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The Breast-feeding Conversation
A Philosophic Exploration of Support

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Nurses play a vital role in mothers' early experiences with breast-feeding. Literature enumerates both supportive and nonsupportive behaviors, as well as the "interpersonal" aspect of breast-feeding support, although little direction is given to nurses about how to facilitate the relationship. This article conceptualizes breast-feeding support within Gadamerian hermeneutics as a conversation among nurses, mothers, and their newborns. Hermeneutically, breast-feeding conversation encompasses a text (a particular feeding at the breast), conversational partners (a mother, her newborn, and a nurse), and a dialogue that facilitates effective breast-feeding and maternal breast-feeding confidence through interpretation or understanding of the text. History and language are essential as a partnership is formed. **Key words:** *breast-feeding*, *Gadamerian hermeneutics*, *nurses*, *philosophy*, *support*

SUPPORT FROM OTHERS such as family, friends, and healthcare providers is an important aspect of breast-feeding. Nurses can be active participants in improving the health of women and children by offering support to new mothers that facilitates effective breast-feeding and maternal breast-feeding confidence. Most early breast-feeding experiences in the United States take place in a hospital on a maternal-newborn care unit under the supervision of nurses. The quality of these early experiences can influence a woman's decision to breast-feed and how long she chooses to breast-feed.[1,2] Greater understanding of how nurses can offer support is needed. This article presents a philosophic inquiry of breast-feeding support through the perspective of Gadamerian hermeneutics.[3] It is argued that breast-feeding support is a hermeneutic encounter involving a text (a particular feeding at the breast), conversational partners (a mother, her newborn, and a nurse), and a dialogue that facilitates maternal breast-feeding confidence and effective breast-feeding through interpretation or understanding of the text.

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BACKGROUND

Nursing literature abounds with sources of and directions for nurses regarding best practices for breast-feeding support of women and their newborns. Nursing literature also abounds with studies regarding nursing nonsupport of breast-feeding women, as well as women's experiences of nurses' breast-feeding support and nonsupport. Researchers have identified 4 kinds of support that nurses offer breast-feeding mothers: informational; tangible or instrumental; emotional; and interpersonal.[4–6] The best predictor of supportive behavior is a nurse's knowledge of breast-feeding,[7] along with hands-on help with positioning,[5,8] practical advice about topics such as sore nipples and engorgement,[5,8] appropriate referrals, and physical presence throughout entire first feedings.[5,6] Nonsupport is demonstrated by either nurses who fail to perform breast-feeding assessments and offer assistance, fail to follow-up after a feeding, provide

inaccurate or inconsistent education, leave materials to be read without follow-up, and provide formula as an easy solution for difficulties or those who appear too busy, unconcerned, or display negative feelings toward patients.[4–6,9,10]

This current literature seems to portray breast-feeding support as a nursing task, the goal of which is to facilitate breast-feeding through giving information, assisting the mother in getting her newborn latched correctly, and solving breast-feeding problems. Much of the literature centers on mothers' and nurses' perceptions of what nurses did or did not do. Breast-feeding support encompasses a broader vision that includes the elements of mutual respect and dialogue. Nursing literature acknowledges that women are unique and come from a wide range of backgrounds and cultures and, in addition to physical presence and guidance from nurses, recommends that nurses ask mothers what they need and follow through with an individualized plan of support.[11] According to Nelson, "professional breastfeeding support is an ever-changing science, as well as an art" for which professional education alone is inadequate.[9(p36)] Yet, no literature gives nurses direction for how to enact the human or interpersonal elements of mutual respect and dialogue with breast-feeding women. Gadamerian hermeneutics, through its emphasis on understanding through participatory conversation between nurses and their patients, provides direction as a philosophic framework for exploring breast-feeding support as a conversation.[12] A discussion of the breast-feeding conversation follows a brief overview of key concepts from Gadamerian hermeneutics. The article ends with implications of this philosophic exploration for practice and research.

GADAMERIAN HERMENEUTICS

Developed by H. G. Gadamer (1900–2002), philosophic hermeneutics is the "theory and practice of interpretation."[13(p183)] Hermeneutics first referred to the interpretation or understanding of written texts, but Gadamer extended the definition of texts to encompass works of art and human experience.[3] Within hermeneutics, understanding is the fundamental structure of the experience of being human. Hermeneutics recognizes "the interpretive character of our experience in the world"[14(p13)] and strives to help humans make sense of things. Rejecting the tendency of the scientific method to objectify the research subject, the goal of Gadamerian hermeneutics is not explanation or conceptualization "but listening to one another—for example, the listening to and belonging with . . . someone who knows how to tell a story."[15(pxi)]

Nurse researchers have used Gadamerian hermeneutics as the methodological framework for understanding and interpreting the needs of patients and clients within health environments.[12] Koch[13] interviewed a group of older men and women in order to understand their experiences of being admitted to an acute care hospital in the United Kingdom. Ford and Turner[16] investigated pediatric nurses' experiences of caring for hospitalized children with special needs and their families. Grassley and Nelms[17] explored women's experiences of breast-feeding confidence through their hermeneutic analysis of women's stories. Other nurse researchers have used Gadamerian principles to develop research methods such as hermeneutic interviewing.[18] Fleming et al[19] proposed a 5-step Gadamerian-based research method for investigation of questions related to understanding a phenomenonon. The application of Gadamerian hermeneutics extends beyond research to a framework for exploring nursing practice. Phillips[12] applied Gadamer's exposition of understanding to how nurses interpret the experiences of their patients and clients. Spence[20] explored how Gadamerian hermeneutic notions illuminated cross-cultural nursing experiences. Gadamerian hermeneutics can be a useful lens for exploring experiences of breast-feeding through the concepts of dialogue or hermeneutical conversation, history and language, prejudice, and horizon.

Dialogue or conversation

The central concept of Gadamerian hermeneutics is a dialogue or a conversation with a text. Gadamer broadened the definition of text to include not only written texts but also works of art and life experiences. He argued that the ability to understand or interpret a text takes place through the partnership of conversation and the give and take of genuine questions and answers that allow one to be present to the text, guided by the text, and open to where the text leads. "What characterizes dialogue . . . is precisely this: that in dialogue spoken language—in the process of question and answer, giving and taking, talking at cross purposes and seeing each other's point—performs the communication of meaning."[3(p368)] A Gadamerian approach enhances the nurse's ability to understand the unfolding meaning of an experience to an individual through the language of conversation. The nurse researcher or the clinician does not take a privileged position as the expert asking the questions or providing the answers but enters into a partnership with the patient/client.[12]

History and language

Each conversational partner brings history and language to the hermeneutic conversation. Interpretation is influenced by each conversational partner's history and language. History, which includes experiences, family, culture, and historical tradition, conditions the choices a person makes and the problems a person notices. As human beings situated within a time and place, we understand ourselves as members of a family, a community, and a culture. Gadamer wrote, ". . .history does not belong to us; we belong to it."[3(p276)]

As we understand our history in relationship to a particular phenomenon, we become aware of our prejudices or the frames of reference we use when encountering the world.[21] Gadamer emphasized the importance of understanding the prejudices we bring to interpretation of texts. He wrote,

> It [the hermeneutically trained mind] will make conscious the prejudices governing our own understanding, so that the text, as another's meaning can be isolated and valued on its own. . . . It is impossible to make ourselves aware of a prejudice while it is constantly operating unnoticed.[3(p299)]

To understand a text, Gadamer argued that we need to first understand our own history with the text. For example, in offering breast-feeding support, the nurse as a conversational partner with the mother and the newborn brings "the inner historicity of experience"[3(p346)] to the breast-feeding encounter. In becoming conscious of their personal, professional, and sociocultural history of breast-feeding, nurses will understand how their breast-feeding history influences how they interpret the text of a particular breast-feeding encounter.

History also determines the language a person uses about the text. Gadamer emphasized the importance of language, ". . .in language the order and structure of our experience itself is originally formed and constantly changed . . . It is from language as a medium that our whole experience of the world . . . unfolds."[3(p457)] Gadamer argued that "understanding is verbal"[3(p476)] and it is through language that we enter into a dialogue with the text. It is through our awareness and understanding of our language and the language of our conversational partners about the text that genuine dialogue takes place. We interpret the text through our language about the text. For example, describing the breast-feeding process as "supply and demand" may encourage nurses and women to interpret breast-feeding as production of a product (breast milk) rather than a relationship process.[22] History and language define the horizon or vantage point from which a person views and interprets reality.[3] "Language, history and culture create the tradition through which understanding occurs and through which we are able to understand."[18(p41)]

Fusion of horizons

Gadamer defined *horizon* as "the range of vision that includes everything that can be

seen from a particular vantage point."[3(p302)] He did not believe that one's horizon or standpoint was static. He argued that one's understanding of a text could change by engaging in conversation or dialogue with the text. He called "this coming together of different vantage points"[14(p177)] a "fusion of horizons."[3(p306)] We come to a new understanding about a text by being willing to open ourselves to the standpoint of others so that their standpoint can speak to and influence us. Gadamer wrote, "To reach an understanding in a dialogue is not merely a matter of putting one's self forward and successfully asserting one's point of view, but being transformed into a communion in which we do not remain what we were."[3(p379)] The desired outcome of the breast-feeding conversation is a fusion of horizons among the mother, her newborn, and the nurse that includes an understanding of the breast-feeding that can facilitate effective breast-feeding and enhanced maternal breast-feeding confidence. We incorporated these concepts into a model of breast-feeding support that we identified as the breast-feeding conversation, which is depicted in Figure 1.

THE BREAST-FEEDING CONVERSATION

The breast-feeding conversation is a hermeneutic encounter that takes place in the early postpartum and encompasses a text (a particular feeding at the breast), conversational partners (a mother, her newborn, and a nurse), and an understanding of the text by the conversational partners. One desired outcome of the breast-feeding conversation is *effective breast-feeding* defined as "the interactive process between mother and baby, resulting in the direct transfer of breast milk from the mother's breast to the baby in a manner and quantity adequate to meet both maternal and baby needs."[23(p334)] How a mother interprets the effectiveness of the breast-feeding influences her breast-feeding confidence or belief in her ability to adequately nourish her newborn through breast-feeding.[17,24] An effective breast-feeding will enhance a mother's confidence, whereas an ineffective breast-feeding may diminish it.[17,24–26] Although effective breast-feeding and maternal breast-feeding confidence may take time to realize, the nurse can facilitate their development through the process and

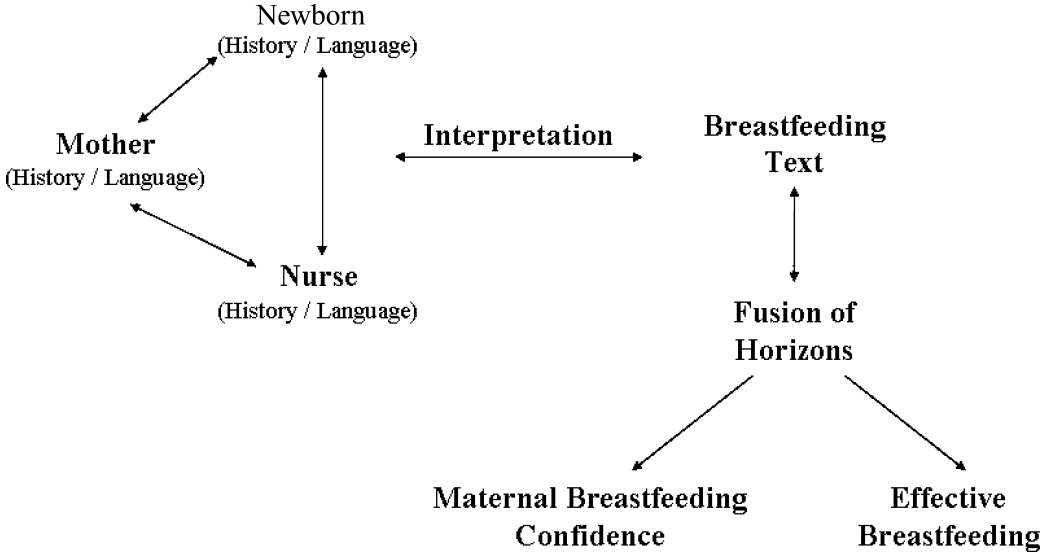

Figure 1. The breast-feeding conversation.

structure of the breast-feeding conversation. The breast-feeding conversation is not so much a way to fix breast-feeding problems as an approach to understanding the meaning for the mother of a particular problem. For example, the nurse can ask a mother whose newborn is having difficulty latching what it means to her to use a breast pump to establish her milk supply when she expected breast-feeding to be easy because it is natural.

In the breast-feeding conversation, support begins with a question-and-answer dialogue, whereby the mother, her newborn, and the nurse enter into a participative conversation with the expectation of greater understanding of the breast-feeding. Through attentive and respectful listening and thoughtful questioning, the nurse is drawn into the world of the mother's and newborn's experience of breast-feeding.[12,18] The breast-feeding conversation encourages a cocreated partnership among the mother, her newborn, and the nurse through facilitating understanding of the breast-feeding. In Gadamer's conceptualization of understanding as "both a process and a mode of being,"[20(p625)] there is potential for all participants to change through the process.[12] The nurse seeks to understand the mother and the newborn she is caring for, whereas the mother seeks to understand the situation from her horizon.[12(p91)] In this way, the mother, her baby, and the nurse are "tied together in dialogue, or fused in the process of understanding."[12(p91)]

The following example from the clinical practice of one of the authors illustrates the dynamics of the breast-feeding conversation.

I went to help a mother breast-feed her newborn whose room was full of visitors. I asked her how breast-feeding was going and her mother, who had not breast-fed, answered, "He doesn't want it." The mother described how when she would put her newborn to breast, he would either not open his mouth or push her nipple out of his mouth and fall asleep. She was thinking about giving the newborn formula. I knew from experience that some mothers expected their newborns to readily and easily breast-feed, but that some newborns had initial difficulty latching. I also knew that some newborns could be easily overwhelmed by a high level of sensory stimulation. I asked if I might help her breast-feed. She agreed. The visitors left; the room became quiet. I observed that although the newborn appeared to be sleeping, his brow was furrowed and his breathing was rapid and shallow, all possible signs of being overstimulated.[27] I shared my observations with his mother and suggested we turn the lights down and she hold the newborn skin to skin, which she did. The newborn visibly relaxed, opened his eyes, and began sucking his fists. I helped his mother position him at her breast; he opened his mouth, but kept his tongue back behind his gums. I showed his mother how to gently stroke his lips; his tongue came forward and he began to suckle.

Not all breast-feeding difficulties are solved this readily, but the story does exemplify how the breast-feeding conversation can facilitate the mother's ability to effectively breast-feed through understanding and responding to her newborn's language. The mother, her newborn, and the nurse were active conversational partners. The nurse used her clinical skills and knowledge of newborn behavior as language to engage in a dialogue with the mother and her newborn. Through listening to the mother's interpretation of the breast-feeding and by observing the newborn's behavior, the nurse was able to facilitate the mother's understanding of her newborn's language and guide her to respond appropriately.

This story illustrates the assumptions about breast-feeding that guided our conceptualization of the breast-feeding conversation. First, breast-feeding is a dynamic, embodied, and interdependent relationship between a mother and her newborn. Second, the newborn is an active and equal conversational partner through his or her breast-feeding behavior, which includes infant state, sucking competence, and consolability.[27,28] Third, the mother, her newborn, and the nurse are each active participants in the dialogue. The mother participates by observing and responding with sensitivity to her newborn's feeding cues, as well as positioning and guiding her newborn during feeding.[27] The newborn participates through his or her ability to regulate behavioral state to latch

and suckle.[27] The nurse participates by facilitating the mother's understanding of her newborn's feeding language and guiding her to position and latch her newborn.[27] Finally, the mother, her newborn, and the nurse each bring a context or horizon to the breast-feeding conversation, which has been formed by their history and language.

Mother's history and language

The mother brings a history grounded in her family's experiences with breast-feeding, her experiences breast-feeding other children, her birth experiences, and her early experiences breast-feeding this newborn. Most women growing up in the United States have limited exposure to breast-feeding because infant formula has been the feeding norm for more than 100 years.[29] Women who grew up in families in which breast-feeding was the norm are more likely to initiate and continue breast-feeding than those who did not.[17,30,31] Those who have had experience observing breast-feeding are also more likely to feel confident in their ability to breast-feed.[17,26] A previous ineffective breast-feeding experience can diminish a mother's breast-feeding confidence.[17] Nurses can talk with a new mother about her breast-feeding history by asking her to describe her experiences with breast-feeding. They can ask questions about whether her mother breast-fed her, her family's support of her decision to breast-feed, her experience observing other women breast-feed, and if she has other children, what it was like to breast-feed those children.

Before and during pregnancy, mothers construct a horizon of what they think breast-feeding will be like. They bring this horizon to their experiences of breast-feeding this newborn.[17] When breast-feeding progresses as planned or as expected, mothers report higher levels of breast-feeding self-efficacy or confidence.[24] Incongruities between expectations and experiences, however, can diminish women's breast-feeding confidence.[17,25,26,32] A woman who expects breast-feeding to be easy may interpret her newborn's difficulty latching to her breast as "he doesn't like it." She may describe breast-feeding as "it wasn't working"[33] or "breast-feeding is natural; I didn't expect problems."[17,26] Her language about milk supply may be indicative of her breast-feeding confidence.[25] By listening with intent to a mother's language about breast-feeding, the nurse can discover her concerns, perceptions, expectations, and understanding of how breast-feeding her newborn is going.[34]

Newborn's history and language

A newborn also brings a horizon formed from history and language to the breast-feeding conversation. The newborn's history includes the birth experience, gestational age, health, age at first breast-feeding, and early feeding experiences that may affect the newborn's ability to be positioned, latch, suck, and transfer milk.[23,30] Birth injuries such as a fractured clavicle, cephalhematoma, and facial nerve damage present challenges to the mother as she positions and latches her baby to her breast.[35] Newborn conditions such as cleft palate, congenital heart disease, and Down syndrome can influence a newborn's ability to latch, suckle, and transfer milk.[36] Newborns who are preterm and their mothers encounter numerous barriers to successful breast-feeding owing to their physiologic and metabolic differences.[37]

The newborn also brings his or her early experiences with breast-feeding. A newborn held skin to skin and who latches and suckles in the first hour after birth has an increased chance of initiating effective breast-feeding.[30,38,39] Positive early feeding experiences enhance a mother's breast-feeding confidence.[17,25,26] Introduction of artificial nipples such as pacifiers and bottles can adversely affect the newborn's ability to effectively latch and suckle at the breast and is correlated with early termination of breast-feeding.[40]

Although newborns lack verbal language, they communicate their needs through their behavioral language of infant state, consolability, and sucking competence. Nurses can teach parents to view their newborns'

behavior as language.[27] *Infant state* is defined as the level of wakefulness or sleepiness.[41] State determines how responsive the newborn will be to the environment and provides a framework for observing newborn behavior. Wolff[41] identified 7 infant states that have been refined by researchers into 6 states: quiet sleep, active sleep, drowsy, quiet alert, active alert, and crying. Each state is defined by specific characteristics of newborn motor activity, level of consciousness, respiration, and responsiveness to stimuli. For example, characteristics of the quiet alert state include minimal body movement, regular respirations, eyes that are open and bright, and attention to stimuli.[42] Because newborns respond best to their environment in the quiet alert state, this is the infant state that provides the most optimal opportunity for initiating feeding. In the first hours after birth, most newborns spend an extended period in this state,[42] so mothers are encouraged to initiate breast-feeding as soon after the birth as possible. Early initiation of breast-feeding predicts increased duration of breast-feeding.[30,43]

Newborns' ability to regulate infant state facilitates effective breast-feeding.[27] A newborn who is sleepy may not latch or feed well initially, lose too much weight, and then need to be supplemented.[35] A newborn in the active alert or crying state may seem to be fighting at the breast and have difficulty breast-feeding effectively.[28,44,45] Newborns also signal when they are having difficulty managing environmental stimulation with behaviors that parents may misinterpret. Parents may misunderstand yawns as sleepiness, sneezes as getting a cold, or gaze aversion as "the baby doesn't like me." Some newborns signal that they are stressed by closing their eyes, which parents may misinterpret as being asleep.[27]

Consolability refers to the newborn's responsiveness to efforts to be soothed or "settled."[36,42] The newborn may use self-consoling measures such as hand-to-mouth movements and sucking on fingers, fist, or tongue. Consolability is important to breast-feeding because crying newborns do not latch well. Crying newborns may arch their back or push away from their mother's breast as well as keep their tongue up and at the back of the mouth, neither of which are conducive to a correct latch. The ability to either self-console or be readily consoled by the mother facilitates effective breast-feeding.[28]

Sucking competence is essential to effective breast-feeding because it is the mechanism by which the newborn expresses milk from the breast. To achieve sucking competence, the newborn must exhibit normal characteristics of the jaw and the tongue as well as master the mechanics of sucking.[44] Researchers observed that younger newborns had better sucking ability than older newborns, which supports the importance of early breast-feeding experiences.[44]

The newborn's breast-feeding language influences the mother's interpretation of the breast-feeding experience.[17,25,26,28,32] A newborn who is unsettled or difficult to console may undermine a mother's breast-feeding confidence.[17,25,26] If her newborn does not seem satisfied with the breast-feeding experience or readily takes a bottle, the mother may perceive that her milk supply is inadequate and that her baby prefers formula.[17,25,26,45] Lothian[28] concluded that infant characteristics and breast-feeding competence were the most important factors influencing breast-feeding duration. The newborn's behavioral responses to breast-feeding influence a mother's interpretation of her ability to effectively breast-feed.

Nurse's history and language

Nurses bring their personal and professional breast-feeding history to the support of new mothers.

> As a result of our education and socialisation as nurses we are collectively oriented towards understanding the problems we care for in a certain way. At the same time our preconceptions are shaped by a myriad of understandings shaped from our individual life stories.[12(p91)]

History influences the sources of knowledge that nurses use when offering breast-feeding support. These include their own breast-feeding experience, attending

workshops, research, colleagues' advice, and hospital policies.[46] Nelson[9] concluded from her interviews of 12 maternal-newborn nurses that the nature of a nurse's experience with baby feeding influenced the support she offered a new mother. Those who had breast-fed described the "connection" they felt with mothers who were breast-feeding.[9(p33)] Those who had formula-fed their children said that they would tell mothers, if asked, that formula would not harm their children. Nurses often rely on what has worked well for them in the past.[9,46,47] However, this may not reflect current best practices, nor be relevant to the current breast-feeding conversation. For example, in several studies, mothers reported that nurses offered inconsistent advice and often recommended giving the newborn a bottle if breast-feeding was not going well.[6,28] Differing breast-feeding histories can produce conflicts and frustrations among staff,[9,46] as well as inconsistencies that confuse new mothers and adversely affect effective breast-feeding and diminish breast-feeding confidence.[6,17,25,33]

The language the nurse uses while interpreting the breast-feeding interaction influences a mother's breast-feeding confidence. Nurses communicate their own expectations about breast-feeding through their language. Mothers experienced dissonance when nurses' language differed from their experiences. One mother commented, "You are told over and over that there is only pain if the baby is not latched properly ... I beg to differ."[25(p793)] Another study participant wrote, "[breast-feeding] is portrayed as being natural and therefore easy when it is not."[25(793)] Dykes,[22] in her ethnographic study of women's early breast-feeding experiences on a maternity unit in the United Kingdom, found that the language used by midwives when offering breast-feeding support reinforced new mothers' concept of their bodies as machines. She concluded that this language diminished mothers' confidence in their ability to breast-feed.[22] Not all studies focused on nurses' unsupportive language. Gill,[5] in comparing mothers' and nurses' perceptions of breast-feeding support in the early postpartum, found that nurses' words of encouragement bolstered mothers' breast-feeding confidence. The importance of affirmation to breast-feeding mothers was supported by Kingston et al[48] in their study of breast-feeding self-efficacy enhancing experiences. They found that mothers who received praise from their partners or own mothers had significantly higher levels of breast-feeding self-efficacy (or confidence).[48]

Nurses communicate their expectations about support through their language. Although studies consistently have found that mothers want nurses to stay with them during their initial breast-feeding experiences,[5,6] a nurse in one study expressed why she did not think this was necessary. She commented, "Breastfeeding is not that difficult. Moms just need to read the information that we give them."[5(p407)] Mothers can interpret language such as this as unsupportive. One mother who participated in this study said, "I don't think they really cared if I breastfed or not. When I was having problems, they told me to give her sugar water for now, that she would catch on in a few days."[5(p407)]

Fusion of horizons

The conversational partners—the mother, her newborn, and the nurse—bring a horizon formed by their history and language, which influences their interpretation of the breast-feeding text. By becoming aware of the horizon they bring to breast-feeding, nurses can offer more effective support to the breast-feeding dyad as illustrated by the following story from a clinical practice experience of one of the authors:

In my experience, many Latinas choose to supplement their breast-feeding with formula in the early postpartum. One busy weekend one of my patients, a Latina, had designated her feeding preference for her second baby as breast and bottle. I interpreted this choice as "it's her cultural belief" and did not consider her a priority for my support that day. I found out that my assumptions about her feeding choice were incorrect. When I finally took

the time to enter into a breast-feeding conversation with her, I discovered the history of her choice. Her first child, whom she had exclusively breast-fed in the early postpartum, had been readmitted to the hospital for jaundice. She had been told by the physicians and nurses that the jaundice was caused by her inadequate milk supply. She decided this was not going to happen with this newborn, so she chose to supplement her breast-feeding from the beginning. I was then able to offer her support and reassurance as I helped her breast-feed her newborn. I based my erroneous first interpretation on what I thought I knew about her culture; she based her decision on a past experience with breast-feeding. By taking the time to dialogue with her, a fusion of horizons occurred and I was able to help her effectively breast-feed.

This story also illustrates that the horizon one brings to the breast-feeding conversation is not static, but it expands and changes during conversation with the text.[12] The fusion of horizons occurs as the mother, her newborn, and the nurse engage in a dialogue with the text of an individual feeding and create a partnership that facilitates understanding and meaning of breast-feeding and enhances maternal breast-feeding confidence. Even if we as nurses have encountered a particular breast-feeding problem before and think we know how to "fix it," we do not know what the problem means for this mother at this time.[12]

The breast-feeding conversation provides a process and structure for support through dialogue with the text of a breast-feeding. Through the give and take of open-ended questions, mothers and nurses can cocreate an understanding of what is going on in a particular breast-feeding conversation. Possible questions that nurses could ask mothers as they enter the breast-feeding conversation include: "What's breast-feeding like for you? What have you noticed about your newborn's responses when breast-feeding? How does your newborn tell you it's time to breast-feed? What experiences have you had with breast-feeding? What were your expectations of how breast-feeding should go? How has your experience been different?" The nurse might also ponder: "How do I understand the newborn's breast-feeding behavior? How can I facilitate this mother's understanding of her newborn's breast-feeding behavior? How can I facilitate effective breast-feeding and maternal breast-feeding confidence?" If the mother and the newborn are having difficulties with breast-feeding, the nurse can inquire with the mother how she understands the problem and its meaning for her experience.

IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH

This philosophic exploration of breast-feeding support as a hermeneutic conversation informs nursing practice and research. In practice, we encourage maternal-newborn nurses to conceptualize their role as conversational partner rather than as the expert giving advice or teaching the mother about breast-feeding. Although nurses need to know and communicate current best practices as part of their breast-feeding support, they can create partnerships with mothers that acknowledge and validate mothers' experiences. By engaging in the give and take of dialogue, they empower mothers to become the experts of breast-feeding their newborns by understanding their newborns' responses to breast-feeding.[17,26,49]

The breast-feeding conversation through its concepts of language and history also informs nursing practice. Nurses' language is a powerful clinical tool.[49] Nurses need to be aware of their own language because mothers are sensitive to what nurses say about breast-feeding and how they say it.[22,25,26] Listening to a mother's language also can assist nurses in understanding her perceptions of the support she is receiving. Nurses need to listen for mothers' descriptions of conflicting advice from nurses,[6,9,25] such as whether nurses have recommended giving her baby a bottle of formula.[6,25] The breast-feeding conversation also suggests that nurses need to be aware of how their personal and professional history influences the breast-feeding support they offer. The nursing literature acknowledges that nurses' history influences

how they interpret a particular breast-feeding conversation.[9]

This philosophic exploration also suggests areas for research. To explore the breast-feeding conversation as a model of support, an ethnographic study of the mother-newborn-nurse interaction during breast-feeding could take place on a maternal-newborn hospital unit. Data collection strategies could include participant observations of these encounters and interviews with mothers and nurses. Similar studies of breast-feeding support have been reported in the literature,[5,22,26] and this study would focus on analysis of the dialogue that occurred, particularly attending to the language and history of the conversational partners. To identify language that may facilitate the creation of a supportive partnership with new mothers and their newborns, breast-feeding interactions between the mother, her newborn, and the nurse could be videotaped at the bedside and analyzed using content analysis of the language used by the mother and the nurse to interpret the newborn's breast-feeding language. Researchers have used this strategy to investigate the role of "chatting" between mothers and nurses in the neonatal intensive care unit,[49] as well as describe the role of the relational conversation in creating partnerships between advanced practice nurses and caregivers.[34] To investigate this approach, nurses could be introduced to the breast-feeding conversation and encouraged to incorporate it into their support of new mothers. Mothers and nurses could then be interviewed about their perceptions of its effectiveness. The influence of gender on the nurse's horizon has not been addressed in the literature and would be a potential area for research. Although from the literature and our own clinical experience, we have observed that men do not tend to practice in maternal-newborn settings. They do work in the neonatal intensive care unit and may encounter breast-feeding there. Although we believe that engaging in a hermeneutic conversation with patients is not dependent on gender,[12] including male nurses in a study of the breast-feeding conversation might provide helpful insights into the influence of gender on the horizon nurses bring to the interpretation of the breast-feeding.

CONCLUSION

Nurses play a vital role in mothers' early experiences with breast-feeding. Through its concepts of dialogue, history and language, and fusion of horizons, Gadmerian hermeneutics informs nurses about the support they offer new mothers. Breast-feeding support is more than giving new mothers information and helping them correctly position and latch their newborn to their breast, although these are important. Breast-feeding support involves creating a partnership with mothers that acknowledges and validates her interpretation of their newborn's responses. Through dialogue, nurses empower mothers to become the expert of breast-feeding their newborn.

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