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Feeding Issues for Mothers of Very Low-Birth-Weight, Premature Infants Through the First Year

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Adequate feeding is an area of concern for both clinicians and parents of very low-birth-weight, premature infants while in the special-care nursery and through at least the first postterm year. How feeding issues are labeled or described may make a difference in the effectiveness with which they are addressed by families and professionals. Internal working models of parenting offer a framework to explore meaning (goals, expectations, and intentions) and to evaluate progress in addressing feeding issues, viewed from the perspective of both the nurse and the family. Three case studies are presented to illustrate the framework, as used by nurses, to assess the adequacy of the infant's nutrient intake in the first year post birth. Questions are raised for further study.
Key words: *adequacy of nutrient intake*, *feeding concerns*, *internal working model*, *premature infants*, *very low-birth-weight infants*

FEEDING and nutrient intake is a concern for both mothers and clinicians of very low-birth-weight (VLBW), premature infants through at least the first postterm year.[1–8] A major goal of nurses and physicians who provide care for VLBW infants, either in hospital or in the home, is to ensure that nutritional intake meets requirements for adequate growth.[9–12]

Little is known about feeding issues (ie, feeding problems, challenges, or goals that are in the forefront of thought and perhaps action) from the perspective of either mothers or nurses. Nurses, in general, limit their documentation regarding infant feeding to clinical problems (eg, trouble coordinating sucking, swallowing, and breathing; regurgitation). For the most part, feeding issues, from a mother's perspective, are described in published studies at only a topical level (eg, how much formula the baby takes, how frequently the baby feeds, choking or coughing during the feeding).[3,6] What is lacking is description of the meaning of these issues and the experiences mothers have in dealing with them on their own, with family members, or with clinicians. On the whole, the family or personal context of a feeding issue is rarely documented. This context includes who is contributing to the meaning of a feeding for a mother as well as who is helping her with

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the feeding. The context also includes the history of the infant's feeding that a mother has experienced and the scope of her current, anticipated, and desired responsibilities. As a case in point, nurses who work with a breastfeeding mother may be aware of the perspectives of family members regarding her concern about the adequacy of her supply of breast milk for her VLBW infant. What the nurses have learned, however, may be lost in a topical labeling of her concern, for example, as "inadequate breast milk supply."

Understanding of the meaning feeding has for mothers of VLBW infants, how they deal with issues through time, and the context in which issues are experienced could help nurses to better understand mothers' experiences and their needs for guidance and to offer problem-solving support tailored for a specific mother. However, means of efficiently describing the meaning of feeding issues for mothers, how mothers manage them through time, and the family and personal context in which mothers experience them have not been available. We propose that a concept of the internal working model may help nurses to explore with mothers the meaning, management over time, and the personal and social context of feeding issues.

INTERNAL WORKING MODELS OF PARENTING

A *working model* is an internal or mental model of experience that operates in relation to events to regulate goal-directed thought and action. An example of a goal of an internal working model of parenting is giving safe and nurturing care to the very young, VLBW baby. Evidence for and components of a mother's working model of parenting were described initially in relation to processes of forming an attachment relationship by Bowlby[13,14] and later by Solomon and George.[15] A working model regulates maternal thought and action by directing and shaping perception, interpreting the information that is received, evaluating the significance of what is happening, and forming intentions and plans of action.[16] Working model components that operate in the process of regulating thought and action include expectations of how things should be and how they are likely to be; intentions concerning these expectations; and plans of action, including strategies and explanations for them. Expectations concern the infant and the mother in relation to the infant, the parenting task of concern, and other people who may be involved with the mother in the task (eg, feeding). A mother's motivations, feelings, thoughts, and feeding behaviors are functions of her internal working model. A working model is constructed and reconstructed through experience, including relationships with and the guidance of others, and response to changing need. The working model operates actively during a feeding and is likely to be in a mother's conscious awareness whenever a challenge to feeding goals is confronted. For example, a mother who expects herself to feed her infant the prescribed amount of formula may intend to adjust her feeding strategies if the goal is important to her or, depending on what she expects of her infant, she may persist in her feeding strategy if her intentions for feeding offer little latitude for adaptation.

A mother's working model is revealed in her description of the feeding experience and the meaning it has for her.[17,18] Meaning includes the motivation, feelings, and goals she describes or implies in the outcomes she wants to see or in the things she wants to avoid, resolve, or overcome. As a mother describes her goals (eg, what she wants to happen or what she wants to do), her expectations of what she wants or anticipates will happen and what she intends to do in light of her expectations become evident. Her explanations of the strategies she uses to deal with feeding issues also reveal expectations and intentions and the goals to which they are linked. The purpose of this report was to describe feeding issues for mothers of VLBW infants through the infant's first postterm year (ie, age adjusted for prematurity) using narrative data from a nurse intervention study. This description was constructed in terms of mothers' working

model of parenting within family and personal contexts.

METHOD

The 3 mothers whose feeding issues are described in this report were participants in the treatment group of a randomized, clinical intervention study. Mothers who were recruited to this study gave signed informed consent to participate about the time the infant was beginning to be fed primarily by gavage. Participating mothers in the original study ranged in age from 19 to 35 years, had 8 to 21 years of formal education, and had 1 to 6 children, including the VLBW infant. The 3 mothers selected for the case study ranged in age from 19 to 31 years, had 11 to 14 years of formal education, and 1 or 2 children.

The intervention study began immediately after study enrollment and continued, after the infant's discharge to home, through the first 12 months, postterm age. The relationship-based intervention was provided to a family by a specific nurse through the duration of a mother's participation. The intervention was designed to support a mother's development of competencies for feeding a VLBW, premature infant through guided participation in feeding experiences that were viewed from the perspective of her life circumstances. Intended outcomes, in addition to maternal feeding competencies, included the infant's development of feeding competencies (K. Pridham, R. Brown, R. Clark, et al, and the Feeding Support Research Team, unpublished data, 2004). The nurse made weekly home visits through at least the first month after the infant's hospital stay. Through the remainder of the first postterm year, visits were made at weekly, biweekly, or monthly intervals, depending on the infant's condition, family circumstances, the mother's availability, and the extent of her need to develop feeding competencies. The nurse made telephone calls between visits to answer questions and problem-solve concerns.

For each visit made in hospital and home and for each telephone call during which any guidance was provided, the nurse completed a structured field note. This note included the issues that the mother and the nurse discussed and the nurse observed, and was written to review the mother's feeding expectations and intentions as she described them and the guided participation that had occurred and to define next steps. Issues concerned being with the baby, knowing the baby, caregiving (eg, feeding), or communicating and problem solving with family members and clinicians. The nurse recorded whether she and the mother had shared attention to an issue and moved to understanding, clarifying, making connections, and problem solving the issue. The field note included information about the family context (eg, changes in membership or housing, health of family members, and concerns about family circumstances). The field notes on 3 families were the basis for this case report.

Selection of cases

For the selection of the 3 cases for this report, we reviewed the field notes for 17 of the 24 mothers who had participated in the intervention through the infant's 12th month. Five of these mothers were very occupied with family and personal circumstances and had little energy to attend to feeding issues, either self- or nurse-identified. Within the remaining 12 cases, we identified 2 major types of family and personal contexts, defined by stability or its lack in relationships, living arrangements, and social and economic resources. With these 2 types of family and personal contexts in mind, we selected 3 cases that illustrated variations in working models of parenting when the adequacy of the infant's feeding was a foremost concern. One nurse worked with 2 of the families. A second nurse worked with the third family.

Case analysis

The analysis of case material was guided by the general principles outlined by Miles and Huberman.[19] For each mother, the field notes for the entire study period were read for identification of feeding issues and description of

the working model of parenting in relation to feeding. This description was sometimes expressed by the mother in her own words and sometimes expressed in the observations and summary of the nurse. The description included, to the extent of documentation, components of the mother's working model, including her motivation, agenda, or goal; her expectations and intentions; the strategies she used; and her explanations of strategies. When a feeding issue was identified, it was followed through the field notes for subsequent visits. The working model description was elaborated as additional information became available and as the feeding issue evolved with the passage of time and accrued experience of infant and mother. The nurse's interpretation of and conjectures about the mother's description of working model components were also coded.

Case studies

Melanie, Regis, and their son Mark

At the first encounter in the special-care nursery, Melanie told the nurse that she was trying to breastfeed her then 32-week-old (postconceptional age [PCA]) infant and anticipated that she would be disappointed in her goal. She indicated her commitment to breastfeeding by her intention to do whatever was recommended, including increasing her fluid intake and pumping her breasts around the clock. Despite the strategies that she used to increase her milk supply, she continued to express disappointment in what she produced, indicated lack of confidence in her ability to meet her expectations for herself, and raised questions about breast-fed babies gaining weight more slowly than did bottle-fed babies. She eagerly accepted the input of the nurse and the opportunities she provided to get to know her baby. Melanie reported that, on occasion, Mark would not nurse and then was fed by bottle. Regis enjoyed giving Mark a bottle on these occasions. After 3 weeks, and just before hospital discharge, Melanie said that she was not pumping regularly because she was only getting a few drops when she pumped. Melanie's waning expectation of successfully breastfeeding Mark and of Mark being a good breastfeeder was reflected in the diminishing importance of breastfeeding. Melanie did not mention support from her husband and the nursery staff as a factor in the maintenance of her goal, although the nurse thought it might be. Melanie's expectations of Mark had been colored by his slowness to progress in nipple feeding because of chronic lung disease and respiratory compromise during feeding. Her strategies to promote breastfeeding had not changed, but she was less committed to employing them, given the expectation that they would make little difference.

By the time the nurse made a home visit a few days after Mark's discharge from the nursery, Melanie had stopped breastfeeding. Both parents had observed that Mark had more skill in coordinating and pacing sucking and swallowing. They attributed his progress to their strategy of finding a nipple and a bottle that resulted in lower flow and Mark's need to organize his sucking. Melanie described Mark's feedings in terms that made clear her expectations of her baby's ability to handle new things and of her own ability to figure out his preferences, a sign of her growing confidence in her caregiving competency. Melanie also pointed out differences between the ways she and Regis fed Mark and, in the process, indicated that she fed her baby in a cradled position that allowed her to experience the motherly feelings that she expected to have and that allowed Mark to experience the closeness that he needed from her in order to feed.

In several weeks, Melanie was getting ready to go back to work. Her goal then was more patterned feedings, both for her own convenience and to be able to enjoy Mark during a predictable awake period in the evening. She explained her ongoing experimentation with nipples and feeding bottles in terms of finding a system that would not be a big effort for Mark and that would support coordinated sucking, swallowing, and breathing. She rejected one feeding bottle that did not permit her to see the amount Mark had taken as he fed, indicating that the adequacy of a feeding and, perhaps, efficient feeding were feeding issues for her then.

At this time, with encouragement from the nurse, Melanie described her feelings about feeding Mark in the hospital and her observation that he fed better with his father. Melanie said,

> . . . I just figured it was because Regis was more comfortable with [feeding]. And then the other thing was that, when Mark was near me and I was breastfeeding for awhile, that maybe it was kind of confusing to

him. And I had heard some other people [say] that babies don't always take bottles well from their mothers if they do breastfeed. So it didn't bother me. I just felt that Regis was more comfortable. Now, once Mark has been home, I don't know what my response would be if Regis could feed him better. I don't think it would bother me if other people could feed him as well as I can. [But if other people could feed him better], then I would start to think about that maybe I need to go with his needs instead of the clinical, you know the way that we were told to try and feed him. [I would] try and think about what did they [the people who could feed better than she] do that was different that he liked . . . . Then I'd like to try that with him.

The meaning of the breastfeeding issue for Melanie and her seeming readiness to give it up despite declared intentions to do everything she could to be successful at it may have had something to do with her expectations of herself as being as competent as other feeders. Her discomfort during breastfeeding sessions was, to Melanie, evidence of her lack of competence, especially in light of her husband's apparent comfort and competence. Her strategy, given her expectations of herself, was to use a method (ie, formula feeding) that she could master technically. She soon realized that she surpassed her husband in skill because she had greater opportunity and patience for trying new approaches and observing Mark's responses. In sum, exploration of Melanie's working model expectations in relation to Mark's feedings indicated 3 intertwined goals: (*a*) successfully feeding Mark in terms of an adequate amount taken efficiently; (*b*) feeding Mark as competently as other feeders, including his father; and (*c*) feeling close to Mark and motherly as she fed him.

Stella, Kenneth, and their daughter Daphne

Daphne was Stella and Kenneth's first-born baby after 5 pregnancy losses. Stella found it difficult to be confident of Daphne's viability and held back on getting close to her emotionally. Kenneth, on the other hand, said that the moment he held Daphne, he had fallen in love with her. Kangaroo care was offered to Stella to help her feel close to Daphne and to support her goal of breastfeeding. Stella became very tired with working a demanding job, pumping her breasts, and coming to the hospital to do kangaroo care and quit attempting to supply breast milk just before Daphne came home from the hospital at 36 weeks, 10 weeks after her birth, on supplemental oxygen.

After several weeks of getting acquainted with Daphne's need for breathing support during bottle feeding, Stella described Daphne's feedings as being more organized. She was generally very eager to feed, her suck was stronger, she took less time to feed, and Stella was confident that Daphne would take the prescribed amount. She expected Daphne to have preferences for her feeding, and tried to accommodate them. Stella had learned not to keep Daphne waiting for a feeding, and was giving her help to get organized when she seemed frantic at the beginning of the feeding. She wondered if Daphne might think her grandmother, Stella's mother, who provided day care was her mom.

Daphne continued to present behavior that puzzled her mother or challenged her expectations for her baby. Stella expected herself to learn how to meet Daphne's special needs, and asked the nurse questions about what she was observing, including occasional decreased intake. She expected Daphne to be a reasonably good spoon feeder, as a sign of her developmental intactness, by the end of her fifth postterm month and worked hard to help her daughter master the spoon. Daphne grew steadily in weight at the 50th percentile through her fourth postterm month despite regular spitting up after feedings. However, in her fifth month, Daphne's weight dropped from the 50th percentile. Both parents were perplexed about her disinterest in feeding and much lower formula intake while she continued to take about the same amount of cereal, fruit, and vegetables from a spoon. By the end of her fifth month, Daphne had an acute care visit for respiratory symptoms to her primary care physician. Daphne had been aspirating gastric contents and was treated medically for gastro-esophageal reflux.

Poor nutrient intake and growth continued despite Stella's attention to what Daphne was taking in and both parents' concern about the adequacy of day-care providers to feed her carefully. Stella made it clear that she expected to carefully monitor Daphne's intake. She said that increasing the amount that Daphne took in was the most important thing for her to accomplish. Although she was persisting in her goal, she revealed that she was not confident of her ability to make a difference. She felt inexperienced and sometimes disagreed with Kenneth on approaches to increase intake. Stella expected Daphne to indicate hunger by crying, whereas Kenneth expected that Daphne

should not have to fuss. His strategy was to offer a bottle every 2 to 3 hours. The problem of inadequate intake, and consequent, growth faltering, could not be solved simply by increasing the number of formula feedings, the amount or caloric density of formula fed, or the amount of solid food given to Daphne. Stella commented:

> I wish I had more time. I pick her up from the babysitter, and it is run, run, run. We have 100 things to do. Then it is feed her and give her a bath. I always want to be with her when I am not. Then when I am, I am always rushed. There is just not enough time.

In sum, for Stella, the feeding issue of increasing Daphne's intake, although seemingly straightforward, was complicated by the infant's physiologic condition of gastro-esophageal reflux and its effects on feeding behavior. The feeding issue was also complicated by Stella's self-expectations of being on top of her daughter's needs and her expectations of a normal developmental course for Daphne. Both she and Kenneth expected that Daphne's intake problem would be managed without resorting to tube feeding or a gastrostomy. Stella was intimidated by her sense of being a novice, and did not expect that she could influence the family members who were Daphne's day-care providers about infant feeding practices.

When Daphne's intake of solid foods was severely decreased, medical management for treatment of Daphne's gastro-esophageal reflux and to reduce inflammation in her esophagus was intensified. To Stella and Kenneth, Daphne's behavior and physiologic condition were not only unexpected but also distressing because of what they portended about her well-being, her future, and the care she would need. Stella persisted in exploring foods that Daphne would take and in arranging a meal to support intake. She could not bring herself, however, to encourage Daphne's interest in self-feeding because she was worried that her daughter might choke on food that was not given by her mother. Stella's goal of increasing nutrient intake continued through the first postterm year. This goal, however, was complemented by a parallel goal of staying committed to increasing Daphne's nutrient intake and, at the same time, to make her daughter's feedings fun for her. Daphne's enjoyment of her mother during the feeding was evident to the nurse. The nurse hypothesized that Daphne's enjoyment reinforced Stella's intentions.

Jacquie and Chelsea

When Jacquie brought Chelsea home to her apartment, she felt "terribly alone" with her baby's care. She had recently moved to a safer neighborhood with her 3-year-old daughter across the city from her mother, grandmother, and older sister. Still in her teens, Jacquie's expectations may have been as confusing to her as they sounded to the nurse. At the first home visit, when Chelsea, born at 27 weeks' gestational age, was 37 weeks' PCA, Jacquie expected her baby to want to eat all the time, whether she was hungry or not. Jacquie was not sure about what she should be expecting of herself. She expected her baby to love her, but knew that Chelsea should be getting love from her instead of her getting love from her baby daughter. Jacquie thought that her baby might be trying to get to know her mother, and added, "I haven't known her really, and she's been out of my stomach for two months." A month later, Jacquie described Chelsea, now 41 weeks' PCA, as a "bad baby" who willfully pushed the bottle out of her mother's hands and as "mean" when she grabbed at her mother's face. Jacquie was opposed to thinking of her baby's age in terms of her prematurity and instead made feeding decisions, including feeding solid foods, based on chronological age. She explained that thinking of her daughter in terms of her age corrected for 13 weeks of prematurity would result in Chelsea being able to do less. If Jacquie thought of Chelsea as being at her uncorrected age she would have higher expectations for her daughter that would result in advanced development. She was, for example, expecting Chelsea to walk at 12 months of age, uncorrected for prematurity.

Jacquie was, in general, too preoccupied with getting through a day, her own chronic illness, and hardships of her life to pay attention to details of Chelsea's feedings. She had not made an appointment with Chelsea's primary care physician for a well-baby checkup, and was not giving her the medications prescribed for gastro-esophageal reflux. These medications were to be given half an hour before a feeding, but Jacquie said she could not predict the time of her baby's feeding. She could not give a reason for not having made an appointment for Chelsea's well-baby checkup. Jacquie talked about not having a choice in Chelsea's physician, and expected not to have much power because she was African American, young, and single with 2 children.

With the nurse's support and encouragement, Jacquie showed interest in learning what her baby's behavior meant. She was particularly invested in observing Chelsea's positive responses to her actions (eg, holding Chelsea's finger helped her calm) and in figuring out what her baby's behavior indicated she wanted. Jacquie continued to assert that she could not "make [Chelsea] do anything, because she still has a mind of her own and she's a difficult baby." At the same time, Jacquie explained, "I overfeed her sometimes and she sleeps all day long. I overfeed her at nighttime and she sleeps all night long. That's the good part about it—stuffing her. And it helps her reflux, too." Jacquie recognized that her strategy had undesired as well as desired effects in relation to her goal of supporting her baby's developmental accomplishments.

At 5 months, Chelsea's percentiles of weight, length, and head circumference began to drop on the growth graph, which generated the nurse's question about the amount and type of the baby's feedings. Initially, Jacquie attributed Chelsea's poor growth to teething. However, when her baby's gain of only 6 oz in the previous month was brought to her attention, Jacquie said to Chelsea, "You didn't gain any weight! What's wrong with you, girl? You look fatter." With the nurse's assistance in structuring problem solving, Jacquie thought about Chelsea's recent acute illness as another potential reason for poor weight gain. At this point, Jacquie questioned the adequacy of Chelsea's caloric intake and her own feeding practice:

> Maybe I should just start feeding her early in the morning and then later in the evening, 'cause probably for her age, she's not getting enough calories . . . She tells me when she's hungry . . . Sometimes, you know, if I have the urge to just go feed her, she'd probably take it. If she didn't, then she wasn't hungry.

Although Chelsea's behavior did not indicate hunger, she took a half jar of pureed fruit and about 2 oz of formula. Jacquie and the nurse continued to explore foods that would support Chelsea's growth and Jacquie indicated her intentions to modify the foods she had been giving her daughter. A few days later, Jacquie provided a 24-hour food record that indicated adequate intake of developmentally appropriate foods, for the most part.

Two weeks later, when Chelsea was $6^1/_2$ months old, her growth graph showed that her weight percentile was no longer dropping and her weight trajectory had become level. Jacquie commented that Chelsea would start to grow in head and length, and, if she continued to eat the way she had been, she'd be a pretty big baby soon. Jacquie was surprised and pleased at how well Chelsea took table foods, such as soft cheese, that the nurse had suggested. When Chelsea developed an acute respiratory illness, Jacquie anticipated that it might affect her appetite, and identified criteria for having her baby seen by her primary care physician.

Evidence that Jacquie's expectation of having little capacity to influence outcomes, including her daughter's dietary intake, was modified was demonstrated in her intention to try feeding Chelsea more often and to offer her nutritionally dense foods. The evidence of her success was tangibly presented in the growth graphs that the nurse shared with her. Jacquie's goal of feeding Chelsea an adequate amount for growth made it necessary for her to think about what foods her baby could manage and utilize from a developmental perspective. Her expectations for accomplishing this, which were based on arbitrarily defined criteria of achievement, had to be replaced with expectations in keeping with Chelsea's oral-motor, hand-mouth, postural, and communication abilities. Growth lag in weight, length, and head circumference was in conflict with Jacquie's aim of having a robust, competent daughter, and made grappling with the issue of adequate nutrient intake of developmentally appropriate foods an important goal. Although Jacquie continued to experience challenges, including working on her high-school diploma and taking a job, and to falter in her provision of adequate nutrition to Chelsea, she now had a history of having had the power to influence events and outcomes for her daughter that she could recall.

In sum, the adequacy of an infant's feeding may be a concern to mothers through a VLBW, premature infant's first postterm year. However, what this concern means may vary widely from mother to mother, depending on the personal and social contexts. For the first mother, Melanie, the meaning of the adequacy of her infant's feeding included the expectation that she would be more competent in feeding than were others and, somewhat later as the time to go back to work drew near, that her baby could feed efficiently

with a suitable nipple and feeding technique. For Stella, a decline in her infant's feeding adequacy resulted in expectations of herself as being needed to maintain her daughter's interest in feeding, despite a sense of uncertainty about her own competence and usefulness to her. Jacquie, the third mother, was engaged in modifying her expectations for her daughter's developmental capabilities when she was confronted with the baby's faltering growth. She developed an expectation of herself as having an effect on her daughter's growth by improving the adequacy of her nutrient intake when she could see the change in the growth graph.

DISCUSSION

Although all 3 mothers of VLBW, premature infants in the cases had to deal, in some form, with the adequacy of the amount of their infant's nutrient intake, its meaning to the mother and its family and personal contexts differed considerably from one mother to another and at various times throughout the first postterm year. However, for all 3 mothers, a coherent sense of the feeding issue could be obtained by exploring the mother's working model of parenting in relation to feeding adequacy. Working model components, summarized by the meaning of a feeding issue to a mother, include motivations, feelings, goals, expectations, intention, and strategies. A mother is likely to describe these components as she tells her story of how things are going for her and her baby, what she wants and expects to happen, what she intends to do and what she does, and what makes things difficult or easy.

In general, clinicians who take the traditional problem-solving approach to a feeding issue, such as adequacy of nutrient intake, expect to complete the process and conclude the problem solving in one or a few clinical encounters. These cases show that feeding VLBW infants may be a long and challenging process for mothers. Using the concept of internal working models of parenting may help nurses to understand each unique situation in order to effectively guide and teach individual parents.[20] Motivations, goals, expectations, and intentions are a function of personal and social circumstances, and are likely to change over time.

Nurses' understanding of feeding issues, such as adequacy of nutrient intake, can be extended by study of mothers' descriptions of their working models of parenting in relation to feeding. However, many questions concerning working models and their usefulness in understanding feeding issues from a mother's perspective remain to be answered. One question concerns the kind of clinical settings, encounters, relationships, and documentation or reflection that permit learning about a mother's working model of parenting. Nursing strategies that best help mothers describe their working models relative to infant feeding remain to be identified but may include opportunities to tell in detail and with as much specificity as a mother can manage what feeding her infant is like in the context of her day. Another question concerns the kind of support from and collaboration with nurse colleagues that aids learning about a mother's working model and its development over time.

Identification of mothers who most warrant the investment of a nurse's time and energy in exploration of their working models and intervention depends on specification of criteria of vulnerability to challenges, problems, dissatisfaction, or failure to achieve clinical goals. For example, Melanie's expectation of being a better feeder than others may or may not have served her well when she went back to work and had to rely on others to feed her baby when she could not feed him, herself. Stella's working model expectations for herself made her vulnerable to being disappointed with herself, frustrated with her daughter, and hopeless about the adequacy of the baby's feeding. Jacquie's expectations of her baby were unrealistic both in terms of developmental achievements and motivations that an infant could have. In addition, Jacquie's expectation that she lacked power or capacity to affect consequences was another

indication for working model assessment and intervention.

Attentiveness to and exploration of a mother's working model of parenting could advance nursing practice beyond what identification of a topic, such as adequate nutrient intake, can offer. Knowledge of topics that are or are likely to be salient to a mother of a VLBW, premature infant is important from the standpoint of being prepared to support mothers in problem-solving infant-care issues. However, patient- and family-centered care requires understanding of a feeding issue from the perspective of the mother's working model of parenting, including its components: motivations and goals; expectations for self, infant, task, and others involved in it; intentions; and strategies. Knowledge of these working model components could help a nurse to understand what matters to a mother and to define barriers and facilitators of her adaptive feeding actions in terms of expectations and intentions that could be effectively and efficiently addressed.

Research studies need to be conducted to examine the concept of internal working models as a means to understand the feeding experience for mothers of VLBW infants. In addition, study is needed to determine common themes among mothers' working models. Once themes are identified, nurses will be in a better position to find effective ways to approach feeding with mothers and to support their learning.

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