Seeking to Do What's Best for Baby: A Grounded Theory

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Abstract

The purpose of this classic grounded theory study was to develop a theory of how rural breastfeeding women respond to their main concern associated with exclusive breastfeeding. Exclusive breastfeeding is recommended for infants through the first six months of life. Mothers living in rural U.S. communities exclusively breastfeed less frequently than their urban counterparts. The theory *Seeking to Do What's Best for Baby* emerged from the data and describes the process that mothers work through to do what is best for their baby. The theory consists of a temporal three-stage process: pre-pregnancy nescience, working through, and succeeding or surrendering. The process is influenced by evolving internal conditions and basic social processes which account for the variation in the pattern of behavior. The results of this study begin to fill the gap in knowledge about the choices made by mothers to exclusively breastfeed to six months or to end exclusive breastfeeding.

Keywords: *exclusive breastfeeding, rural, classic grounded theory*

Introduction

Exclusive breastfeeding is considered the healthiest source of nutrition for infants from birth through age six months (American Academy of Pediatrics [AAP], 2012; Center for Disease Control and Prevention [CDC], 2014; World Health Organization [WHO], 2015). Exclusive breastfeeding is defined as giving a baby no food or drink other than breastmilk (WHO, 2015). While researchers have provided evidence that there are numerous health advantages to breastfeeding, most new mothers in the U.S. do not practice exclusive breastfeeding through the recommended six-month period. Rates of breastfeeding initiation in the U.S have risen, yet only 18.8% of new mothers continue to breastfeed for six months (CDC, 2014). No regions within the nation have met the Healthy People 2020 breastfeeding goals, and new mothers in rural areas are significantly less likely to breastfeed or exclusive breastfeeding for the first six months compared to their urban counterparts (U.S. Department of Health and Human Services, Maternal and Child Health Bureau [MCHB], 2015). This is especially concerning for new mothers who live in rural areas as rural residence is associated with negative health outcomes for residents (Fahs et al, 2012; MCHB, 2013a).

The choice to not breastfeed impacts the health of mother and infant, and creates economic and environmental disadvantages for the family and community. For women, failure to breastfeed is associated with an increased risk of breast cancer, ovarian cancer, cardiovascular disease, metabolic syndrome, and type 2 diabetes (Faupel-Badger et al. 2012; Figueroa et al. 2012; Ip, Chung, & Raman, 2007; McClure, Matov, Ness, & Bimla

Schwarz, 2012; Stuebe, 2009; Stuebe & Schwarz, 2010). The benefits of exclusive breastfeeding for infants are dose dependent with an increased odds of disease as the duration and intensity of breastfeeding decreases (Kramer & Kakuma, 2012). Infants never having been breastfed or having limited breastfeeding exposure also have increased odds of infection-related mortality, childhood obesity, type 1 and type 2 diabetes, leukemia, sudden infant death syndrome (SIDS), gastrointestinal infection, upper and lower respiratory disease, and otitis media (Ip et al. 2007; Taylor, Kacmar, & Nothnagle, 2005). Rural infants have poorer health outcomes compared to urban infants including increased incidence of low birth weight and preterm birth (U.S. Department of Health and Human Services [HHS], 2013b). Moreover, the postnatal mortality rate is 27% higher than the urban mortality rate including SIDS deaths occurring during the first year of life (HHS, 2013b). The negative impact of failure to exclusively breastfeed, particularly in the rural population, cannot be overstated.

The researcher began this study with a preconceived notion that exclusive breastfeeding to six months was a decision making process and sought to determine why some mothers exclusively breastfed to six months and others did not. The researcher was open to discovery and emergence and as is normal in grounded theory research, hence, a change in the purpose of the study occurred. It became quickly apparent that this medical plan to continue exclusive breastfeeding for a period of time was not a concern of the parents, rather it was to do what they considered best for their baby. The initial purpose of the study was altered to reflect the main concern of the participants: to develop a theory of how rural breastfeeding women respond to their main concern associated with exclusive breastfeeding. S*eeking to do what's best for baby* emerged as the main concern and was continually resolved with the core category, w*orking through,* by every study participant. This concept is one that has not been seen in the literature previously.

Method, Data Collection Analysis

Classic grounded theory was chosen for this study. As little was known about mothers' decisions surrounding exclusive breastfeeding, a theoretical approach using grounded theory was determined to be an efficient method to explore socially-related issues that pertain to women and family health such as breastfeeding (Glaser & Strauss, 1967). Classic grounded theory also allowed the researcher to understand the experience of exclusive breastfeeding as reported by mothers who have breastfed.

Prior to the start of the study, institutional review board approval was obtained from the university as well as from the hospital system in which participants were recruited. Following approval, a purposive sample comprised of participants who met the inclusion/exclusion criteria was collected. Inclusion criteria for the study were: women who delivered a live singleton infant in the last 12 months and exclusively breastfed beyond hospital discharge, and English-speaking. Exclusion criteria were: non-English speaking, maternal health complications that limited the woman's ability to initiate breastfeeding following delivery, prolonged separation of the infant from the mother preventing feeding upon demand, having an infant who was admitted to the neonatal intensive care unit (NICU), having an infant with congenital or physical illness that impacted breastfeeding, multiple gestation, and unwilling or unable to sign the consent. Fifteen women were initially

recruited and interviewed. Once the data began to accumulate, and relevant concepts and categories emerged, the researcher conducted theoretical sampling of participants and another four participants were interviewed to elaborate the emerging concepts (Glaser, 1978).

The 19 participants were women between the ages of 19 and 40. All lived in communities in Virginia or West Virginia designated as rural using the Rural Health Information Hub "Am I Rural" (Health Resources and Services Administration, 2015). The distance to the hospital where they sought prenatal care and delivered their babies was between 15 and 50 miles from their home. The majority of participants self-reported as Caucasian (89.47%). The majority also reported having private or military insurance (73.68%) with three reporting federal insurance (Medicaid) and two covered by their parents' insurance. Six (31.58%) of the participants were first-time mothers with the others reporting having two or three children (68.42%). Most of the participants returned to work before their babies were weaned from breastfeeding, with six who did not return to outside employment while breastfeeding. All participants had completed high school with the rest completing some college, college, or graduate school.

Data collection commenced following participant consent. Theoretical sampling was employed to continue participant recruitment until saturation of data occurred. Interviews were conducted in a location of the participants' choice and was stimulated with an initial spill question, "tell me about breastfeeding," followed by additional questions to clarify new ideas that emerged from previous data. No notes or recordings were collected during the interview to promote trust and encourage communication; however, field notes containing observations and a summary of the interview were constructed following each interview (Glaser, 1998).

The analysis of data began with an open exploration of notes, starting with the first interview. This exploration of data was not a linear process. Instead, it was a back and forth process of concurrent data generation and analysis in which the researcher examined all of the data collected and continued throughout the entire process of data collection, to memo, to sort, and to write. The data was analyzed, coded, and sorted using constant comparative analysis. Glaser and Holton (2004) described three types of comparative analysis: (1) incident to incident, (2) concepts to more incidents, and (3) concepts to concepts. Employing these three types of comparative analysis allowed the researcher to discover how the data, concepts, and categories were integrated to become a hypothesis followed by theory generation. The researcher employed a continuous internal cognitive process of constant comparison throughout the study. Substantive coding also began with the first interview as the researcher employed line by line review of all notes (open coding) to identify and categorize the data emerging form the participant's experience. As the core category emerged from the data, the researcher began selective coding to limit coding to only those concepts or fragments of data that related to the core category. Fracturing of the data through constant comparison allowed for the conceptualization of the categories and core to become abstract. As the data were fractured in substantive coding, the researcher began to conceptualize the manner in which the fractured data symbolized the core category and looked to generalize the data beyond individual or group. It was during

this process that the fractured data were pulled back together to create a framework for the emerging theory.

Memoing also began with the first interview. For this study, each memo was written individually and stored in a memo fund that was sorted and resorted as new data and memos were added. While the quantity of memos was daunting, the process empowered the researcher to contemplate the data, codes, notes, and impressions while making higher level associations of conceptualization, beyond the individual participant to the process, in the generation of a theory. Through memoing, the researcher was able to identify gaps in existing analyses and develop a conceptualization of the emerging theory. Additionally, the paper trail created by memoing provided an ongoing record of the research process.

As the memos began to accumulate, the researcher began to sift through them and organize them into a conceptual order. This sorting process was also circular in that memos were moved from one pile to another as the theory coalesced. Often the process of sorting generated additional memos or directed the researcher to seek additional data. After sorting resulted in categories that were becoming saturated, the researcher began the next stage of research which was the writing of the first draft of the research.

Methods to assure rigor in all steps of the research were applied and included Glaser's (1998) criteria for rigor—fit, workability, relevance, and modifiability. Throughout the entire process the main concern was identified through the statements of the participants. Each in their own voice and story spoke of the desire and efforts to do what was best for the baby. Therefore, seeking to do what's best for baby emerged as the main concern of rural mothers who planned to exclusively breastfeed. This substantive theory evolved as a three-stage conceptual theory and the concepts that emerged were: (a) stage one, pre-pregnancy nescience; (b) stage two, working through; and (c) stage three, succeeding or surrendering. The component, *working through,* is impacted by four basic social processes and their properties. This substantive theory describes how rural mothers navigate those basic social processes that they encounter as they strive to provide their best for baby.

The Theory of Seeking to Do What's Best for Baby

S*eeking to do what's best for baby* consists of a three-stage process that occurs over time. The stages are *pre-pregnancy nescience, working through,* and *succeeding or surrendering*. The processes are influenced by evolving internal conditions identified as *enculturating*, *believing*, and *lacking knowledge*. Also identified are basic social processes and conditions that influence the core category of *working through* and affect the three-stage process. The basic social psychological processes that impact working through are *struggling, needing support, winging it*, and *admitting fed is best*.

Seeking to do what's best for baby was the most common theme that emerged from all interviews. The actual wording *"best for baby"* was heard repeatedly, particularly in support of breastfeeding as a source of infant nutrition. Indeed, the statement *"best for baby"* was often heard when the participant was asked why she chose to breastfeed–"it's best for baby." The process of *seeking to do what's best for baby* begins with *pre-pregnancy nescience*.

Stage One: Pre-pregnancy Nescience

A period of unknowing exists before women become pregnant and have little or no personal connection with child-rearing. This period is defined as *pre-pregnancy nescience* and describes the insouciant behavior that accompanies a period of time in which concerns of pregnancy, delivery, and childcare are not considered. *Pre-pregnancy nescience* ends when women become pregnant and realize that they will be responsible for caring for their infants. This cutting point signals a change in attitude and focus to the infant.

Evolving Internal Conditions

Most new mothers are concerned with the health and wellness of their newborns. They make decisions on the care and feeding of their newborns while *seeking to do what's best for baby*. Health care professionals recommend that new mothers should exclusively breastfeed for the first six months of their baby's life. A mother's intention to breastfeed her infant exclusively is an essential piece of her strategy when *seeking to do what's best for baby;* with the decision to breastfeed, plans for the duration are frequently made prior to the birth of her infant. A mother will declare her intent to breastfeed often without considering barriers that may occur to prevent her from *succeeding*. Plans to return to work often result in a modification to breastfeeding goals, but mothers adapt and adjust accordingly by pumping to provide breastmilk to sustain their goals of exclusive breastfeeding for the first six months. An example includes mothers who breastfeed while at home with their infant but pump while at work, carefully storing and transporting the milk home to prevent any need for formula supplementation.

Women entering motherhood experience evolving internal conditions that influence their decisions for caring for their infants. These conditions develop from life experiences, exposure to external ideas, and the vision of themselves as mothers. As *pre-pregnancy nescience* ends, the influence of the evolving internal conditions impacts their plans for childbirth and child-rearing. The three concepts overlap and are titled *enculturating, believing*, and *lacking knowledge.*

Enculturating

This process occurs as women are exposed to breastfeeding. The exposure may have been by having breastfed themselves, having friends who are breastfeeding, and/or education that presented the benefits of breastfeeding. For these women, there is an expectation from their family, friends, and health care providers that breastfeeding will be their choice of infant nourishment. By the time she delivers her infant, the mother has chosen to breastfeed and is prepared to do so regardless of any barriers encountered.

Enculturating was identified in most of the participants interviewed. One reported "breastfeeding is natural, it's what I'm supposed to do." *Enculturating* was reported by the participants as influential in their decision to continue breastfeeding when experiencing issues and barriers to *succeeding.* Indeed, *enculturating* continued beyond the end of breastfeeding with the mothers voicing their intention of breastfeeding subsequent children. A participant who had experienced a very difficult time breastfeeding was asked if she would breastfeed again if she had another child; she responded, "Well yes – why wouldn't I?"

Believing

A second evolving internal condition was identified as *believing* and is comprised of two different components: *believing* in one's ability and *believing* what one is told. The first component describes a mother's vision of her ability to succeed at breastfeeding. *Believing* that breastfeeding is the best way to nourish her infant, a mother also believes that she is able to succeed. *Believing* in the benefits for her infant, she will plan to initiate breastfeeding, and, while aware that she may struggle, will trust that she will be able to overcome any obstacles she encounters. *Believing* overlaps *enculturating* in that it encompasses the opinion that breastfeeding is a normal behavior. This belief was noted in participant statements such as "I knew it was *best for baby*, so I did it" and "I never considered stopping even though it was a struggle."

Before and during pregnancy women are exposed to information related to child care from multiple sources. *Believing* in the veracity of the information, the mother incorporates the knowledge into her plans for raising her infant. This is especially true of recommendations for breastfeeding and infant nutrition. *Believing* in the advice from a trustworthy individual will influence a mother's decision to exclusively breastfeed while she is *seeking to do what's best for baby*, especially when the advice comes from a trusted health care professional. She is conditioned to believe health care professionals and will follow their instructions even when the instructions may oppose her own goals and ideas. This component of *believing* was identified by statements such as "I was told I should breastfeed but no one told me how hard it would be" and "the hospital gave me formula to take home so I guess it's okay to use it."

Lacking knowledge

Unfortunately, while a mother is enculturating and believing, she may be doing so with a knowledge deficit. Her knowledge is limited by her ability to understand, integrate, and utilize any instruction she has received. *Lacking knowledge* impacts a mother's decision-making process to exclusively breastfeed or to problem-solve when encountering barriers to exclusive breastfeeding. Despite the availability of information about breastfeeding, some mothers may not have received instructions, comprehended the content, or were able to apply it as a "hands-on" process. Lack of prenatal education and support after birth further exaggerates the lack of knowledge. Later, while *working through*, mothers who are lacking knowledge will work harder to try to solve a problem. They often fail due to their lack of understanding and fear that they are not doing what is best for the baby. Several participants demonstrated lacking knowledge when issues with breastfeeding, such as poor latch or how to deal with a decreasing milk supply, occurred and no solutions came to mind. One participant offered her infant formula because "her [breast] milk didn't fill her [baby] up." Another reported that she did not know that her "milk supply would decrease if [she] missed feedings and didn't pump."

The most significant example of lacking knowledge was the failure to understand what exclusive breastfeeding entails. Many participants considered exclusive breastfeeding to be the abstinence of any formula supplementation. They did not realize that offering any other food, including cereal, constituted an end to exclusive breastfeeding. Lacking

knowledge was perpetuated by getting mixed messages from pediatricians who informed participants that they should introduce cereal to their infant between four-six months of age.

Stage Two: Working Through

The theme of *working through* represents a mother's decision to continue to breastfeed despite various barriers she encountered. The suggestion of *working through* evokes an image of an individual struggling through something that is difficult. This refrain is one that was heard during every interview--whether from a mother who *succeeded* in exclusively breastfeeding through the first six months or one who had quit breastfeeding in the first weeks. One participant even used the term when she reported that she "*worked through* the pain" to breastfeed. The idea describes the mothers' commitment to breastfeeding regardless of the difficulty or situation--they simply *worked through*.

Basic Social Psychological Processes (BSPP)

During the process of *working through*, the mother experiences different situations identified as BSPPs that influence the success or failure of her exclusive breastfeeding attempt. These events are variable in nature with mothers experiencing some or all of them at different periods while *working through.* The BSPPs are *struggling, winging it, needing support,* and *admitting fed is best. Struggling* is influenced by the properties *sacrificing, lacking knowledge, searching for help, pumping instead, changing emotions,* and *encountering public stigma*. For the sake of brevity the discussion of the properties will be limited to *sacrificing, pumping instead,* and *encountering public stigma.* Properties of *needing support* are identified as *receiving validation* and *getting mixed messages.*

Struggling. The first BSPP to impact mothers while *working through* is *struggling.* Many breastfeeding mothers experience s*truggling* in their effort to exclusively breastfeed their infant. The specific difficulties that trigger s*truggling* are unique to each mother and are not isolated to a single incident. Rather, *struggling* is a fluid variable that occurs randomly, may be repeated, or may be one of many different events experienced. Some causes of s*truggling* include lacking the necessary support to exclusively breastfeed, decreasing milk supply, and experiencing other physical issues such as fatigue, pain, or illness. Participants recounted *struggling* to pump or increase feedings in an attempt to keep up their milk supply to provide breastmilk for their infant. One participant reported that she "struggled to keep her baby's weight up" while exclusively breastfeeding. The *struggling* mother will *work through* successfully or she will not; either outcome would result in an end to the struggle.

Mothers who are *struggling* while *working through* may experience different elements that influence how the mother resolves her main concern of *seeking to do what's best for baby.* Five properties of *struggling* were identified in the study and three are discussed in this section. They were identified from the data and titled *sacrificing, pumping instead,* and *encountering public stigma.* Each was noted to exert either a positive or negative force towards successful *working through.*

Sacrificing. The first property of *struggling* is *sacrificing.* Mothers are often called on to give up or "sacrifice" something for the sake of their infants. One notable example of *sacrificing* is the loss of sleep when exclusively breastfeeding. While nearly all infants will sleep through the night by six months, the months and weeks until then are often disrupted by mothers waking to nurse several times during the night. Mothers are cognizant that these nighttime feedings are essential and that their infants will eventually sleep through the night; however, it is a *sacrifice* of sleep which later impacts a mother's daytime hours.

Pumping instead. A second property of *struggling* is *pumping instead* and describes the extreme actions that a mother will take to provide breastmilk to her infant rather than supplement with formula. Mothers aware of the benefits of breastfeeding decide to use a breast pump to extract milk, store, and later feed their infants. This commonly occurs when mothers are returning to the workforce. Allowing working mothers the opportunity to pump at work is supported by state and federal policies, yet some mothers are unaware of the benefit. One participant stated, "I didn't know that pumping at work was even a thing…"

Pumping instead can also be instituted when mothers believe that their milk supply is low. It can be a means by which to increase their supply. One participant set an alarm to wake up every three hours to pump during the night. The amount of work that is needed to organize, schedule, pump, and store the milk is significant; yet the participants interviewed recounted many examples of *pumping instead* including "breastmilk is best so I pumped even though it was a hassle."

Encountering public stigma. A third property of *struggling* is *encountering public stigma.* One significant issue impacting any breastfeeding mother revolves around what to do in public when the baby needs to breastfeed. For mothers who are exclusively breastfeeding, this topic is of utmost importance. Public breastfeeding has been a topic of discussion in social media and mothers are aware of the stigma related to it. Therefore, they must decide whether to breastfeed their infants in public and how they will deal with any negativity associated with the act.

Participants in this study all reported being aware of the potential for *encountering public stigma,* but few reported having experienced negative comments or reactions themselves. Regardless, they described putting much thought and planning into how they would react to any criticism encountered. One participant said she "didn't want to feel trapped in her home" so she ignored comments and looks from others. Some comments heard were not openly aggressive but still unkind*.* One example was reported by a participant who was asked by a co-worker, "Aren't you done with that yet?" Ultimately, the real or perceived stigma associated with public breastfeeding was something that each participant considered when planning to breastfeeding their infants.

Winging it. A second BSPP encountered is *winging it.* While some mothers sought help to work through the issues they encountered, other mothers chose *winging it*. This BSPP describes the instances where the mother is unprepared for the breastfeeding experience or specific circumstance related to exclusive breastfeeding but is willing to "give it their best try." It also describes the trial and error method of mothering and breastfeeding. Common characteristics of mothers who wing it include being a first-time

mother, having little social support, and having little understanding of what resources are available. While admitting to *lacking knowledge*, the mother desires to breastfeed her infant and plans to do her best or try by *winging it.* One participant summed it up by saying, "I didn't know what I was supposed to do but I knew I was supposed to do something!" She was *winging it* by seeking out information and using social media. Later, she was offered resources through community agencies.

Needing support. The third BSPP encountered is *needing support* and describes the necessity of emotional and physical support required by the mother to exclusively breastfeed. The presence or absence of this perceived or actual support directly influences the outcome of exclusive breastfeeding. The mother's significant other is most commonly considered the primary support. Participants interviewed reported that their significant other "was my biggest supporter," "got up in the night and brought the baby to her to nurse," and helped to "shield her so she could breastfeed in public."

The maternal grandmother is the second most common individual to offer support and encouragement, especially if the father of a baby is absent. Other family members and friends are also called upon to provide support for a new mother. One participant commented "even though my mom didn't breastfeed me, she has been right there to help me from the beginning."

A final external support can come from a mother's employer upon return to the workforce. This support includes an employer's understanding of a mother's desire to continue to breastfeed, as well as the willingness to provide breaks at regular intervals and a private location for mothers to pump while at work. Failure to provide this support to breastfeeding mothers can sabotage her efforts. There were mixed reports from participants about their experiences with pumping after returning to work. One participant reported that her colleagues "arranged the room so she could pump privately in a corner and not miss the meeting." This was not always the case, as another participant recounted, "they [employers] said I could only pump in the bathroom but there was only one bathroom and the entire time I was trying to pump people were knocking at the door to use it."

The BSPP *needing support* is impacted by two properties identified as *receiving validation* and *getting mixed messages.* Both were noted to exert either a positive or negative force towards successful *working through.*

Receiving validation. Mothers commonly seek out validation for their breastfeeding efforts and of their ability to do what is *best for baby. Receiving validation* communicates a needed reminder of a mother's self-efficacy, of her success at doing what was best for baby, and by providing the needed encouragement for her to continue *working through* when encountering barriers. This positive reassurance reminds mothers of their goals and promotes their ability to achieve them.

The concept of *receiving validation* was heard throughout the interviews. An example of *receiving validation* was heard from one participant who said that her spouse told her he was "proud that she was able to do this for their baby." In this case the positive statements validated the mother's efforts and encouraged continuation of exclusive breastfeeding.

Conversely, a lack of validation negatively impacted another participant's breastfeeding efforts when her significant other "thought it [breastfeeding] was gross."

Getting mixed messages. Another property of *needing support* is *getting mixed messages.* The ability for mothers to *work through* and *succeed* at exclusive breastfeeding is impacted by their capacity to understand the information they receive. This includes information from the health care professionals they encounter. Inconsistent information and support are termed mixed messages. Mothers who *get mixed messages* may become confused, frustrated, and angry. *Getting mixed messages* was noted by participants in this study. One reported that she offered cereal to her baby before six months because she was given nutritional guidelines from her pediatrician suggesting the introduction of cereal between four and six months of age. *Getting* m*ixed messages* on a larger scale was perpetuated by the hospital in which all study participants delivered their infants. One participant pointed out that "the hospital promoted exclusive breastfeeding while I was there; they stressed how important it was for my baby--then they sent me home with a gift bag of formula."

Admitting fed is best. The fourth BSPP found to impact *working through* is *admitting fed is best.* The participants all shared the common belief that breastmilk was best for the baby but not all were able to exclusively breastfeed or continue breastfeeding at all. The concept admitting fed is best was heard from several participants who perceived or experienced low milk supply, had infants who did not tolerate breastmilk, or underwent difficulties with breastfeeding. One participant stated that it was "better to feed [baby] formula that to starve her."

The introduction of formula to supplement breastmilk ends exclusive breastfeeding and often precipitates the early discontinuation of breastfeeding altogether. One participant stated that after beginning to supplement her baby with formula "what I had (breastmilk) got less and less and eventually dried up." While mothers reported *struggling* in *seeking to do what's best for baby*, ultimately they *admitted fed is best* was indeed, best.

Stage Three: Succeeding or Surrendering

The process of *seeking to do what's best for baby* concludes with either *succeeding* or *surrendering.* Either *succeeding* or *surrendering* is experienced by a mother and describes the mother's belief in her success.

Succeeding

Ostensibly, *succeeding* with exclusive breastfeeding signifies that a mother exclusively breastfeeds her infant for the first six months of life. In reality, *succeeding* is less prescriptive and instead symbolizes a mother's satisfaction with *seeking to do what's best for baby.* Meeting set goals for exclusive breastfeeding was less important to participants in this study than the overall health and welfare of their infants. This included supplementing with formula if they believed it was in the infant's best interest. Participants reported no feelings of lingering guilt or remorse for their decisions made in the process of *working through* any barriers or complications experienced. S*ucceeding* in this context is therefore

an individual experience and the perception of satisfaction with the achievement of *seeking to do what's best for baby.*

Some participants in the study believed that they succeeded at their breastfeeding effort despite not reaching their goal of exclusive breastfeeding until six months. While some said they had succeeded with exclusive breastfeeding and "never had any issues with breastfeeding;" others experienced setbacks in their plans but believed themselves to still be *succeeding*. A statement by one participant summed it up: "I wanted to do what was best for my baby and breastfeeding just wasn't it; that didn't make me a failure."

Surrendering

Not all mothers believed they were successful in *seeking to do what's best for baby* and surrendered instead. This symbolic giving-in occurs when mothers determine they are no longer able to maneuver through the obstacles encountered during *working through.* The *surrendering* results in the discontinuation of breastfeeding, either voluntarily or unwillingly. In some cases participants were encouraged by either a support or health care provider to "give up" when they were no longer able to work through the struggles encountered, or the health of the mothers or infants was in question. Many different scenarios bring about a *surrendering,* but ultimately it is an emotional giving up of the plan for providing their baby breastmilk for nourishment and a belief that they have not been able to do what's best for baby.

Surrendering was most often heard by participants stating they had done everything they could but were simply unable to continue breastfeeding. Examples included an infant who would not nurse from the breast, a participant's diminishing supply of milk, and instruction by a health care professional to cease breastfeeding. Another example of *surrendering* occurred when a participant received discouragement for breastfeeding from her significant other. In that situation, the mother felt compelled to give up and surrendered to keep the status quo of her family. This situation highlights the influence of the BSSP within the culture and hierarchy of families.

Once mothers work through *changing emotions* associated with *struggling* and then *surrendering,* they again focus on *seeking to do what's best for baby*. Each participant was willing to breastfeed if she had another child. One participant said it best: "It didn't matter how hard it was, I would do it again because it's better for the baby."

Discussion

Seeking to do what's best for baby represents a new substantive theory that emerged from the stories of the participants. The theory explains how rural mothers attempt to exclusively breastfeed for the first six months and navigate the basic social processes they encounter to resolve their main concern: doing what is best for their baby. The three stage process occurs over time during which mothers are influenced in their decision to exclusively breastfeed by their families and social interactions. Mothers also find that they are faced with both BSPPs that may support or hinder their success at exclusive breastfeeding. Exclusive breastfeeding ends the process of *working through* and the mother is left with the emotional response of *succeeding* at her goal to do what is best for baby or *surrendering* to

the realization that she did not do what was best. Regardless of the response, the mother will eventually move forward in her plans to do what is best for baby.

Limitations

Limitations of the study included having a small, relatively homogenous, and well educated group of participants. Another participant-related limitation was identified when one participant self-identified late in an interview that she did not meet two of the inclusion/exclusion criteria having had a history of Buprenorphrine use and her baby being admitted to NICU. The interview was completed and the data translated to field notes. The memos and coding were not affected by the inclusion of this participant's data. Indeed, there were such similarities to other data collected that the researcher was struck by commonalities despite the breach of protocol.

Other limitations of the study related to the rigor of the study. Credibility was impacted by the researcher's personal experience as well as an early literature review required in the dissertation process. Fit may have been compromised by potential forcing of data although a clear relationship between the participants' stories and the concepts found in the theory were recognized. The emerging concepts were generalized and each participant was able to identify their own journey in the process of *seeking to do what's best for baby*, but until the study is repeated the generalizability and relevance to other groups is unknown. Finally, modifiability was addressed by the many revisions and ongoing mixing and remixing of components and their properties. The ending of the study should not limit the introduction of new ideas nor close the findings to correction and change (Glaser, 1978).

Implications

The new grounded theory of *seeking to do what's best for baby* is one that has many potential implications for nurses and the discipline of nursing. While the theory speaks of the mother caring for her infant, the need for changes in education, practice, breastfeeding policy, and research was identified as essential to promote exclusive breastfeeding and maternal success in doing what is best for her baby. Further, the need for closer scrutiny of the health care and organizational policies related to exclusive breastfeeding is essential. In keeping with the focus and concepts, the new grounded theory *seeking to do what's best for baby* contributes to the discipline of nursing by exploring the meaning of the situations experienced by new mothers as they exclusively breastfeed, provides an understanding of the pattern of evolving forces shaping their experiences, and guides future actions to promote exclusive breastfeeding (Newman, Smith, Pharris, & Jones, 2008).

Education

To promote success, health care workers must provide mothers with comprehensive education endorsing exclusive breastfeeding prior to delivery and offer resources for continued education throughout the duration of their breastfeeding efforts. Education offered only during pregnancy will increase the rate of initiation but will not support long-term exclusive breastfeeding (WHO, 2016a, UNICEF, 2005). This includes elaborating on what the actual practice of exclusive breastfeeding involves. Many mothers do not understand that the introduction of cereal before six months ends exclusive breastfeeding

(Arts et al., 2011; Nor et al., 2011; Thet et al., 2016). Having an understanding of what defines exclusive breastfeeding may produce an increase in the duration of exclusive breastfeeding for some mothers.

The educational resources should also be available for families as well as mothers. Educating fathers and grandmothers can promote successful exclusive breastfeeding through hands-on and emotional support. The lack of familial support has been shown to interfere with exclusive breastfeeding support (Goodman, Majee, Olsberg & Jefferson, 2016; Herndon, 2015; Hohl, Thompson, Escareno, & Duggan, 2016). Including families in breastfeeding education and advocating for exclusive breastfeeding may be one way to help achieve success.

Practice

The need for consistent and standardized education for rural mothers is essential to success in exclusive breastfeeding. Nurses who provide care for new mothers should practice using current evidence-based methods to establish early exclusive breastfeeding (Allen, Perrine, & Scanlon, 2015; Hjalmhult & Lomborg, 2012: Sheehan, Schmied, & Barclay, 2013). Therefore, nurses should be trained to provide consistent and standardized education and care to new mothers' that is uniform between nurses and practitioners and in accordance with CDC recommendations for breastfeeding (Baby-Friendly USA, 2012; CDC, 2015).

A repeated theme of a perceived lack of compassion and assistance from lactation consultants was heard from participants during interviews. This perceived failure of support during the first days following delivery later impacted the mothers' willingness to seek out help when *struggling* with exclusive breastfeeding. The perception of lack of caring by lactation consultants is very concerning and should be investigated.

Finally, the need to cease offering mixed messages to mothers is paramount to promoting exclusive breastfeeding to six months. This idea was identified by other authors (Ahluwalia, Morrow, D'Angelo, & Li, 2012; MacVicar, Kirkpatrick, Humphrey, & Forbes-McKay, 2015) as well as in this study. The specific concern was voiced by mothers who received formula at discharge from the hospital and who received instructions from their pediatricians to introduce solids to their infant between four-six months of age. The mixed messages created confusion and negated the mothers' intention to exclusively breastfeed for the first six months of life. Acknowledging that the journey of breastfeeding is individual and specialized for each mother/baby dyad, the baseline information must still be consistent and evidence-based following set guidelines.

Policy

State and federal breastfeeding policies should be reviewed, revised, and enforced. Lack of support for continued breastfeeding after returning to employment was noted in the literature (Hohl et al. 2016; Thet et al. 2016). Participants in this study reported a lack of knowledge regarding their rights for public and workplace breastfeeding. Participants reported being allowed to breastfeed their infants or pump their breasts at work but then were forced to do so in a non-private place or in a public bathroom. Laws that endorse public and workplace breastfeeding or pumping are state-specific but are all supportive in

their language of advocacy. Unfortunately, the message is not publicized or enforced. Methods to communicate a mother's right should be clearly stated on websites of federal and state laws.

Research

The findings of this study exposed many gaps in literature and demonstrated many avenues of future research to promote exclusive breastfeeding practices for rural women. A majority of the empirical literature concerning exclusive breastfeeding for rural populations is from international studies. The need for research focusing on rural U.S. populations was identified. Other areas that were identified as needing specific emphasis include: exploration of theory concepts, assessment of educational innovations, enculturating to breastfeeding, providing additional resources, and failing in exclusive breastfeeding.

Conclusion

The theory *seeking to do what's best for baby* is supported by scientific and theoretical literature. It helps to fill the gap in knowledge that was noted between the mothers' decision to exclusively breastfeed to six months and the end of their exclusive breastfeeding experience. The knowledge that previously exists does not fully explain the experience nor personalize the journey that occurs when exclusively breastfeeding. Additional research is called for to promote the practice of exclusive breastfeeding for both mothers and practitioners, as the lack of consistency in information and care impacts all mothers who are seeking to do what's best for baby. The issues relating to exclusive breastfeeding have not changed over the last thirty years, yet new literature identifying methods to improve the statistics are slow to emerge. This research employs grounded theory to return to the root of the problem by exploring "what is going on" and discovered several new insights that beg further exploration by all researchers to promote healthy outcomes for infants living in rural communities.

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