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ANALYZING THE SOCIAL CONTEXT OF DISPARATE BREASTFEEDING OUTCOMES THROUGH INTERSECTIONAL PARADIGMS: LESSONS LEARNED FROM A QUALITATIVE STUDY OF AFRICAN AMERICAN MOTHERS

By

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ABSTRACT

ANALYZING THE SOCIAL CONTEXT OF DISPARATE BREASTFEEDING OUTCOMES THROUGH INTERSECTIONAL PARADIGMS: LESSONS LEARNED FROM A QUALITATIVE STUDY OF AFRICAN AMERICAN MOTHERS

By

Angela Marie Johnson

Recent studies indicate that breastfeeding initiation rates among African American mothers lag behind breastfeeding initiation rates of other mothers. Data collected shows that 65% of non-Hispanic black infants born during 2005-2006 were breastfed compared with 80% of Mexican American and 79% of non-Hispanic white infants born at the same time. Likewise, National Immunization Survey (NIS) data of U.S. children in born 2006 indicated that overall, 73% had ever been breastfed. Further examination of the NIS study sample indicated that 57% of non-Hispanic Black or African American mothers initiated breastfeeding compared to 75% of non-Hispanic Whites and 82% of Hispanic or Latina mothers. This difference is important since breastfeeding is considered ideal for both mothers and infants from nutritional, physiological, and developmental perspectives.

The purpose of this research project is to explore the social context that impacts African American mothers' breastfeeding thoughts, attitudes, and behavior. Through in-depth, semi-structured interviews with 15 African American mothers, this study explores the role of various dimensions of social context as they influence these mothers' thoughts, attitudes and outcomes around breastfeeding. This study uses the perspective

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of intersectionality as posited by Black feminist literature to analyze the social context of African American mothers' thoughts, attitudes, and behavior around breastfeeding.

Previous research has suggested a variety of social and cultural factors that may explain disparate breastfeeding initiation rates for African American mothers, including differences in motherhood experiences, the early exploitative reproductive experiences of African Americans women, class based differences, employment environment, and relationships with spouse and family. Although there is an understanding about the advantages of breastfeeding and although research has documented the historical differences in breastfeeding rates, the underlying factors and reasons for lower breastfeeding rates among black mothers have not been clearly identified and are not well understood.

The outcomes of this qualitative study demonstrate that mother's breastfeeding behavior, when contextualized, was shaped by the dynamics of complex social conditions she experienced upon education and social status. Mothers considered infant breastfeeding an important and positive motherhood activity because of its health and developmental benefits. But, their awareness of breastfeeding's advantages did not always translate into the act of breastfeeding. Micro social factors like family support, cultural and religious beliefs, and chronic health problems intersected with structural conditions such as health care provider messages, demanding work schedules and the lack of pumping stations to decide mothers' infant feeding choices. Results from this study support the idea that micro-level social factors operate within broader macro-level structural constraints to predict mothers' breastfeeding thoughts, attitudes and behavior and so breastfeeding is best understood as a maternal behavior impacted in sociologically complex ways.

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DEDICATION

To my Mom, Gwendolyn E. Jackson, whose strength, determination, and selfless spirit still carries me today. You taught me that everything happens in Divine Order. This project owes special recognition to those who have passed from this world but who added great value to my work: Dr. Harriette McAdoo, for inspiring the topic; Dr. Christopher Vanderpool, for guidance; Dr. Ruth Hamilton, for high expectations as an advisor; and Fred Morey, who believed in me.

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ACKNOWLEDGMENTS

First and foremost, I'd like to thank all the mothers who shared their experiences with me for this study. Without their participation, this project would not have been possible.

To Dr. Maryhelen MacInnes, for your wisdom, faith, and inspiration; thank you for serving tirelessly as my committee chair. You made the experience far more enjoyable than I would have imagined it to be. Special recognition should go to other members of my committee as well. To Dr. Gold, for your steadfast commitment and for teaching me to work on this project as if it was impossible to fail. To Dr. Broman and Dr. Canady, for your invaluable insight, time, and support throughout this project. To Tammy Spangler, for always being there to assist me as I navigated the process to get things done.

To my partner, my friend, my loving husband, Oliver Johnson, for shouldering added burdens just as willingly as you shared in my accomplishments; thank you for your patient support. My deepest gratitude to Alfreda Rooks, Sharon Redmer, Laurita Thomas, Pat Warner, and Lynn Wooten for firm encouragement and positive reinforcement.

To the countless others who are too numerous to name individually, including many family members, friends, and others, thank you for sustaining this project in so many meaningful ways.

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CHAPTER 1

Introduction and Statement of the Problem

Research indicates that breastfeeding rates among African American new mothers lag behind the breastfeeding initiation rates of all other racial groups of mothers. This is true despite the fact that breastfeeding initiation rates steadily and significantly increased for all women in 2005-2006 survey years compared to outcomes from survey conducted in 2003-2004 (McDowell, 2008). Breastfeeding rates among non-Hispanic Black women increased significantly from 36% in 1993-1994 to 65% in 2005-2006. However, Mexican American and non-Hispanic white children were significantly more likely to have been breastfed compared with non-Hispanic black children in each birth year. In 2005-2006 birth cohort group, 65% of non-Hispanic black infants were breastfed compared with 80% of Mexican American and 79% of non-Hispanic white infants[1]. National Immunization Survey of U.S. children in born 2006 indicated that overall, 73% had ever been breastfed. An examination of the sample in this study indicated that 57% of non-Hispanic Black or African American mothers initiated breastfeeding compared to 75% of non-Hispanic Whites and 82% of Hispanic or Latina mothers (CDC, 2010). This is significant, as breastfeeding is considered ideal for both mothers and infants from a nutritional (McDowell, 2008), physiological, and developmental perspectives (Ip, 2007; Kuzela, Stifter, Worobey, 1990; Persad, 2008; U.S. Dept. Health and Human Services, 2000). Breastfeeding is often considered one of the greatest sources of good health for both mother and child.

Despite the health benefits associated with breastfeeding, and a clear racial disparity in rates of breastfeeding, relatively little is known about the causes of such a

[1] This report makes no information available on other Hispanic groups.

disparity. Some scholars suggest that the differences in motherhood experiences have negatively affected breast feeding practices (Blum, 1999; Litt, 2000). Particularly, that early exploitative reproductive experiences of African Americans women (Blum, 1999; Litt, 2000), differences in information and support from healthcare providers (Raisler, 2000), class based factors (Kurinji, 1988), cultural norms enforced by spouse and family, (Ludington-Hoe, 2002; McCarter-Spaulding, 2007) and major shifts in U.S. child care practices (Apple, 1987; Thulier 2009) all have influenced African American's attitudes about breast feeding. This discussion argues that racialized ideas about motherhood and reproductive behaviors color attitudes of breastfeeding practices both toward and among African American women (Blum, 1999). Finally, social class status stratifies this relationship and helps create differences in attitudes across class lines (Blum, 1999; Litt, 2000).

Existing research can help us understand some of the cultural context of African American women's attitudes toward infant feeding, citing early introduction of cereal feeding, misinterpretations of infant's crying cues, and attitudes of breast feeding as a private affair needing to be separated from the public world all as functions of family support (Ludington-Hoe, 2002; McCarter-Spaulding, 2007). However, these studies fail to discuss the influence of class, income, and other structural factors. Other studies (Bentley, 2003; Raisler, 2000a, 2000b) that attempt to contextualize African American mothers' breastfeeding experiences include only the experiences of low-income African American mothers. These research designs are not comparative and thus leave unanswered questions. Comparative differences between two subpopulations in society are better demonstrated through the use of a qualitative research design which collects

data from both populations and draws conclusions based on a comparative analysis between the two groups while considering the broader social factors involved. Better, more sociologically comprehensive considerations have been made by others (Litt, 1999; and Blum, 2000). The ideological basis for breastfeeding attitudes are contextualized by the social landscape that characterizes mothers' lives in these descriptions. But attitudes about breastfeeding in (Litt, 1999) are based on interviews of mothers from more than 60 years ago and may differ in perspective based on the changed social context of women's and mothers lives since that time.

It is important to understand African American mothers' attitudes about breast feeding from the unique socio-historical context of their lives. Although African American mothers nursed their infants in previous generations, they remain at the bottom in breastfeeding rates among American women for the past century. This is problematic given the clear health and other advantages and the relationship that breastfeeding has to good health through adulthood often cited by health experts. To date, the underlying factors and reasons for lower breastfeeding rates among black mothers have not been identified and are not well understood. Though 1960's second wave feminism emphasized women's right to control their own bodies, breastfeeding held little appeal in this discussion (Thulier, 2009). Furthermore, feminist perspective provided little voice to women of color and to poor woman. Much of the discourse on motherhood and child rearing exclude or discount African American women's experiences. Mothering and child rearing practices are racialized and class based. Because much of African American women's experiences are rooted in the socio-historical and cultural context of their lives in American society, examining their breast feeding practices directly from

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their perspectives may help shed light on the relationship between racist social experiences, social class, and breast feeding attitudes among African American mothers.

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CHAPTER 2

Review of the Literature and Conceptual Framework

Breastfeeding provides multiple and significant benefits for infants and their mothers. (U.S. Department of Health and Human Services, Healthy People 2010) There is considerable evidence that breastfeeding produces positive outcomes in physical health (U.S. Department Health and Human Services 2000; Vennemann, 2009; Merrett, et. al., 1998) psychological health (U.S. Department Health and Human Services 2000), cognitive development (Anderson, Johnston, & Remley, 1999; Mortensen, Michaelsen, Sanders, & Reinisch, 2002), for both infants and their mothers (U.S. Department Health and Human Services 2000). For instance, breastfed infants receive antibodies from breast milk which protect them against infection in the early postpartum period which may reduce the risk of sudden infant death (SIDS) (Venneman, 2009). There is also an abundance of other health and developmental benefits associated with breastfeeding. Breastfeeding also protects an infant from a wide array of infectious and noninfectious diseases. Human breast milk provides the most complete form of nutrition for infants, including premature and sick newborns. Proponents of breast feeding emphasize that aside from being a premium source of food nutrition, there is also evidence that the polyunsaturated fatty acids available in breast milk are important for brain growth and development. Although it is not conclusive yet, current studies on neurological and cognitive outcomes in breast feeding children have led to a hypothesis that early visual acuity and cognitive function of breastfed children is greater than in non-breastfed children (U.S. Health and Human Services, 2000).

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Research also indicates that breast feeding improves maternal health in a number of ways. Mothers may reduce postpartum bleeding and may lower the risk of premenopausal breast cancer and ovarian cancer by breast feeding their newborn baby (U.S. Health and Human Services, 2000). Mothers who breast feed experience psychological benefits, such as increased self-confidence and emotional bonding with their infants (Kuzela, et.al. 1990). Yet despite these benefits, breast feeding initiation rates among African American women still lag behind those rates of all other mothers. This is true even though breast feeding initiation rates among all women have risen significantly in recent years.(McDowell, 2008).

The factors that contribute to differences in breast feeding among African American mothers are likely complex and multi-faceted. Various perspectives across disciplines provide important answers. This research study will consider the major theoretical approaches on the subject of breast feeding and African American mothers and assess the value and shortcomings of each. In particular, this study will examine the importance of and the comprehensive relationship between structural factors and micro-social factors, and how these impact attitudes, perceptions about breastfeeding, and the ultimate affect on the decision to breastfeed. Macro-structural factors could include racism, indifferent attitudes and treatment, limited support from health care providers, or lack of access to employment opportunities. Micro-social factors include cultural norms or behaviors around infant feeding, interactions of spouse and partner, inflexible work environments, and/or lack of understanding and education on breastfeeding.

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Role of Socio-demographic and Micro-Social Factors in Breastfeeding

Research by members of the medical community reflects a biomedical approach which focuses on disparities in breast feeding initiation rates as the result of micro-social factors such as social networks and family support (Ludington-Hoe, 2002; McCarter-Spaulding, Deborah, 2007; Meyerink, 2002; Ryan, 1997). In addition, others draw correlations between the socio-demographic characteristics of maternal age (Kuzela, 1990), maternal education (Kurinji, 1988; Kuzela, 1990) and income (Kuzela, 1990).

One scholars who have explored the impact of employment on breastfeeding (Visness 1997) found that mothers who returned to work weaned their babies earlier than the mothers who did not return to work. Furthermore, white professional mothers, who may have greater access to structures of opportunity, were the most likely to breast feed after returning to work and had the longest duration of breast feeding, despite a median of maternity leave as short as or shorter than that of other employed women. Thus breastfeeding may be tied significantly to mother's work employment environment. Ludington-Hoe (2002) and Kurinji (1989) similarly found that class based characteristics affected differences in breast feeding rates. This research focused on African American mothers and cited disparities in breast feeding between white, Hispanic, and African American women (based on race and ethnicity). Disparities in breast feeding were minimized when education and income level were similar. In another example, Holmes (2009), blames lower breastfeeding rates among poor African American mothers on the provision of and mothers' preference for free formula. Others (Blum, 1999; Litt, 2000; Kurinji, et. al. 1988; Bentley, Dee, Jensen, 2003; Lee, 2005: Raisler, May/June, 2000)

draw similar conclusions and suggest an important intersection between maternal race, maternal ethnicity, and maternal class.

Recent public health perspectives on maternal and child health may be useful for our sociological understanding of breast feeding disparities. Public health's "relationality" paradigm (Jackson, 2007) is promoted as a "new" idea and says that infant health outcomes are socially determined by the relationships that connect them with other human beings. Mothers and their babies are not just individuals; they are part of families, communities, and a larger social system that impacts health outcomes. Additionally, the importance of "economies, opportunities, environmental influences, and risk as well as protective factors" function to shape health (Jackson, 2007).

Sociological studies (Litt, 2000; and Blum, 1999) have made significant contributions. Infant feeding attitudes are contextualized by the social landscape that characterizes mothers' lives in these descriptions; these attitudes become apparent in interviews with a diverse representation of mothers. Litt interviewed African-American and Jewish mothers during 1991 to 1992 who raised their children in the 1930's and 1940's in Philadelphia, Pa. Her study focused on how these mothers' childrearing practices were impacted by medicalization.

Given the significant role that healthcare providers played in mothers' thoughts and behaviors around breastfeeding, it seems important to further analyze the context of this medical encounter so that we might develop a better understanding of the ways in which the interaction between healthcare providers and mothers impact their infant feeding attitudes and behavior. Waitzkin (2000) argues that medicine ultimately is inseparable from the wider society and as such, the medical encounter is a micro-social process

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embedded within a social and historical context that reinforces macro-level or structural patterns of domination and subordination in society. Specifically, this raises another important question about the dynamics of healthcare professionals' interactions with mothers. In what ways does the medical encounter between the mothers and healthcare providers in this study impact mothers' infant feeding decisions?

Considerable research has documented the challenges associated with communication in patient-doctor relationships. Waitzkin (1991, 2000, 2001) explored the context of the patient-physician relationship extensively and argued that this medical encounter is an unintentional measure of social control (on the part of the physician and the patient) that tries to manage patient's medical and social needs in ways that leave the patient's social needs largely unmet. Patient-doctor interactions are all too commonly marked by communication patterns that exercise domination and authority through the use of medical knowledge and language and the medicalization of social problems. Waitzkin (1991) provides some understanding of physician-patient interaction dynamics in his discussion of "politics of medical encounters" though which he argues that doctors control the focus of and direction of the medical discourse through the use of scientific language (Waitzkin, 1979), verbal techniques, and other "gestures of dominance". Further, "problems in medical care derive from and reinforce social contradictions. Pharmaceuticals are used to address patients' concerns that are commonly of social origin. Carrying the authority of medical science, the doctor dominates the interaction" (Waitzkin, 2000). Additionally, barriers to communication between patients and physicians have derived from differences in social class, education, gender, ethnicity, and cultural background (Waitzkin, 2001). Waitzkin provides important clues about the

impact that healthcare providers may have on mothers' breastfeeding thoughts and behavior both during pregnancy and after birth. This relationship is likely an important factor in the social context of mothers' breastfeeding experience since mothers rely on obstetricians, midwives, nurses, and other healthcare providers for medical care, information, expertise, and support for a considerable amount of time before she feeds her baby. Healthcare providers then interact with mothers around pregnancy, birth, and infant care and likely help shape mothers' ideas around breastfeeding.

The biomedical approach offers important assumptions but it falls short of establishing a clear sociological basis for understanding disparities in breast feeding rates. Instead, it offers only preliminary explanations and points to a need for deeper understanding about disparities in breast feeding rates among mothers. Socio-demographic characteristics or individual circumstances may help us begin to develop a better understanding. They provide clues to how the role of broader social context shapes these social relationships and their subsequent experiences (Schulz and Mullings, 2006). This is not to say that socio-demographic characteristics don't play an important role in determining disparate outcomes. We may argue that they do. But they are best understood as first steps to broader and more comprehensive issues. Differences in breastfeeding behavior among women of different incomes, for instance, may be better understood in terms of issues of access to education, training and to other structures of opportunity.

While it may be true that white professional mothers enjoy time breaks, flexible scheduling and other allowances that support breastfeeding by allowing the mother time to pump milk while away from baby, other factors may be more important. Other factors

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may include: limited access to advanced educational training, racist employment practices, hyper-concentrated or segregated neighborhoods that limit social, educational, and employment opportunities. These may make it less likely that African American, poor, or less educated mothers will secure employment with more flexible work environments that better support their breastfeeding needs.

Several of the research studies (Bentley, Dee, Jensen, 2003; Holmes, 2009; Lee, 2005: Raisler, May/June, 2000) that found a relationship between class based factors and maternal health do not make important connections because of limited research design and population. Many, for example, include only Women Infants and Children (WIC) participants in their study population and hyper-concentrations of low income mothers (Fooladi, 2001). By doing so these researchers cannot make a valid comparative analysis between different social groups that might yield a more accurate understanding of class and race based determinants among others.

These studies further limit our understanding because they discuss the particular dynamics of mother's infant feeding behaviors within the context of only social class. They may miss other important social or structural factors that a comparison of multiple classes might include. Holmes focuses too much on poor African American mothers' behaviors and attitudes around infant formula and makes only cursory reference to workplace and employment barriers as reasons for lower rates of breastfeeding. Broader structural factors like limited educational opportunities and racist employment practices limit women's income and social status. These are not cited as factors though they likely play a role in the lives of these women and have been much discussed. Nor are they a clear understanding of the critical role that macro-structural factors play in health.

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Medical sociological paradigms demonstrate that the production of health and health behaviors are posited within an intersection of structural forces, access to structures of opportunity, and individuals' social experiences (Williams and Collins, 2001).

Litt (2000)'s "Medicalized Motherhood: Perspectives from the Lives of African-American and Jewish Women" provides important sociological ideas about mothering practices like infant feeding. But the basis for these ideas – recollected attitudes from mothers about earlier child rearing days -- is dated because it is based on interviews of women who were mothers more than 60 years ago. As well, mothers were interviewed 40-50 years after they'd raised their children. Finally, this text focuses on the broader experiences of motherhood and with no particular focus on breastfeeding or infant feeding practices or attitudes.

This literature provides us some important ideas about the socio-demographic landscape of mother's lives and how these determine their decision to breast feed. They also urge further investigation of the broader social context and intersections between demographic, cultural, environmental, and institutional factors that influence African American mother's attitudes and behavior about breast feeding. Differences in breastfeeding rates among African American women are a function of intersections between these aforementioned factors. These ideas surfaced in focused individual interviews with African American new mothers who participated in this study in a way that demonstrates the complex and pragmatic nature of breastfeeding in U.S. society.

Through individual interviews, I identified, documented, and analyzed common themes that I believe will reflect a sociological basis for differences in breastfeeding initiation rates. This sociological understanding points to a broader and more

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comprehensive relationship than has been offered by medical sociological perspectives thus far. These ideas will be discussed more in the Conclusion chapter.

Breastfeeding Through the Historical Lens of Feminism

Feminist discourse furthers our understanding of women's health issues by questioning the prevailing focus on the biomedical model, and by proposing new sociologically relevant theories (Clarke and Olesen, 1999; Weitz, 1994). Feminist perspectives tie ideas about women, gender and motherhood to breastfeeding. Early feminist ideas shaped cultural perspectives on motherhood and thus mothering practices (Blum, 1999; Litt, 2000). These perspectives included ideas like "exclusive motherhood" (Blum, 1999) placing mother as center of the family and epitomizing women as the authoritative expert in the role of infant feeding. Human milk was deemed as the most important infant food source. This all helped insure that the majority of infants were breast fed. The "exclusive motherhood" of 18th century white mothers (Blum, 1999) gave way to "scientific motherhood" when mothers depended more on physicians as the authority on their baby's feeding. Unfortunately, eighteenth century infant feeding practices were reflections of class based (Thulier, 2009) and racist (Fildes, 1988) ideas about motherhood.

Voluntary mother's groups like La Leche League reinforced the philosophy of "good mothering through breastfeeding" from the organization's start in 1956 but it also countered feminist motherhood perspective in other ways. Founded by seven white, middle-class Catholic mothers, the League's philosophy echoed exclusive motherhood practices that emphasized the child's need for the mother's presence and the need of both mother and baby to share an intimate, physical relationship best fulfilled through

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breastfeeding (Blum, 1999). Although La Leche League was considered a proponent in the demedicalization of breastfeeding, the organization included medical consultants and medical research that showed the superiority of breastfeeding (Apple, 1987).

There is little analysis and discussion in the literature about La Leche League's role in motherhood practices and experiences of poor and minority mothers. A few pieces of literature do note, however, that the League was focused on embodied motherhood and that in this way, it's work and messages were incompatible with motherhood ideas and infant care practiced by the increasing number of mothers moving into the workforce. While La Leche League and other mothers self-help groups are credited for representing a positive challenge to women's subordination, the group is criticized for representing the motherhood interests of White middle class mothers only and largely ignoring the needs and interests of poor, or non-white mothers (Blum, 1999).

Feminists reviews of U.S. breast feeding ideas and practices (Apple, 1987; Carter, 1995; Hausman, 2004) essentially ignored African American mothers' experiences on maternal practices like breastfeeding --- perspectives that might reveal important ideas about current infant feeding behavior among African American mothers. For example, physicians' support of breastfeeding during this time created demands for wet nursing which were met and intensified by a shortage of available wet nurses for pay during this period. Demands for breastfeeding were satisfied through forced or cheap labor at the hands of wealthier women who could not or who did not desire to breastfeed their own children (Blum, 1999; Fildes, 1988; Apple,1987). Black slaves were commonly forced to breast feed owners' babies often at the neglect of their children. (Fildes, 1988). In her book, Fildes (1988) shares accounts of slave mothers being beaten when they were

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caught breastfeeding their own baby instead of breastfeeding the master's baby. As well, Black slave mothers often had their children sold away from them or sent away to other plantations to work. Frequently, they never saw their children again. Thus, Black motherhood and motherhood behaviors have historically been devalued and subordinated to service the needs of white mothers. This is particularly important as it may have shaped cultural feelings about breastfeeding that may have lasting implications even today.

High rates of infant mortality (Apple, 1987; Wolf, 2001), increasing questions about "appropriate" or "suitable" wet nurses (Thulier, 2009), and the increased reliance on the use of alternatives to breast milk produced a decline in breast feeding among women by the end of the 19th century (Apple, 1987) and the increased use of scientifically created infant formula to feed babies. Historical accounts of infant feeding practices during the 19th and 20th centuries chronicle this medicalization of breastfeeding. Second wave feminism during 1960's gave rise to conflicting feminist perspectives and created ambivalence in attitudes about breast feeding. At the center of the debate between feminists were conflicting ideas about the importance of gender differences -- whether to minimize gender differences as a way to enhance women's rights or if women should embrace and highlight differences by fighting to remove constraints imposed by patriarchy and capitalism. For example, one might see bottle feeding as freedom from the demands and restrictions of lactation or, on other hand, as imposed on women by formula manufacturers depriving them of a unique womanly experience. (Carter, p. 90)

In the quest to highlight sexist injustice, feminists focused almost exclusively on male domination, making the movement "more a declaration of war between the sexes

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than a political struggle to end sexist oppression" (hooks, 2000). Racial privilege for members of this movement was overlooked and the marginalized experiences of poor mothers and mothers of color were sidelined in the discourse on the subject.

Cultural Models of Breast Feeding Behavior

Some researchers have attempted to explain differences in African American women's breastfeeding practices using cultural models (Corbett, 2000; Ludington-Hoe, et. al. 2002; McCarter-Spaulding 2007). Differences in African American mothers' ideas about breastfeeding are cited as "cultural norms" based on race or ethnically-based group belief systems. A mother's decision to breast feed her baby is mediated by cross-generational familial perceptions and ideas on the subject (Fooladi, 2001), often compromised, for example, by the idea that breast feeding is a private affair between her and baby, best supplemented with bottle feeding when she is in the public eye. This is supported by reports of mothers expressing a reluctance to breast feed in public because of shame or modesty issues (Ludington-Hoe, 2002; Raisler, 2000).

Cultural arguments for mother's hesitations to breastfeed infants are also tied to socialized ideas about crying as indications of hunger and not prompts for infants' socio-emotional needs. Picking up or holding the baby is viewed as "spoiling," is systematically discouraged, and substituted sometimes, instead, with the commonly practiced premature introduction of cereal feeding (McCarter-Spaulding, 2007). This is motivated by the idea that the mother's milk is not enough and that the baby is still hungry as indicated by the baby's crying. This belief is common among lower SES mothers especially and older African American mothers (Ludington-Hoe, 2002). Though

this phenomena is not unique to African American mothers, it is particularly prevalent among this group (Litt, 2000; Ludington-Hoe, 2002). This is an important point as it illustrates a cultural perspective about child care and mothering based on an intersection between race and class. This is a critical idea in sociological perspective. Research has established that mothering practices are reflections of class inequality and culturally-based values and beliefs (Blum, 1999; Litt, 2009).

Cultural explanations provided a historical perspective and color the relationship between breastfeeding and motherhood. But cultural ideas about breastfeeding have been criticized for overlooking the relationship between social or structural constraints and personal lifestyle factors. As well, the spotlight on cultural factors suggests broader structural connections. These structural connections might include: differences in the treatment and information received from health care providers (Beal, 2003; Waitkin, 2001), medicalized motherhood practices (Litt, 2000), class based and racist treatment from health care providers (Barbee, 1993) and limited institutional support for breastfeeding mothers (Raisler, 2000). All this aforementioned create a social context characterized by race and class based differences in the treatment of African American women's mothering practices. Like demographic-focused explanations, cultural explanations constitute just one element in a broader context of social conditions.

African American Mothers Reject Exclusive Motherhood

Blum (1999) found that racialized and sexualized attitudes and environments shape breastfeeding practices through the ideological constructs of motherhood and womanhood. So the meaning of motherhood is historically different for African American mothers compared to white mothers based, in part, on a legacy of American

slavery and its'effect upon the long term and systematic exploitation of African American women's sexuality and reproduction (Blum, 1999; White, 1994). First, African American women, considered "naturally maternal" in their care giving were procured to feed, raise & otherwise care for white children while their own children were neglected or sold away. White slave owners demanded slave mothers wet nurse white children at the sacrifice of the slave mother's own baby's needs (Fildes, 1988). African American children experienced a devalued existence. African American mothers and children could not expect to experience the protected childhood that white children enjoyed. Blum's notion of "exclusive motherhood" was not intended for the black slaves, servants, wet nurses and other women who supported its' existence. Instead, exclusive motherhood meant that the privileged white middle class mothers' existence as mothers was legitimized and protected under "moral essentialism" and that black mothers became the other, disreputable black mother or, undeserving "welfare queens" who feared state intrusion and control of their child rearing to such extent that they rejected many of the cultural norms like breastfeeding that they believed to be associated with exclusive, white motherhood (Blum, p. 179).

Black Feminism as Theoretical Framework

Qualitative research on the breastfeeding practices of African American mothers may be better considered within black feminist theoretical framework since this perspective recognizes the unique social experiences of African American women, by incorporating race (hooks, 2000) as it intersects with gender (Baca Zinn, Dill, 1994) and with class (Shulz, 2006; Weitz, 1994). Feminist's extensive writings on motherhood are

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accused by black feminists of first attacking and later romanticizing motherhood. (hooks, 2000) Black feminists pointed out that "exclusive motherhood" was a racialized, class based, status idea. Hooks (2000) argues, for example, that feminists' focus on liberating women from the constraints of domesticity such as: unpaid household labor, and devalued, unpaid child care, is contrasted by Black women's desire to achieve freedom from racist experiences and treatment in society:

> "Had Black women voiced their views on motherhood, it would not have been named a serious obstacle to our freedom as women. Racism, lack of jobs, lack of skills or education, and a number of other issues would have been at the top of the list – but not motherhood" (hooks, p.133)

By assuming that social theory will be applicable regardless of social context, feminist scholars fail to realize that they themselves are rooted in specific locations and that the specific contexts in which they are located shape how they view the world. While theories are presupposed to be universal, they are typically partial perspectives reflecting the white, middle-class context in which their creators live (Collins, 1994). Liberation from domestic demands and sexist institutional control are not a focal point in Black feminist movement. For Black feminists, these are a luxury afforded only to other feminists whose racial power and class based resources elevate them to their privileged status. African American did not perceive motherhood as an obstacle to working in paid labor force since they always had to work anyway – whether paid or unpaid.

It is clear that women liberationists did not represent the voices of white working women class either. This is an important omission since this study is premised on the notion that social class, as well as race, has an important influence on the perceptions of and attitudes about breastfeeding and in breastfeeding outcomes. Mullings (2006)'s ethnographic and case studies on birth outcomes in African American women provide

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significant evidence that demonstrates the complex relationship between gender, race, and class that interact to produce health and illness within local contexts. Theorizing about motherhood experiences such as breastfeeding will not be helped supplanting white middle class women's motherhood experiences with that of women of color's experiences either. Rather, it is necessary to develop understanding that recognizes the variations of experiences based on differences in placement in system of privilege whether race or class based (Collins, 1994).

As long as infant feeding practices of African American mothers are critiqued by class based and racist standards, we will continue to miss the value of that comprehensive and interdisciplinary approach might afford us. We might develop a better understanding if we can analyze structural issues like equal access to employment and educational opportunities, and racist treatment from health care providers as representations of intersectionalist perspective. An examination of motherhood practices like breastfeeding from multiple feminist perspectives which incorporate a range of positions, promises to recontextualize mother's experiences and to promote a better understanding of differences in motherhood outcomes.

There are few discussions within the black feminist paradigm that center specifically on African American mothers breastfeeding behaviors and practices. Collins (2000), hooks (2000) and other black feminists have done more extensive writing on the related issues of motherhood and women's social and economic status. But because motherhood and mothering practices of infant feeding have a symbiotic relationship, and more importantly, because intersectionalist perspectives in black feminist thought tie together the social factors of health, race and gender, to frame our perspective -- much in

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the same way we expect to see these themes emerge from our discussions with mothers on this topic. In this way we expect to gain a more sociologically comprehensive understanding of African American feelings about breastfeeding and how these feelings influence their decision to breastfeed.

Research Questions

We know that individual behaviors are important but that they must be considered in a broader context (Link and Phelan, 1995) As well, we know that access to and availability of structural opportunities like quality health care, educational and employment opportunities and place of residence also have a critical impact on differences in health outcomes. (Williams and Collins, 2001; Zambrana and Thornton Dill, 2006). This study is aiming to provide a sociological perspective on breastfeeding attitudes among women – one that will provide the most useful understanding because it supports a broader and more comprehensive understanding than do those positioned by the medical community.

Generally, this study aims to better understand: African American mothers' thoughts about breastfeeding, African American mother's attitudes about breast feeding, and how these thoughts and attitudes about breastfeeding are influenced by the social context of their lives. Some specific research questions include: What are some of the cultural beliefs about breastfeeding among African American mothers and how do these influence attitudes about breastfeeding? How does class affect African American mothers' breast feeding attitudes? How does the spouse or partner influence breastfeeding attitudes of African American mothers? In what ways might other family members influence breastfeeding? How does the health care system influence African

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American mothers' attitudes about breastfeeding? In what ways does employment environment affect these same attitudes? What is the impact of larger social messages, particularly those represented in the media, on African American mothers' attitudes about breastfeeding?

Until we better understand what factors influence disparities in breast feeding initiation rates in African American mothers, we cannot effectively address lower incidence of breast feeding among African American mothers. Through interviews with African American mothers and an examination of the social context of their lives, we may create a better understanding about the social context that influences African American mothers' decision to breast feed.

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CHAPTER 3

Methods

Introduction

The purpose of this study was to explore the attitudes and perceptions that African American mothers have about breastfeeding and how these attitudes and perceptions are shaped by the social context of their lives. To explore these issues, I used a qualitative study design approach that involved that involved in-depth interviews in order to explore these attitudes and perceptions. In this chapter, I will provide detailed justification for this method and a discussion of the limitations of the methods

Rationale For Qualitative Research Design

Qualitative research is concerned with how the complexities of the socio-cultural world are experienced, interpreted, and understood by a particular individual's context and at a particular point in time. A qualitative research approach was undertaken to gather data because it was thought to be the best way to promote a deep understanding of the social experiences embedded in African -Americans mothers' lives from their own perspectives as research participants. I used this approach, as well, because there is limited existing literature in this area and because the qualitative research approach is a valid and effective broad approach to the study of social behavior and phenomena. (Denzin & Lincoln, 2000). This study is premised in ideas centered around social constructionism – that mothers' realities are socially constructed and that multiple perspectives surface from different mothers as a result of their own individual experiences. Each mother might profess a different subjective meaning of her experience (Lincoln & Guba, 2000). I thought that this approach might effectively guide a

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necessary focus on the specific contexts in which the research participants lived in ways that helped understand the influence of their particular cultural and historical settings.

Further qualitative methods were utilized for this study because of their strength in inductive investigation. Because of the indefinite nature of mothers' experiences and the indefinite relationship between those experiences and their perspectives and behaviors, an open and emergent design that induces ideas and theory would produce a more accurate and complete findings compared to the less flexible method of starting with a theory and basing findings upon it. Grounded theory approach was used as the general methodological approach in this study given its' strength in building theory from data (Corbin & Strauss, 2008). For purposes of this study, grounded theory is used in a more generic sense to denote theoretical constructs derived from qualitative analysis of data.

The Importance of Intersectionalism

This study's methodological approach is also grounded in the general assumption that structural issues like equal access to employment and educational opportunities and treatment from health care providers paint the landscape of maternal health outcomes and behaviors like breastfeeding. Specifically, the black feminist perspective is situated within intersectionalist approach and it might help support a better understanding in this study.

There are few discussions within the black feminist paradigm that center specifically on breastfeeding behaviors and practices among African American mothers. Collins (2000), hooks (2000) and other black feminists have done extensive writing on

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the related issues of motherhood and women's social and economic status. But because motherhood and mothering practices of infant feeding have a symbiotic relationship, and more importantly, because black feminist thought ties together the social determinants of health, race and gender to frame this perspective, I expected to see these themes emerge from our discussions with mothers on this topic and include this as one basis for developing a framework for understanding. This perspective lends itself to qualitative research designs. By giving voice to women through in-depth interviews focused around key structural and culturally-based research questions, I expected to gain a sociological understanding of breast feeding thoughts and behavior among African American mothers.

I used the semi-structured face to face interview as the specific qualitative data collection method for four main reasons. First, the interview itself was thought to be a productive and effective method for obtaining perceptions, thoughts, and attitudes. Its strength is in obtaining more in-depth answers and insight than that uncovered by other methods (Morgan, 1996). Secondly, the interview method was felt to be a useful approach for this study because it has the potential to elicit rich, thick descriptions and it gives the researcher an opportunity to clarify statements and probe for additional information. Denzin and Lincoln (2000) state that a major benefit of collecting data through individual, in-depth interviews is that they offer the potential to capture a person's perspective of an event or experience. Conducted effectively, the interview can serve as a reliable and productive social interaction between the interviewer and the interviewee that yields valuable insight and understanding to the research. (Goode, 1952) Thirdly, the semi-structured was chosen versus the structured or unstructured interview because it allows the researcher to both direct the conversation through specific questions

and to follow-up and clarify points of understanding between researcher and participants through the use of probes. Finally, face to face interviews gave the added advantage of the ability to use and view non-verbal cues to that might assist in conveying meaning. The semi-structured face to face individual interviews conducted in this study helped uncover participants' descriptions of their social exchanges and experiences as they related to their infant feeding experiences. Mothers' responses to questions during interviews helped provide understanding of the social and environmental elements that mothers thought were important in shaping their infant feeding preferences. Most importantly, the interviews revealed mothers' beliefs, intuitions, reactions, fears, and motivations regarding breastfeeding.

Information shared and collected from mothers' responses provided a basis for analysis that was also shaped by my own interpretations and judgments as the interviewer. I understood that the research process and my interpretations were influenced by my own background. Thus I worked throughout to consider my own bias and perspective within the research process so that I considered the influence my involvement had on the findings. It is important to consider my own bias as it impacts the meanings and values assigned to outcomes.

Researcher Reflexivity and Insider Research

As an African American mother who chose to breastfeed and use formula too, I was interested in the challenges that other African American mothers faced around breastfeeding. Thus, part of this research involves an insider perspective on my part. The advantages and limitations of insider research have been well documented by others

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(Corbin and Strauss, 2008; Collins, 1991, Hash & Cramer 2003). It is clear that researchers as well as research participants bring to the study, biases, beliefs, and assumptions. This is not necessarily negative since people are the products of their cultures, the times they live in, their genders, experiences, and training. It is important, however, to recognize when either our own or the respondents' bias, assumptions, or beliefs are intruding into the analysis. (Corbin & Strauss, 2008) I will provide a brief overview of these issues as they relate to this study. One key advantage of insider research for me is that as an insider, I had some resources for finding populations because of my familiarity with my community. Insiders are able to gain trust of participants, especially in the case of minority populations since it may be believed that the insider has the interests of community at heart and will not take advantage or misconstrue their statements the way an outsider might. Entry into African American social groups was done fairly effortlessly, perhaps because of this. Because participant recruitment was accomplished through personal and professional networks and channels, many knew that I was an African American mother. Another advantage of insider research for me was that because of my position as an insider, and because I sometimes shared a similar lens with participants, I was able to ask questions that others could or would not (Baca Zinn, 1979).

Among the drawbacks of insider research, however, is that sometimes participants may have taken for granted that I, as the researcher, understood the meaning of what they said, or vice versa, and areas that needed further probing and explanation may have been missed (LaSala, 2003). As well, participants sometimes assumed a certain degree of familiarity, rapport, and comfort with me that prompted them to introduce topics and

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interests to the interview that were unrelated or irrelevant to the research questions. In this way, interviews might become chat sessions and had to be re-directed to original interview goals. Finally, I acknowledge that despite being an insider in the African American mothers community, I am also an educated, married, middle-class suburban community resident. This fact cannot be ignored considering that a significant proportion of my sample falls into this category and despite being an insider, my difference from some African American mothers, namely mothers who were not married, mothers who exclusively used formula, and mothers who were less educated, makes me an outsider as well. These issues will be revisited as part of the discussion of other ethical considerations and general limitations.

Overview of Research Design

Preceding the actual collection of data, I conducted a selected review of the literature to study the contributions of other researchers and writers in the areas of medical sociology, public health, nursing, and other areas that examined structural and social dimensions of breastfeeding outcomes. Following my proposal defense, I acquired approval from the Social Institutional Review Board (IRB) at Michigan State University to proceed with the research. The IRB approval process involved outlining all procedures and processes needed to ensure adherence to standards put forth for the study of human subjects, including participants' confidentiality and informed consent. With guidance from my graduate committee chair and members, I used the study's research questions as the framework to develop the open-ended interview questions. With the committee's approval, one pilot interview was conducted to test questions for clarity with an African

American mother whose youngest child was six years old. The preliminary themes that emerged revolved around infant feeding thoughts, ideas, and choices confirmed the interview schedule as a viable interview tool and provided some insight into expected future outcomes. The final interview schedule is included as Appendix D.

Various methods were used to recruit study participants including use of personal and professional networks, community organizations, local area businesses, snowball sampling, and through the distribution of flyers placed where eligible population for this study most likely might be found. Semi-structured in-depth interviews were conducted with 15 African American mothers who had given birth within the last five years. Five were breastfeeders, four were formula feeders, and six used a mix of both methods. These interviews were conducted over a two month period during the fall of 2009 in locations around southeastern Michigan. Participants were chosen from this geographic area primarily because of their proximity to my place of residence, thus allowing for greater ease in scheduling of and traveling to interviews. As well, it was decided that these areas would yield a balanced representation of SES, and infant feeding methods across participants.

The interviews focused on understanding the factors which influenced these mothers' decisions about breastfeeding versus formula feeding. Interview responses were analyzed within and between groups of interviewees. More details will be presented in the discussion that follows. The sections that follow will discuss sampling and recruitment strategy, the research sample of mothers who served as participants, and data collection methods used. As well, I will discuss how data was managed, organized,

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Sampling and Recruitment Strategy

To insure an adequate mix of participants, study participants were recruited through the use of multiple strategies. Again, methods of recruitment for this study included use of personal and professional networks, community organizations, local area businesses, snowball sampling, and through the distribution of flyers placed where eligible population for this study most likely might be found.

Recruitment flyers were distributed widely through various networks including but not limited to individuals, church groups, African American parenting groups, professional organizations, and personal networks. Recruitment contacts received the flyer either as hard copies through the mail or electronically as an attachment to an email. A copy of the flyer is included in Appendix C. Both methods included a brief personalized cover letter that announced the study, stated its' purpose as a dissertation project, and kindly asked the contact for their assistance in sharing the information about the study with others who might be eligible participants or those who might know eligible participants.

Initial recruitment flyer information was modified approximately two weeks after recruitment began. The first study flyer titled, "Breastfeeding Thoughts and Attitudes Among African American Mothers" was edited to read, "Infant Feeding Thoughts and Attitudes Among African American Mothers" to help insure that a balanced number of both breast feeding and formula feeding mothers were recruited. Recruitment efforts

yielded approximately 60% more respondents than study enrollees in an effort to increase initially low rates of respondents who exclusively formula fed their babies. A note must be made as well regarding the challenge of recruiting a diverse SES sampling of participants. When initial recruitment efforts did not yield adequate numbers of less educated mothers, added efforts were undertaken to find more mothers who fit this last population through snowball sampling. In addition, members of my professional and personal networks were asked to share recruitment information with other mothers who may have had access to this population of mothers. This purposive sampling method was intended and is consistent with qualitative research goals which are to select rich cases that might provide insight and understanding of the phenomena under investigation.

All those who responded and expressed an interest in participating were asked a few questions to assess their eligibility and to help recruit a balanced socio-economic distribution of mothers. This eligibility or screening questionnaire was administered prior to inviting the interested mother to participate in the study and completed in order to consider whether the potential participant qualified to take part in the study. Potential participants were asked: 1) What year did you give birth to your last child? 2) How old is your youngest child? 3) What is your age? 4) What is your race? 5) What is the highest level of education you've completed? 6) What is your marital status? In order to qualify to participate in the study, participants had to have given birth within the past five years, be aged 18-45, and self-identify as African American. Eligible participants could be of any educational background or level and could be of any marital status (i.e. single, married, divorced, etc.). Respondents who responded later in the study were also asked: 7) how did you feed your baby? Formula? Breastfeeding? This was done in an effort to

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increase the number of formula feeding mothers as initial recruitment efforts yielded too few of this desired population.

These respondents were told that information they shared for purposes of the study would be kept confidential and that all face to face interviews would be audio-recorded. Eligible respondents who expressed an interest were invited to participate and scheduled for an individual interview. Interviews were scheduled to take place at the earliest dates that were convenient for participant and myself. Most interviews were scheduled to take place within one to two weeks of the screening. A few interviews took place beyond this period of time when participant indicated that they needed to have their interview rescheduled. Scheduled respondents were telephoned or emailed a day or two prior to scheduled interview in order to remind them about our scheduled time and to inquire about their intent to attend. This reminder was done to convey to participants that they were needed and valued participants in this research study and to maximize the number of completed interviews.

Information collected on women who failed to meet eligibility requirements was destroyed immediately following this eligibility assessment. A copy of the screening questionnaire is included in Appendix A. Study participants were given the choice of a small incentive consisting of one $25 gift card to a local grocery store, Busch's, Target, or Walmart. Eligible mothers who arrived for their scheduled interview were offered the incentive with a clear explanation during the informed consent procedure that they were entitled to the gift card regardless of whether they completed the interview or not and regardless of the outcome of the interview. All participants who began an interview completed it.

Research Sample

Research participants are African-American mothers aged 18-45 who gave birth to a child sometime in the past five years and not earlier than July 2004. A delimiting time frame of five years since birth was decided on to insure that mothers were able to best recall their birth experiences. Participants self-identified as "black" or as "African American". Participants' babies are of different birth orders-- the first, second, third, or a later baby born to the mother. Directly following screening, mothers were given the choice to be interviewed at their home, the nearest local public library, or at a location that was convenient for them. Seven participants were interviewed at their home per their request. Five participants were interviewed at a local library of their choice. Of the three remaining participants, two were interviewed at their workplace, and one was interviewed at the local YMCA in an empty exercise room. Initially, eligible respondents were given the choice of being interviewed on a Friday, Saturday, or Sunday during the daytime. Scheduling difficulties led to the need to schedule interviews for other weekdays and a few evenings.

Eighteen respondents were scheduled for an interview from which a total of fifteen mothers completed a face to face interview. All interview participants were asked to complete a consent form prior to the start of the interview. Each participant was given a copy of the consent form to keep so that they would have contact information for me, the responsible investigator, and contact information for the institutional review board. All fifteen participants completed the written informed consent. Individual interviews lasted anywhere from 30 minutes to 90 minutes. A copy of the informed consent for

individual interviews is included in Appendix B. A description of the participants (by pseudonym) is included in Table 3.2.

A total of 36 women responded during the research recruitment period. Respondents either called the telephone number listed on the flyer or sent emails indicating their interest in being considered for the study. Twenty-seven were screened. Two mothers did not qualify to participate in the study because their youngest child was older than age five and born before July 2004. The factors that account for the nine mothers who responded but were not screened include lack of response in follow-up to voicemails or to follow-up emails to conduct the screening. Of the 25 mothers who qualified to participate in the study, a total of 15 mothers were interviewed. Factors that account for the difference between total number of mothers who qualified but were not interviewed include: scheduling difficulties, no shows, over-response from breastfeeding mothers, and lack of response after screening.

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Table 3.2 Participant Demographics and Characteristics[2]

	Participant by Pseudonym	Age	Breastfed or Formula Fed Baby?	Educ SES	Employment Sector	Marital Status
1	*Mary*	35	Mixed	M-U	Public Univ. Admin	M
2	*Allison*	38	F	L	Public Comm.. College Clerk	M
3	*Lisa*	38	Mixed	M-U	Public Univ Admin	M
4	*Ella*	28	BF	M-U	SAHM Service PT in home-Child Care	M
5	*Jane*	26	F	L	Student PT – Service	S
6	*Michelle*	33	BF	M-U	SAHM	M
7	*Julie*	36	Mixed	M-U	Public Service – Univ Admin	M
8	*Faye*	35	BF	L	Public Library	M
9	*RunCat*	28	BF	M-U	Public Univ Admin	M
10	*Peaches*	27	BF	M-U	SAHM	M
11	*AKA*	34	Mixed	M-U	Student PT –Self Employed	M
12	*Nicole*	26	F	L	Public Health Sys Clinical Care	S
13	*Toya*	19	F	L	Service Fast Food	S
14	*Terry*	41	Mixed	M-U	Private Service-Bank	M
15	*Margaret*	38	Mixed	M-U	Public Health Sys. Admin	S
	N = 15					

Data Collection

Respondents who contacted me and expressed an interest in participating in the study were given more information about the study, including the purpose of the study

[2] **N** = total number participants, **F** = formula, **BF** = breastfed, **L** = lower socioeconomic, **M-U** = middle to upper socioeconomic, **S** = single, **M** = married.

and expectations of study participation (interview time requirements, audio-recording, confidentiality and informed consent rights, screening requirements and eligibility). Prospective participants were then asked if they were interested in participating. Those prospective participants who expressed an interest in participating were administered six screening questions to determine eligibility. Eligible mothers were invited to participate and if they agreed, scheduled for a face to face interview. Mothers were given the choice to interview at their home or at another place that was mutually agreeable.

Seven mothers chose to be interviewed at their home, five mothers chose to be interviewed at their local public library, two mothers asked to be interviewed at their place of employment during their lunch hour, and one mother asked to be interviewed at a local YMCA while her daughter attended a dance class. Before the interview commenced, each interviewee was asked to review and sign a university consent form required for participation in this study. A copy of the IRB-approved informed consent can be found in Appendix B. Interviews were digitally audio-recorded, professionally transcribed and coded for analysis. Handwritten notes were also taken during interviews as a back-up to the audio-recorder and to confirm audio-recordings as data sources. Digital recordings were sent to a professional transcriptionist to be transcribed verbatim into typed manuscripts.

The demographic information collected included: age, race, marital status, whether they gave birth within the last five years, and the highest level of education completed. Perceptual information collected included: mother's general ideas and thoughts about breastfeeding, infant feeding ideas and thoughts she heard from her family, friends, and other personal community around breastfeeding, infant feeding

information and experience she received from prenatal and pediatric care providers and representatives of Women, Infants, and Children (WIC), her thoughts and ideas about employment experience as it relates to her infant feeding decisions, the images and ideas she heard from print, televised, and other media, and her perceptions of society's treatment of mothers who breastfeed in public. The perceptual information collected in this study is perhaps, the most critical source of information since perceptions were gathered through the process of interviewing and the interview was the major tool for data collection in this study.

Data Management and Coding

The challenge throughout data collection and analysis was to make sense of large amounts of data, reduce the volume of information, identify significant patterns, and construct a framework. Additionally, I wanted to maintain a sense of the unique features and experiences that characterized each participant as individuals while at the same time develop an understanding of the common factors from mothers' similar shared experiences that might help answer research questions. Data was prepared for analysis by coding and organizing it through an inductive process consisting of three major steps. First I individually read and coded each interview to identify and highlight relevant words, phrases and ideas as they related to my research questions. A document summary was developed for each participant from this first read of the interviews. The document summary served as a profile of each participant and as a basis for further data reduction. Secondly, participant's document summaries were grouped by infant feeding

method such that all the mothers appeared in one of the three groups list: mixed methods, formula, and breastfeeding.

The third step of coding involved further dissecting and classifying the data to place it into sections of categories or relevant themes. Research questions served as categories for emergent themes around African American mothers' breastfeeding thoughts, attitudes and ideas and how these attitudes and perceptions are shaped by : 1) family members including her spouse/partner, her mother, and other family members, 2) community and members of personal network, 3) interactions with healthcare providers, 4) education and her employment environment 5) messages portrayed by the media, and 6) her perceptions about society's treatment of breastfeeding mothers. Additionally, other categories were created for several other emergent themes and ideas that were not represented by the research questions. This step used an open coding method with a careful line by line reading of all transcribed manuscripts. As the process of coding the transcripts proceeded, new theme summary sheets were added until all major themes were represented in the table of summary themes and labeled in participants' manuscript as well. This level of coding created a long list of themes across feeding method groups. This list was then recoded and collapsed to place similar or identical codes under the same code theme with a notation of the specific mother and her feeding method next to themes. This list of collapsed themes can be found in Appendix E. This allowed an inter-group analysis for themes across infant feeding groups to identify common or shared experiences, thoughts, ideas, and perceptions as well as differences in these areas between groups.

I tried to remain flexible and open to change or to the need to add more categories based on new emergent themes. As a result several additional themes were added in addition to those represented by the research questions. Once categorized, data appeared in data summary lists. Data summary lists served as a vehicle for capturing all relevant themes by research question. These lists included relevant points stated briefly, participants' infant feeding method, direct quotes, and names organized by the categories which emerged or were added. This data summary list was shared with the committee chair to review and discuss common themes that were being discovered.

Data Analysis

Once data was coded and organized, participant data profile information was crossed referenced with the data summary lists (categories/emergent themes) so that information collected in both forms separately could be blended, checked and further analyzed to gain insight into the relationship that participant could be checked against major themes that emerged. I selectively listened to recorded interviews, conducted several reads of interview transcripts, handwritten notes, participant profiles, and data summary lists in an effort to identify inconsistencies, contradictions, as well as to pinpoint similarities, discover relationships, to develop some findings that might reveal the effects and intersections of micro-social and macro structural factors. The goal of this final phase was to make sure that key points related to these major themes had not been missed in earlier phases of coding. The major themes are considered and discussed in detail in the Findings chapter.

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These aforementioned phases of analysis helped determine how infant feeding, and particularly breastfeeding attitudes have been affected by the social and cultural context of mothers' lives and how these attitudes and perceptions have influenced their decisions about breastfeeding their baby. In this way, the data itself provided pertinent answers to the questions at hand. Additional themes including: religious beliefs, pregnancy experience, prior health status, and birth experience all emerged from the data providing some insight into the context of breastfeeding in these mother's lives.

Ethical Considerations

As a researcher, I understood that I was responsible for informing and protecting respondents. This meant that the study was to rely on voluntary cooperation and that all participants would be informed about the study's specific purpose. I took this responsibility seriously and took steps to insure that both tasks were accomplished. To this end, careful consideration was given to the ways in which participants' information was treated. Although it was anticipated that no serious ethical threats were posed to any of the participants or their well-being, this study used several safe-guards to help protect the confidentiality and other rights of participants.

First, study respondents were informed of study purposes and requirements, before being screened. Secondly, eligible respondents were told of their rights as research participants and given a choice as to location where their interview would take place. Participants could be interviewed at their home or at another place they felt was

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comfortable to them and that would help maintain confidentiality. Thirdly, only participants who volunteered were screened. Several names were submitted, by well-intentioned friends, colleagues, and other participants as recommended participants. When this was done, those who made referrals were asked to give research information and contacts to those persons likely to be interested in the study and to ask them to initiate contact. This was done to ensure fully voluntary participation. Fourth, written consent to participate with the study was received from each participant prior to beginning any interview. Finally, all participants' feedback and personal information was kept confidential. Participants were asked to choose pseudonyms. All participants chose their own pseudonym with the exception of two participants who asked that pseudonyms be chosen for them. Measures were taken to secure the storage of research-related records and data, and no one except the responsible investigator and myself had access to this material.

Limitations of the Study

There has already been some discussion of my researcher bias and opportunity as an insider earlier in this chapter. Briefly, I enjoyed some advantages of an insider's perspective within the target population. Being an African American mother with young children afforded me the ease of locating and attracting other African American mothers of young children as study participants. However, my middle class status meant limited direct access to less educated mothers and subsequently formula feeding mothers. To address this limitation, I gave added attention to snowball sampling. Mothers who participated were asked to refer non-professional, blue collar or lower social class

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African American mothers to the study. As well, other members of my social network were asked to asked share recruitment material with mothers of diverse social class status. Study flyers were shared at several community meetings, posted at a public health department, forwarded to the district public library system to post, and sent to several African American churches. These efforts yielded a few more less educated participants.

A related limitation was that interviewees may have had some difficulty adjusting to me as a researcher. Because six participants knew me personally in advance of the interview, their responses may have been influenced or affected by our familiarity. They may have given responses they thought were expected or those they thought might be helpful to the study. Conversely, because a participant knew me, these few participants may have been guarded and therefore less candid in their responses. Recognizing these limitations, I continued to reflect on how and in what ways I might have influenced participants. I did all I could to encourage an interview environment that facilitated honest and open dialogue. Mothers were reminded at the beginning of the interview that they were not obligated to participate and that they could withdraw their participation at any time and still receive the incentive. Mothers were also encouraged to decline to answer questions they were not comfortable in answering. As well, mothers limited answers were affirmed with positive brief responses such as "Tell me more", and with encouraging non-verbal cues as much as possible.

Other noteworthy limitations exist as well. One such limitation stems from time restrictions. Due to the busy nature of most mothers' lives, I experienced some difficulty with scheduling interviews. This was experienced to a lesser degree and to lesser extent than aforementioned limitations, but it introduced some challenges. To accommodate

mothers' scheduling needs, I gave mothers several options for appointment times and always encouraged them to call or email me if they were unable to make the scheduled time. Several interviews had to be rescheduled for later times because of scheduling conflicts. Two mothers said they'd forgotten about the interview – despite a reminder call the day or two before. Two other mothers elected to have their interview conducted in the middle of their work day during a lunch hour. One mother asked to be interviewed late at night at home after her work shift was over. And a few mothers asked or chose to have their young child or children present at the interview. Scheduling difficulties were especially problematic for mothers who could not or who did not secure child care for their young child or children for the interview session. Some mothers, especially breastfeeding mothers, indicated that they did not take their baby to daycare normally because they were stay-at-home mothers. Thus there was no formal arrangement for daycare. Furthermore, many mothers' significant others or partners were busy working or at school during scheduled interviews. Mothers' limited availability, lack of regular formal daycare arrangements, and evening/weekend scheduling times contributed to an increased likelihood that children would be present at the interview. Several interviews were conducted with small child or children present. This also made it difficult for mothers to focus primarily on the interview itself. Recognizing that all of the participants in this study had children, I always encouraged mothers to choose a time when they could participate in the interview alone. Additionally, a number of interviews were rescheduled to be held at a time when mother could arrange for a sitter, family member, friend or other person to keep the child. When children were present, interviewing and audio-recording was paused at moments to accommodate needs of

mother and child and resumed as soon as possible. Finally, no information was collected on health insurance status of participants. This issue surfaced at times during discussions with mothers around their healthcare experiences. Focusing on this issue might allow a better understanding of the social context of mother's healthcare and the way this impacted their breastfeeding thoughts, attitudes, and behavior.

Transferability

Although generalizability was not the intended goal of this study, it is important to consider whether lessons learned in this study might be useful in other research settings and with other populations. What was addressed was the issue of transferability or the the likelihood that findings might be allocable to other situations under similar, but not identical conditions. To this end, I attempted to address the issue of transferability by way of thick, rich description of the participants and the context of their breastfeeding experiences. The mothers who served as participants for this study were all residents of small to mid-size urban communities in Southeastern Michigan and predominantly representative of middle class status. Despite efforts to recruit a more diverse socioeconomic representation of mothers, a significant proportion of the mothers interviewed for this study were well-educated and employed in professional capacity enjoying opportunities available to them because of their social status, including opportunities to breastfeed. Additionally, the majority of the mothers who participated in this study were married to men. All but one of the husbands was gainfully employed and in a position to provide familial support in ways that may have made it more possible for these mothers to engage in breastfeeding. I believe that this study has made it possible to

observe phenomena that might exist in similar form in other settings and communities of African American mothers. Mothers' struggles to combine breastfeeding, work, and other life challenges, for example, is certainly not unique to their specific social context nor to the confines of this study's scope. In addition to increased recruitment efforts, I attempted to address this issue of transferability by providing thick rich descriptions of the participants and the context of their lives. Depth, richness, and detailed description provide some basis for qualitative research such as this study to extend relevance in some broader context. (Schram, 2003)

Participant Reactivity

Another issue relevant to this study's methodological validity is the issue of participant reactivity. Interviewee may have had difficulty adjusting to me as a researcher taking on the role of interviewer. This issue may have manifested in various ways. One way participant reactivity may have surfaced is through the presence of young children during interviews. Eligible mothers were encouraged to plan that their interview be conducted without their children. But several mothers brought children to their interview for various reasons. The presence of children may have impacted what the mother said in response to questions. As well, a mother may have been distracted or preoccupied by her children in such a way as to affect the outcomes of the interview. This issue is discussed in more detail in the Conclusion Chapter. Another way that participant reactivity may have surfaced is through social desirability bias. Social desirability bias is a basic human tendency to want to present oneself in the best possible light and in this way study participants may report insight, ideas, or thoughts that might not be true representations of themselves but ones that they perceive as correct or socially acceptable

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based on cultural norms of the time. (Maccoby and Maccoby, 1954). This phenomena is thought to occur commonly in virtually in all types of self-report measures and across nearly all social sciences. (Fisher, 1993) Social desirability bias among study participants is equally important as that bias that may be introduced by the researcher since it threatens to render research data output less valid and thus inapplicable to other social contexts and populations.

When asked to share what their thoughts and attitudes were around breastfeeding, almost all the mothers espoused positive ideas and perceptions about breastfeeding. Additionally, mixed methods mothers particularly seemed to highlight breastfeeding intentions and behaviors over and above their ideas and behaviors about formula, although they may have used both methods equally. Because this study relied on self-reported thoughts, feelings, and perceptions of mothers infant feeding experiences as a primary source of data, it is reasonable to question the validity of participant's answers in terms of accuracy and objectivity.

I made all efforts to minimize participant bias. First, this study's purposive sampling design required that participants be included only if they met certain definitive, characteristics deemed important for purposes of this study. Eligible participants were required to self-identify as African American and to be mothers of young children either breastfeeding or formula feeding their baby. But this last detail (i.e. feeding method) may have been missed initially as the recruitment flyer was titled, *"Breastfeeding Thoughts and Attitudes Among African American Mothers"*. Several respondents remarked that, based on this title, they thought the study was only interested in recruiting mothers who breast fed. Secondly, more mothers who classified themselves as

"breastfeeders" responded to that initial recruitment flyer than did mothers who used other feeding methods. Third, several mothers labeled themselves as "breastfeeders" when they had, in fact, used formula and breast milk equally to feed their baby. This fact was sometimes not clarified until the face to face interview had begun.

In this chapter I have discussed my methodological goals and limitations and the methods for my research. This discussion includes an overview of the benefits of qualitative research techniques including grounded theory approach, and intersectionalist perspective as an analytical basis. This chapter has also discussed the recruitment and sampling techniques, sample characteristics, issues of researcher bias, data collection methods, data analysis approach (including coding schemes), ethical considerations, and study limitations.

CHAPTER 4

Findings and Results

The analysis that follows is based upon 15 in-depth semi-structured interviews conducted with African American mothers. The data were primarily analyzed using a template approach. Key codes or categories of ideas were determined a priori by the research questions developed and all information collected during participant interviews was organized within these categories. These codes served as basis for clarifying the perceptions, thoughts, and ideas from mothers, but they also allowed some flexibility as additional themes emerged. In the subsequent discussion, findings are organized by the method with which mothers chose to feed their baby: formula, breastfeed, or a combination of both formula and breastfeeding. Findings are considered within the context of structural constraints or limitations, micro-social influences, and cultural factors.

The first section in this chapter describes the key demographic characteristics of mothers who participated in the study. I then detail the major findings organized by the research questions stated in chapter two. I conclude with a contextualized discussion of mothers' experiences. Participants' quotes are used with details that support and explain each finding. Analysis is conducted throughout this chapter by comparing the experiences of formula feeding mothers with the experiences of mothers who exclusively breastfed their babies as well as to those experiences of mothers who used both methods. Of the mothers interviewed, a total of four mothers exclusively formula fed their babies, five mothers exclusively breastfed their babies, and six mothers used a combination of both methods (often referred to as mixed method feeders in subsequent discussion). All

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mothers interviewed were asked to choose a pseudonym to be used during their audio taped interview; all names used henceforth are these pseudonyms. Thirteen of the mothers chose their own pseudonym, two of the mothers asked that one be chosen for them. My aim is to present the social context of mothers' lives as they relate to their infant feeding experiences, allowing research participants to illustrate the relationship between their social world and their infant feeding experiences. In so doing, I hope to portray multiple participant perspectives and to capture some of the richness and complexity of the subject matter covered in this research project.

Participant Demographic

During interview screening, participants were asked about a number of demographic characteristics, including their age, marital status, educational attainment, employment status, number of children, and place of residence. Noteworthy patterns emerged with regard to several of these characteristics. In general, formula feeders tended to be younger, less educated, in lower-wage jobs, and more likely to be single mothers than were either breastfeeders or mothers who used both breast milk and formula to feed their child. Breastfeeders and mixed method feeders were both more likely to be older, married, and more educated than formula feeders. However, these two groups differ dramatically with regard to their employment status. The following section provides details of the demographic differences and similarities between the aforementioned groups of mothers.

Mother's Race

All 15 of the mothers who participated in this study self-identified as African American or as black. When asked, "What is your race?" More than half indicated that they identified as "African American" and or "Black" clearing stating one or both these terms. For purposes of this study, I interpret both African American and Black to have similar or same socio-political meaning for mothers namely that mothers identify as American citizens of African ancestry. For this reason, the terms are presumed to used interchangeably. It should be noted that one mother, Mary, revealed later during her interview that she was born in Haiti and arrived in the United States with her mother and sister when she was a young child. She grew up in a major northeastern U.S. city and identified herself as an African American. There was no discussion about Mary's rationale or ideas around self-identifying as African American rather than Haitian-American.

Mother's motivations or reasoning for their chosen racial identity were not investigated in this study nor are they central to the study's theoretical focus. Of importance, though, are the cultural, social, and other implications inherent in the shared experiences of this group that may contribute to their breastfeeding differences. This investigation of African American mother's breastfeeding thoughts and behavior was premised on the fact that African American mothers may experience a distinct or unique social context that supports their differences in breastfeeding behavior; recognizing, again that breastfeeding rates have increased among all other groups of mothers except for African American mothers. The issue of race is an important matter for consideration in this sociological investigation. The impact of class and race-based domination and power on interpersonal exchanges between individuals in society has been well

documented as an important sociological issue (Collins, 2001; Waitzkin, 1991, 1979). Moreover, racialized and sexualized attitudes and environments are said to shape breastfeeding practices (Blum, 1999; Litt, 2000) Most importantly, race along with other contextual elements like age, gender, and class have profound affects on the medical encounter in ways that may shape decisions to breastfeed. For this reason, I understand that it is critical to investigate race as a cultural factor in relation to structural, environmental, and ideological factors in breastfeeding behavior. This issue will be covered more in the next chapter.

Mother's Age

Mothers who formula fed were younger (mean: 27 years) than mothers who breastfed their babies. Mothers who breastfed tended to be older (mean: 30 years) than mothers who formula fed but younger than the mothers who used a mixed method to feed their baby -- both formula and breastfeeding. (mean: 37 years).

Relationship Status

Mothers who formula fed their baby were more likely to be single. Three of the four mothers who formula fed were never married. Two of the mothers Toya and Nicole had live-in boyfriends, and a third, Jane, was single. Only one formula-feeder, Allison, was married and lived with her husband who fathered her three daughters. All of the breastfeeding mothers and all of the mixed method mothers with the exception of one mother, Margaret, were married. Although the majority of formula feeding mothers were never married, there was a tendency for these mothers to have a live-in boyfriend, usually the baby's father.

Educational Training and Social Class

In this study, I use education as a proxy for social class. Social class is a multi-faceted concept, but I chose to focus on the educational component because I think that infant feeding behavior is related to type of employment and health knowledge generally rather than just income. Mothers who attained up to a high school diploma were categorized as "lower" socioeconomic status (SES). Those mothers who had completed any post-secondary education or training were categorized as "middle-upper" SES. Educational status was assessed at initial contact and as part of the screening.

A mother's level of completed education or social class was often a predictor of her infant feeding behavior. All four of the mothers who formula fed had completed little to no post-secondary educational training. Additionally, all four of these mothers were employed but held lower wage earning positions that permitted little flexibility in their workplace environment. The lower paying and less stable employment circumstances left most of these mothers with inadequate incomes to support their families. This is a critical point as all of these mothers were primary breadwinners for their families.

The educational background and training of breastfeeding mothers and mixed method mothers were in stark contrast to that of formula feeding mothers. Mothers who breastfed their babies, even if in conjunction with formula use, were much more educated. Mothers who exclusively breastfed their babies tended to be stay at home mothers or to be employed part time supported by professional-level incomes of their husbands. Mothers who mixed feeding methods were middle to upper class as well but tended to lead busy out of home lives often navigating between school and work in pursuit of career advancement.

Although education is commonly used as a proxy for social class, it should be considered a limitation because education does always translate into higher social class status for African American women in the same that it does for other populations. Residential segregation, discrimination in employment and hiring practices, and racism adversely affects social class status of African Americans in ways that compromise how well education might be used to determine socio-economic status (Mullings, 2006; Williams, 2000). This issue will be discussed further in the Conclusion chapter.

Number children

Mothers who formula fed their baby had fewer children (mean = 2) than mothers who breastfed (2.8), on average. Mothers who used a combined method to feed their babies had the least number of children (1.83). However, the average number of children for breastfeeding mothers was skewed by one mother, Michelle, who had six children. If we exclude Michelle in the calculation, the average number of children for the remaining breastfeeding mothers was the same (2) as that of the formula feeding mothers and still higher than mothers who combined feeding methods. I believe this to be a function of mother's age primarily. Formula feeding mothers reflected less collective time as mothers. Breastfeeding mothers were older than their formula feeding counterparts. Mothers who used a combination of both methods were significantly older than both aforementioned groups. Having fewer children might be explained as a function of mixed methods mothers being busy upwardly mobile individuals actively pursuing advancement through their careers or through graduate level education sometimes simultaneously; something that would afford them less time and opportunity for having children.

Place of Residence

The geographic area that mothers resided in often reflected their socioeconomic status and subsequently – her choice of infant feeding method. Almost all of the mothers who formula fed lived in rental spaces located in small working class southeastern Michigan communities in the metro Detroit area. Only one mother who formula fed her baby, Jane, lived in the more affluent city (though be it in a rented space with her mother and children) at a housing cooperative. Another mother resided in a working class community that is home to a once bustling manufacturing plant. The other two mothers who formula fed lived in a more economically and racially diverse city. Three out of five of the mothers who breastfed their baby reside in the more affluent residential community located thirty-five miles west of Detroit, Michigan. Mothers who used mixed methods were evenly split for their place of residence, though the majority lived in more affluent cities.

The Role of Social Context in Infant-feeding

The following section outlines the study's major findings as they relate to each research question. Reported findings focus on a total of six major theme areas. Major theme areas are based on research questions and major concepts that emerged during interviews. Themes based on research questions include general thoughts and attitudes around breastfeeding, healthcare, health provider experiences, employment experiences, family and personal community experiences, and thoughts about public treatment of breastfeeding mothers. Among those themes that emerged from the data itself, I explore the ways that mothers defined breastfeeding and the significance of mothers' health status, religious or spiritual beliefs.

Defining Breast Feeding

The mothers whom I interviewed defined breastfeeding differently than the operational definition used for purposes of this study. For purposes of classification as breast, formula, or mixed feeding methods, this study defined a mother as breastfeeding if she breastfed her baby exclusively for the first six months of baby's life. However, the mothers I spoke with had a more inclusive definition of 'breastfeeding.' When mothers were asked how they feed their baby, at least four mothers indicated during initial screening that they had breastfeed their baby when they had actually used a combination of formula and breastfeeding. This was clarification was typically made during the face to face interview. Mothers felt that if they initiated and breastfed their babies -- even if in combination with formula – that they had breastfed their baby. It is not entirely clear as to why these mothers had an expanded definition of breastfeeding. Perhaps mothers wanted to see themselves as breast feeders because breastfeeding is socially valued as an important cultural norm of motherhood.

General Thoughts and Attitudes

A significant proportion of mothers used a combination of infant feeding methods – formula and breastfeeding. Six mothers reported having combined methods of infant feeding during the first 6 months of baby's life. Almost all of the mothers interviewed reported that they believed breastfeeding provided better nutritional and psycho-emotional value for their baby's growth and development. For many, this belief motivated their efforts to breastfeed. This positive view of breastfeeding was held even by mothers who, for various reasons, elected not to breastfeed or who chose to mix

methods. For these women, realities of their lives such as psychological difficulties, physical health problems, or the realities of working caused them to decide not to breastfeed despite their reportedly positive view of it.

Mothers were asked, "What are some of the things that influenced your thoughts about feeding your baby?" Most mothers seemed well informed about benefits of breastfeeding, Mary, for instance used both formula and breast milk to feed her baby and she was convinced of breastfeeding's multiple advantages:

> "The bonding with the child is number one. And that the milk that a mother produce has a lot of nutrients in there, and as a kid, because when they are in your stomach, they are very close to the heartbeat, and that's another way to bring them back to you and then kind of comforting them, making sure that they're OK. So, kind of building a sense of security and giving them a sense of security and also a sense of peace and confidence."

Lisa similarly explained that: "I definitely wanted to breastfeed. I did my homework and I know that breastfeeding is the best milk you can provide for your baby, so I did want to do that." Lisa intended to breastfeed exclusively, but after the premature birth of her baby, her plans were complicated by baby's extended hospital stay and worries about her baby's health. She ultimately moved from exclusively breastfeeding her baby to supplementing with some formula within several weeks of her baby's birth. Likewise, Julie, who also used formula and breast fed, felt that breastfeeding offered her baby physical health benefits as well as psycho emotional advantages. This motivated her to breastfeed her second child for as long as she felt she could:

> "So, definitely the immunological benefits of formula – of breastfeeding drove that. I think I always advocated for breastfeeding. I wouldn't say I'm a staunch advocate, but you know, I think the benefits are clearly there. Also I think because with my second son, I had to exclusively pump. (With this third baby) It was having the ability to have that bonding experience with Tyler (pseudonym) probably influenced it."

We see that the majority of mothers interviewed firmly believed breastfeeding offered their baby optimum health advantages as well as ideal opportunities for mother-child bonding. But for the mixed-method mothers, decisions to breastfeed were negatively impacted by perceived limitations or personal challenges in the environment, issues which I discuss at length below. Yet not all mothers perceived benefits to breastfeeding. Two mothers, both, who formula fed their babies stated that they did not see any real benefits for babies in breastfeeding versus formula feeding. For example, Jane felt that her formula-fed baby was actually healthier than her aunt's baby who had been breastfed:

> "My aunt breastfed her son until he was about 13, 14 months. He's the sickest kid I know off breast milk. Always has an ear infection. Always has a runny nose. Always coughing. Always has strep throat. He's sickly. Yeah. They say they're healthier. My son was formula fed. He's not as sick as my aunt's son."

Nicole had heard from "older women" at work who'd breastfed that "it (breastfeeding) was healthier". "Their thoughts were that, you know, they – well, pretty much that the doctors told them it was healthier. So, that's why they went that route" But these ideas had little impact on Nicole:

> "I guess it was just, you know, seeing the difference in baby – not necessarily seeing the difference in baby that was formula fed versus breastfed, but I didn't see any difference as far as their behavior or how they acted versus a baby that was bottle fed and formula fed. As far as the kid's development or anything."

For many of the formula feeders, the perceived health benefits of breastfeeding generally were undermined by their perceptions that, in their case, breastfeeding was not the healthiest feeding method. Three of the four mothers who formula fed indicated that their own poor nutritional intake, alcohol or tobacco use, or prescription drug use was a

concern and a major factor in their decision to formula feed their baby versus breastfeed or use a combination of the two. Jane struggled with caring for herself and her baby both during and after her pregnancy. Jane indicated early in the interview that she doubted that breastfeeding gave baby better nutritional and developmental advantages but later admitted that she felt breastfeeding might offer health benefits; in the end, she thought that it was best not to breastfeed her baby based on her ongoing use of prescription medication.

> "Breastfeeding can be healthy only if mom has healthy lifestyle. I mean the benefits can be really healthy for the baby, and there are some benefits that are not so healthy as far as like, when you get sick, what do you do when you have to take medication? You have to switch your baby to formula. If you have to take certain types of medication when you come home from the hospital after you have the baby, you have to give your baby formula. You can't take narcotic pain pills and breastfeed your baby and then you can't smoke cigarettes and breastfeed your baby."

Jane also acknowledged that she smoked and that she didn't want to continue to subject her baby daughter to effects of cigarette smoke after delivery though she'd smoked during her pregnancy.

> "I smoke cigarettes. I knew that I was not going to be quitting any time soon. I smoked while I was I was pregnant with her, but my feeling was, you know, just because I smoked the whole nine months, why continue to feed her this nicotine now that she's out in the open. At least try to give her a chance to be able to survive out in the open without these cigarettes. I sometimes consume alcohol. You can't consume alcohol and breastfeed your baby. I was selfish to smoke while I was pregnant – very selfish, but I would be more selfish to continue to give her cigarette. So, it (breastfeeding) wasn't for me."

Jane later confessed as well that she was taking medication for bi-polar disorder and depression and that she felt that these were important reasons not to breastfeed her baby.

Nineteen year old Toya faced a number of challenges to her thoughts around

breastfeeding her baby including her concerns about proper nutrition and healthy eating. Toya had hoped breastfeeding might help her eat better:

> "I wasn't a healthy eater anyway. And I had wanted to try it so I could start eating right or whatever. But I wasn't that much of a real healthy eater. I mean I drunk milk a lot. Like I would go through a gallon of milk a week. So, I was – I drank a whole lot of milk and I did eat vegetables, but I ate a lot of junk too. So that was another reason why I needed to try to eat more healthier for myself and for my child. So it just didn't really work out."

Nicole echoed this point, by saying, " It was pretty much, also too, about the simple fact that what you intake is also what the baby is gonna intake, as well."

Among these mothers, breastfeeding was almost universally viewed in a positive light. Most mothers reported that they believed breastfeeding, generally, to be the 'healthier' approach to infant feeding. Yet not all mothers made the decision to breastfeed or to breastfeed exclusively. Realities of these women's lives, such as their own health issues, influenced many to make decisions about infant feeding regardless of their positive views of breastfeeding.

Religious or Spiritual Motivations

One third, a total of five mothers, revealed that their spiritual or religious beliefs motivated their infant feeding decision. These mothers chose either to breastfeed their baby or to use a combination of breast milk and formula for their baby, noting that their choice to include breastfeeding as a infant feeding method was somehow tied to their religious or spiritual values they held. Mothers professed to Christian beliefs as well as beliefs based on Muslim faith practices and doctrines and expressed that their motivation to breastfed was, in some way, tied to their religious doctrines. Faye, who breastfed her

baby, shared that her Muslim faith encouraged her to make motherhood and homemaking a "first choice" in her life with children:

> "Yes. I mean, it's not discouraging for working mothers because there's examples of that in my religious history, as well. But just, if you have the choice, if you have the option, you know, of course, being a homemaker would be the first choice. Even if it is for a period of time, like, for myself, with my first two children, I was at home up until they started grade school."

Likewise, Margaret says that her decision to breastfed was motivated by her faith as a Christian:

> "My belief in God – that's where it originated from. I felt like God gave us this ability to breastfeed. It's the best for the baby and, you know, it's more economical" And I felt that's what women should do. They should choose to breastfeed."

Other mothers who all breastfed or used a mixed method of breast milk and formula feeding added similar thoughts that reflected a relationship between their religious faith and breastfeeding:

(Michelle):

"Breastfeeding is what God intended – which what breasts are for; breastfeeding is natural"

(Peaches):

"Muslim faith recommends breastfeeding your baby for two years"

(Lisa):

> "Maybe that how God's plan is ...he provides food, milk for babies...like with other animals. You know, the mother provides the milk for her babies. So it is with human beings, as well. You know we have the source needed for them to survive".

Religious beliefs played an instrumental role in breastfeeding behavior for some mothers who initiated breastfeeding. This was true for mothers who breastfed exclusively as well as for those mothers who used a mix of breast milk and formula to feed their babies. This is important to note as it serves as an example of how cultural beliefs might impact mothers' breastfeeding behaviors.

Mothers' and Baby's Health Status and the Role of Healthcare Providers

More than half of the mothers reported that they or their baby experienced medical difficulties during their pregnancy or birth and that this experience in some way

influenced their infant feeding experience or decision. For example, Lisa used a combination of both formula and breastfeeding because she felt "disillusioned," guilty, and ill-equipped to breastfed her premature baby because of the prenatal focus on her health:

> **Lisa:** "I had been in the hospital for six weeks before I even had my baby. So, I didn't have any opportunity to kind of do any research. So it hadn't been something I thought about. I just thought I was going to breastfeed as a natural process. I had toxemia; I had high blood pressure during my pregnancy, and it just caused me to have a lot of problems. You know, I was thinking because I wasn't healthy as I should have been or wasn't doing what I needed to do, I was scared that, you know, maybe the reason why I became had toxemia or give it to her or just, you know. I just didn't know if that would affect anything that was going on with her. My own health issues, I didn't want them to affect anything that was going on with her because she was already having to deal with her own health issues at the time."

Difficult pregnancies often led to more focus and concern on mothers' and baby's state of health and subsequently less focus on breastfeeding by healthcare staff and others. Difficult pregnancies included those where mother's prenatal status was moved from normal to "high risk" because of one or more health conditions experienced by either the mother or the baby. Lisa, for example was hypertensive and subsequently was hospitalized for the last several weeks of her pregnancy. This sometimes fostered more uncertainty in the mother's mind about whether breastfeeding was best. Lisa tried pumping breast milk in the hospital after her baby was born prematurely at 32 weeks gestation but she wasn't confident that breast milk was best for baby:

> "Because my baby was a preemie, I just was concerned; that I wanted to make sure that she got everything she needed to maintain growth and to make sure that she had all the essential, everything she needed. I didn't know if she needed something extra because she was a preemie, because they put her on this special formula because she was a preemie and it just made me unsure if, you know, I could provide everything she needed. Although now, in retrospect, I look back

> and I know that was, you know, I guess I was nervous, first time mother, young. Didn't realize what I was thinking at the time. Stress, I don't know."

For Julie, who also used a mixed method of feeding, the reverse was true. Because of her history with problematic births, Julie was considered "high risk" by her health care provider and felt she led a cautious pregnancy. And so with this next baby, Julie was excited to breastfeed so that she might have the "bonding experience" she feels she missed with her previous babies:

> **Interviewer:** "do you think there's any relationship between what it was like for your [child's] birth and that decision to breastfeed?"
>
> **Julie:** I would... just the fact that it was a complicated pregnancy, but an uncomplicated delivery. So you know, we successfully got through the pregnancy and she, you know, was born healthy and all. And I don't know if I was conscious to say that sort of prompted me to breastfeed, but I'm sure on some sub-conscious level, you know, the fact that we sort of made it through the journey and just having that bonding experience that breastfeeding offers."

Mothers reported a variety of physical health conditions they experienced during pregnancy including: toxemia (pre-eclampsia), hypertension, gestational diabetes, excessive hemorrhaging, jaundiced baby, premature birth, and "high risk" birth. Allison, who chose to formula feed her baby, suffered from gestational diabetes and hypertension throughout all three of her pregnancies. These health challenges contributed to her decision to formula feed her baby, in part, because her healthcare providers focused more on her health during the pregnancies and less on breastfeeding and other post-partum issues. When asked what infant feeding information her obstetrician provided during her pregnancy Allison indicated that there was no discussion about infant feeding; and that the focus was on her health:

Interviewer: "Did she discuss baby feeding at all?

Allison: "Not at all. It was (inaudible) on my health because I was a high risk pregnancy so she more concentrated on me, like, my blood pressure. I had gestational diabetes, so she was more concentrated on me."

Mothers' mental health difficulties, in particular, seem to play a decisive role in infant feeding thoughts and behavior. A number of mothers reported that mental health issues like bi-polar disorder, depression, and anxiety, made it difficult or impossible for them to breastfed their baby. This was true for mothers who formula fed as well as those who breastfed or used a combination of both formula and breastfeeding to feed their babies. Margaret suffered from depression both during her pregnancy and after she gave birth. She cites her depression as a key factor that contributed to her decision to switch to formula after having first breastfed exclusively for baby's first few weeks of life:

> "I had a lot going on. It was just, I guess I was somewhat, I thought it (breast feeding) was very demanding and it was just more convenient for me to formula feed with all that I had going on. I was in a depression during my pregnancy. And after my pregnancy, I was just trying to survive myself."

Similarly, Jane battled bi-polar disorder and depression. For Jane, the decision to formula feed her baby was practical and clear. Along with other prescription medication she was taking and the fact that she was an active smoker meant that breastfeeding was not a reasonable choice for her. Jane revealed other barriers to breast feeding:

> **Jane:** "I take medication; for bi-polar disorder. I take medication for severe depression. The medication that I take for my bipolar, I can take that at 7:00 in the evening and I might not wake up until 11:00, 12:00 the next day. So, why would I give my baby this medication, this jolt of medication? If it's knocking me out like that, what do you think it's doing to my baby?"
>
> **Interviewer:** "Right"
>
> **Jane:** "So, she can be a zombie? No thanks."

Similarly, another mother, Peaches, indicated that the mental trauma of a sexual assault influenced her decisions about infant feeding. Peaches suffered a sexual assault before she was pregnant with any of her three children and decisively chose to pump and feed her first two babies the breast milk because of disturbing feelings related to the assault. By her third baby, Peaches was remarried to a second husband who, along with her midwife, made Peaches feel more supported and able to breastfeed directly from the breast.

The health status of mothers and their babies seems to be a major factor in mothers' decisions around infant feeding. But while health status weighed heavily in mothers' minds, the ultimate choice and behavior was further impacted by the relationship that mothers had with their healthcare provider and the information and support they received from them as well, be it in negative or positive ways. For example, Lisa spoke about the utter lack of information she received from her health care provider about infant feeding:

> **Interviewer:** "Research indicates that what health care providers say and do may have some relationship to you ideas about feeding your baby. What information did you receive from your health care provider regarding feeding your baby?"
>
> **Lisa:** "You know what, none. Now that I think about, now that I think back on it. He (Ob-Gyn) didn't provide anything. He just told me to get this book. And I got the book. And there was a, "What to do when You're Expecting" or "What to expect When You're Expecting."
>
> **Interviewer:** Yes. Any more?
>
> **Lisa:** "So he did not – we didn't talk about – he talked about my health and the concerns with me. He talked about my pregnancy, but he really didn't talk in terms of after baby was born, what then. He just talked about because I think that has to do with, you know, the fact that I had toxemia, high blood pressure. That kind of thing. So he was more concerned about the right now and not more so – because I didn't ask him about that either."

Lisa also pointed out that the nurses who cared for her and her baby while they were hospitalized were not very supportive of her interest in breastfeeding:

> "I know that one thing that really influenced me was that some of the hospital, you know they give you the free samples [of formula] in the bags. I just kind of got the feeling from the nurses. I mean, they never verbalized in saying, but I think their actions were kind of like, you know, 'we need more. Try this.' Or they weren't very supportive to me as far as, 'OK, take your time. You know, you can do this. Or here's different resources that you can maybe, that I can refer to. But because she [baby] was a preemie and because they weren't very – you know, I did ask questions, but I kind of just felt like they weren't very supportive"

Other mothers, though, did relate stories of health care providers who were supportive of breastfeeding. For example, as Margaret experienced depression and struggled to care for herself and for her baby, she recalled some help she received from someone in the hospital who she thought might have been a lactation consultant:

> "When a I was in the hospital, a lady came around. Are they lactation consultants? Or are they – I don't know. She came into the room and, you know, she showed me what to do and explained and really, really pushed breastfeeding on me. And I, you know, I was a believer in breastfeeding, and I had the heart to do it."

Likewise, AKA was satisfied with the support she received from her healthcare provider in learning to breastfeed baby:

> "My OB/GYN actually talked with me about the whole process, what would need to be done after I gave birth, the initial steps in the process. You know latching on. I don't think they really explain to you in detail the pain that is involved with breastfeeding, [but] I think that will probably discourage a lot of people. So it's probably something you need to experience. And it depends on how committed you are to it. But my healthcare provider probably was pretty instrumental in providing me with literature that I could read and things like that. The nurses at [name of hospital] were very supportive. They were very helpful. They actually come in and they help you, you know, latch the baby on and things like that."

Most of the mothers, regardless of whether they formula fed or breastfed their baby, used an obstetrician for their prenatal care. Four mothers, Faye and Peaches both of

whom breastfed their babies, Toya, who formula fed her baby, and Mary who combined both breastfeeding and formula, indicated that they had seen midwives for some or all of their prenatal care. Mary, Peaches, and Toya experienced involuntary changes from having prenatal providers from midwives to obstetricians during their pregnancy. Mothers who switched care mid-way through their pregnancies noted that their midwife was more likely to offer, personalized, attentive care and more likely to encourage breastfeeding. Though she preferred to have a midwife for the prenatal care, Mary says she was switched from her midwife to an obstetrician because she began experiencing problems with her pregnancy and at age 36, was considered a "high risk". Mary noticed that there was a difference in the way her obstetrician interacted with her versus how the midwife had interacted with her; she expressed discontent about the less personable care she received from the obstetrician and longed to go back to the midwife:

> "Well, I wanted a midwife. I started with a midwife, but because of pregnancy difficulties and problems that I had, they transferred me to an Ob/Gyn. The midwife – from the beginning, the midwife was more – it feels like, more personal. It was, there was more caring, more thought into it. For the Ob/Gyn and the way I see it, the midwife, maybe I could be wrong, too. To me, it seems like they had less clients so they could focus on the patient more. My mid-wife spent more time to show me breastfeeding"

Peaches had a midwife throughout her pregnancy until the day she went into labor. She had planned to give birth to her third baby at home but her plans were sidelined when her midwife became unavailable for the birth. The change in plans left Peaches disappointed that she did not have her midwife present at her baby's birth. Additionally, Peaches was not happy about this change nor about the problems she experienced later in giving birth at the hospital:

"I--so what I did is, is by baby number three I didn't really deal much with the doctors. They were messing with me a lot anyway. I did my midwife and she was gonna do a home birth. The sad part is my midwife got sick and was in the hospital the day I gave birth, in the hospital for two days, so she wasn't there to kind of keep me at home. So when the pain got to transition labor--cause remember I gave birth to the other two in the hospitals--I had never felt transition labor. I had never felt real labor. When I finally felt that real, that real, real, real--.... So I went. I said, "I have to get,"--you know, at a home birth you don't get any painkillers. So I was like, "I gotta go."

Peaches felt her mid-wife to be critical part of her pregnancy since her midwife discussed the breastfeeding in detail, and because she strongly encouraged Peaches to breastfeed despite Peaches' hesitation to do so because of past sexual trauma:

"And then I talked to my midwife about it and there was a lot of--she was--she's awesome. She's amazing. Beth (pseudonym) is probably one of the most amazing phenomenal human beings ever. But with Moonlight (pseudonym for baby) my midwife convinced me, she said, 'Look, breast milk is the best,' she's like, 'But the, but the benefits of actually breastfeeding the child from your breast,' she said, 'Honey, it helps you with cancer,' she says, 'It helps you, your uterus go back down, so your stomach,' she says, 'I want you to promise me that you'll at least breastfeed from the breast at least for at least three months,' and I told her fine. And I did it and let me tell you this; I'm so happy that I did that. I started telling my mom; I was like, Mom, why didn't you tell me that this was breastfeeding'?"

Toya began seeing a midwife when she became pregnant and says that information her midwife shared with her about the benefits of breastfeeding inspired her to breastfeed. But after switching to an obstetrician at another health system, Toya says the emphasis on breastfeeding disappeared and she received no information:

Interviewer: 'Did you feel you were getting the information you needed from your health care provider?"

Toya: "At first I was, and then – at first I was but, then I had a (inaudible) health care providers, and they really didn't tell me much after I had switched to a different health care provider. But, at first, they [the midwife was] were just saying that children who are breastfed are less likely to get ear infections and their brain develops more or something like that. But basically, they had said a whole lot of positive things about breastfeeding children. So, that's what made me want to try it. But after I had changed my care providers, they really didn't speak much about it."

Faye chose a midwife because she knew that she would be more likely to get a woman than if she chose an obstetrician. This was important preference for her based on her religion (Islam) and her desire for a less medicalized approach to her pregnancy:

> **Interviewer:** "So, you had a midwife. Was it your choice? How did the idea of a midwife come?"
>
> **Faye:** "From the likelihood of it being a woman. (laughs) Because of my religious background we have a strong sense of separation of men and women. Particularly physically. You know, if you can find a female doctor, as a woman, you prefer that over a male. But if need be, you won't turn the male away and refuse health care if the woman's not available type thing.
>
> **Interviewer:** "Yes, yes."
>
> **Faye:** "But the likelihood of coming in contact with women as opposed to a man encouraged the midwife decision. And the less clinical approach to giving birth and going through the gestation period was attractive for me in choosing a midwife."

These examples demonstrate that mothers who received prenatal care from midwife, even if only for brief duration of their pregnancy, articulated a clear preference for a midwife to handle their prenatal care and that midwives may have played a more instrumental role in some mothers' decisions to breastfeed. Healthcare providers generally promoted breastfeeding as a good choice when they discussed the option with mothers. Most mothers reported that they had shared a discussion with their healthcare provider on infant feeding but the discussions, themselves, tended to be brief and not detailed. Moreover, healthcare providers often did not indicate whether they favored breastfeeding or formula feeding. This was especially true for mothers who used obstetricians for their prenatal care. Likewise more formula feeding mothers reported that they'd received neutral messages about infant feeding. Infant feeding discussions with

midwives seemed to be more in depth and more likely to encourage breastfeeding. Mothers also reported that they'd received information from pediatricians, and several women reported representatives of the Women Infants and Children (WIC) program discussed infant feeding with them.

A significant number of the mothers indicated that breastfeeding was offered neutrally alongside formula as an infant feeding option. Seventy-five percent of formula feeding mothers indicated that messages were neutral compared to 67% of mixed feeding method mothers, and 60% of breastfeeding mothers. Mothers typically reported that they were simply asked, "Which method are you going to use to feed your baby?" with little detailed discussion or conversation about the chosen infant feeding method. Nicole, who formula fed her baby, doesn't feel that she had much discussion about infant feeding methods with her obstetrician:

> **Interviewer:** "What information did you receive from your health care provider regarding feeding your baby?"
>
> **Nicole:** "I just remember a lot of pamphlets, what their thoughts were on, and about breastfeeding or whatever versus bottle. So they give you information for going both routes."
>
> **Interviewer:** "Was it helpful at all? Did they sway you one way or the other?"
>
> **Nicole:** "Not necessarily sway me. No. You know what, and then what I also think about, too, is I don't know, they really don't -- my Ob/G, pediatricians, or whatever, they're not necessarily, I mean, they ask you what method of feeding do you want to do, but they really don't try to – I don't know. I don't seem like I got a lot of information on why you should breastfeed versus bottle feed again. You know, they didn't try to push either one on me."

Allison, who chose to formula feed her baby, similarly describes her experience of having a very brief conversation with a WIC representative her provider about options for feeding her baby:

> **Allison:** "No. You know they did ask me which one was I going to do, and I told them (formula). And they had someone from WIC come in, which was new to me.

They weren't (there) when my other two children (were born). They carry them into the room and asked me. It was always afterwards." They asked me which one I was going to do. I told them I was going to formula feed, and she just signed me up."

Interviewer: "No talk about breastfeeding?"

Allison: "No"

For Michelle who breastfeed her baby, the experience was similar with more information provided to her once she indicated her decision to breastfeed:

Interviewer: "What information did you receive from your healthcare provider regarding feeding your baby?"
Michelle: "Well, my doctor, 'cause they asked me before I you know, while she was in what was I gonna do, breastfeed or bottle feed, so they didn't sway me any way.
Interviewer: "Did give you a lot of information about breastfeeding?"
Michelle: "--mm-hmm, they gave me a lot of--I--when I made the decision to breastfeed they did give me a lotta information on breastfeeding. They gave me storage containers with the ounces on the outside and a little bag on--and then they gave me the pamphlet on how to store my milk, how long, where was best to store it and, and stuff like that. So they did, they did pretty good with that."

Impact of Interactions With Healthcare Provider

More than half of mothers' indicated that their infant feeding experience and decision were negatively influenced by experiences and interactions with healthcare providers. A majority of the mothers noted that their experiences with their healthcare providers discouraged or hampered their plans to breastfeed their baby. Breastfeeding and formula feeding mothers were equally represented in this observation. A total of nine mothers including evenly distributed across all feeding method groups described conversations and interactions with obstetricians, nurses, and pediatricians that mothers felt steered them away from breastfeeding. As discussed in an earlier section, Toya's early plans to breastfeed were hampered by a switch to an obstetrician who engaged Toya in little discussion about feeding her baby. After giving birth, Toya's request to "try

breastfeeding first" was not supported. She was asked which formula she wanted to use and strongly encouraged to feed her baby formula:

> "When I had gave birth to my child, I had asked the doctors because they asked me which formula I wanted between Similac or Enfamil, and I told them I would like Enfamil, but I wanted to try to breastfeed first. And they told me that my son needed to eat right then. So, they didn't have time to get him to latch on and then made me choose the formula for him."

After struggling to try breastfeeding alone at home later, she became frustrated, abandoned plans to breastfeed and fed her baby formula.

Another mother, Peaches angrily recounted her experience with hospital staff shortly after the birth of her baby. Peaches recalls that she delivered at the hospital using health providers she didn't know because her midwife was not able to come. Though she asked them to bring her the baby so that she could breastfeed, hospital staff would not bring her the baby, she says. They indicated that baby was connected to heart monitoring equipment and that she might hemorrhage if she left the bed. Because she threatened to leave her bed, Peaches insists that hospital staff deceived her to remain in the bed by indicating that they would bring her the baby if she did not leave the bed. She says that she later found that they'd fed her baby formula without her permission. When asked why she thinks hospital staff would not bring the baby back to her, Peaches stated that nurses felt the baby's and her health were at risk because of birth complications:

> **Peaches:** "they said they had her on this thing, because of when she was born the heart--the lungs and there was this air pocket so they had to have her down there. I said, 'Well, let me go get her,' "She's hungry, she's hungry," so let me go get her. The doctor was like, 'Wait here for an hour.' I said, 'I want to breastfeed her because she's hungry. Let me start.' They're like, 'Well, let us give her formula.' I said, 'No. I don't want you to give her formula. She's a freakin infant. The first thing she will need to taste is my (breast milk),'

(Peaches is visibly upset as she recounts)

Peaches: "You know, I'm arguing with these people, listen-- I'm in the hospital just giving birth and you're telling me I can't walk down the hall less than 100 yards to breastfeed my child? And I'm arguing with you about this... This is my freakin body. Don't tell me about women's rights when you're not listening to me tell you in your face let me walk down the hall, 'Well, you're gonna--well, you're bleeding, you're bleeding heavily.' I just gave birth you idiot. Okay?. I really just gave birth. And do you know what they did? They, they fed her with a bottle."
Interviewer: "Against your wishes?"
Peaches: "--yes, they did. I, I, I sit--I sat there. The doctor came in. The nurses is like, 'No, no. Don't get up.' The doctor came in, 'Can I just let you sit here for an hour? I'm just worried about your health.' I was like, 'Fine, fine, fine. I want to breastfeed my child.' So they were like, 'Fine, fine, fine.' They made me believe that if I sat there for an hour they'd let me. When I walked in there to breastfeed her, 'Oh, well she's not hungry cause' we gave her a little bottle. Well, she was starving. I mean, she was just hungry. She was so famished,' and I was like, 'Really? Cause a 9 pound 11 ounce baby's just gonna starve to death, isn't she? She's just gonna drop dead from the fact that she didn't have food for an hour. I mean, the things they did at that hospital I seriously if I ever see that nurse I will seriously just sock her in the eye [inaudible] but you know, I want to. But the thing is like these people are ridiculous. They're ridiculous."

Ella changed her breastfeeding plans momentarily because her baby's pediatrician suggested she use formula. She was determined to breastfed her baby, but she felt that there was no clear preference for breastfeeding or for formula from her physician's perspective:

"It's interesting. I think they're more – I don't see them really caring one way or another if you breastfeed or use formula. Like a few months ago, Paris wasn't gaining enough weight because I actually wasn't eating enough. And so, she suggested I supplement, which – she suggested supplementation before asking me to eat more which I kind of thought was interesting. So, she gave me some formula, actually. But he wouldn't take it, so I had to start eating more.

Additionally, it was not uncommon for mothers to be given a supply of formula for their baby even when they had told hospital or other health care providers that they planned to breastfeed or were breastfeeding their baby. This left Terry, who breastfed and used formula, questioning the motivations of her obstetrical care:

"But when I left, even though I said that I was breastfeeding, they gave me a new mother's kit from one of the formula companies that had a book by one, like a famous

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> pediatrician. I don't know, maybe Dr. Sears, about baby development, along with a couple of generous samples of formula. So, even though I said I was breastfeeding, they still offered it (formula) to me. And to me, I would have been, like, OK, if my patient is breastfeeding then I'm not going to give her that kit."

Conversely, positive relationships or interactions with healthcare providers supported a few mothers' behavior and helped them to follow through on plans to breastfeed their baby. Margaret was offered the services of a lactation consultant while she was still in the hospital after the birth of her first baby. As well, because she was in a health program for "high risk" mothers due to her age, Margaret was assigned a case manager who talked with her about various issues like depression and feeding her baby. She was able to receive a hospital grade pump at a deeply discounted price and professional therapy sessions later for her relationship difficulties with baby's father and "deep depression." Though Margaret's ability to breastfeed was compromised by emotional and psychological difficulties, she says that "having the breast pump helped". Margaret breastfed exclusively for a few weeks and then she supplemented with formula for her baby's first year. Likewise, AKA who breastfed and used formula, says that she received lots of information and help from hospital nurses she interacted with post birth. AKA described the staff in the hospital as "very supportive" and "helpful" because they provided training that helped her learn how to properly latch baby for breastfeeding. Similarly, Julie was determined to breastfeed her baby because she had been unable to breastfed her previous baby. The previous baby was born 17 weeks premature which resulted in significant developmental delays and his inability to suck for breastfeeding. Because of her history of problematic births, Julie was considered "high risk" by her

health care provider and felt she led a cautious pregnancy well-supported by her health care provider.

Interaction with Healthcare Provider and Mother's Demographics

Mother's responses indicate that their relationship with their healthcare provider served as a strong pivotal point in their infant feeding decision. Although mothers described wide variations in the subtleties of power evident in healthcare providers' interaction with them, most of the mothers described interactions with their healthcare provider that seemed to indicate the exchange was invariably led by and/or dominated by the healthcare provider. Mothers' descriptions of their healthcare interactions often revealed that they did not direct the exchanges, themselves, but rather they followed the direction, inclinations, and ideas introduced or promoted by their healthcare provider usually willingly, but sometimes reluctantly. Conversely, two other mothers, Julie and Lisa, voluntarily acquiesced to their provider's focus on their problematic pregnancies and didn't shift attention nor initiate discussions around breastfeeding ultimately sacrificing the help with breastfeeding they both said they needed. Even Ella followed her physician's suggestion that she stop breastfeeding and switch to formula although she nonverbally questioned the rationale.

It is important to note that patient-provider relationships are commonly problematic across all populations. This fact is well documented (Waitzkin, 1991, 2000; 2001; West, 1984). But differences between physician and patient in education, social class, gender, ethnicity, and race make communication more difficult between the two (Waitzkin, 2000). Though it is not certain, it is certainly possible that race played an active role since all the mothers in this study shared the same racial group membership and most

likely, interfaced with non-African American providers. But what is clear is that there were sometimes differences between lower SES mothers and mothers of higher SES in the ways that they received and made use of information from their provider. One formula-feeding mother, Jane, who was of lower SES, alluded to the challenges she faced because of her perceived class differences; she felt this mattered in her ability to manage breastfeeding with her personal life and work demands:

> **Jane:** "She was eight weeks when I went back (to work)."
>
> **Interviewer:** "Did you want to go back when she was eight weeks old?"
>
> **Jane:** "No, I didn't want to go back, it's just the economy forced me to go back"
>
> **Interviewer:** "Tell me more."
>
> **Jane:** "I don't have a husband with the house and the white picket fence and the dog. And it's just mom."

Jane reported that she chose to "follow my own personal instincts" by using formula for two reasons: she felt that she had "conflict of interest" between she and her health care providers (pediatrician and the WIC health educator) and because she felt the information she received from these providers was also conflicted and confusing. Another lower SES mother, Nicole, reported similar inclinations about motivations for her infant feeding decisions. Nicole reports that she had no discussion with her healthcare provider about infant feeding methods or information. While Nicole thought there might be some value in breastfeeding, she leaned on her own judgment and her family's input as an important factor in her infant feeding decision. A third lower SES mother, Toya, emotionally recounted how her efforts to elicit information about breastfeeding from hospital staff were ignored, replaced, instead with a push from hospital staff and her grandmother (who was present at the hospital) to feed her baby formula "because he had to eat right there

and now." It is noteworthy that Toya was 17 years old at the time of her baby's birth – the youngest mother in this study. The fact the she was a much younger mother, as well, likely played a role in her interactions with hospital providers.

By comparison, a higher SES mother, AKA, described her exchange and information gathering experience with her health care providers to be relatively thorough and helpful:

> **AKA:** "My OB/GYN actually talked with me about the whole process, what would need to be done after I gave birth, the initial steps in the process (of breastfeeding). You know the latching on. I don't think they really explain in (enough) detail the pain that is involved with breastfeeding. I think that will probably discourage a lot of people if they actually told them that initially. But my healthcare provider probably was pretty instrumental in providing me with literature that I could read and things like that. The nurses at _____ (Name of hospital) were very supportive. They were helpful."

Other higher SES mothers, namely Margaret, and RunCat shared similar stories of having received some support in their infant feeding efforts.

The social context of mothers' interactions with their healthcare providers illuminates important ideas about the role of race, class, age, and other socio-demographic factors. We must consider the broader role of race, class, gender, age, beyond the patient-healthcare provider relationship as social determinants of illness and health is a critical factor in understanding the social origins of health. Researchers have advanced our knowledge in this and made it clear that class and race remain the most important determinants of health outcomes. (Willams and Collins, 2001; Williams, 1999). More discussion about the social context of doctor –patient interactions as well the social origins of health will be covered in the next chapter.

Multiple Births and Mothers' Infant Feeding Support

To a lesser degree, the variation in the amount of information and in the degree of support received might be related to whether the mother had previous births and what infant feeding method the mother used with babies born earlier. Several mothers who had multiple experiences of childbirth seemed to gloss over discussions they shared with obstetricians, mid-wives, pediatricians, and WIC representatives and more quickly concluded that they made decisions about which infant feeding method to use before they had conversations with their health care provider on this subject. This was true for mothers who had breastfed as well as mothers who formula fed their baby. Given this, health care providers may not have as much of an effect for second time or births as they might have for a first birth. Nicole had given birth to her third baby and didn't seem open to considering any other infant feeding options beyond bottle feeding – the method she'd used for her previous two babies:

> **Nicole:** ""To me, they just gave me the information and was like, 'it's up to you, how you feel and what you do'"
>
> **Interviewer:** "is this the same OB/Gyn you used for your other two babies?"
>
> **Nicole:** "Not the same doctor, no. The same, you know, clinic, yeah.
>
> **Interviewer:** "Ok. Was it enough information or did you wish they had given you more information one way or the other?"
>
> **Nicole:** "You know, not with this one. Probably with my first baby, yeah. Probably with my very first one, I probably would have wanted more information. But with the third one, it was like – I already had made up my mind that I was bottle feeding, so it was not really too much they could say."

Similarly, Terry made her decision to breastfeed her second baby before she discussed it with her obstetrician:

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Interviewer: "In what way did this information from your OB... how did this information affect your choice of method, if it had any effect at all or did it have any effect?"

Terry: "I don't think it had an effect. Because really my main reason for breastfeeding was to help my son. Because I knew breast milk would be better for him than formula."

Interviewer: "OK. So, sounds like you made some decisions – were these decisions prior to health (provider), OB?"

Terry: "I want to say we had this discussion probably right before I delivered. And I really decided before then that I would breastfeed."

Mary's decision to breastfeed her second baby was not impacted by interactions with her obstetrician either:

Mary: "And nothing was really, any – actually, I guess not research or extra help was given out there to help breastfeed. And I think that if they did provide information, that would have make (sic) it easier for everybody else. Not me, but that – because I knew what I would be expecting, and I knew where to go to get the information if I needed."

Working outside the home had a major impact on infant feeding behaviors in mothers. The majority of mothers who participated in this study were employed outside of the home or were attending school at the time that they gave birth, with the exception of mothers who breastfed exclusively. Those mothers who exclusively breastfed their babies tended to be stay at home mothers or part-time workers supported by the professional-level incomes of their husbands. Three out of the five mothers who breastfed stayed at home. A fourth breastfeeding mother worked part-time and a fifth mother returned to a work environment that she indicated was very supportive of her decision to breastfeed. All four of the mothers who formula fed their baby were

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employed full-time. Formula-feeding mothers, Jane and Tiffany, also were attending school. All six mixed methods feeders were employed full-time. Two of the six mixed methods feeders attended school in addition to working. Work represented a concentration of public sector or service industry occupations. The majority of mothers – eight – work full time in the public sector. The remaining mothers worked in the service sector (3), some while attending school or stayed at home with their children. Only one mother worked in a private sector occupation.

Employment or school was a factor in whether mothers breastfed and how much they breastfed. Twenty-seven year old Peaches who breastfed said that she and her husband agreed that she would stay at home to care for their two children while he worked, in part so that she could care for their children. Similarly, Ella remained at home with her two children while her husband attended medical school, but she also cared for a neighbor's children two full days each week in her home. Ella attributes the relative convenience of breastfeeding to her ability to stay at home full time with her two young children. It seems important to distinguish work conducted outside of home versus work done within the home because Ella's part time in-home child care job afforded her a chance to work but to do so in an environment that allowed her more flexibility and a greater opportunity to breast feed than other employed mothers had.

This highlights an important point about the difficulty of combining work and breastfeeding. The majority of the mothers in this study expressed an interest in breast feeding, and the majority initiated breastfeeding, but few exclusively breastfed their baby while they worked or attended school. A majority of the mothers who went to work after baby's birth reported that workplaces lacked things necessary to support breastfeeding

like private space to pump and flexible working conditions. These factors shaped mothers infant feeding behavior and made them less likely to breastfeed once they'd returned to work. Especially for the mixed-method mothers, decisions to breastfeed were sometimes negatively impacted by perceived limitations or personal challenges in the environment. Julie breastfed exclusively for first four months, then supplemented with formula during month five and six; she then felt she should stop breastfeeding baby when she was offered a new job. Julie worried that adding the demands of pumping at work to the task of learning the new position might make seem like a liability on the office, so she stopped breastfeeding just before beginning her new job:

> "I think the transition to exclusively formula feeding was driven because I was going into the unknown. I was, you know, starting a new job. I did not know the environment. I didn't know, can I leave my desk at 10:00 and go pump or can I not? I think because there was this unknown, it was like, I sort of prepared myself to say I have to make this transition into something different. And I guess I could have easily asked, 'well, this is my story, and I can pump' But you sort of, when you're entering a new, you don't want to invite too many, 'oh is she going to be one of those 'problem people'?"

Likewise, Terry returned to her position as a senior bank auditor; although she could pump at times, a heavy meeting schedule and demanding travel schedule made it difficult to pump. As well, she lacked private closed space to pump since her office windows were not covered. Terry did not feel comfortable asking for accommodations to pump; she felt that it might be asking too much:

> "Just that, I guess, the corporate culture. And really, I wouldn't even know how to, who to talk to in human resources to say, 'can we have a mom's room.' And even being able to make the business case for them to set aside the resources to do that in this type of an environment. And there may not be that many pregnant women to utilize it. You know, is it really something that the bank would do? I mean, I guess thinking of it selfishly versus common sense. And then maybe even going the extra step to say, "well, gosh, maybe they would feel like they would have to do that because I was an officer in the bank and this is what I'm

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> asking for even though it's unreasonable.' You know, there were a lot of things in play, and I just said, you know, it's just better to just be quiet about it."

AKA, too, returned felt that her heavy work travel schedule in a non-family, male-dominated work place dictated how long she breastfed. She weaned her baby at 4 months of age when she resumed her travel at work:

> "The individuals that I worked with either did not have children, which was very few women that I worked with. I mostly worked with men. So, I was not in a position where I would have been able to breastfeed for the long term because I travel for weeks at a time."

When Mary returned to work, she reports she had to find her own physical space to pump several times each day. Mary shared, "I had to post my own sign saying 'Do Not Enter' on the locked office conference room to pump. When the conference room was not available, I had to use the bathroom."

A majority of mothers who formula fed or combined breastfeeding and formula feeding reported that their employment environment and interactions at work shortened or discouraged their breastfeeding plans and prompted them to use more formula. Physical accommodations were sometimes made for mothers who needed to pump. This was more true for mothers in higher professional work positions, but demanding travel and meeting schedules, inflexible job role requirements, and general time demands prevented mothers from following successful pumping schedules to support breastfeeding. Professional working mothers reported more flexibility but little time to pump and lower level working mothers reported little to no time or opportunity to pump at work.

In addition to physical accommodations, and supportive work atmospheres influenced whether mothers chose to breastfed. Mothers experienced a variety of maternity leave times. Mixed feeding methods and breastfeeding mothers tended to have longer maternity leaves than formula feeding mothers. Mothers who breastfed were on maternity leave for a minimum of eight weeks to an indefinite period of time since most of them were stay-at-home mothers. Mixed method feeders had maternity leaves lasting six weeks to five months. The maternity leaves for formula feeding mothers showed a stark contrast with mothers on leave between three weeks to eight weeks. Shorter maternity leaves can be attributed primarily to financial constraints, non-professional work status, and limited employer sanctioned leaves, while longer leaves were supported by greater employer flexibility, professional work status, access to Family Medical Leave Act (FMLA) allowances, and greater household financial stability (especially for stay-at-home mothers). Challenges that mothers faced when they returned to work or school included lack of pumping accommodations, inflexible work schedules, demanding work and travel schedules, or perceived indifference or intolerance among supervisors and co-workers. The availability of and length of maternity leave mothers enjoyed seemed to be an indication of how flexible and supportive work environments were of their breastfeeding efforts. Employers who offered longer maternity leaves tended to be more supportive of mothers once they returned to work. This was especially true for mothers who held positions of higher status. These mothers tended to enjoy longer leave times than mothers who worked in lower status.

Faye revealed that she wanted to remain at home for a longer period of time with her baby for as close to the two years that her religion, Islam, recommended that she

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breastfeed. But "financial circumstances" at home prompted her to return to work at a local public library six weeks after her baby was born. She added that her job was generally understanding about her pumping schedule and that they did not "hassle me as long as it (pumping) didn't impact my ability to work". But eventually, Faye's daily milk supply for baby began declining when increasing responsibility on a traveling book mobile gave her only "fluctuating opportunities to pump". This occurred after baby was past six months of age but still much sooner than she planned. Jane was studying culinary arts at the local community college and working part time in food service. Although she wanted to stay at home longer with her newborn baby, Jane returned to work eight weeks after her baby was born. She resents the fact that she lacked the resources she felt would have made it possible for her to stay at home with her baby longer:

Interviewer: "Did you want to go back when she was eight weeks old?"

Jane: "No, I didn't want to go back it's just the economy forced me to go back. I don't have a husband with the house and the white picket fence and the dog. It's just mom."

Interviewer: "Economic conditions kind of forced you. You had to go back. Yeah, that's bad. OK. OK. What would you have done if you had your choice? If you didn't have to go back because of economics?"

Jane: "I would have sat home until my baby was a year. I believe when you have that baby, that your baby is supposed to be around you and the father and any siblings that you have in your home so that baby can get used to you. That first smell that that baby gets should be the mother. That first contact that that baby should be drawn to is the mother. That's the most crucial bond. And to have to go straight to work after that."

By contrast, Terry returned to work as a senior auditor for a major bank 12 weeks after her baby's birth. But she resorted to giving formula and gradually weaning her baby from the breast as she eased back into a travel-intensive and demanding schedule at work:

> "I was in the office maybe two days a week with the option to work from home, but I was traveling the other days; this plus a lot of face to face meetings made it almost impossible to pump."

Still Terry considered herself fortunate because her boss had been "very supportive", approving her "extended maternity leave" request "because he wanted me to come back". Moreover, she suspected that the greater flexibility she enjoyed was not experienced by other mothers in lower positions at her workplace. She recalls that one mother, a teller at the bank, did not breastfeed her baby. Terry feels that she, herself, was able to leverage her higher position for greater autonomy and flexibility but that this was tempered by a demanding work schedule and a "corporate culture" that left her unsure about how approach human resources with a request for space to pump.

Educational attainment also seemed to play a role in mothers' decisions around breastfeeding. Mothers who used a mixed method of formula and breastfeeding had attained a higher level of post-secondary education than had their formula feeding counterparts. All of these mothers held at least a Bachelors degree; half held Master's degrees. All five of the mothers who breastfed exclusively had attained some post-secondary training. Two of these mothers earned a Bachelor's degree or better while the remaining three mothers indicated that they were just a few credits shy of attaining the Bachelor's degree. All four of the mothers who formula fed earned less than a bachelor's degree. This was true despite age of mother. Thirty-eight year old Allison, for example, worked as telephone dispatcher at a college and said that even going to the bathroom was a concern as there was no one to cover her regularly in these instances. She planned in advance to formula feed her baby because she knew that she would have no time at work to pump breast milk – something she had tried to do with her previous baby. Nineteen

year old Toya who was still in high school when her baby was born, was shocked to find out she had been fired from her position at a fast food restaurant, while on her one-month long maternity leave though the restaurant told her to keep her uniform in preparation for returning to work after her baby was born. Twenty-six year old Jane was attending the local community college to pursue training in culinary arts, but was overwhelmed with the birth of her second baby and chronic mental health issues and eventually left school. The discussions around employment seemed to indicate that while mother's educational level determined whether she initiated breastfeeding, her employment environment undermined her breastfeeding efforts and reduced the chances that she breastfed once she resumed working. Less educated women tended to have blue collar jobs without the flexibility needed to support breastfeeding once they return to work. Among more educated mothers, all breastfeed to some extent. Those who worked outside the home tended to become mixed-method feeders once they returned to work, when the time and environmental demands of work left less opportunity for pumping. This contributes to their decision not to breastfeed, along with other factors like health and health care, health behaviors, cultural and family beliefs, to decide breastfeeding behaviors.

Family and Personal Community

Mothers were asked to share thoughts, attitudes, and ideas that family members had about breastfeeding. Additionally, mothers were asked what infant feeding method the baby's maternal grandmother used. Mothers were not asked about the infant feeding behavior of the baby's paternal grandmother, specifically. Though, some mothers may have included thoughts about these women in their discussions about family. For purposes of this study, discussions about "grandmother" refer to baby's maternal

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grandmother only. I believe that maternal grandmothers are more likely to influence the attitudes and behavior of mothers in this study simply because they are more likely to share a closer and longer-lasting relationship to mothers.

Discussions with mothers suggest that there is a strong relationship between infant feeding behavior of the baby's maternal grandmother and the infant feeding behavior of the baby's mother. All the mothers who breastfed reported that baby's maternal grandmother had used breastfeeding as their infant feeding method. Additionally, mothers who breastfed, were, themselves, breastfed. This was in contrast to formula feeding mothers and to mothers who used a mixed method for infant feeding. Half (2 of 4) of all of the formula feeding mothers revealed that baby's maternal grandmother used formula to feed their baby. One formula feeding mother, Nicole, shared that baby's maternal grandmother breastfed, but that her mother "left the decision up to me." The remaining mother, Toya, said that they did not know what infant feeding method baby's grandmother used. The experiences of mixed-feeding method mothers, again, showed a marked difference to those experiences of formula feeding and breast-feeding mothers. The majority, 70% of all mixed-feeding methods mothers stated that baby's grandmother formula fed their baby. One mixed-feeding mother shared that baby's grandmother breastfed; and the one remaining mother indicated that she did not know what infant-feeding method baby's maternal grandmother used. This comparative analysis reveals that infant feeding behaviors of maternal grandmothers are predictive of the infant-feeding behaviors of their daughters. Specifically, mothers are more likely to breastfeed their baby if they have been breastfed. Moreover, when the mother was formula fed or when she did not know what infant feeding method she was subjected to, she was more

likely to use formula to feed her baby. This finding suggests that there is a strong generational relationship between a mother's and a grandmother's infant-feeding behavior and that infant feeding behaviors can be modeled for subsequent generations. One breastfeeding mother, Terry, introduced the powerful effect that her mother had on her infant feeding behavior; she offered this comment very early in the interview and before she was asked about her family's influence:

"I always just assumed I would breastfeed... because Mom breastfed me and my brother."

Similarly, one breastfeeding mother, Peaches shared that she did not breastfeed her first baby despite her mothers' encouragement but that ultimately after settling into a second, more supportive relationship, she did breastfeed her third baby:

> "My mother was a breastfeeding guru. My Mom was a 'hippie-in-the-Black-Panthers and Nation of Islam-type. She didn't force me, but she encouraged me with my first baby. I resisted and she backed off... but now we talk about breastfeeding."

Toya, who formula-fed her baby, did not share any input or relationship around infant feeding with her mother because her mother died a few years before she gave birth to her first baby. Additionally, Toya does not know what infant feeding method her mother used for she and her sister.

Perhaps more decisive were the thoughts and ideas that grandmothers shared with mothers on infant feeding. Formula feeding mothers recalled hearing fewer positive thoughts from their mothers about breastfeeding. The majority of breastfeeding mothers shared that the baby's grandmother encouraged breastfeeding. Grandmothers did not always advise their daughters on infant feeding techniques but they sometimes shared their own experiences with their daughters. When asked what thoughts and attitudes her

baby's grandmother shared with her about infant feeding, Jane, who used formula to feed her baby, says that her mother described breastfeeding as a painful and undesirable experience:

> "Mom said that it felt like fire when she tried it. It was real uncomfortable; feels like somebody's sticking a match to your nipple."

Similarly, a breastfeeding mother, Runcat, said that her mother breastfed three children and espoused positive ideas about breastfeeding:

"Mom thinks that breastfeeding is the healthiest thing but that it was my decision".

Mothers were also asked about infant feeding ideas and thoughts shared by other family members including baby's father and/or their partner. Seventy-five percent of formula feeding mothers stated that the baby's father and/or spouses had neutral or non-committed ideas about breastfeeding. Only one formula feeding mother, Jane stated that her baby's father discussed his infant feeding preference with her. He had indicated that he supported Jane's decision to use formula because she smoked:

> "Her father feels the same way that I do, because he knows that I smoked cigarettes. Why would you continue to smoke cigarettes and breastfeed your baby?"

Another formula-feeding mother, Allison, shared that her husband "couldn't care less." This was a marked difference from the experiences of mixed-feeding method mothers as well as that of breastfeeding mothers. Mothers in these latter groups described experiences that seemed to indicate that their spouses gave more input into mother's infant feeding decision and that they were also more supportive of mothers' infant feeding decision. Eighty percent (4 of 5) of all breast feeding and 67% of mixed methods mothers reported that the baby's father indicated a preference for baby to be

breastfed and that the father actively supported her decision to breastfeed. When Ella began supplementing with formula and considered ceasing breastfeeding, she got some extra encouragement from her husband: "When I had trouble nursing and I stopped, he pushed me to keep breastfeeding and to stop supplementation".

Faye shared that her husband was "very strongly for it (breastfeeding)" and that "he believes it is important for the comfort and positive development." Peaches said that her husband also actively supported her to breastfed: "Rashid (pseudonym) wanted to find out what's best because this is his first baby; he encouraged breastfeeding because of benefits to baby and Mom"; she shared that her husband considered them "partners" in breastfeeding. She further shared that her husband was an attentive and caring breastfeeding supporter even in public. She says that when visiting friends, for example that when she left the room to breastfeed, he would go with her so that he could rub her back while she breastfed the baby.

Formula feeding mothers shared stories that generally reflected much less breastfeeding supportive attitudes and behaviors from other family members as well. Shortly after Toya gave birth to her son, Toya's grandmother was present at the hospital and advised her to give the baby formula when she heard Toya talking with the hospital staff about breastfeeding. "My grandmother said 'you don't have time for that (breastfeeding); just go ahead and feed that baby a bottle'!" Similarly, Nicole's stated that her family suggested she use formula because breastfeeding her baby would make the baby "too close," overly attached to mother, and not able "to go to anybody else". At times, though, input from family members seemed to indicate that they disagreed with the

mother's decision to use formula. Jane's aunt, Lilly (pseudonym) was a strong breastfeeding advocate who'd breastfed two children for more than one year each. According to Jane, her Aunt Lilly had encouraged her to breastfed and told her that she was being "selfish because she did not breastfeed her baby." Despite pro-breastfeeding input, Jane used formula.

There were similar tendencies regarding other family member's input between the infant feeding groups of mothers. Most formula feeding mothers indicated that their family members did not favor one infant feeding method over the other. Family members of formula feeding mothers tended to be more concerned about the practical implications of breastfeeding baby e.g. how and whether adequate milk would be available during mothers' time away from baby, whether baby would take a bottle when away from mother, or whether baby could be left in the care of someone else if the baby was too closely attached to the mother. Likewise, most of the breastfeeding mothers describe experiences with other family members that mirror their own feeding choice. However, a few breastfeeding mothers, like Michelle also recalled family and friend mothering experiences that were different from her own. She described her close friend's attitude about feeding her own baby as clearly in favor of formula and opposite Michelle's preference for breast feeding:

> "I have a really close friend that I call a sister and we have babies that's exactly one month apart. She never even thought – it never crossed her mind to nurse and – but I do, so she'll say all the time, 'Oh I forgot you're nursing', or whatever, because she is the type. She'll just plop her baby a bottle and hey, make her a bottle, hey, toss her a bottle.."

Finally, the infant feeding attitudes and behaviors of friends and other family members was not as indicative of mixed methods mothers. At times experiences were

the same. Margaret says that some family members favored breastfeeding while others did not. As well, she shared similar experiences with other family: "my one cousin did half and half – part formula, part breast milk. I think that was encouraging, but it did change my behavior – it might have encouraged me to try breastfeeding more."

Most mixed methods mothers described friends' infant feeding ideas and behaviors that were disparate from their own. Although AKA breastfed and formula fed her baby, she said that older women she knew were not as interested in breastfeeding "because of the idea of having baby stuck and grabbing on your breast for a year." Although there were some variations, input from the mothers points to a predictive relationship between those thoughts and behaviors of baby's father, family, and friends and mother's breastfeeding thoughts and behavior.

Breastfeeding Sexualized and Racialized

The majority of mothers reported that they witnessed the expression of sexualized ideas associated with breastfeeding through family, friends, and especially through media and the public treatment of breastfeeding mothers. I define sexualized as ideas and thoughts related to the breasts being viewed as sexual items. Additionally, at least two mothers reported that they never saw African American mothers reflected in visual images of breastfeeding. These mothers indicated that the images they witnessed depicted only White mothers or mothers of Asian descent. Mothers were not asked a question specifically on these topics, but rather these ideas surfaced during discussion related to research questions around general thoughts and attitudes, on media's breastfeeding images, or society's ideas on breastfeeding. Mothers from all three infant feeding groups had seen or heard expressions of breastfeeding as a sexualized behavior. However,

breastfeeding and mixed feeding mothers were more likely to convey discomfort about these ideas, to believe that the ideas are wrong, and to recognize that they represent a conflict centered about the sexualization of women's bodies. Mary, who breastfed and used formula, for example, was disturbed about she thought was a distorted and sexualized popular characterization of public breastfeeding:

> "It is outrageous that society does not allow breastfeeding in the open such that it creates a public uproar; to me it shows that they see it as a sexual thing instead of looking at it in a different way, which is feeding a child. It's just like you're giving them a piece of bread."

Similarly, Runcat, who breastfed, perceived the ideas regularly associated with public breastfeeding to be hypocritical:

> "They're so involved with a woman has her shirt up, feeding her child, but they're not concerned with all these billboards of women running around half-clothed to sell cars and trucks and shoes, but they're concerned about – like I've never seen a billboard on 75 with a mother nursing, saying, 'nurse your child'".

Only two mothers, Jane and Nicole, both who formula fed, seemed to agree that breastfeeding represents sexualized or inappropriate public behavior. Jane and Nicole both felt that mothers who breastfed their children beyond an acceptable age were indulging in sexual behavior this way. Nicole felt that if the baby has teeth and can walk then it is not appropriate to breastfeed that baby:

> "Some people think it's nasty. I think it's gross after, you know, you got a kid that's standing up, walking up to you to get breastfed."

Jane similarly felt that breastfeeding an 'older' child is akin to "child abuse"

> "That's abuse, turned me off completely because parent getting off by having these big grown children suckling on their breast. That's freaky"

Jane, especially, seemed to embrace sexualized ideas about public breastfeeding; she felt that mothers should breastfeed discreetly by hiding their breasts:

> "I think women who breastfeed in public, if that's what you choose to do, please put a blanket over yourself and your baby. It shouldn't be for everyone to look at you raw breast going into this baby's mouth and for people to watch this baby feeding. You know, that's supposed to be a bonding time. You're sitting there looking at your baby. Your baby is looking at you. You're feeding your baby. This is not for everyone to sit there and look at you feed your baby."

Most of the mothers in this study felt that media and/or society reflected conflicted perceptions about breastfeeding behavior. Mothers felt that media sexualizes breastfeeding and denotes it as private affair. Mothers perceived that breastfeeding is considered an acceptable social behavior but that mothers should not breastfeed in public places like malls or restaurants. Conversely, media also promotes other sexual images around women (e.g. scantily-clad women in magazines and on television, etc.) as appropriate for public view. Additionally, a few breastfeeding and mixed methods mothers felt there is general lack of positive breastfeeding images in print and televised media. Despite the negative imagery and treatment that these mothers experienced, most indicated that it not deter nor encourage their infant feeding choice, especially for African American mothers. Faye, who breastfed, reported seeing print images in magazines she felt communicated the message that breastfeeding wasn't for African American mothers. This study explored the attitudes and perceptions that African American mothers have about breastfeeding and how these attitudes and perceptions were shaped by the social context of their lives. For social context the following were considered: structural conditions such as her education and her employment environment and interactions, interpersonal dynamics such as the attitudes held by family members including her

spouse/partner, her mother, and other family member, interactions with healthcare providers, and with personal community members, and cultural factors such as messages portrayed by the media, and her perceptions about society's treatment of breastfeeding mothers. While the goals of this study centered on these aforementioned areas, other major themes emerged. Specifically: religious beliefs, mothers' health status, and a re-defining of breastfeeding.

Attitudes and thoughts mothers shared during interviews indicated that, overall, mothers considered infant breastfeeding an important and positive motherhood activity because of its health and developmental benefits. However, mothers' awareness of breastfeeding's advantages did not always translate into the act of breastfeeding. Micro-social factors like family support, cultural and religious beliefs, and chronic health problems intersected with structural conditions such as health care provider messages, demanding work schedules and the lack of pumping stations to determine mothers' infant feeding choices. Other barriers to breastfeeding for mothers across feeding methods included pre-existing chronic health conditions, baby's health, inadequate health provider information and support, and perceived lack of employer support. For formula feeding mothers, barriers included lack of financial resources, shorter maternity leave times, and inflexible work schedules. Mixed method feeding mothers were more likely to breastfeed, but periods of exclusive breastfeeding were cut short by returns to work and school. These mothers faced demanding work schedules and little time to follow a set pump schedule and ultimately resorted to using formula.

The outcomes of this qualitative study demonstrate that mother's breastfeeding capacity, when contextualized, was shaped by the dynamics of complex social conditions

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she was subject to based on her education and social status. Mothers were best able to initiate breastfeeding when they possessed sufficient health care provider support and information, family and partner support, and adequate income. For mothers who worked, gainful employment and supportive work environments facilitated breastfeeding. Mothers' infant feeding preferences, having been pre-formed by these subtleties of resources and opportunities, were further shaped by her immediate social world including family and cultural beliefs. Mothers could pursue breastfeeding best when breastfeeding had been modeled, she was in good health, positive perceptions about breastfeeding were present, and other cultural beliefs supported these conditions. Micro-social factors operated within broader macro-structural constraints to predict mothers' breastfeeding thoughts, attitudes and behavior.

CHAPTER 5

Conclusion

The purpose of this study was to explore the attitudes and perceptions that African American mothers have about breastfeeding and how these attitudes and perceptions are shaped by the social context of their lives. Social context of mothers' lives includes structural conditions such as her education and her employment environment and interactions, interpersonal dynamics such as the attitudes held by family members including her spouse/partner, her mother, and other family members, interactions with healthcare providers, and with personal community members, and cultural factors such as messages portrayed by the media, and her perceptions about society's treatment of breastfeeding mothers. I believed that these factors, alone and in interaction with one another, would affect the ways that women think about breast feeding and thus their preferences about infant feeding methods, as well as their ability to act on these preferences. The literature supports the idea that reproductive health practices among African American women are contextually specific (Canaday, 2001; Mullings, 2006), that mothers respond to specific material conditions as well as to cultural values (Blum, 1999) and to other environmental conditions.

Research indicates that breastfeeding rates among African American mothers lag behind those breastfeeding initiation rates of all other racial groups of mothers. This is true despite the fact that breastfeeding initiation rates steadily and significantly increased for all women in 2005-2006 survey years compared to outcomes from survey conducted in 2003-2004. (McDowell, 2008). Differences in breastfeeding rates among children born as late as 2006 still represented as much as a 17% difference between White and

Black children. (CDC, NIS, 2010). This is also problematic given the multiple health benefits associated with breastfeeding not only for children but also for women.

Data was collected by conducting 15 in-depth face to face semi-structured interviews. Only mothers who self-identified as African American were accepted to participant in the study, so that all 15 mothers in the study self-identified as African American. Eligible participants included mothers who gave birth to a child within the past five years and used one of the following infant feeding methods: formula, breast milk, or a combination of both methods. The data were coded, analyzed, and organized first by research question and then by categories and subcategories as guided by the conceptual framework. The analysis was based on the research questions developed for this study as briefly outlined in the section above.

Despite the advantages associated with breastfeeding, African American mothers initiated breastfeeding at lower rates than all other groups of mothers (McDowell, 2008). Yet this lower level of initiation does not seem to be the result of a devaluation of breast feeding by the African American mothers I interviewed. A key finding of this study revealed that mothers considered infant breastfeeding an important and positive motherhood activity because it offered multiple health and developmental benefits for themselves and their babies. The social context of mothers' lives affected their thoughts, attitudes, and behavior on breast feeding. Social context of mothers' lives included micro-social factors and macro-structural factors. Micro social factors like family support, cultural and religious beliefs, and chronic health problems intersected with structural conditions such as health care provider messages, demanding work schedules and the lack of pumping accommodations to decide mothers' infant feeding choices.

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Additionally, barriers to breastfeeding included pre-existing chronic health conditions, baby's health, inadequate health provider information and support, and perceived lack of employer support. For formula feeding mothers, barriers included lack of financial resources, shorter maternity leave times, cultural beliefs, and inflexible work schedules. For mixed method feeding mothers periods of exclusive breastfeeding were cut short by returns to work and school. These mothers faced demanding work schedules and little time to follow a set pump schedule and ultimately resorted to using formula.

The previous chapter presented the findings of this study by organizing data from interviews to produce insight into breastfeeding attitudes and behavior among African American mothers. This chapter analyzes, interprets, and synthesizes the findings. This chapter is organized by the following analytic categories: The relationship between mothers' demographics and breastfeeding thoughts, attitudes, and behavior; the influence of family, cultural and religious beliefs on breastfeeding thoughts and behavior; the relationship between health status, health provider relationship and breastfeeding thoughts and behavior; relationship between employment environment and breastfeeding thoughts and behavior; and the intersections of micro social factors and macro structural factors and breast feeding behavior.

The prior analytic categories are directly aligned with each of this study's research questions. These same analytic categories were used to code the data and present the findings in the previous chapter. In the analysis I search primarily for connecting themes and patterns within each analytic category as well as themes or connections that may emerge among the various categories. For the secondary level of analysis, I try to tie in relevant theory and research as these themes are compared and

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contrasted to issues raised by the literature. In this chapter I intend to develop an integrated story about these mothers' breastfeeding experiences. I will accomplish this by framing the analysis in the following way: (a) highlight connective threads among mothers who participated, (b) detail ways in which mothers understand and explain these connections, (c) detail consistencies and the inconsistencies that I found with the literature, (d) list ways in which the data go beyond the literature. Further, my goal in this discussion was to enhance the understanding of why African American mothers may breastfeed at lower rates than do other mothers. I conclude this chapter with a re-examination of my assumptions identified in the first chapter, a summary of limitations of the study, directions for future research, and policy implications.

The first research questions sought to discover the demographic profile of mothers and to determine how these demographic features related to mothers' breastfeeding outcomes. Participants' demographic information indicate that mothers who breastfed tended to be older, married, more educated, middle to upper class, and to be employed in professional level capacities when they worked. Moreover, mothers who exclusively breastfed tended to work part-time or to be stay at home mothers while their spouses worked to support the household. Conversely, formula feeding mothers were younger and were more likely to be single, less educated, and employed in lower wage earning positions.

When compared to formula feeding mothers and to mothers who exclusively breastfed, mixed methods mothers were more likely to work full time, to combine employment and training, and to have slightly fewer children. But no matter which infant feeding method mothers chose, almost all the mothers I interviewed felt that "breast is

best" and acknowledged so by reciting the multiple developmental, psychological, and health advantages that they'd heard. Consistent with other studies (Blum, 1999), the majority of mothers in this study did not demonstrate a lack of knowledge or information about the benefits of breastfeeding. Rather, breastfeeding success was attributable to a number of other factors embedded in the social and cultural context in their lives, forces that were beyond mothers' control.

Findings in this study demonstrate the strength of social class or class-related factors such as education and employment as predictors of breastfeeding behavior and are consistent with previous studies (Blum, 1999; Litt, 2000; Kurinji, 1988; Visness, 1997) which highlight this fact. Professional as well as non-professional mothers felt that work environments made it difficult to breastfeed. Furthermore, maternity leave duration varied by occupational level and in turn helped determine how willing mothers were to begin or to continue breastfeeding. Professional mothers enjoyed more time at home and initiated breastfeeding before returning to work while non-professional mothers returned to work faster and more readily rejected breastfeeding as an impractical option. Several mothers commented that household financial constraints required that they return to work in relatively short time – three weeks to one month in some cases and that furthermore, they were not able to breastfeed or to continue breastfeeding since constraints at work made it impossible to pump.

In discussions around the logistical barriers to breastfeeding, formula feeding mothers in this study openly acknowledged their perceived challenges to breastfeeding while working and they consciously decided that formula was the best infant method for them since they needed to return to work. Allison described her frustrations with the

physical limitations of her job as a telephone dispatcher at a college. When she gave birth to her child, she was employed at this position and she felt that combining breastfeeding with work would not be possible because of time demands associated with her position. Beyond the relief of her one half-hour lunch and bathroom breaks, Allison said she felt a great deal of pressure to be at the phones constantly.

Generally, mothers' work environments were not supportive of breastfeeding, but lower-wage earning roles were even more prohibitive of breastfeeding. Maternal age also provides some insight into this issue. The fact that breastfeeding and mixed-methods mothers were older than formula feeding mothers was less a function of how long they had been mothers, and more a function of pre-birth educational experience. This finding highlights an important relationship between mothers' age and her occupational status. Mothers who breastfed often had more pre-motherhood educational experience and began motherhood at a later age. This is true despite the fact that all groups of mothers had an equal number of children. And the fact that mixed-feeder mothers were older (mean = 37) than both breastfeeding (mean = 30) as well as formula feeding mothers (mean = 27) follows this logic. The majority of breastfeeding and mixed-methods mothers had undergone some post-secondary education or training prior to the birth of their youngest child. And mothers who formula fed found themselves in a perpetual economic bind: limited employment and career opportunities because they lacked training and subsequent inflexible work environments that sabotaged their ability to breastfeed. This is an especially important point as African American mothers are disproportionately represented in all of the lower socioeconomic levels compared to their white sisters. Additionally, this conclusion supports earlier studies which highlight the relationship

between maternal race (Ludington-Hoe, 2002; Waitzkin, 2001), maternal age (Kuzela, 1990) maternal education (Kurinji, 1988; Kuzela, 1990) and maternal income (Kuzela, 1990).

Intersectionalist Perspectives from Black Feminism Re-Examined

The employment conditions mothers experienced was shaped by their collective economic history in U.S. society and seem to confirm intersectionalist perspectives of Black Feminism. Long-standing patterns of race and gender discrimination in the employment sector have shaped Black women's employment experiences. This, coupled with recent global processes of massive manufacturing job loss, relocation of domestic jobs overseas, cuts in social services, and privatization of publicly funded institutions have added to economic instability in Southeastern Michigan. The once expanding black middle class is now experiencing unprecedented job loss and economic opportunities for working-class families in once reliant automotive and industrial centers are disappearing and there isn't an end in sight for all. The significant expansion of the Black middle-class these past three decades was a result of the Civil Rights movement and the subsequent legislation. But the jobs that Black mothers hold are disproportionately concentrated in the public sphere and social sectors of the economy – areas most affected by government disinvestment. (Mullings, 2006)

Uncertain economic conditions undermine Black mother's job security and may explain why several mothers, even when of they held a higher position in their organizational structure, were unwilling to challenge breastfeeding-unfriendly work environments or to resume working while breastfeeding for fear of being seen as a liability to an employer. Krieger (1994) highlighted numerous studies which established

that the economic return for same level education is lower for black than it is for whites, that within the same occupation, Blacks are likely to find themselves in lower-paying and lower status positions; that poor Blacks are much poorer than White poor; that many Black women are segregated in menial, low-paying, dead-end, insecure jobs; and that there are significant pressures on high-achieving Black career women. Because of historic patterns of race and gender occupational segregation, African American women are disproportionately concentrated in the public sector jobs (Burbridge, 1994). This was evident for the mothers in this study as well. The majority of mothers interviewed were employed in public sector occupations. This is problematic because public sector and service industry employment are particularly susceptible to disinvestment and downsizing in economic crisis like the one we currently face. African American mothers face unique employment related difficulties that jeopardize breastfeeding. In this way, race and class effectually interact to discourage breastfeeding for African American mothers.

The difficulties that mothers experienced around employment help us understand further how race, class, and gender interact to shape breastfeeding. Higher education status and thus higher socioeconomic status (SES) predicated breastfeeding for mothers in this study. Lower SES mothers described limited or no access to time resources (maternity leaves) or opportunities (short or no breaks to pump) that effectively discouraged their breastfeeding. But higher socioeconomic status was not a protective factor for breastfeeding either since employment related issues effectively discouraged breastfeeding for all mothers irregardless of their social class. Higher SES mothers were more likely to initiate breastfeeding and to continue while on maternity leave but

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often scaled back or discontinued breastfeeding once they returned to work. These mothers were subjected to demanding work schedules and perceived lack of support from employers. Despite having higher status in work environments, longer maternity leaves, and other advantages, higher SES mothers were more likely to have initiated breastfeeding while on maternity leave, but often stopped breastfeeding when they returned to work. It is clear that social class standing, alone, did not have a significant impact to breastfeeding. I believe that other factors combined with social class standing to impact mother's breastfeeding behavior.

These findings are reminiscent of Black mothers' early reproductive and work experiences as they are characterized by demanding work environments which jeopardized infant care and breastfeeding. Perhaps more important is the fact that employment experiences of working mothers in the study represent an intersection for mothers' race-based and class based position in society.

Breastfeeding is a Cultural Value for African American Mothers

Results from this study demonstrate that cultural beliefs and values were an important factor for mothers' breastfeeding decisions and behavior regardless of her class standing. Mothers derived their cultural ideas about breastfeeding from their own religious beliefs, family's infant feeding ideas and practices, friends' input, and the media. An examination of mothers' responses in these analytic categories reveals that overall, Black mothers interviewed in this study valued breastfeeding as an important motherhood activity and that reasons for their lower breastfeeding rates have more to do with structural constraints and mediating micro-social factors and less to do with cultural values. Almost all the mothers indicated that they were *interested* in

breastfeeding but many felt unable to pursue it for various reasons. Additionally, more than half of the working class mothers in my study expressed an interest in breastfeeding in similar ways that the middle to upper class mothers did despite that fact they did not all breastfeed. Thus, my findings call into question past research conclusions which contend that working class Black mothers are not concerned with "exclusive motherhood" practices like breastfeeding which makeup the cultural norms of motherhood (Blum, 1999). Media images were sometimes racialized and perceived as messages that breastfeeding was intended for African American mothers.

Interviews with mothers invite us to reconsider the particular Black Feminist claim that Black women view other issues outside of motherhood as critical obstacles to their freedom as women. As an example, one scholar, hooks (2000) argued that Black mothers view racism, lack of skills, and access to education and jobs as more important issues than are issues around motherhood. Findings in this study suggest mixed ideas. Mothers in this study did value work and higher education as a necessary means of survival. Almost all mothers worked and/or attended school. Professional status working mothers recognized the relative level of class based privilege they enjoyed. But all of the working mothers whether lower-wage or professional considered the impact of their infant feeding choice on their work as well. Fear of losing work or of being considered a liability at work was great enough to determine work movements. But mothers also indicated that they perceived work to be a significant barrier to their breastfeeding and other motherhood interests. I think the value of breastfeeding to mothers in this study was best demonstrated through their statements about wanting to breastfeed more. Most indicated that they wanted to breastfeed, or to breastfeed for

longer durations but that they were unable to because they needed to return to work. By focusing on women's concerns about access to economic and social resources, researchers like Collins (1999) may minimize mothers' concerns about her ability to participate in successful motherhood. Mothers described problematic exchanges between their work lives and their interests in breastfeeding that highlight the importance of each as well as the critical connection between the two. The fact that mixed feeding mothers, particularly, experienced conflicted participation in breastfeeding demonstrates that breastfeeding is important to them regardless of social class standing and regardless of a society that does not value black motherhood as much as it does white middle class motherhood (Collins, 1999). Breastfeeding is important as a mothering practice and they wanted to do it, but paid work outside the home is critical to their lives and demonstratively viewed as a means of survival as well despite the logistical difficulties it presents in their lives. Black Feminist perspectives explain that African American mothers have always worked long hours outside the home and away from their own children to ensure their family's survival. (Collins, 1994; 1991). Work for mothers in this study bore the signs of necessity. Additionally, the fact that several breastfeeding mothers chose to stay at home signifies how highly mothers value motherhood. Perhaps given the access to resources and opportunity, Black mothers would choose to breastfeed in place of working. African American mother's motherhood experiences are a reflection of their social and class position in society. The majority of mothers because they must work, move between their private lives as mothers to work in ways that they hope do not jeopardize their paid work while enjoying motherhood as best they can.

Black Feminist paradigm also emphasizes the importance of extended family structures and the practice of "othermothering" (Collins, 2001; 1994; James, 1993) relieve the tension brought on by maternal separation due to employment and the needs of dependent children. This point is illustrated well in thoughts shared by at least two of the formula feeding mothers, Nicole and Jane, and at least one mixed methods mother, Allison. Nicole was more concerned that her baby easily separate from her and stay with family and caregivers when she returned to work. She felt that breastfeeding her baby would make her baby too attached to her and jeopardize her baby's ability to separate from her. Jane similarly rejected breastfeeding, in part, because she felt that baby "hanging on her boobs" was prohibitive of her autonomy to work and to return to school. Julie abruptly stopped breastfeeding so that she could start work at a new position. Julie's sentiments and behavior suggest that she felt her paid work and breastfeeding were separate worlds both important but unable to co-exist.

All but two of the mothers in this study defined successful motherhood in part, at least, by whether they breastfed their baby or not. Certainly this is true for the middle-upper class mothers who often defined themselves as breastfeeding even when they used a combination of both formula and breast milk to feed their babies. Furthermore, mothers viewed employment circumstances as an important part of their capacity to breastfeed and they defined inflexible work conditions as problematic if they restricted their breastfeeding activity. But, working class mothers, too, valued breastfeeding as an endorsement of motherhood. Consistent with earlier findings, working class mothers I spoke with reported knowing that "breast is best" and they did not lack knowledge about the developmental and health advantages of breastfeeding. Mothers described tales of

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failed attempts to breastfeed that were accompanied by disappointment and frustration and reminiscent of the "failed bodies" of white working class mothers (Blum, 1999). Macro-cultural constructs of motherhood shaped breastfeeding but were further refined by micro-cultural factors in mothers' lives. Religious beliefs, for instance, surfaced as a source of cultural beliefs and are important to consider as we review the broader context of mother's breastfeeding outcomes.

A significant proportion of mothers indicated that spiritual and religious beliefs shaped their breastfeeding thoughts, attitudes, and practices. One third of all mothers I interviewed revealed that their spiritual or religious beliefs motivated their infant feeding decision. These mothers chose either to breastfeed their baby or to use a combination of breast milk and formula for their baby, noting that their choice to include breastfeeding as a infant feeding method was tied to their religious or spiritual values they held. Both Christian and Muslim mothers cited their religious beliefs as a source of motivation for breastfeeding, saying things like, "Breastfeeding is what God intended" and noting that "Muslim faith recommends breastfeeding your baby for two years".

Extensive examinations conducted by past researchers support these findings by suggesting that religious beliefs have significant salutary effects on distress and well-being in African American populations. (Williams, et. al. 2001; Chatters, 1995) African American mothers may pursue breastfeeding because they feel "greater peace and assurance that their life is part of a divine master plan and they perceive their daily lives as infused with spiritual power" (Chatters, 1995). Further, mothers may be more likely to pursue, tackle (and to continue) the challenging task of breastfeeding because of their religious beliefs. As believers, they may be less vulnerable to stressors than others,

perhaps because stressful events and conditions cannot threaten their core identity (Williams, et. al. 2001).

The Sexualization of Breastfeeding

The second major cultural factor that threatened breastfeeding was those ideas generated around the sexualization of women's breasts and bodies. Interviews with a majority of the mothers confirm that media including print and television advertisements, serve as a major source of these ideas. Personal networks of family and friends, too, perpetuated the distribution of these ideas. And public treatment of breastfeeding mothers policed mothers' breastfeeding efforts and enforced the social norm of mothers' bodies as sexual creatures at the risk of being violated by suckling babes. I was surprised to hear that although mothers were subjected to numerous tales that demonized breastfeeding as a sexual act, few seemed to internalize these ideas and most openly rejected them. Only two mothers, Jane and Nicole, stated that they agreed with these ideas and indicated that their choice not to breastfeed was motivated by these ideas. Several respondents indicated that they received messages linking breast feeding to sexuality from family and friends. Mothers described being privy to communication from relatives and friends that promoted ideas of baby sucking at the breast as "nasty", unsightly, and akin to sexual acts. The domain of reproductive behavior was clearly intertwined with that of women's bodies as sexual beings with the latter possessing greater importance. This is consistent with Blum (1999)'s accounts of black mothers bodies being demonized as over-sexed and breastfeeding ultimately being sexualized. Fortunately, cultural and religious beliefs originating from kin and personal networks

mediated broader cultural ideas about African American women's bodies and breastfeeding and supported mothers' breastfeeding efforts in ways that mattered.

Interactions with the Healthcare Provider

There is abundant evidence which demonstrates that the American healthcare system offers differential treatment for African Americans and other minority groups. Studies examining the care of patients already in the health care system (minimizing access to care as a factor) found differences in the quality of care for procedures at all levels of intervention that were unfavorable to racial minorities and to poor people (Waitzkin, 2001). The medical encounter between mothers and their healthcare providers are characterized by power, dominance, and authoritative control through the use of technical (medical) knowledge and language, and gesturing (Waitzkin, 2000). Findings from this study confirm that mother's interactions with their healthcare providers reflect inherent communication patterns of dominance and control. In several instances, mothers reported that healthcare providers displayed overt or general disregard for their infant feeding preferences. The most disturbing examples were mothers' descriptions of their babies being given formula without their permission. Most mothers felt hesitant to question healthcare providers even when they experienced this extreme undesirable care. Only one respondent directly challenged her hospital providers' care that she said sabotaged her ability to make breast milk her baby's first meal. Several other mothers reported that they were given a supply of formula despite the fact they clearly indicated they intended to breastfeed. I believe that these incidents represent benign, yet significant resistance to mothers' breastfeeding efforts. It is appropriate for

mothers to expect breastfeeding support and care from their health care provider. However, some mothers encountered resistance and general lack of support.

A significant number of mothers reported that they or their baby experienced health problems which required they receive medical attention during or immediately following their pregnancy. Many mothers reported having problematic interactions with healthcare providers during the course of receiving this medical care. Mothers felt that obstetricians were preoccupied with their health condition and spent little to no time educating and supporting them with the challenges around breastfeeding. Several mothers interrupted this as a sign that breastfeeding was not important. Further this seemed to encourage mothers' use of formula and to discourage breastfeeding. Mother's health status is a critical finding that is missing from earlier accounts of African American mothers' breastfeeding experiences. It is important, first because it may point to mother's prenatal health as an additional predictive factor. Secondly, this finding highlights the saliency of African American mothers' health status in the discourse about her stratified healthcare. Because African American women disproportionately experience worse health, it may connect and perhaps help explain her disparate breastfeeding outcomes. Mothers' infant feeding experiences were clearly contextualized by their interactions with healthcare and also by the challenges of prevalent health problems. Formula feeding mother, Allison, suffered from chronic health problems, namely hypertension and toxemia, throughout all three of her pregnancies as well as the constraints of living with limited income and inflexible work conditions. Allison regretted that she could not breastfeed her baby. But Allison had remarkably positive birth outcomes despite the challenges she encountered, Allison's resiliency is reminiscent

of Mullings' (2006) "Sojourner Syndrome", a behavioral strategy that allowed Allison to navigate the stressful demands of work and home life. [3]

Mothers' encounters with healthcare providers around prenatal care and breastfeeding support were characterized by an imbalance of power. Mothers described problematic interactions with their healthcare providers that appeared more intense because providers focused attention on a healthcare concern outside and in addition to pregnancy. Mother's experiences in these areas may demonstrate that the quality of reproductive healthcare received by women is racialized and influences overall health outcomes (Barbee and Little, 2000; Collins, 1991; Litt, 2000). Additionally, the healthcare interactions many mothers in this study described reflected an imbalance of power and control over their motherhood practices. Mothers' breastfeeding experiences clearly reflect class based tendencies; breastfeeding mothers were likely to be middle to upper class. As well, the numerous stories mothers shared about sexualized breastfeeding beliefs heard within their community, gave clear indication that breastfeeding experiences are gendered. These findings seem to support past research which suggests that mothers' health experiences reflect a complex relationship between gender, race, and class that interact to produce health outcomes within local contexts (Shulz and Mullings, 2006).

These findings are not surprising nor are they new phenomena in the context of Black women's reproductive care experiences. The historical context of Black mothers'

[3]The Sojourner Syndrome is a conceptual framework developed by Sherman James to demonstrate the multiplicative effects of class, race, and gender on health on health. The concept is considered the gendered version of John Henryism because it describes a high-effort coping or a strong behavioral predisposition to cope actively with psychosocial environment stressors. The lengendary John Henry was a 'steel-driving" man who was known for his strength and endurance. In a contest of man against new technology, Henry and his nine-pound hammer were pitted against a mechanical steam drill. In a close race, Henry won, but died moments later from physical and mental exhaustion (Mullings, 2006).

experiences with the medical community around reproductive care are characterized by long struggles against racist, and sexist social practices facilitated by the medical community, the federal government, and other major social institutions. Black women's reproductive freedom has been long threatened and highlighted by forced procreation during slavery, forced sterilizations, birth control movement during the early 20th century, and other attempts to control Black mother's fertility Ross (1998). I believe it likely that mothers problematic experiences with their healthcare providers in this study were reflections of racist and sexist institutional practices given the persistent and common nature of their problematic encounters with healthcare providers. But I am encouraged by their active resistance to this interaction as reflected by their interest in breastfeeding.

Social Networks Reinforced Mothers' Breastfeeding Behavior

Mothers' personal social networks including her family, spouse or baby's father, and friends, produced a significant impact on mother's breastfeeding activity. First, a comparative analysis of mothers' responses about her family infant feeding behavior and input revealed a strong relationship between the baby's maternal grandmother and the infant feeding behavior of the baby's mother. All the mothers who breastfed reported that baby's maternal grandmother had used breastfeeding as their infant feeding method. Moreover, when the mother was formula fed or when she did not know what infant feeding method her mother used, she was more likely to use formula to feed her baby. This finding suggests that there may be a strong generational relationship between a mother's and a grandmother's infant-feeding behavior and that infant feeding behaviors can be modeled for subsequent generations if African American mothers continue to

chose to breastfeeding and if they are supported in their efforts. Further, findings may point to class issues across generations.

Mothers reported the significant impact of support from baby's father as well. Overall, mothers indicated that baby's father supported their infant feeding preference – whether they selected breast feeding, formula, or a combination of the two. Mothers who breastfed were more likely to report that they'd received positive messages, attitudes, and behavior from baby's father. Several mothers remarked that after fathers voiced their support for choice of infant feeding, the choice was ultimately theirs'. Mothers commonly had the "final say" for infant feeding choice. Mothers who pursued breastfeeding were generally supported more in verbal than in nonverbal ways. But fathers supported mother's breastfeeding activity in nonverbal ways as well. Mothers reported that fathers physically helped by providing massages and supplying water when they breastfed.

Breastfeeding mothers in this study tended to be married and to be supported by their spouses' professional level employment. For these mothers, paid employment was the most significant support they received from baby's father because it made it possible for them to spend time at home focused on caring for their baby, and it freed them from the need to work outside the home immediately following the child's birth. But even mothers who were not married discussed their partner's influence on their decision. Formula-feeding mother, Jane, discussed how she accepted thoughts and input from her baby's father on her infant feeding plans. She indicated that baby's father agreed with her plans to formula feed because he knew that she smoked. It was evident that having support from their baby's father mattered to mothers in this study. This point was also

illustrated by mothers who did not receive support from her baby's father. Margaret's painful recount of her disappointment and depression because her baby's father failed to support her during pregnancy and breastfeeding, illustrates the importance of male involvement to mothers. Although she could not depend on baby's father, Margaret was happy that her mother stepped in to assist her.

This underscores the importance of relationships in mothers' lives (Canady, 2001) and as a reflection of socially valued motherhood practices. Additionally, it questions early feminist perspectives that presume the absence of male-dominance to be critical to women's independence. The centrality of women in Black families is not characterized by the absence of husbands and fathers. Men may be physically present and/or have well-defined and culturally significant roles in the extended family and the kin unit may be women-centered (Collins, 1994). This finding supports documented historical perspectives that emphasize the importance of extended family and relationships as essential social networks reminiscent of Afrocentric cultural values. (Collins, 2001, 1994; James, 1993).

Findings also support a relationality paradigm confirming that mother's birth and her other motherhood outcomes like breastfeeding are determined by the relationships that connect her to other human beings (Jackson, 2007). As discussed earlier, those micro-social networks available to mothers and including religious organizations, family, baby's father, and friends may function as a buffer against the stress experienced during motherhood (Shulz and Mullings, 2006; Blum, 1999), minimizing the effects of difficult employment conditions, racist or perceptions of racist health care treatment (Geiger, 2008), and chronic health conditions making it more likely that she participate in

breastfeeding. This point was well-illustrated by Margaret, who suffered from depression and felt emotionally abandoned by her baby's father; Margaret emphasized that it was her faith in God, strong support from her mother, and personal encouragement from her health provider, helped her start breastfeeding. These findings confirm Black Feminist motherhood paradigms which emphasize the importance of "othermothers" and women-centered networks as central to black mothers' survival, and that the centrality of women in kin networks is not predicated on male powerlessness (Collins, 1994).

Stress and Resilience in the Context of Breastfeeding

We've discussed the importance of employment and healthcare provider relationships as structural factors, as well as ideas about motherhood, and sexualization of breastfeeding as cultural values. An examination of breastfeeding within the context of these issues emphasizes the complex and comprehensive relationship between socio-cultural issues and African American mothers' breastfeeding activities. My interviews with mothers also reflected the importance of stress on these women's reproductive lives as another major theme in this research project. Whether mothers breastfed, formula fed, or used a combination of both, mothers' interactions with employers, health care providers, family, and their community seemed to indicate that they were constantly maneuvering around life demands and challenges in ways that reflected their unique social class, race, and gender; further defined by their infant feeding and health outcomes. Other intersectional research approaches have documented the importance of the social context of African American mothers' reproductive experiences. Canady (2001)'s empirical investigation on mental health, race, and pregnancy outcomes concluded that African American women experience greater psychological distress

during pregnancy than women of other races and that the psychological state of mothers is determined more by the social context of her life than by the immediate state of her pregnancy. Mullings' (2006) extensive anthropological research on infant mortality and reproductive health during the late 1990's in the Central Harlem Birth Right Project established that race, class, and gender, as witnessed through employment environment, housing status, and her social relationships, significantly shape mother's birth outcomes These earlier studies provide critical benchmarks for subsequent investigations like mine by questioning previous research which focused on biology and culture as causes of racial disparities in health and demonstrates how the intersectionalist approach more effectively enhances our sociological imagination about mother's reproductive lives.

Lessons learned from Mullings' three-year examination of Harlem mothers were echoed in the experiences of the southeastern Michigan mothers I interviewed and in many ways they confirmed my own study interpretations. I believe that my findings confirm Mullings' conclusions about the relationships between the unequal distribution of resources (class), race, and gender. These factors intersected to determine mothers' access to employment opportunities, housing, health care, and supportive social relationships. Moreover, the Sojourner Syndrome may help explain the high incidence of pre-existing and chronic disease rates among mothers in my study by highlighting the interactive relationship between social factors, constraints mothers experienced as a result, and their resilient responses. Mothers' responses to conditions imposed upon them from restrictive social position may indeed be an example of the effects of stress on Black women's reproductive health.

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Limitations of Study

As discussed in an earlier chapter, this study includes several notable limitations. First, I enjoyed some advantages of an insider's perspective within the target population. Being an African American mother with young children afforded me the ease of locating and attracting other African American mothers of young children as study participants. However, my middle class status also meant limited direct access to less educated mothers. Subsequently, fewer lower SES and fewer formula-feeding mothers responded during initial recruitment efforts. Increased efforts to diversify recruitment by snowball sampling and through expanding the list of organizations and persons contacts yielded a few more mothers who were not middle class and who were not breastfeeding mothers. This was problematic because inadequate numbers of mothers from a broad range of social class backgrounds make it difficult to draw relevant and useful conclusions about study findings in ways that may help answer critical research questions on breastfeeding in African American mothers. Further, I wondered whether the merits of purposive sampling for this study were diminished because I was unable to include greater variation in my sampling.

A related study design limitation had to do with the conflict between my role as a researcher and my pre-existing relationship with some of the participants. It is possible that interviewees may have had some difficulty adjusting to me as a researcher. Because six participants knew me personally in advance of the interview, their responses may have been influenced or affected by our familiarity. This may have hampered attempts to collect honest, open, and accurate dialogue. Mothers may have given responses they thought were expected or those they thought might be helpful to the study. Conversely, participants who knew me may have been guarded and therefore less candid in their

responses. Unfortunately, it was not possible to identify if and with which participants this may have occurred.

Similarly, the effects of social desirability may have produced responses from mothers that they believed were socially acceptable but not necessarily accurate. Recognizing these limitations, I continued to reflect on how and in what ways I might have influenced participants throughout the research process. I worked to encourage an interview environment that facilitated honest and open dialogue. First, I reminded mothers at the beginning of the interview that they were not obligated to participate and that they could withdraw their participation at any time and still receive the incentive. Second, when possible, details about my own infant feeding and breastfeeding experiences remained unknown to participants. I tried to refrain from sharing my own personal insights, perspectives, and experiences as much as possible to help ensure less biased feedback from participants. This was not always possible or easy since I was acquainted with some of the participants prior to the study and because discussions during interviews could develop into enjoyable, friendly conversations. My research interview skills were tested in this way. To counter this effect, I re-directed interview discussions at times in order to collect necessary data. And after each interview, I reflected on discussions I completed in order to imagine ways that I could improve on methods for the next interview.

Thirdly, any answers I received from mothers that appeared limited were followed-up with brief positive responses such as "tell me more", and "what do you mean" in order to encourage greater transparency from mothers and to help confirm or clarify insights into their thoughts and attitudes on breastfeeding. Finally, I combined

encouraging non-verbal cues such as listening, maintaining eye to eye contact when I wasn't writing notes, and affirming mothers' responses with slight nods to affirm what I'd heard. Future research efforts should include efforts to recruit more mothers who are not familiar to the research investigator.

I addressed the effects of social desirability across all groups of mothers through the recruitment flyer as well. As discussed in an earlier chapter, the first version of this study's recruitment flyer seemed to yield more breastfeeding mothers and mixed methods mothers than non-breastfeeding mothers. I surmised that the flyer, titled "Breastfeeding Thoughts and Attitudes Among African American Mothers" was perceived as an interest in recruiting breastfeeding mothers only. In an effort to recruit more non breastfeeding mothers, I secured IRB approval to re-title the recruitment flyer to "Infant Feeding Thoughts and Attitudes Among African American Mothers." This change resulted in a marked increase in the number of non-breastfeeding mothers and confirmed the misleading nature of the first flyer. Similarly, despite focused efforts, a majority of the participants were of middle to upper middle class. I expect that recruiting a more class diverse research team might increase the number lower SES mothers. Additionally, including a broader range of social organizations in the initial recruitment strategy might shape a more well rounded group of participants.

Finally, another possible limitation of the study is the possibility of reactivity bias introduced by the presence of young children during a number of interviews. Eligible mothers were encouraged to plan that their interview be conducted without their children. But several mothers were stay home parents, or worked part-time and were without regular child care. These mothers indicated that they needed to bring their child to the

interview. A few other mothers brought their child to the interview without indicating that they planned to do so. Seven of the participants completed their interview with their young children present. Children at interviews aged anywhere from 6 months to3 years old. This presented as a challenge in a few ways. First from a practical perspective active young children sometimes made it difficult for mothers to focus on the interview questions and on the interview process generally. At times it was necessary to pause the audio-recording so that mothers could attend to the needs of their young children and then to resume once things were organized. Secondly, it is possible that mothers altered their responses because their children were present. I thought this possible especially at times when mothers answered questions that were of a sensitive nature. For examples, mothers often discussed relationships with significant others, spouses, or a child's father, maternal grandmothers, and healthcare providers. These discussions sometimes prompted what seemed to be sensitive or emotional responses from mothers and/or more furtive glances at the baby suggesting, perhaps, that she was more conscientious of responses she may be providing because her child was present. All efforts were made to prevent children from being present or if present to minimize the effects that children might have on the interview process. First, mothers were encouraged to schedule their interview at a time that was convenient for them and their family. I added weekend and evening interview slots in order to accommodate the needs of busy mother's schedules. Secondly, I regularly offered to reschedule interviews when child care plans fell through or needed to be re-arranged. Thirdly, when children were present, I asked mothers to indicate with verbal or non-verbal cue, time or times when they would like to cease the

interview once we began. I recommend that similar investigations offer or include a child care provider or providers arranged by the investigator themselves.

Similar Context Might Mean Similar Breastfeeding Experiences

Other limitations inherent in the study design are evident. The first set of these has to do with issues around generalizability and transferability. This study recruited all African American mothers as participants, prompting us to question whether outcomes from this study can help us develop an accurate analysis of all mothers' breastfeeding experiences. I do not expect to that findings from this study to be generalizable to all other settings. But I believe that this study has made it possible to observe phenomena that might exist in similar form in other settings and communities of African American mothers. To this end, I attempted to address the issue of transferability by way of thick, rich, description of the participants' experiences and the context of their experiences based upon the interviews.

Other comparative studies (Litt, 2000; Blum, 1999) include various groups of mothers and demonstrate contextualized disparities in breastfeeding outcomes. Similarly, all mothers were residents of the greater Metro-Detroit area of Michigan. The structural context of metro-Detroit mothers' experiences might be characterized by economic and social crisis conditions similar to those experienced by mothers in Mullings' (2006) Harlem study during the 1990's. Global economic restructuring, a shift from an industrial-based economy, the relocation of domestic jobs overseas, cuts in social services, and other changes in economic conditions are said to have negative effects on residents in urban areas like Harlem and Detroit. Additionally, mothers are subjected to "longstanding patterns of race and gender discrimination", which interact with these

global economic pressures, to produce certain occupational conditions inherent in these. African Americans are disproportionately concentrated in a public sector dominated by health, social service, and education. (Mullings, 2006). Current conditions of downsizing and job cuts in these industries explain the vulnerability of the Black middle class in metro Detroit, Harlem, Chicago, Philadelphia, and numerous other cities across the country. We can recall that mothers I interviewed (at all social classes) clearly prioritized their employment and sacrificed their breastfeeding.

To the extent that many urban areas environments resemble those of metro-Detroit, the economic crisis simultaneously affect other areas in similar ways, and the cultural and social contexts of black mothers reproductive lives is same determines how well we might transfer these findings. Based on this criteria, we might expect to find similar issues and outcomes in other geographic areas.

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CHAPTER 6

Discussion and Recommendations

Broad cultural and religious beliefs, healthcare interaction and support, and maternal and child health status, paid employment outside of the home were all major factors that negatively impacted mothers' breastfeeding attitudes and behavior. When mothers had higher levels of education, she was more likely to breastfeed; but the class based, racist nature of employment environments and healthcare provider interactions often discouraged breastfeeding. Public treatment of breastfeeding mothers conflicted with promoted cultural ideas of breastfeeding creating ambivalent ideas and uncertain environments for mothers. When available, supportive personal networks neutralized broad social ideas, making it more likely that mothers breastfed.

An intersectional understanding based on Black Feminist perspective helps us to understand these factors as contextualized issues related to race and class. Race, class, and gender are multiplicative and simultaneous; "interlocking" and "interactive" rather than "additive" factors (Mullings, 2006) that influenced breastfeeding for mothers in this study. The following sections review African American mothers' major social and structural breastfeeding barriers explored in the study and provide a brief overview of policy recommendations that might offer solutions. First, mothers' employment environment shaped her infant feeding decisions. Many of the formula feeding mothers indicated that they would have initiated breastfeeding had they received more support and flexibility in their work lives. Minimizing or eliminating employment barriers would likely increase breastfeeding initiation rates among African American mothers and narrow the current gap between African American and other groups of mothers.

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Structural platforms like employment that are strongly associated with breastfeeding behaviors should be addressed in a comprehensive and systematic way in order to encourage more working mothers to breastfeed. It is critical that we counter racist and sexist employment hiring and promotion practices which have produced those long term inequities and imbalances of power experienced by African American mothers. Equitable work environments would be more sensitive to the needs of breastfeeding mothers by mandating a standard minimum period of paid maternity leave time for all mothers regardless of her occupation or position, making provisions for mothers to pump at work, and enhancing training and opportunities for mother's professional advancement.

I support a few recommendations made by other researchers. First, Blum (1999) suggests that structural changes within the workplace are needed to help keep pace with the number of mothers who return to work breastfeeding and with those mothers who *want* to return to work breastfeeding. Blum recommends passing legislation that provides tax incentives to employers to make the work environment more breastfeeding friendly (tax incentives to employers to rent breast pumps, provide space, and significant time to pump); "much cheaper than the maternalist reforms like extended, paid leaves common in Western Europe" (Blum, 1999). Secondly, Williams (2008) suggested that more states enact the Workplace Accomodations for Nursing Mothers Act passed in 16 states as of August 2009. The Workplace Accomodations for Nursing Mothers Act requires that employers provide reasonable time (paid or unpaid) for mothers to pump milk; make reasonable efforts to provide suitable, private space for this purpose, and not discriminate against women for pumping milk in the workplace.

A second major issue in about breastfeeding is the impact of cultural ideas, norms, and beliefs, particularly those major ideas that media and social outlets promote . The reality is that better support for breastfeeding may only be possible if women's bodies are not sexualized and African American women's bodies are not demonized as over-sexed creatures in need of control (Collins, 2001; Blum, 1999; Barbee, 1993) Further, mothers' descriptions of the public's treatment of breastfeeding mothers is probably not unique to breastfeeding experiences of African American or Black mothers. But the cultural norms associated with "exclusive mothering" are not intended for Black nor poor mothers. It is my belief that poor peoples' activism, led by poor and minority women is worth considering. One such movement could emphasize a comprehensive agenda of poor and minority women's health, mother's employment rights, and women's community leadership development and advancement. This campaign for a cultural perspectives shift should be targeted to the medical community, business community, throughout the political rank and file, and in other major social institutions. Social problems require active resistance and activism (Waitzkin, 2001). Past major social and civil rights victories were hard fought and slowly won only with broad–based support. Further, grassroots activists have successfully fought and ended the widespread practice of offering free formula to new mothers upon discharge. This was considered a major victory because studies have shown the provision of free formula make mothers end breastfeeding earlier and start using formula sooner than they would have otherwise.

Though not an immediate solution, an organized demand for structural change would encourage improved fundamental understanding and benefits of a family-friendly work necessary in the face of a growing interest and participation in breastfeeding among

working women. A successful campaign would also mean the prospects for improved health care for low and working class mothers and legislative protections for both said policies.

The third major issue mothers identified as a barrier to breastfeeding was their relationship with healthcare provider. Waitzkin (2001)'s recommendations provide insightful, evidence-based considerations for change. I do agree with his point that improving the power balance of patient-provider relationship is a challenge because the patient-physician relationship inherently operationalizes patterns of dominance and social control, particularly when race and class differences between mothers and physicians are greater (as in the case of lower SES mothers in this study.) But I disagree with his inference that the ideal source of effective support, information and resources for patients (mothers, in this case) should be the physician. Past exchange between mothers and the medical community suggests this should be carefully considered. First, mothers in this study showed clear preference for midwives to provide their prenatal care. Secondly, physicians' office time allotments are limited and may not permit enough time for adequate support for breastfeeding training. Finally, although there has been an influx of women and minorities into the healthcare field in recent years, an authoritative and hierarchal spirit still dictates the patient-physician relationship.

Given the current state of healthcare, the continued dominance of technical knowledge, proliferation of pharmaceutical industry, and the physician continuing as the locus of healthcare power, mothers may fare better if they interface with a healthcare professional who is positioned at a different level within the healthcare hierarchy. I see a several issues and another possible solution here: Physicians are not always equipped to

provide dedicated breastfeeding support to mothers. There are wide variations and significant gaps in the quality of care as evidenced by mothers in this study. They may have been well informed, but mothers did not always receive the best breastfeeding care and support that breastfeeding clearly requires and they needed.

Currently, many healthcare institutions assign the lead for such care to lactation consultants. But current activity by this group is short-lived and ill-placed; occurring only on occasional, fee-based instances that make it unavailable to the majority of women who need it, especially lower SES and black mothers. For these reasons, I recommend that a dedicated professional role of breastfeeding advocate be assigned to a health professional other than the physician and preferably not within the context of a set of comprehensive duties. This breastfeeding advocate should be chosen based on measures of cultural competence and should be an individual whose sole function in the healthcare world is to train new and returning mothers, both before and after birth and to support their breastfeeding activity for the first several months or until mother feels she has mastered techniques. Ideally, a breastfeeding advocate would be a veteran mother herself and experienced in breastfeeding. Most important, the breastfeeding advocate is paid by the health system in which mother gives birth or by local area public health department. This proposal might call for the installation of a national universal healthcare program that resolves questions about access to care, drastically reduces current wasteful administrative practices, and may standardize the provision of breastfeeding care in the form of the breastfeeding advocate.

The breastfeeding experiences of African American mothers exist at the intersection of class, racist institutional treatment, and gendered social contexts that determine mothers' attitudes and behavior around breastfeeding. Mothers are knowledgeable about the benefits of breastfeeding and they value breastfeeding as a motherhood activity. They are generally supported by their personal networks. But the structural, social, and cultural context conditions under which African American mothers must negotiate breastfeeding as well as other mothering behavior is characterized by sexist, class based, and racist practices within broadly placed structural and social institutions. Breastfeeding should be recognized as a vital source of good health for infants and their mothers and supported through the multiple areas that make up the social context of mothers' lives. Cultural messages about breastfeeding need to be de-sexualized and to replace the current focus on women's bodies with messages that recognize and celebrate maternal and infant health and well-being. Sociologist, David Williams (2010) noted that "There is more to health than healthcare; where we live, work, learn, and play determines health." At the employment level, employers should be indoctrinated into a larger social system that recognizes the cost benefits of family-friendly work policies at all levels of occupations and provides tangible support for women no matter their social position or race.

Recommended future studies will explore the feasibility of these ideas to better determine how these proposed policies might work. Finally, future research interests might consider limitations of this study in its research design and implementation and develop a protocol that minimizes effects of social desirability and that includes a

comparative analysis between African American and other groups of mothers to further explore the intersections between race and class.

APPENDICES

APPENDIX A

Participant Screening Questions

Thank you for your interest in the Breastfeeding Attitudes and Behavior Study. The purpose of this study is to explore the thoughts and attitudes about breastfeeding for African American mothers. Participants who are eligible and who agree to participate will be scheduled for an individual interview. Information collected on women who fail to meet eligibility requirements will be destroyed. In order to assess your eligibility, I'd like to ask a few questions.

1) What year did you give birth to your last child?

2) How old is your youngest child?

3) What is your age?

4) What is your race?

5) What is the highest level of education you've completed?

6) What is your marital status?

7) How did you feed your baby?

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APPENDIX B

Informed Consent-Individual Interviews

Michigan State University
CONSENT FORM FOR HUMAN SUBJECTS PARTICIPATING IN AN INVESTIGATION
Social research institutional review board (SRIRB)
Michigan State University - College of Social Sciences

Title of Investigation: ***Breastfeeding Attitudes Among African American Mothers***

Investigators and Titles: Maryhelen MacInnes, PhD., Angela M Johnson, PhD Candidate

Department: MSU Department of Sociology

Address: 316 Berkey Hall, East Lansing, MI 48824

PURPOSE:

You are being asked to participate in a research study of new mothers' attitudes about breastfeeding. The purpose of this study is to explore African American mothers' attitudes and perceptions about breastfeeding and how these mothers' thoughts and attitudes about breast feeding are impacted by the social context of their lives. It is our hope that insight into the thoughts and attitudes shared in this study will enhance understanding about the personal and social context of breastfeeding experiences in African American mothers.

You have been selected as a possible subject in this study because you have met initial screening criteria and have indicated an interest in participating. Up to 34 women are being asked to participate in this study.

Your participation in this study will take approximately 90 minutes.

POTENTIAL BENEFITS:

You will not directly/personally benefit from your participation in this study. Your participation in this study may contribute to the understanding about differences in thoughts and attitudes among African American mothers on breastfeeding.

POTENTIAL RISKS:

This study is comprised of individual interviews in which your answers will be audio recorded. During the course of the study, audio tapes of interviews will be stored in a locked office of Maryhelen MacInnes, PhD located at: Michigan State University, Department of Sociology, 401B, Berkey Hall, East Lansing, MI 48824-1111 for three years.

PROCEDURE:

Selected participants who agree to participate will meet at the home of the participant or at a location that is mutually agreeable to both participant and researcher. The interview will last one hour to one and half hours. The will be audio-taped and also recorded through the use of handwritten notes.

WHAT THE RESEARCHERS WILL DO:

Angela Johnson will ask questions of the interview participants. Responses will be audio-taped.

WHAT YOU WILL DO:

You will discuss the issues presented to the best of your knowledge and ability. You may decline to answer any question presented to you.

CONFIDENTIALITY:

Your answers will be kept confidential and the responses will not be shared with any other person, organization, or other entity. The audio recording of the session will be transcribed and will be maintained in a secure site accessible to only the researchers. The results of this study may be published or presented at professional meetings, but the identities of all research subjects will not be revealed for purposes of the presentation.

YOUR RIGHTS: the right to say no and to withdraw.

Your participation in this research project is completely voluntary. You have the right to refuse to participate at any time. You do not have to be a subject in this study. Once the interview has begun, you may change your mind at any time during the study, withdraw your participation and any given responses. You may decline to answer any question for any reason.

COSTS AND PAYMENT FOR BEING IN THE STUDY:

You will be given a $25 gift certificate for your participation in this study at the completion of the session.

THE RIGHT TO GET HELP IF INJURED:

If you have any questions or concerns regarding your role and rights as a research participant, or if you would like to obtain information or to offer input, or if you would like to register a complaint regarding this study, you may contact, anonymously, if you wish, the Michigan State University Human Research Protection Program at telephone: (517)355-2180 or fax: (517)432-4503, or email: irb@msu.edu, or regular mail at 207 Olds Hall, Michigan State University, East Lansing, MI 48824

If you have any questions, please ask us. If you have any questions after the conclusion of the session, please feel free to call Angela Johnson at 734-395-1816 or you may contact Maryhelen MacInnes, PhD., Department of Sociology, 316 Berkey Hall, Michigan State University, East Lansing, MI 48824-1111.

You will be given a copy of this form to keep.

You are making a decision whether or not to be in this study. Your signature means that you have read this consent (or have had it read to you) and that you have decided to be a participant. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at anytime without penalty or loss of benefit to you are otherwise entitled.

I voluntarily agree to participate in this research study

_____ _____

Date Time (AM/PM)

_____ _____

Signature of Participant Signature of Investigator

I agree to have my participation in this study audio-recorded. _____ (Initials)

APPENDIX C

Recruitment Flyer

Are you African American and a mother? Have you given birth to a child anytime in the past 5 years (since July 2004)?

We'd like to hear your thoughts on infant feeding!

Angela Johnson, a researcher from Michigan State University, is talking with African American mothers who have given birth within the last 5 years to share their thoughts and attitudes about infant breastfeeding influences. Mothers who have formula fed or breastfed are eligible to participate.

Participation includes:

- A one to one and a half hour face-to-face interview
- Mothers who participate will be asked questions related to their thoughts about breastfeeding, and influence from family, community, healthcare provider, employment, media, and society.
- Mothers who agree to participate will be offered $25 gift card
- All interview information remains confidential

For more information or to participate contact Angela Johnson at (734)395-1816 or via email at olivialaila.johnson@gmail.com

IRB #09-788 REVISED 9-25-09

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APPENDIX D

Interview Questionnaire

General Questions

1. What are your thoughts about breastfeeding? How did you feel about breastfeeding before you gave birth?
    a. Did you breastfeed or formula feed your baby?
    b. What are some of things that influenced your thoughts about feeding your baby?

Spouse, Partner, and Family Questions

2. What thoughts and ideas does your family have about breastfeeding?
    a. How does your spouse or partner feel about breastfeeding?
    b. What impact has your spouse or partner had on your feeding decisions for baby?
    c. What does your mother think about breastfeeding?
    d. Did your mother breastfeed?
    e. What do other close female relatives think about breastfeeding?
    f. What do you think about your family's ideas regarding breastfeeding?

Community

3. We've talked about the role of family in shaping your ideas about infant feeding. Let's talk about others that are in your personal community – friends, co-workers.
    a. What kind of ideas and thoughts about breastfeeding did you hear from your personal community before your child was born?
    b. Has what you heard from your personal community changed since you gave birth?
    c. Do you know family, friends, co-workers who have given birth in last few years?
    d. How did the ideas affect your thoughts and behavior around breast feeding your baby?

Health Care Provider Questions

4. Research indicates that what health care providers say and do may have some relationship to ideas about feeding infants.
    a. What information did you receive from your health care provider regarding feeding your baby?
    b. In what way did this information affect your choice of method for feeding your baby?
5. Let's talk about breastfeeding messages and information from baby's pediatrician.
    a. What kind of breastfeeding information and support were you offered before your baby was born by pediatrician?
    b. What kind of breastfeeding information and support were you offered by baby's pediatrician after your baby was born?

Employment Environment Question

6. Research suggests that a mother's employment environment may play some role in breastfeeding and the decisions around. Tell me about your work environment. For those of you who worked, how did your work environment affect your thoughts about breastfeeding?
    a. How did your work environment affect your ability to breastfeeding your baby?
    b. In what ways did this environment support breastfeeding?
    c. In what ways did this environment not support breastfeeding?

Media Images – Perceptions Question

7. It has been suggested that media – television, magazines, books -- portrayals of infant care, particularly infant feeding have an impact on way people care for their babies. What messages and images have you seen portrayed in the media regarding breastfeeding?
    a. What do you think about these images and messages and images?
    b. In what ways have these images influenced your decision about breastfeeding (or not breastfeed) your baby?

Society Treatment/Behavior Question

8. There is some indication that the way society views and treats mothers who breastfeed has some impact on mothers' thoughts and behaviors around breastfeeding.
    a. What do you think about U.S. society's attitudes about breastfeeding?
    b. What are some of the messages and images you've seen?
    c. What do you think about society's treatment of women breastfeeding in public?

APPENDIX E

COLLAPSED THEMES AND EMERGENT THEMES

Breastfeeding - Defined differently
It was common for many women to describe themselves as "BF" Moms when in fact they both BF and formula fed their baby. Often it was during the interview & data review process that a more accurate description of their BF behavior surfaced. For purposes of this study, mothers were considered BF mothers if they BF for at least 6 months exclusively. Many who supplemented saw BF at all – though it was mixed with formula feeding – as a major victory.

Healthcare - PREGANCY & BIRTH EXPERIENCE – Previous & current: Mother's discussions demonstrated that BF was tied in many ways to previous & current births and previous BF experiences.

- ✓ **Medical difficulties during pregnancy was significant theme – surfacing in at least half (check) of the women interviewed.**
- ✓ **Difficult pregnancies – physically or emotionally - often led to more focus and concern on mother's state of health and subsequently less focus on BF & other after birth behaviors.**
- ✓ **At least two mothers experienced mental health problems during pregnancy (Jane, Margaret) -** Margaret (cried often when she said): **"***I was in a deep, deep depression during my pregnancy. After my pregnancy, and I was just trying to survive myself" "I would candy coat it because I was afraid that I would lose my job because my health insurance carrier was also my employer. So, I felt like I couldn't really be honest about what was going on. But I really should have been. She asked me, you know, was I depressed? I didn't really tell her really what was going on. I minimized it. And I really should have got the help that I needed. And I did go to a therapist."... I could barely function at work" (p.3-4)*

- ✓ **As well, poor relationship or interactions with healthcare providers impacted BF tendencies. (e.g Peaches, Jane,)**
- ✓ **Conversely, positive relationships with healthcare providers supported moms behavior and found them more likely to be BF when they received support this way (e.g. Michelle, Margaret,)**
- ✓ **Finally, mothers – typically had very little to no discussion with OB re: BF intentions and plans. Mothers were more likely to have conversations or discussions with midwife. Often, however, discussions were brief just consisting of the question: "are you going to BF?" "That's good" and being given pamphlets. Several women indicated that they wished they could have had more information and/or discussion with their provider but felt that he/she was "too busy" or had "a lot of patients and no time" (Mary)**
- ✓ **BF was generally promoted as a good idea but failed to make mothers aware of the challenges & problems that they might face – especially during the first days and weeks of BF (e.g. Mary, Toya,): *MARY:***

Structural - HOSPITAL/HEALTHCARE threatened or SABOTAGED MOTHER'S EFFORTS TO BF (also see birth experience)

- (Ella) (BF) baby's pediatrician suggested I give baby formula b/c concerned about wt gain
- (Nicole) (F) "scary, once you got home…you got to do it by yourself" Is this baby going to latch on? Can you handle this? What type of emotional effect it was going to have on you? (p.7)
- (Toya) (F) just gave me baby formula – didn't ask me
- (Peaches) (BF) Hospital staff deceived me & gave my baby formula
- (Terry) – (mixed) Even though I said I would BF --- pediatrician's office gave "generous samples of formula" (new mother's kit)
- Mary (Mixed) needed more info. than OB provided.—wish could have stayed w/midwife who was more personal, individualized, more caring.." (p.10)
- Mary – had bad experience w/doctors & nurses giving birth to 1st baby @age 22 & not married – doctors or nurse were really rough –
    - no communication at all – "even though fiancee was at delivery then" –
    - "and to me it felt like they just ripped the baby out and just "here you go". And just move on.. the nurse was really really rude (p.16)
    - no communication re: BF, no communication about what to do after birth, no follow-up after I gave birth, there was nothing." (p.16) ***"makes you feel like you are one of the problems of society"*** (p.15) I was overwhelmed with emotions & then right after I passed out b/c I was just thinking…"How am I going to take care of this kid?"

Structural - EMPLOYMENT – INFLEXIBLE OR PERCEIVED INFLEXIBLE & NON ACCOMMODATING WORK ENVIRONMENTS SHORTENED BF OR DISCOURAGED IT'S ADVENT. Even for the moms w/high SES & with income, education – formal & BF, resources, relatively better accommodations, and support at home, etc. there was a struggle to BF/pump baby. Often appeared to be "moral support: from employers e.g. time allowance to pump, encouragement to return to work "when ready", but there was fewer examples of less likelihood that this would be backed by physical or other tangible accommodations so no "tangible supports" (pump station, etc.) though there were some e.g. Mary's boss loaned her a shirt when she leaked at work.

- AKA – (Mixed) – just too much to travel & BF/pump after awhile; pumped in bathroom
- Julie – (Mixed) – learned re: new job opp when baby a few months old – so decided time to end BF b/c didn't think it would fit into new work demands
- Mary – (Mixed)- grants specialist @ univ. - had to make my own sign "Do not enter" & lock door & use conference room. When conference room not available, I had to use the bathroom" (p.7)

- Terry –(Mixed) – on the road & away from office in meetings 3 days of the week – difficult to pump; when in office – windows no way to pump b/c couldn't cover windows; didn't know if ok to ask HR for accommodations (had previous bad interaction w/HR person who denied her ability to combine 2 wks vacation w/6weeks FMLA

- Allison –(F) – working as telephone dispatcher at college – barely had bathroom breaks – no one to relieve me if needed to; absolutely no allowance for pumping – didn't even try to BF w/next baby
- RunCat (BF) boss would take a walk for 20 minutes so I could use her office to pump; my work environment was very supportive
- Peaches (BF) my husband encourage me to stay @ home even though we needed the $$ so that I could BF baby

Structural & micro-social - BF EXPERIENCE (current and previous)

- AKA (mixed) no – I would not have like to BF longer… I wasn't into whole process..BF 4 mos.. I liked flexibility of not having them totally dependent on me; " some moms like having kids next to them" "for me…OK, I need to have some me time too" ; moving into formula gave me that time & gave Daddy time w/baby too. "really helped to have him involved" (p.3)
- (AKA) work environment w/1st baby – though had lactation room, accommodations, etc. --was not conducive to BF b/c had to commute so thought..forget this.." w/2nd baby – no lactation room – but ..if had been much more comfortable environment where could sit..would have been easier..may have BF longer" Everything was always so rushed (p.8)
- Faye: having had previous BF experience – gave me "fortitude" that just had to figure out mechanics of what was causing BF problems - saw lact. Consult in hospital & after
- (Faye) "Knowing (confidence) that BF was better thing for as long as I could do it"
- Faye: "not easy to keep the commitment when you're in pain" (p.9)
- (Terry) (mixed) real positive re:BF b/c had BF w/older child who is 4 years older (for one year)
- (Terry) used lactation consultant w/baby#1 – then didn't find need w/current baby (2yo)

Micro-social factor - AGE MOTHER

- TOYA – (FORMULA)– was worried b/c I was young (17yo), still in high school
- PEACHES (BF)– indicated that when she younger – w/previous 2 births – "young & wouldn't listen to my mother" – she failed to learn as much as she realized she could have learned frm mom.
- MARY (MIXED) – indicated that her first pregnancy 14 years b4 found her a young & unprepared mother who BF very briefly b/c she didn't understand the process – this experience later impacted her most recent pregnancy as an experience that made her more aware & informed of what she needed to do to care for herself to produce milk – ultimately leading to BF (w/supplementation) for 1 year.

Micro-social - BONDING WITH DAD

- Several mentioned that they thought BF took away from Dad's bonding experience
  - AKA (mixed): "biggest thing was @least trying to find out a way so that he could help in the process" one of advantages of supplementing – Dad could have "special time with baby" & I could get time to myself (p.2)

    - Nicole
- Others saw BF as opportunity for Dad to be involved as well
    - Faye (BF): saw the BF (dad would bring drink of water) & return to work as opportunity for Dad to have time w/baby
    - Peaches (BF): dad would leave room w/her when time to BF baby to rub her back as show of "support"

Cultural/Micro-Social – FAMILY IMPACT:

- Many mothers indicated that family had a neutral or non-committal ideas re: BF. Several indicated that family like healthcare, or other community factors did not favor one infant feeding method over the other.
    - (Margaret-Mixed) *"I didn't have any cheerleaders, and I didn't have anyone against it. It was what it was, you know? No one really expressed their position on it one way or the other "* *(p.6)*

BIRTH ORDER: PREVIOUS BF EXPERIENCES SERVED AS PREDICTOR OF FUTURE BF BEHAVIOR

- Julie – b/c previous baby was very premature & she missed opp. to BF & bond w/baby (could only pump) – really wanted to have bonding experience with this baby
- Terry (Mixed) since I'd BF 1st baby – I knew what to do and had no question that I would do it; even my mother "wasn't surprised" when I indicated I would BF 2nd baby – though she was surprised with 1st baby
- Nicole (F) well, I'd formula fed my 1st baby and 2nd – so question as to whether I'd formula feed this baby

POOR NUTRITIONAL INTAKE AS BARRIER TO BF (MOTHER'S CONCERNS ABOUT)

Cultural - RELIGION/SPIRITUAL FAITH/BELIEFS

- (Michelle) (shrugged her shoulders when she said) BF is what GOD intended – that what breasts are for; natural"
- (Faye - BF) Muslim Faith recommends "wifely" role caring for home & family = 1st choice
- (Faye) Muslim religion dictates preference of women vs man clinician – hence Faye's choice of midwife (p.7)
- (Peaches - BF) Muslim faith recommends BF 2 years
- Lisa – (Mixed) "maybe that how God's plan is …he provides food, milk for babies..like with other animals. You know, the mother provides the milk for her babies. So it it with human beings, as well. You know we have the source needed for them to survive" (p.8)
- (Margaret- Mixed) felt BF "God gave us this ability to BF" "best for baby & is more economical" (p.1) My belief in God – that's where it originated from (p.1) God has given us ab

Cultural factors – OF ETHNIC BACKGROUND

Micro-social - RELATIONSHIP ISSUES

- (peaches) BF thoughts & behaviors would be affected more by community if I were younger – 3rd husband now

- (Margaret) ; I felt overwhelmed by just having this new baby, getting up every two hours at night, you know? And just undergoing, like, some issues in our relationship; 85% of the time, you know, at night, when the baby would cry or want to be fed every two hours, I was the one that was getting up out of the bed to get the baby. Whereas, I felt like had he shared in that, that would have been less on me" (p.2)
- (Margaret-Mixed) Pregnancy ... "was happy and sad emotion. I was sad that I was – the timing wasn't quite the way I wanted it. Again, we weren't married, so I was disappointed in myself that I was pregnant out of wedlock, but then I was happy that I was having a baby"
- (Margaret) You know, American dream: white picket fence and the whole nine. And life didn't play out like that for me.... And so I was just waiting to get married. I just happened to be getting older and older and older. (p.6)

FINANCIAL STATUS

Cultural - SEXUAL ASSOCIATIONS – connected to BF by themselves or by others: media sexualizes BF & denotes as "private affair" but promotes other sexual images as OK to view; yet many of mothers say that the media's negative depictation of BF did not affect their decision to BF. MARY: Didn't affect my decision – "if I were looking at the media I would not be BF" (p.13)

- AKA (self & society)
- Jane (herself): BF is "not natural" Saw mother BF 5yo & 10yo on Dateline 1 year ago. "That's (sexual) abuse" turned me off completely from BF b/c seemed parents were getting off by having these big grown children suckling on their breast." "that's freaky" (p.2-3)

"SPOILING"– FEAR TOO CLOSE ATTACHMENT

- Nicole (formula), (don't want) " major attachment then all of sudden pulling away b/c will have to come to an end one day"; want baby to be able to bond with other family, friends, or whatnot
- AKA (mixed), not really into the whole –BF – didn't want baby too dependent on me-daycare person wanted to be able to give bottle & was impt to have dad involved too – it helped
- Jane (F) – just nasty esp. with older child BF
- RunCat (BF) some family – not in favor b/c weren't ready to experience intimate closeness (p.3)

Micro-social - OVERWHLEMING RESPONSIBILITY / A LOT OF WORK

- (Allison) "It takes a lot of work" (p. 1) ; " I was tired --requires time, energy, and being at home"
- (Ella) BF but she says "I have no desire to pump; I pumped a little but just too much (work) with two kids now; I just don't really think I have extra milk. I don't know. He nurses a lot"
- (Toya): I got frustrated.. and figured it wasn't meant for me to do
- (Mary) felt that it was an injustice the moms are not prepared with awareness of just how challenging BF is

- (Margaret-Mixed) "I felt overwhelmed by just having this new baby, getting up every two hours at night, you know? And just undergoing, like, some issues in our relationship; 85% of time I was one getting up to get baby; I was very, very sleep deprived (p.2)

Structural: Community Organization: WIC interactions with mothers demonstrate different experiences for different mothers – some served as BF advocates other WIC discouraged

- (Faye) was very instrumental – esp during time when problems found with baby formula in China & found to be in America too; helped get a lactation consult
- (Ella) found interesting WIC sends formula home w/ you "just in case" as if to say that when you experience difficulty – this is your alternative
- Nicole (F) know that I have the WIC coupons as resource if I formula feed
- AKA – really was for BF
- Mary (Mixed) – Washtenaw Co. Public Health – "WIC was helpful" b/c of information, teach you how to eat, how to produce more (BM), & provided me with a pump" (p.7)
- Toya (formula) - difficulty with Focus Hope & WIC – in struggles to get formula when early BF attempts @ home failed

RACE/ETHNICITY as FACTOR

- Faye (BF) – images are generally in favor of and better than in past – but usually show White or Asian baby. BF messages are not for me
- Terry(mixed) -

NUTRITIONAL , PHYSIOLOGICAL , DEVELOPMENTAL BENEFITS

- most all mothers – especially those who BF at least in part -- all noted this as major motivator
- even formula –feeding mothers were aware of the various benefits to some degree & were not BF b/c of other reasons e.g. Jane – mental health issue & psychiatric medications
- (Mary- Mixed) - Bonding with child is #1 (reason why I wanted to BF) also: milk mother produces has a lot of nutrients in it; & b/c they have been close to heartbeat (b4 birth), BF is way to "bring them back to you and then kind of comfort them..making sure thy are OK" (p.2)
- (Terry) mixed – "my main reason to BF is to help my son" "I knew BM would be better for him than formula" p.7

Structural - POLICY AND OTHER RECOMMENDATIONS/REQUIREMENTS

- Faye (BF) – would like to see paid maternity leave for both parents up until baby is walking.
- TOYA (formula) – generally government ignores BF – the system does not encourage
- WIC encourages BF a lot "just so they won't have to give you those extra benefits of buying formula..it's cheaper to buy milk, eggs, and cheese than buying 8 cans formula" .. . other than that I don't really see it"

- (Terry) (mixed) maternity leave is too short in U.S.
    - quit previous job had around birth of baby#1 – in tears b/c employer refused to tack 2 week saved vacation days onto FMLA (6 week) paid leave
    - unfortunate that FMLA can be "legislated in any that the employer feels is beneficial"
    - Terry left that job as result… (p.17)
- Terry (mixed) – impt for companies to develop good policies b/c "where I met most resistance" (p.16)
- Terry should be "corporate common sense" for them to support BF by:
    - Small area for pumping w/refrigerator (as example) – would be seen as family-friendly company
- (MARY) – society doesn't support BF – they say they do, but they don't. They say you should BF but they don't give you the resources – or they give you the resources, but you have to go find them… they don't make them accessible to you" (p.13)
    - Why isn't it (like cigarettes) "right in your face, right there?"
    - There should be "physical stations like abortion clinics" equipped with information re; BF and pregnancy….every ten blocks especially in poor communities" where people who need the information will feel more comfortable with pursuing the information. (p.13)

COST – served as barrier or as motivator -- to BF –

- (Runcat - BF) Saw that formula's cost = $300/month - & thought "you can buy a really quality pump for that" (p.8)
- (Terry -mixed) felt that income/resources played a role - had not been able to afford $300 pump – would not have BF as long after returning to work. If Hand-held pump – then "no way" there are resources for formula – it's not very expensive in that way. Received LOTS of formula samples in mail.
- (TOYA-formula) tried BF on own at home b/c price of formula was "ridiculus" else I had to go to Focus Hope or WIC (p.3);
- (TOYA –formula) planned to go out & buy a breast pump so could give baby BM but "finances weren't there" (p.5)
- (TOYA-formula) b/c I was low-income, unemployed, FT student, I was "luck the State let me get WIC" otherwise, I would have had to find out how to BF b/c formula costs $14-23/container & WIC's supply doesn't always last the whole month" (p.8)
- (Lisa-Mixed) money issues, in general did not come up " I just had this feeling that God would provide…" "I was prepared to provide & my husband was working; I did think: "if I BF, you know, we wouldn't have to buy milk" (p.13)

Structural - Employment Environment

- Terry (mixed) felt not easy to negotiate with corporate culture for space to pump -- "just better to be quiet about it" since "resources are real thin everywhere" (p.10)
- Terry (mixed)considered herself luckier than most who have to work and BF baby (her friend in Texas – pumped in car)

- Faye: (BF) If I didn't make a big issue of it, they didn't make a big issue of it. (p.11)
- Julie: (Mixed) thought best not to even expect no ask re: BF accommodations with new job; simply ended baby's BF when began new job.

SOCIETAL TREATMENT OF MOTHERS BF IN PUBLIC – make sure to discuss

- There seems to be an almost universal feeling among all mothers interviewed that society has progressed in its way to deal with BF come so way but still does not feel it ok for Mom to BF in public mainly based on ideas around the sexualization of BF. Several of moms internalized these feelings and expoused them during the interview but others recognized that it signified shortcomings in society's collective cultural expectations & that mothers should be permitted to BF in public without being made to feel ostracized or considered making a sexual spectacle of the act of BF.

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