mothers without perinatal depression.

Deliberate Persevering

The third constituent of the general structure was *deliberate persevering*. The mothers in the current study encountered many struggles. Some of them had to overcome

physical obstacles of breastfeeding that involved positioning at the breast, latch dysfunction, pain, and relactation. All of them had to overcome psychological obstacles that included perinatal depression, frustration, mental exhaustion, and lack of support. However, the mothers were driven and determined to succeed, despite their perceived struggles. Day by day, the mothers pushed themselves to mindfully confront and surmount these shifting hardships.

Deliberate persevering was shown by the participants actively seeking out resources to assist them through breastfeeding and psychological struggles. Many of the participants searched for breastfeeding information on their own through use of the Internet and support groups. Some mothers participated in online support groups because they were not able to attend face-to-face groups. They felt comfortable asking questions of other mothers in similar situations, and they enjoyed the convenience of online groups. Others attended in-person support groups with peers who were experiencing the same trials, such as breastfeeding difficulties or perinatal depression.

Some of the support groups accepted any new mother, whereas others accepted only mothers with perinatal depression. Whatever the type of support groups, the participants' peers walked with them through the challenging times and helped them see that others were in the same situation. In all the groups, the members encouraged the participants to move forward and push through their struggles to fulfill their breastfeeding intentions.

Some mothers in this study did not receive proper instruction from their health care providers in the antepartum period or in the hospital after birth. The participants reported that health care providers gave inconsistent or inaccurate information regarding

breastfeeding. Although some of the mothers felt exasperated by their interactions with health care providers, they did not give up and continued to search for solutions to breastfeeding struggles. Some consulted with groups such as the La Leche League for advice on breastfeeding techniques. Others returned to the hospital to seek assistance from lactation consultants. The mothers could have easily given up, but they persisted in the search for answers to their problems.

Deliberate persevering was also impacted by support and encouragement from family and friends. Although one participant had no family support, most described family members who pushed them to breastfeed to avoid future disappointment in themselves. They had significant others who understood the health benefits of breastfeeding and who reminded them how important it was for the baby. Their family and friends believed in their ability when the mothers themselves were not mentally able to do so. The mothers' personal commitment to breastfeeding and the support and encouragement from others was instrumental in their ability to overcome breastfeeding difficulties.

The constituent of *deliberate persevering* was a consistent finding of previous studies on breastfeeding. A phenomenological study revealed the concept of individual persistence and the importance of this characteristic so that mothers might continue to breastfeed (Bottorrf, 1990). Other studies found that mothers who breastfeed depended on outside support, whether from professionals, family members, or peers, to continue breastfeeding despite difficulties (Grassley & Helms, 2008; Guyer, Millward, & Berger, 2012; Hauck et al., 2002; Hegney et al., 2008; Powell, Davis, & Anderson, 2014). Both

individual persistence and support from others were characteristics found in *deliberate persevering*.

The significance of this constituent was that the mothers in the current study also had perinatal depression. Previous studies suggested that women with perinatal depression were less likely to initiate and maintain breastfeeding (Akman et al., 2008; Dunn et al., 2006; Field et al., 2002; Figueiredo et al., 2014). Hatton et al., 2005; Henderson et al., 2003). Other studies noted a higher incidence of breastfeeding cessation for mothers with depressive symptoms (Akman et al., 2008; Dunn et al., 2006; Forster et al., 2006; Henderson et al., 2003; Lindau et al., 2015). With reference to previous findings, the mothers in the current study were at risk for ceasing to breastfeed, but they did not. These mothers successfully persevered and overcame their struggles by finding solutions to the issues that beset them and relying on themselves and others to rise above the hardships. Health care providers must understand that their support of new mothers' breastfeeding can have an important impact on breastfeeding maintenance for mothers with perinatal depression.

Discerning Meaning

The fourth constituent of the general structure of breastfeeding was *discerning meaning*. Throughout the postpartum period, mothers in this study experienced self-doubt in their maternal ability, which was amplified by depressive symptoms. Through accomplishments with breastfeeding, they came to value their role as mothers. Most participants believed that breastfeeding their baby was the only moment in which they felt good about themselves as mothers. They were in awe of their body's ability to nourish another human being and to promote their baby's healthy growth.

Other participants discussed the importance of breastfeeding to increase the bond between mother and baby. At the height of their depressive symptoms, many participants felt distanced from their baby. However, they knew that breastfeeding allowed for physical connection despite emotional disconnection, and this recognition bolstered their feelings of maternal competence. These mothers, despite their perinatal depression, slowly and steadily recognized their importance as mothers through the act of breastfeeding.

Previous literature aligned with this constituent, and findings indicated that mothers with postpartum depression felt that breastfeeding was a primary connection to their baby; this belief promoted healthy maternal-child attachment (Zauderer & Galea, 2010). Other studies focusing on first-time mothers without perinatal depression also demonstrated that breastfeeding fostered a special relationship between mother and baby and was associated with good mothering (Kronberg et al., 2015; Phillips, 2011;). In a study of mothers without perinatal depression who breastfed for less than 2 weeks postpartum, it was found that these mothers believed that breastfeeding was not only a means of infant nutrition but also a symbol of nurturing and caring which exemplified motherhood (Mozingo, Davis, Droppleman, & Meredith, 2000).

A meaningful aspect of this constituent for the current study participants was that, despite suffering from perinatal depression, which increased feeling of maternal inadequacy and incompetence, the mothers recognized their value as mother due to the act of breastfeeding. The quantitative study by Borra et al. (2015) also highlighted the importance of breastfeeding for mothers with depressive symptoms. The results indicated that women with signs of depression during pregnancy had a decreased risk of

developing postpartum depression if they breastfed as planned. Mothers with signs of depression during pregnancy who did not breastfeed as planned had an increased risk of developing postpartum depression. It may be concluded from this quantitative study and the present findings that mothers with perinatal depression who intend to breastfeed require caring and compassionate support from health care providers to promote their dignity and realization of their maternal capability.

Cherishing Intimacy

The final constituent of the lived experience of breastfeeding was *cherishing intimacy*. Breastfeeding connected the mothers and baby physically, but the women with perinatal depression in this study gained more than simply a physical connection. They found breastfeeding to be one of the few intimate and profound moments in which they experienced bliss. Breastfeeding seemed like a pinpoint of light in the darkness of depressive symptoms. When they recounted their stories of the intimacy, their voices exuded an affectionate and dreamy tone. Some mothers described breastfeeding as a calming and happy time. Others described it as a private moment for them to enjoy with the baby. They experienced breastfeeding as purposeful and magical, and it may be concluded that these mothers felt fulfilled.

This finding was consistent with other studies that demonstrated the euphoric intimacy created while breastfeeding. A previous study with mothers who had postpartum depression described their breastfeeding moments as a profound joy never before experienced in their life (Fooladi, 2006). Other studies involving first-time mothers without perinatal depression also revealed the importance of the beautiful and intense emotional and physical bond with baby created by breastfeeding (Kronberg et al., 2015;

Phillips, 2011). In a study of mothers with extraordinary breastfeeding difficulties, it was found that, despite their struggles, they also expressed the uniqueness of the emotional bond created by breastfeeding and the importance of its silent communication to enhance the maternal-child relationship (Hegney et al., 2008).

Although findings in the previous studies were consistent with those of the current study, Haga et al. (2011) revealed disparate findings, which may be due to the cultural differences. Haga et al. (2011) interviewed first-time Norwegian mothers who experienced a range of depressive symptoms. These mothers did not categorize breastfeeding as enjoyable. Rather, they felt it was merely a requirement of motherhood insisted on by societal expectations and health care professionals. The participants were either relieved by the ease of breastfeeding or frustrated by its difficulties. On the contrary, the current research findings revealed that mothers with perinatal depression appreciated the profound moments of togetherness with baby during breastfeeding. Health care professionals caring for mothers with perinatal depression must remember that these moments of breastfeeding provided not only essential bonding between the mothers and their baby but also gave the mothers temporary relief from the unpleasant and often agonizing grip of depression.

Implications

The purpose of this descriptive phenomenological research study was to identify, examine, and explain the breastfeeding experience for women with perinatal depression. The transformation of the data revealed five constituents that were influential in shaping this exploration of lived experience. The significance of the constituents will be helpful in shaping the future of nursing education, nursing research, nursing practice, and public

policy. The following proposals are recommended to transform nursing science for the betterment of clients with perinatal depression and advancement of the profession.

Nursing Education

Throughout this study, some participants discussed the lack of assistance and inconsistent information given to them by nurses and doctors on breastfeeding and perinatal health. The health care providers of one of the mothers gave her written information on breastfeeding and then verbally contradicted it. For other mothers, nurses in the hospital were unable or unwilling to give guidance on breastfeeding and pumping. Some nurses even promoted bottle feeding when breastfeeding was initially difficult for the mothers. In cases in which the nurses were also lactation consultants, the mothers were extremely grateful for the nurses' assistance during the trials of breastfeeding. They even gave credit to these nurses for their breastfeeding success. The difference between the two types of assistance was clear and demonstrated the need to ensure up-to-date breastfeeding education for nurses who work in maternal-child areas.

As a result of the study, the need for basic education regarding maternal mental health was also revealed. Some participants expressed shame for feeling depressed during or after pregnancy; the societal assumption and expectation is that this period was supposed to be a happy time. They did not feel comfortable disclosing their depressive symptoms to health care providers, and some mothers even felt judged by them. The mothers who had compassionate health care providers, however, were thankful for their kind treatment and felt supported during this vulnerable time. Since the foundation of nursing is caring, nursing education must also introduce the basics of maternal mental health to promote improved interactions with clients.

The place to begin improvement and change is prelicensure nursing programs. Although nursing students may not practice in maternal-child health after graduation, they will interact with this population of clients in other areas of the hospital or the community setting. The American Association of Colleges of Nursing (2008) baccalaureate essentials consider clinical prevention and population health (Essential VII) as one of the elements of nursing education. Therefore, program curricula must provide students with basic breastfeeding knowledge and maternal mental health awareness. Nursing students will then be able to use their knowledge to assist and guide clients with breastfeeding and maternal mental health issues.

Another recommendation for change in nursing education pertains to nurses who work in maternal-child areas, such as labor and delivery, postpartum, nursery, and neonatal intensive care units. Their daily work connects them to new mothers, and accurate information on breastfeeding and perinatal mental health is vital for these nurses to help shape positive client outcomes. In regard to breastfeeding, many hospitals have one or two lactation consultants who work limited hours. Childbirth does not take place on a clock, so this arrangement does not work well for mothers who breastfeed and need help outside the consultants' limited times.

To provide continuous assistance with breastfeeding, nurses in maternal-child areas should have certified breastfeeding training. A systematic review of professional breastfeeding support interventions by Hannula, Kaunonen, and Tarkka (2008) suggested that nurses need breastfeeding education to provide accurate breastfeeding support to mothers. Breastfeeding certification trainings are available from either the International Lactation Board of Consultant Examiners (IBCLE, 2016) or the Healthy Children

Project's Certified Lactation Consultant training (Healthy Children Project, 2017). Nurses with relevant training then will have acquired practical skills and strategies to improve breastfeeding outcomes of mothers in the early postpartum period.

Maternal mental health training is another area for enhancement in nursing education. This training will improve caring communication between nurses and their clients. Organizations such as Postpartum Support International and the 2020 Mom (2017a, 2017b) project provide customized maternal mental health awareness training to health care providers. The classes include maternal mental health disorders and differences between disorders, risk factors, and treatment possibilities. Nurses must have an accurate understanding of maternal mental health disorders to confront their own biases and reach a level of understanding that breaks the stigma of perinatal depression and supports new mothers in their pursuit of well-being.

Nursing Practice

Mothers in this study initially believed that breastfeeding would be an effortless process and that they would not have many concerns surrounding this infant feeding technique. Yet most of the mothers experienced problems with breastfeeding. Some of them were uncertain about positioning, treatment for sore nipples, decrease in milk production, or sufficient milk supply. Each mother chose to breastfeed the infant during the antepartum period, but their knowledge was limited to emotional and physical health benefits for the baby. Mothers in this study emphasized the importance of receiving correct information on breastfeeding and possible difficulties, such as incorrect latch and nipple pain, from their health care providers. The mothers believed that breastfeeding education by the health care providers should be honest and thorough from the outset.

Nurses who work in obstetrics offices, public health departments, or hospitals offering childbirth classes should provide comprehensive breastfeeding information, including maternal and infant health benefits and the possibility of struggles with pain, nipple soreness, or incorrect latch in the antepartum period. Client education on both breastfeeding benefits and complications is important early in pregnancy because the mother is deciding on the infant feeding method that she will utilize for the baby. Realistic and consistent breastfeeding education given to mothers by health care providers will also allow them to mentally prepare for the possibility of infant feeding challenges (Bonuck et al., 2014; Graffy & Taylor, 2005; Haga et al., 2011; McCarter-Spalding, 2007; Mozingo et al., 2000).

Nurses who work in the acute care setting should provide breastfeeding support after delivery to uncover difficulties mothers may be encountering and offer appropriate solutions. Some mothers in this study found initiation of breastfeeding to be challenging. As previously discussed, lactation management training for all in-patient maternal-child nurses should make available qualified professionals 24 hours a day to assist mothers with breastfeeding difficulties. Prior to the clients' discharge from the hospital, nurses may also give breastfeeding mothers a list of support groups and hotlines for future reference.

Difficulties with breastfeeding, however, are not limited to the hospital stay. The participants in this study reported having latch problems and nipple soreness for up to two weeks after birth. Studies have recommended postpartum follow-up for breastfeeding mothers (Bonuck et al., 2014; Borra et al., 2015; Grassley & Nelms, 2008; Kimura, McGee, Baird, Viloria, & Nagatsuka, 2015; Mozingo et al., 2000; Phillips, 2011;

Zauderer & Galea, 2010). Health care providers may encourage clients to use a lactation consultant, who is often covered by insurance companies. Ideally, health insurance plans should assign a telephonic health care coach to every postpartum mother after hospital discharge for provision of daily follow-up for at least 2 weeks postbirth and referral to a certified lactation consultant when needed.

Nursing Research

Several limitations of the current study are acknowledged, and these lead to recommendations for further nursing research. The lived experience of the depressed mothers is described from the viewpoint of a primarily Caucasian population (90%), which may not have been representative of the breastfeeding experience of mothers of other races or ethnicities. In addition, all participants intended to breastfeed their babies during the antepartum period and successfully breastfed for at least two weeks. However, the subset of women with perinatal depression who intend to breastfeed and do not successfully do so may have a vastly different lived experience than the current study participants. Further research with these diverse populations may demonstrate a distinct lived experience of breastfeeding and may uncover valuable information for application to nursing practice.

The participants in this study discussed the importance of realistic breastfeeding teaching prior to delivery, follow-up by a lactation consultant in the hospital and home during the first 2 weeks postpartum, and access to support groups for mothers with perinatal depression. Future research must identify the specific breastfeeding support needs for women who have perinatal depression. Once identified, caring nursing therapeutic actions may be developed and implemented for this population of women.

Policy

In the present study during the interviews, some mothers reported lack of acceptance of breastfeeding in public. Two of the mothers were asked to breastfeed their baby in the women's restroom, and others simply felt self-conscious and rejected by the disapproving looks of people nearby when they were breastfeeding in public. Most participants expressed amazement at the continued lack of acceptance of breastfeeding in the United States, and they hoped that public breastfeeding would become the accepted norm in the future.

The initial step in acceptance of public breastfeeding is creation of strong and coordinated national public health leadership that will promote and support breastfeeding as the primary method of infant feeding (U.S. Department of Health and Human Services [DHHS], 2011b). Public messaging regarding the importance of breastfeeding intention, follow through, and maternal and infant health benefits will increase awareness and enhance breastfeeding initiatives (Vanderkruik, Lemon, & Dimidjian, 2015). Because social media is an important part of everyday life, public health messaging must be marketed not only through print and television but through knowledgeable and astute technological means as well. At the local level, community-based organizations must also use their knowledge of the culture and needs of the specific population it serves to tailor educational programs that promote and support breastfeeding.

Mothers in this study found lactation consultants and support groups to be an integral part of their success in breastfeeding. Nurses must continue to raise public awareness about the need for adequate insurance coverage for postpartum lactation management visits and postpartum support groups. At present, insurance companies

cover lactation services, such as clients visiting a lactation consultant or buying a breast pump (Medela, 2017), but coverage may change in the future. Although these services are available, women have had difficulties with insurance companies when paying for lactation consultants or obtaining pumps (Venteicher, 2015). Nurses can support mothers by lobbying the United States government to safeguard lactation services for mandatory coverage by insurance companies.

Summary

This descriptive phenomenological analysis of the lived experience of breastfeeding for women with perinatal depression was viewed through the lens of Swanson's (1991, 1993) theory of caring. The five processes in this theory, *maintaining belief, knowing, being with, doing for*, and *enabling*, were incorporated into data collection, findings, and implications. As the researcher integrated Swanson's (1991, 1993) theory of caring during the interviews, the mothers in this study felt validated and comfortable sharing their intimate breastfeeding experience. These caring processes were also evident in the findings of this study as the mothers cared for self and baby. Lastly, the researcher integrated Swanson's caring processes to implications for nursing education, practice, research, and policy.

Five constituents were elucidated from the data which formed the general structure of breastfeeding for mothers in this study. *Choosing selflessness* encompassed the conscious decision made by the mother day by day to breastfeed for the baby's benefit. *Harboring inadequacy* related to the unrelenting feelings of maternal incompetence experienced by these mothers. *Deliberate persevering* referred to the mindful confronting and surmounting of shifting physical and psychological hardships

encountered by the mothers while breastfeeding. *Discerning value* involved the unfolding acknowledgement of self as a mother through breastfeeding. *Cherishing intimacy* involved the mothers' embracing of profound moments of togetherness with baby. These constituents were interdependent and described the phenomenon of breastfeeding with the study participants.

Choosing selflessness involved maternal intention to breastfeed, which influenced breastfeeding success despite difficulties. *Harboring inadequacy* developed from either depressive symptoms or breastfeeding difficulties that led the mothers to feel incapable. *Deliberate persevering* revealed the importance of persistence and of support from health care professionals and support groups to continue breastfeeding. *Discerning meaning* exhibited the positive impact that breastfeeding had on maternal competence. *Cherishing intimacy* reflected the transcendental moments experienced by mothers when breastfeeding.

In reviewing the extant literature, the researcher discerned findings that both supported or contradicted the current study findings. This study also uncovered unique findings of the lived experience of breastfeeding for women with perinatal depression. By *choosing selflessness,* mothers in the study determined to succeed at breastfeeding despite depressive symptoms, unlike participants in previous studies who stopped breastfeeding when confronted with postpartum depression (Akman et al., 2008; Dunn et al., 2006; Forster et al., 2006; Henderson et al., 2003; Lindau et al., 2015). When the mothers in this study were *harboring inadequacy,* many had to manage both depressive symptoms and breastfeeding difficulties, which led to unrelenting feelings of maternal incompetence. Previous research indicated that mothers with postpartum depression

stopped breastfeeding in the early postpartum period (Akman et al., 2008; Dunn et al., 2006; Forster et al., 2006; Henderson et al., 2003; Lindau et al., 2015). However, by *deliberate persevering*, the mothers in the current study continued breastfeeding for at least 2 weeks after birth. In spite of all their difficulties, the mothers in this study were *discerning meaning* by conquering inadequacy and persistent sadness to realize their maternal competence, which led to *cherishing intimacy* by basking in the purposeful moments of togetherness with baby.

The words of these mothers gave voice not only to their experience of breastfeeding in the midst of perinatal depression but also pointed to needed changes in the profession of nursing. Nursing education must provide basic knowledge of breastfeeding and perinatal mental health to prelicensure students and specific and timely knowledge to practicing maternal-child nurses. In practice, nurses must educate and provide support to mothers about the advantages and the difficulties of breastfeeding throughout pregnancy and the postpartum period. Future research must investigate the development and evaluation of comprehensive interventions for women at risk of breastfeeding cessation. Finally, nurses must become a voice for these women in public policy to promote breastfeeding and change in the United States.

Breastfeeding for the participants, women who self-reported perinatal depression, was a lived experience filled with intention, self-doubt, determination, dignity, and fulfillment. Their journey was full of both darkness and light. Although perinatal depression weighed heavily on their souls, these magnificent mothers struggled yet overcame the difficulties to fulfill their desire to care for their child in the best way they could possibly provide, by breastfeeding.

APPENDICES

Appendix A

Introduction Letter

Dear _____:

My name is Beth Pratt, and I am a PhD candidate at the Florida Atlantic University College of Nursing. I am currently writing a dissertation proposal and would like to discuss placement of a flyer in your office to recruit women for possible participation in this study.

I plan to conduct one-on-one interviews with women who have been diagnosed with antepartum or postpartum depression to discuss their breastfeeding experience. There has been research to support the importance of breastfeeding for these women. This study will provide information to assist nurses in developing appropriate breastfeeding interventions for this population.

Women who meet the following criteria may be eligible:

- Have a diagnosis of antepartum or postpartum depression
- Had a delivery of a full-term infant in the past year
- Has breastfed her infant for at least two weeks after delivery

I look forward to speaking with you regarding my research. I will contact you next week to further discuss the possibility of recruiting participants from your office.

Thank you for your time and consideration.

Sincerely,

Beth A. Pratt, MS, RN

Appendix B

Letter of Cooperation

[Cooperating Organization's Letterhead]

[Date]

To the Florida Atlantic University (IRB):

I am familiar with Beth Pratt, MS, RN and Dr. Joy Longo's research project entitled The Lived Experience of Breastfeeding for Women with Perinatal Depression. I understand [agency/institution name's] involvement to be recruitment of possible participants by posting their research flyer and identifying potential participants.

I understand that this research will be carried out following sound ethical principles and that participant involvement in this research study is strictly voluntary and provides confidentiality of research data, as described in the protocol.

Therefore, as the institutional authority of [agency name], I agree that Beth A. Pratt, MS, RN and Dr. Joy Longo's research project may be conducted in collaboration with our agency/institution/office.

Sincerely,

[Name and title of agency/institutional authority]

Appendix C

Florida Atlantic University IRB Approval

Institutional Review Board
Division of Research
777 Glades Rd.
Boca Raton, FL 33431
Tel: 561.297.0777
fau.edu/research/researchint

Michael Whitehurst, Ed.D., Chair

DATE:	July 22, 2015
TO:	Joy Longo, PhD
FROM:	Florida Atlantic University Social, Behavioral and Educational Research IRB
IRBNET ID #:	757608-1
PROTOCOL TITLE:	[757608-1] Breastfeeding and Perinatal Depression: A Descriptive Phenomenological Study
PROJECT TYPE:	*New Project*
ACTION:	APPROVED
APPROVAL DATE:	July 22, 2015
EXPIRATION DATE:	July 22, 2016
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # *B7*

Thank you for your submission of New Project materials for this research study. The Florida Atlantic University Social, Behavioral and Educational Research IRB has APPROVED your *New Project*. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

- This study is approved for a maximum of 30 subjects.
- It is important that you use the approved, stamped consent documents or procedures included with this letter.
- ****Please note that any revision to previously approved materials or procedures, including modifications to numbers of subjects, must be approved by the IRB before it is initiated.** Please use the amendment form to request IRB approval of a proposed revision.
- All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All regulatory and sponsor reporting requirements should also be followed, if applicable.
- Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.
- Please note that all research records must be retained for a minimum of three years.
- **This approval is valid for one year.** A Continuing Review form will be required prior to the expiration date if this project will continue beyond one year.

If you have any questions or comments about this correspondence, please contact Donna Simonovitch at:

Institutional Review Board
Research Integrity/Division of Research

Florida Atlantic University
Boca Raton, FL 33431
Phone: 561-297-0777
researchintegrity@fau.edu

* Please include your protocol number and title in all correspondence with this office.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within our records.

Appendix D

Recruitment Flyer

FLORIDA ATLANTIC UNIVERSITY

Experiences of Breastfeeding with Perinatal Depression Research Study

- Seeking participants who experienced depression during or after pregnancy, breastfed their baby for at least 2 weeks, and are willing to be interviewed for approximately 1 hour
- Upon completion of the study, each participant is eligible to receive a $10 VISA gift card
- To participate, you must have delivered a healthy full-term baby within the last year, be over the age of 18, and read and speak English.

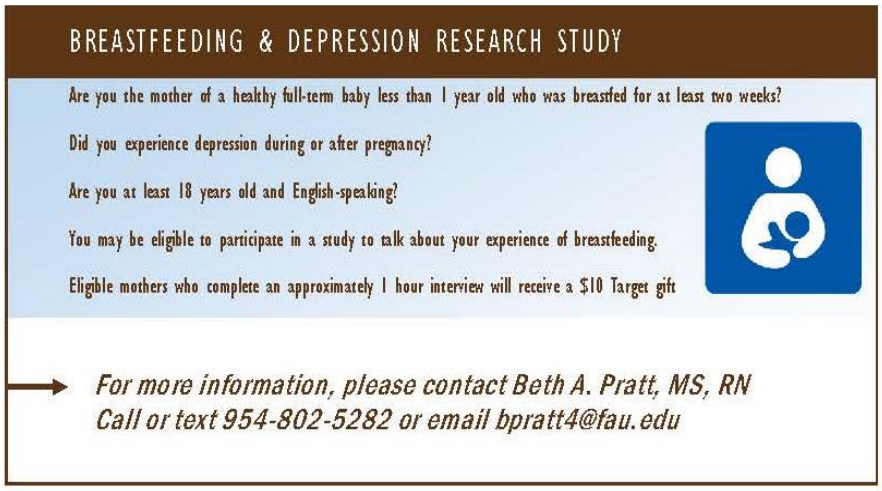
If you are interested, please contact Beth Pratt, MS, RN
954-802-5282;bpratt4@fau.edu

FAU Institutional Review Board

Approved on:	7/22/2015
Expires on:	7/22/2016

Appendix E

South Florida Parenting Magazine Advertisement



Approved on:	3/21/2016
Expires on:	7/22/2016

Institutional Review Board

Appendix F

Florida Atlantic University College of Nursing Recruitment Email

My name is Beth Pratt, and I am a PhD candidate at the FAU College of Nursing. I am currently recruiting participants for my dissertation research study entitled "Breastfeeding and Perinatal Depression: A Descriptive Phenomenological Study".

I am conducting one-on-one interviews with women who have had depression during or after pregnancy to discuss their breastfeeding experience. There has been research to support the importance of breastfeeding for these women. This study will provide information to assist nurses in developing appropriate breastfeeding interventions for this population.

Women who meet the following criteria may be eligible:

- Have a diagnosis of depression during or after pregnancy
- Had a delivery of a full-term infant in the past year
- Has breastfed her infant for at least two weeks after delivery

If you or anyone you may know would be interested in participating, please contact me via email or telephone. I appreciate your support and thank you for your time and consideration.

Sincerely,

Beth A. Pratt, MS, RN

bpratt4@fau.edu

954-802-5282

Appendix G

Updated and Revised Recruitment Flyer

FLORIDA ATLANTIC UNIVERSITY

Experiences of Breastfeeding & Perinatal Depression Research Study

- Seeking participants who experienced depression during or after pregnancy, breastfed their baby for at least two weeks, and are willing to be interviewed for approximately 1 hour
- Upon completion of the study, each participant is eligible to receive a $10 Target gift card
- To participate, you must have delivered a healthy full-term baby within the last year, be over the age of 18, and read and speak English

If you are interested, please contact Beth Pratt, MS, RN
954-802-5282;bpratt4@fau.edu

FAU

Approved on:	3/21/2016
Expires on:	7/22/2016

Institutional Review Board

Appendix H

Florida Atlantic University IRB Continuing Review Approval

Institutional Review Board
Division of Research
777 Glades Rd.
Boca Raton, FL 33431
Tel: 561.297.0777
fau.edu/research/researchint

Michael Whitehurst, Ed.D., Chair

DATE:	July 19, 2016
TO:	Joy Longo, PhD
FROM:	Florida Atlantic University Social, Behavioral and Educational Research IRB
IRBNET ID #:	757608-3
PROTOCOL TITLE:	[757608-3] Breastfeeding and Perinatal Depression: A Descriptive Phenomenological Study
PROJECT TYPE:	*Continuing Review/Progress Report*
ACTION:	APPROVED
APPROVAL DATE:	July 14, 2016
EXPIRATION DATE:	July 22, 2017
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # *B7*

Thank you for your submission of Continuing Review/Progress Report materials for this research study. The Florida Atlantic University Social, Behavioral and Educational Research IRB has APPROVED your *Continuing Review*. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

- This study is approved for a maximum of **20** participants. The project continuing review/progress report notes 7 participants have been enrolled, therefore the study is approved for **13** remaining participants.
- It is important that you use the approved, stamped consent documents or procedures included with this letter.
  - Verbal Consent Script 03162016.docx (stamped)
  - Longo H15-105 Consent_WrittenBAP_final_edit.doc (stamped)
  - Recruitment Flyer - IRB Flyer Edit 03162016.docx (stamped)
  - Revised Recruitment Email FAUCON_Email 03202016.docx (stamped)
- ****Please note that any revision to previously approved materials or procedures, including modifications to numbers of subjects, must be approved by the IRB before it is initiated.** Please use the amendment form to request IRB approval of a proposed revision.
- All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All regulatory and sponsor reporting requirements should also be followed, if applicable.

- Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.
- Please note that all research records must be retained for a minimum of three years.
- **This approval is valid for one year.** A Continuing Review form will be required prior to the expiration date if this project will continue beyond one year.

If you have any questions or comments about this correspondence, please contact Donna Simonovitch at:

Institutional Review Board
Research Integrity/Division of Research
Florida Atlantic University
Boca Raton, FL 33431
Phone: 561-297-1383
researchintegrity@fau.edu

* Please include your protocol number and title in all correspondence with this office.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within our records.

Appendix I

Adult Written Consent Form

ADULT CONSENT FORM

1) Title of Research Study: Breastfeeding and Perinatal Depression: A Descriptive Phenomenological Study

2) Investigator(s): Joy Longo, PhD, RN and Beth A. Pratt, MS, RN

3) Purpose: The purpose of this research study is to learn about the breastfeeding experiences of women who have depression during pregnancy or during the first year after birth.

4) Procedures: Today the investigator will ask you to complete a questionnaire regarding personal information, such as age and occupation, and a depression scale which will take approximately 10 minutes to complete. You will also participate in one face-to-face audio-recorded interview which will last for approximately 1 hour. With your permission, the investigator will audio record and take handwritten notes during the interview. If you choose not to be audio-recorded, the investigator will take hand written notes instead. The interview will be held at a convenient time and place of your choosing. Upon completion of the research instruments and interview, you will receive a $10 VISA gift card.

5) Risks: Although minimal risk may be associated with any research project, the level of risk involved in completing this interview is not greater than ordinarily encountered in daily life. If you feel significant distress, such as anxiety, aggressiveness, or suicidal thoughts during the interview, the investigator will immediately stop the interview, provide emotional support, offer to end the interview. The investigator may not be able to keep confidential any disclosure of thoughts to harm yourself. Depending on how intense the thoughts are or how much you feel like hurting yourself, the investigator will provide you with a referral to the 2-1-1 crisis and help line or will work with you on a plan that may include getting you to a hospital for safety.

6) Benefits: We do not know if you will receive any direct benefits by taking part in this study. However, this research will contribute to a greater understanding of the experience of breastfeeding. You may also feel satisfaction, because the information you give may be an essential factor that contributes to a greater understanding of the breastfeeding experience of women who have depression during pregnancy or during the first year after birth and will assist nurses in developing appropriate breastfeeding interventions for this population.

7) Data Collection & Storage: Any information collected about you will be kept confidential and secure and only the people working with the study will see your data, unless required by law. The data will be kept for 5 years in a password-protected computer in the investigator's office. After 5 years, electronic data will be deleted and paper copies will be shredded. The investigators may publish what is learned from this study. If information is published, the investigators will not let anyone know your name or identity unless you give permission to do so.

8) Contact Information:

- If you have questions about the study, you should call the principal investigator Joy Longo, PhD, RN at (561) 297-2457 or co investigator Beth A. Pratt, MS, RN at (954) 802-5282.
- If you have questions or concerns about your rights as a research participant, contact the Florida Atlantic University Division of Research at (561) 297-0777 or send an email to researchintegrity@fau.edu.

9) Consent Statement:

*I have read or had read to me the preceding information describing this study. All my questions have been answered to my satisfaction. I am 18 years of age or older and freely consent to participate. I understand that I am free to withdraw from the study at any time without penalty. I have received a copy of this consent form.

I agree ____ I do not agree ___ be audio-recorded.

Signature of Participant:_____ Date: _____

Printed Name of Participant: First Name _____ Last Name_____

Signature of Investigator: _____ Date: _____

FAU

Approved on:	7/22/2015
Expires on:	7/22/2016

Institutional Review Board

Appendix J

Verbal Consent Script

VERBAL CONSENT SCRIPT

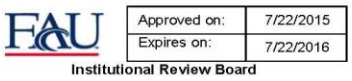
I am Beth Pratt, a doctoral student, from Florida Atlantic University Christine E. Lynn College of Nursing, and I am working on my dissertation. I am conducting a research study on the experience of breastfeeding for women who had depression during pregnancy or during the first year after birth. The research will help me understand the personal experience of breastfeeding for these mothers and will assist in development of appropriate breastfeeding promotion interventions.

Today, I will ask you to complete a questionnaire regarding personal information, such as age and occupation, and a depression scale which will take approximately 10 minutes. You also will participate in an individual phone interview which will take approximately one hour. With your permission, I will audio record and take handwritten notes during the interview. If you choose not to be audio-recorded, I will take handwritten notes instead. The audio recorded interview will be transcribed for analysis. There will be no identifying information associated with this data. The audio recording will be stored in a password-protected computer accessible only to researchers working on the study. Upon completion of the research instruments and interview, you will receive a $10 VISA gift card if you agree to have it sent to your address. Immediately after the gift card is sent, your address will be destroyed by shredding.

Taking part in this interview is your agreement to participate. If you do not wish to continue with the interview, you may stop at any time. The interview will be confidential and your name will not appear on the final write up. Data will be stored in a locked file cabinet for five years and will be accessible only to researchers working with the study. After five years, the audio recorded data will be deleted and papers will be shredded. There will be no personal information retained with the stored data to protect confidentiality.

The risks associated with this interview will not be greater than ordinarily encountered in daily life. If you feel significant distress, such as anxiety, aggressiveness, or suicidal thoughts, the investigator will immediately stop the interview, provide emotional support, and offer to end the interview. I may not be able to keep confidential any disclosure of thoughts to harm yourself. Depending on how intense the thoughts are or how much you feel like hurting yourself, I will provide you with a referral to the 2-1-1 crisis and help line or will work with you on a plan that may include getting you to a hospital for safety.

If you would like a copy of this letter for your records, please let me know and I will email or mail it to you. If you have any questions regarding the research, contact me at (954) 802-5282 or my advisor, Dr. Joy Longo, from the Florida Atlantic University Christine E. Lynn College of Nursing at (561) 297-2457. If you have any questions regarding your rights as a research subject, please contact the Florida Atlantic University Division of Research at (561) 297-0777. Thank you again for your help.



Appendix K

Demographic Questionnaire

Participant ID: _____

All information provided on this form will be kept strictly confidential and will only be used for the purposes of this research project.

1. How old are you (in years)? _____

2. Please circle one or more races that you consider yourself to be.

    a. American Indian or Alaska Native
    b. Hawaiian or Other Pacific Islander
    c. Asian or Asian American
    d. African American
    e. Afro-Caribbean
    f. Hispanic or Latino
    g. Non-Hispanic White

3. Please circle your current marital status.
    a. Divorced
    b. Living with partner
    c. Married
    d. Single
    e. Separated
    f. Widowed

4. Please circle the highest degree or level of school you have completed.
    a. No schooling completed
    b. Nursery school to 8th grade
    c. Some high school, no diploma
    d. High school graduate, diploma or equivalent (for example: GED)
    e. Some college credit, no degree
    f. Trade/technical/vocational training
    g. Associate degree
    h. Bachelor's degree
    i. Master's degree
    j. Doctorate degree

5. Please circle your current employment status.
    a. Employed for wages
    b. Self-employed
    c. Homemaker

d. Student
e. Retired
f. Out of work
g. Unable to work

6. Please circle your current household annual income.
   a. Under $10,000
   b. $10,000 to $19,999
   c. $20,000 to $29,999
   d. $30,000 to $39,999
   e. $40,000 to $49,999
   f. $50,000 to $74,999
   g. $75,000 to $99,999
   h. $100,000 to $149,999
   i. Over $150,000

7. How old is your youngest infant (in weeks)? _____

8. Please circle the type of birth you had with your last delivery.

   a. Vaginal birth
   b. Cesarean birth

9. How do you describe the way in which you breastfed/breastfeed?* ***Please circle the most appropriate response:***

   a. **Exclusive breastfeeding:** No other liquid or solid from any other source enters the infant's mouth.
   b. **Almost exclusive:** Allows occasional tastes of other liquids, traditional foods, vitamins, or medicines.
   c. **Full breast milk feeding:** The infant receives expressed breast milk in addition to breastfeeding.
   d. **Partial:** Any feeding of expressed breast milk.
   e. **Token:** Minimal, occasional breastfeeds for comfort.

10. If you no longer breastfeed your baby, how long after birth did you completely stop breastfeeding? Please be as specific as possible (weeks or months) _____

Note. Adapted from Labbok, M. H. & Krasovec, K. (1990). Towards consistency in breastfeeding definitions. *Studies in Family Planning*, *21*(4), 226-230.

Appendix L

Edinburgh Postnatal Depression Scale (EPDS)

Participant ID: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling.

Please underline the answer that comes closest to how you have
felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all the time
Yes, most of the time - This would mean: "I have felt happy most of the time" during the past week.
No, not very often
No, not at all

Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things.

   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all

2. I have looked forward with enjoyment to things.

   As much as I ever did
   Rather less than I used to
   Definitely less than I used to
   Hardly at all

3. I have blamed myself unnecessarily when things went wrong.

   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason.

   No not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. I have felt scared or panicky for no very good reason.

   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all

6. Things have been getting on top of me.

   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.

   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

8. I have felt sad or miserable.

   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

9. I have been so unhappy that I have been crying.

   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never

10. The thought of harming myself has occurred to me.

    Yes, quite often
    Sometimes
    Hardly ever
    Never

    Administered/Reviewed by _____ Date _____

    Note: From Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786.

    From: Wisner, K. L., Parry, B. L., & Piontek, C. M. (2002). Postpartum depression. *New England Journal of Medicine, 347*(3), 194-199.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing[2]. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Note: From Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, *150*, 782-786.

From: Wisner, K. L., Parry, B. L., & Piontek, C. M. (2002). Postpartum depression. *New England Journal of Medicine, 347* (3), 194-199.

Appendix M

Sample Interview Guide

1. Describe your breastfeeding experience in as much detail as possible.
2. Describe any way in which depressive symptoms affected your breastfeeding experience?
3. What was the most helpful advice you received about breastfeeding?
4. What was the least helpful advice you received about breastfeeding?

Probing questions will be asked to verify and gather additional detail regarding the participant's lived experience.

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