

FOOD FOR THOUGHT:  
BREASTFEEDING EXPERIENCES AND HEALTHY PEOPLE 2010 GOALS

By

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To my dad

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## TABLE OF CONTENTS

	<u>page</u>
ACKNOWLEDGMENTS.....	4
LIST OF TABLES.....	7
LIST OF FIGURES.....	8
LIST OF ABBREVIATIONS.....	9
ABSTRACT.....	10
CHAPTER	
1 INTRODUCTION.....	12
Research Questions.....	14
Sociological Relevance.....	16
Overview of Dissertation.....	18
2 SOCIO-HISTORICAL CONTEXT.....	19
Current Recommendations.....	19
Data Limitations.....	23
Breastfeeding Behaviors.....	26
Correlates.....	30
Social Context.....	36
Intervention Programs.....	38
Summary.....	44
3 RESEARCH DESIGN.....	47
Feminist Theory and Methods.....	47
Feminist Approaches to Breastfeeding.....	58
Setting.....	60
Participants.....	64
Data Collection and Analytical Strategy.....	66
Conceptual Definition.....	69
4 EXCLUSIVITY.....	76
When, What, and Why.....	77
Decision-Making.....	79
Temporary Supplementation.....	85
Embodied Breastfeeding and Father Involvement.....	88
Negotiating Supplementation.....	94

Summary .....	96
5 DURATION .....	98
When and Why .....	99
Expectations and Goals .....	100
Decision-Making .....	104
Conversations .....	104
Plans .....	107
Non-Decisions .....	107
Changes over Time .....	109
Returning to Work .....	110
Teething .....	112
Nursing in Public .....	113
Sexual Relationships .....	115
Negotiating Cessation .....	117
Summary .....	119
6 CONCLUSION .....	123
Women's Experiences .....	123
Implications .....	125
Program Development .....	125
Theoretical Orientation .....	131
Limitations and Future Research .....	133
Conclusions and Reflexivity .....	134
APPENDIX	
A RECRUITMENT FLYER .....	140
B INFORMED CONSENT FORM .....	141
C DEMOGRAPHIC INFORMATION SHEET .....	143
D INTERVIEW GUIDE .....	145
LIST OF REFERENCES .....	148
BIOGRAPHICAL SKETCH .....	154

## LIST OF TABLES

<u>Table</u>	<u>page</u>
2-1 National and state rates of breastfeeding compared to Healthy People 2010 goals .....	46
3-1 County, state, and national characteristics of births.....	73
3-2 Participant characteristics .....	74
3-3 Participant occupations and maternity leaves.....	75
4-1 Details of supplementation among participants .....	97
5-1 Participant goals and durations of breastfeeding.....	120
5-2 Participant descriptions of breastfeeding.....	121
5-3 Comparison of expectation and experience.....	122

LIST OF FIGURES

<u>Figure</u>	<u>page</u>
6-1 Conceptual Model of Influencing Factors.....	139

## LIST OF ABBREVIATIONS

AAP	American Academy of Pediatrics
NFRMC	North Florida Regional Medical Center
WHO	World Health Organization

Abstract of Dissertation Presented to the Graduate School  
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Healthy People 2010 included raising the rates of breastfeeding in their recommendations to encourage a healthier population. These national goals are to have 75% of women breastfeed in the early postpartum period, 50% breastfeeding at six months, and 25% at a year. These goals were amended in 2002 to include having 40% of mothers breastfeeding exclusively for the first three months and 17% breastfeeding exclusively for the first six months.

Framed by a feminist approach to studying and theorizing about women's experiences, this project explores women's experiences with breastfeeding over time. Interviews were conducted with mothers near the time of the baby's birth, around four weeks, eight weeks, twelve weeks, six months, nine months, and twelve months after the birth. The last interview occurred at twelve months or when breastfeeding stopped, whichever was first. All interviews were transcribed and coded during analysis.

Results are significant because they emphasize breastfeeding as a complex process, not a one-time decision. Three key themes were that breastfeeding is challenging, that women are socially situated, and that breastfeeding is an embodied process. These have important implications for public policy and program development

related to breastfeeding. Most current interventions to increase breastfeeding rates are aimed at educational efforts before the birth, but these results indicate that even women who are knowledgeable about the benefits of breastfeeding and current recommendations to breastfeed have difficulty meeting national goals. Based on this research, programs should be designed to assist women after the birth of the child. Additionally, programs should include information about the difficulty of breastfeeding, fathers as significant factors in breastfeeding decisions, and embodied aspects of breastfeeding. Approaching breastfeeding support from these angles provides necessary information and support beyond the current prenatal education programs.

## CHAPTER 1 INTRODUCTION

Margaret Mead once stated, “Nobody has ever before asked the nuclear family to live all by itself in a box the way we do. With no relatives, no support, we’ve put it in an impossible situation” (1978). When it comes to conceiving and raising children, there is a relentless entourage of suggestions, guidelines, and laws that encourage parents to do some things while discouraging others. Even with models of nurturing fathers, most parenting is considered a mother's work, despite the fact that rates of mothers working outside the home have risen considerably. Many researchers have studied the hard place that working mothers often find themselves in. For example, Hays is notable for her work on cultural contradictions of motherhood, Hochschild explores ideas of second and third shifts, and Stone investigates ideas of 'mommy tracks' and the opting out revolution.

While many have focused on the challenges of balancing work and family, I explore what parenting recommendations are made by authoritative bodies and how these recommendations are realized in everyday life. More specifically, this project explores what 'should' be done and what 'is' done with regards to breastfeeding. Mead's words about an isolated nuclear family strike a certain chord with me, and like many researchers, I am drawn to this topic because of my own personal experience. As discussed more in Chapter 3, this project utilizes a feminist approach to understanding women's experiences with breastfeeding. In *Feminist Methods in Social Research*, Reinharz states, “Feminist researches frequently start with an issue that bothers them personally and then use everything they can to get hold of to study it” (Reinharz, 1992, p. 259). The remaining sections of Chapter 1 discuss why I was

personally bothered by breastfeeding and breastfeeding initiatives, while Chapter 2 explores the socio-historical context of breastfeeding.

When I became pregnant, I knew very little about pregnancy, childbirth, or parenting. As many parents-to-be do, one of the first things I did was gather as much information as possible. I learned about the importance of eating well during pregnancy and followed admonitions to not drink alcohol, smoke, or sit in hot tubs during pregnancy. I attended prenatal education classes and started making lists of what we needed to do to prepare for the baby's arrival. I never thought too much about breastfeeding, but upon reading about the health benefits of breastfeeding, I knew that I would breastfeed.

Labor was challenging, and my daughter, Claire, was born with a slight cleft lip that interfered with a correct latch for breastfeeding. I started pumping while we were still in the hospital, and nurses assured me they were using the pumped colostrum in her bottles. We were discharged a few days later, and I continued to pump and give her bottles of breast milk. She spit up a lot, but overall she was a calm baby. I had only a month and a half off before the next semester of school started, and once I was back to school, I carefully timed how long I would be gone and calculated if there was enough stored milk or not. When she was around four months old, Claire finally latched on correctly and I stopped pumping. I breastfed Claire until she was around thirteen months old.

I did not really like breastfeeding. Nonetheless, I also breastfed my son until he was a year old. There were enjoyable aspects, like when they fell asleep at my breast, or when they looked at me with that look of fullness and satisfaction. I did receive a

sense of accomplishment knowing that my body could produce the nourishment they needed and that we were avoiding the expensive, artificial substitute formula provided. But I did not really like breastfeeding. It was stressful. I felt a great deal of pressure in terms of not wanting to fail or fearing how others would think of me if I stopped. I felt alone, as though I was the only one who could do this. I could only be gone for so long, and I was constantly worried about my milk supply.

Sometimes I wonder why I bothered. My mom had breastfed, as had my sister-in-law. I did not want to be a failure, and, in my mind, everyone knows 'breast is best'. I wanted to give my kids the best; I did not want to let them down. All the literature I read told me to breastfeed if I could because it really is better for infants and mothers. I was aware of the recommendations of the American Academy of Pediatrics, and I was going to do everything I could to meet those recommendations. It was not easy, and I did not always enjoy it. In my experience, the focus on scheduling, ounces transmitted, and growth charts distanced me from being able to enjoy the embodied experience. This is on top of issues related to trying to breastfeed and work, involved fathers, and a social context that is uneasy with leaking bodily fluids. There is so much pressure for women to be 'good' mothers at all costs, that I think I lost the enjoyment factor. From my perspective, authoritative recommendations glossed over the nitty-gritty experiences of real mothers, and that is where this project enters the picture.

### **Research Questions**

In *Laboring On*, Rothman writes, "Just as the invisible fetus became the center of maternity care, the mother rendered invisible in ultrasounds and in practice, so now the invisible milk is made visible and the mother erased" (Rothman, 2006, p. 91). The goal of this project is to make mothers visible, to refocus attention on mothers and their

experiences with breastfeeding. This project is about listening to women talk about their experiences with breastfeeding. All the mothers who participated wanted to breastfeed their infant, and I wanted to know more about their challenges with breastfeeding and what support they might have liked to have had with breastfeeding. The following research question guides this project: *How do women describe their experiences with breastfeeding?* More specifically, this study aims to

1. develop an understanding of women's experiences with breastfeeding.
2. ascertain if the participants met AAP and Healthy People 2010 goals.
3. produce culturally relevant knowledge that could be used to guide program development.

The issue of hearing women's voices and considering their experiences with breastfeeding when discussing social policy is of utmost importance as breastfeeding rates continue to fall below recommended levels. Low breastfeeding rates in the United States have been labeled a "public health challenge" in the HHS Blueprint for Action on Breastfeeding, and there have been calls for culturally appropriate strategies to promote breastfeeding (Wolf, 2006). Breastfeeding is a complicated process with many factors, such as medical practice, personal decisions, and social context influencing breastfeeding behaviors. There is a sizable amount of research examining breastfeeding rates and factors associated with breastfeeding duration, and this project adds to existing literature in several ways.

First, this project relied on qualitative data gathered by following women over the period in which they breastfed. Most existing literature is either retrospective in nature or only interviews women at one time point. Following women over time allowed insight into what they experienced at different time points and how challenges with

breastfeeding changed with time. This idea that challenges vary over time is largely glossed over in breastfeeding literature; what does exist tends to focus on the early post-partum period. If we want to help women breastfeed for at least a year, then we need to know more about challenges that women encounter over time.

Secondly, using semi-structured interviews allowed for a broad focus on concerns related to breastfeeding. While depth of information is important to this project, most studies about breastfeeding challenges seem to focus on one limited area, such as the role of social support or issues of low milk supply. Using a feminist approach centered on women's complete experience encouraged me to see how these interrelated parts of breastfeeding experiences fit together to create one woman's breastfeeding narrative. It was important to be able to see how social support, milk supply issues, work concerns, social context, and other factors were all integrated into each woman's experience.

Lastly, this project offers useful information in that it directly connects women's experiences and possible support programming. To my knowledge, these two areas are completely disjointed in the literature. There is information about breastfeeding experiences, and there is information about intervention programs, but the intervention programs do not seem to be directly linked to what women say they need. It seems strange that women's voices about support programs seem to be missing from this literature, but this project is valuable in that it directly links women's voices to suggestions for support programming.

### **Sociological Relevance**

As alluded to earlier, this project is sociologically relevant in several ways. First, it can add to literature surrounding the work/family debate. Most research about working

mothers tends to focus on older children; there is very little about the challenges that working mothers encounter with regards to breastfeeding, and it tends to focus on workplace accommodations related to pumping. Many of the mothers I met with did try to return to work while still breastfeeding, and challenges with doing so moved far beyond having time and space to pump.

Second, this project can also add to discussions of involved fatherhood. If we want to encourage fathers to be involved with their children even as infants, what happens to fathers in breastfeeding relationships? Research on fathers and breastfeeding tends to elusively talk about fathers as important 'social support' for mothers but does little to define social support. Many of the mothers I talked with spoke at length about fathers and breastfeeding, and this is something I hope to follow-up with in future research projects.

Third, the broader framework for the project is to explore recommendations related to parenting and parents' ability to meet such recommendations. This is an important line of inquiry related to sociology of childhood and social inequalities. Policies or recommendations made without an awareness of social context, or developed without appropriate support systems, are going to face challenges. There are many areas in which this framework could be extended, such as reading to children at least twenty minutes a day or letting children play outside at least thirty minutes a day, and this general framework adds to the project's sociological relevance.

Lastly, this project continues a rich history of asking people directly about their experiences and continues efforts to find a place for breastfeeding among feminist research. Policy must be culturally relevant and it must be achievable. If we are setting

unrealistic goals, or if in the process, mothers feel almost unbearably guilty or their experiences are not even considered, I think we're missing something. Social science research can be used to inform policy and program development, but it is crucial that such research accurately reflects people's lived realities.

### **Overview of Dissertation**

Chapter 2 continues with an overview of the socio-historical context surrounding breastfeeding. It provides an extensive review of current literature about breastfeeding recommendations and behaviors, including what the recommendations are, statistics regarding breastfeeding behaviors, and results from previous research about breastfeeding behaviors and intervention programs. Chapter 3 returns back to this specific project with a discussion of the feminist approaches that influenced the theoretical and methodological approaches. More specifically, it discusses standpoint feminism and feminist methodology, as well as the setting and participants that were involved in this project. Chapters 4 and 5 are the analytical chapters; Chapter 4 focuses on duration of breastfeeding and Chapter 5 focuses on breastfeeding exclusivity. Topics discussed in Chapter 4 include women's expectations of breastfeeding, paternal support, changes that occurred as breastfeeding continued over time, and de-breastfeeding cycles. Chapter 5, with a focus on exclusivity, again discusses fathers as central to breastfeeding decisions, but also includes topics of temporary supplementation and the role of pediatricians. Chapters 4 and 5 focus on duration and exclusivity in order to draw attention to Healthy People 2010 goals and the nuances of lived experience while trying to meet those goals. Lastly, Chapter 6 is the conclusion, where I return to the basic goal of rendering mothers visible.

## CHAPTER 2 SOCIO-HISTORICAL CONTEXT

### **Current Recommendations**

The American Academy of Pediatrics, the World Health Organization, and the United Nations Children's Fund, among numerous other organizations, suggest that babies be fed breast milk if at all possible. Other supplemental food is not necessary for babies under six months of age, and there is "no upper limit to the duration of breastfeeding and no evidence of psychological or developmental harm from breastfeeding into the third year of life or longer" (American Academy of Pediatrics, 2005). The American Academy of Pediatrics recommends including breast milk in an infant's diet for at least the first year, but the World Health Organization recommends breastfeeding for at least the first two years of a baby's life (Dennis, 2001). Exclusive breastfeeding for the first six months is recommended because of an increased level of protection against many diseases and because of an increased likelihood of continued breastfeeding for at least the first year of life (AAP, 2005).

Healthy People 2010 included raising the rates of breastfeeding in their recommendations to encourage a healthier population. These national goals are to have 75% of women breastfeed in the early postpartum period, 50% breastfeeding at six months, and 25% at a year. These goals were amended in 2002 to include having 40% of mothers breastfeeding exclusively for the first three months and 17% breastfeeding exclusively for the first six months (United States Breastfeeding Committee, 2008).

The largest factors behind these recommendations are studies that indicate a positive correlation between an infant's health and breastfeeding. More specifically,

breastfeeding is nutritionally sound, offers protective health benefits, and is thought to be associated with greater cognitive and psychological development. The Food and Drug Administration has developed policy statements regarding breastfeeding and declared that breast milk is nutritionally the best food for babies because it meets all their specific nutrient needs. It contains just the right amount of fatty acids, lactose, water, and amino acids for human digestion.

In addition to digestive issues, breast milk is also beneficial in that it protects babies from illnesses. Eighty percent of cells in breast milk are macrophages, cells that kill viruses, bacteria, and fungi. Mothers also produce antibodies to specific diseases present in their environment, so their babies receive custom-designed milk to protect them from diseases they're exposed to, and this protection leads to lower rates of hospital admissions, ear infections, and diarrhea than bottle-fed babies. According to the American Academy of Pediatrics, breastfeeding decreases the incidence and severity of a number of infectious diseases in infants, including bacterial meningitis, diarrhea, respiratory tract infection, and urinary tract infection. Decreased rates of sudden infant death syndrome have also been associated with breastfeeding. Other positive health outcomes, such as a reduced incidence of type 1 and type 2 diabetes, leukemia, overweight and obesity, and asthma have been found in older children and adults who were breastfed when they are compared with individuals who were not breastfed. Perhaps most strikingly, infant mortality rates in the United States are reduced by 21% in breastfed infants (AAP, 2005).

Some studies also indicate that breastfeeding leads to increased cognitive and psychological development. In addition to nutrition and protection from illness,

breastfeeding is beneficial in that it allows for a psychological attachment that involves warmth, security, and comfort. For all these reasons, the FDA and APA recommend breast milk rather than formula for young babies (Williams, 1995).

While it is widely recognized that breastfeeding offers important health benefits to infants, evidence seems to indicate that breastfeeding is also beneficial to mothers. Breastfeeding increases the rate of uterine contraction after childbirth and reduces postpartum blood loss. Increased duration in lifetime breastfeeding is associated with a reduction in premenopausal breast cancer, and breastfeeding also offers a protective effect against the occurrence of ovarian cancer. The connection between breastfeeding and osteoporosis is less clear, but it seems as though longer periods of breastfeeding are associated with lower levels of bone fractures whereas shorter durations of breastfeeding have a more negative impact on bone status. Breastfeeding can also enhance a mother's health by aiding in increased child spacing because full lactation suppresses fertility, even after menses return, and can help women return to pre-pregnancy weights more quickly (AAP, 2005; Lobbok, 2001).

Despite the health benefits of breastfeeding for both infants and mothers, there are several contraindications worth noting. In the United States, it is recommended that women with HIV not breastfeed. This is recommended because sanitary and affordable feeding alternatives exist, and medical care is adequate to prevent infant mortality from other infectious diseases. Likewise, women infected with human T-cell lymphotropic virus should not breastfeed when a safe alternative is available. Hepatitis A, B, and C are not contraindications. If a mother is infected with herpes simplex virus, she can continue breastfeeding as long as there are no lesions on the breast. Mothers with

tuberculosis should not be in respiratory contact with their infants, but it is safe to pump breast milk and have someone else bottle feed the breast milk to the infant. Lastly, exposure to herbicides, pesticides, and heavy metals can be of concern, but only in rare case of unusually high exposure. Therefore, environmental hazards in the United States are not associated with breastfeeding contraindications (Lawrence & Lawrence, 2001).

Some medications also constitute medicinal contraindications because the infant might suffer side effects. Women should not breastfeed if they are taking anti-cancer drugs or if they use cocaine, heroin, or marijuana. Other drugs are safer to use while breastfeeding, but the infant should be monitored for possible side-effects. Drugs in this category include antidepressants, aspirin, oral contraceptives, Zoloft, Paxil, Prozac, Valium, Demerol, and codeine. Medications that have been deemed safe to take while breastfeeding include acetaminophen, ibuprofen, laxatives, insulin, asthma medications, antihistamines, anticoagulants, and anticonvulsants. In addition to the risk of side effects for the infant, some medications inhibit the production of milk. This can complicate the breastfeeding process and the level of risk to milk supply should also be considered when taking medication (Sears, 2006).

Several factors related to lifestyle are also emphasized in discussions of breastfeeding. Maternal diet is not a contraindication to breastfeeding and does not negate its positive effects, although mothers should be counseled to eat well-balanced diets and to be aware of possible deficiencies in their diets (Lawrence & Lawrence, 2001). Women are encouraged to avoid alcohol because alcohol is concentrated in breast milk and because alcohol can inhibit milk production. If alcohol is consumed,

women should wait two hours per drink before breastfeeding again. Similarly, smoking tobacco smoking is not an absolute contraindication, but women are encouraged to refrain from smoking in the home and to make every effort to quit as soon as possible (AAP, 2005). Studies have indicated that women who have had breast implants have more difficulty with breastfeeding, especially if the incision was made in the nipple area. While having breast surgery or any kind of previous breast trauma is not a contraindication to breastfeeding, it does seem to influence milk supply levels and the ability to breastfeed successfully depending on the amount of nerve damage and damaged milk ducts (Lieberman, 2000; La Leche League, 2007).

### **Data Limitations**

While the current recommendations about breastfeeding are quite clear, and while few contraindications exist for mothers in the United States, there is some debate in the medical literature about the benefits of breastfeeding. There is not complete consensus that breastfeeding is indeed beneficial for both mothers and infants, and there are several reasons for this discord. One of the biggest concerns is the methodology that breastfeeding literature rests on. It would be unethical to randomly assign mothers to either a breastfeeding group or a formula-feeding group, and therefore results are always muddled by possible confounding variables. Breastfeeding could be a proxy indicator of a separate social factor that promoted maternal and child health. Therefore breastfeeding may have little impact in and of itself, and its observed association with health is spurious. For instance, studies of infant feeding often recognize that breastfeeding could be an indication of parents' general commitment to their child's well-being but cannot rule out the possibility that this commitment is what leads to differential outcomes between breastfed and formula-fed infants (Labbok,

2001). Also, the correlation between breastfeeding and obesity could occur because mothers who chose to breastfeed for health reasons also promote a healthier lifestyle that includes a balanced diet and exercise. It remains unclear whether a reduced risk of obesity is indeed due to breastfeeding in itself or other factors, such as a different orientation toward healthy lifestyles (Wolf, 2007).

Another methodological concern is that much of the information about breastfeeding relies on large, national studies. While this could be beneficial in some ways, it means that the sample is a household-based sample in which all women are interviewed. Women of particular interest, such as breastfeeding women or women in a certain postpartum period, are only a small portion of the total sample. Therefore, the number of women of interest might be insufficient to provide adequate details about specific issues related to breastfeeding, and a limited number of women of interest would also restrict tests of statistical significance (Labbok, 2001). An additional concern related to using large, national surveys is that breastfeeding is usually included as only a sub-topic within a more general survey, which severely limits the quantity and quality of information about breastfeeding. Most surveys also rely on retrospective information that does not capture the dynamic processes involved in breastfeeding decisions.

In addition to concern about causality and sampling, defining breastfeeding also raises unease when interpreting findings. Efforts have been made to standardize breastfeeding categories, but some ambiguity remains. Breastfeeding, exclusive breastfeeding, full breastfeeding, and bottle-feeding are all terms that are used commonly in breastfeeding research but are rarely consistently defined throughout the literature. It is sometimes unclear what is meant by breastfeeding, how much

supplementation is being used, or what is even really considered supplementation. Similar confusion arises with bottle-feeding. Are bottle-feeding and formula feeding synonymous, or does bottle-feeding include expressing breast milk to feed to an infant? All of these issues make it challenging to compare population statistics and could lead to “artificially inflated rates” of breastfeeding and an inaccurate portrayal of the prevalence of breastfeeding (Dennis, 2001).

Similar to the concern of how breastfeeding is defined is the difficulty of ascertaining if there is a dose-response relationship between positive outcomes and breastfeeding. For instance, does any breastfeeding make a difference, or are benefits only seen after 3 months of exclusive breastfeeding? One study that found a correlation between breastfeeding and intelligence scores in young adulthood indicated that there were no additional benefits of breastfeeding longer than nine months (Mortensen, Michalsen, Sanders, & Reinisch, 2002). Relatedly, one study examining the relationship between overweight and breastfeeding found that breastfeeding for only short durations, less than three months, did not offer protection against overweight. In this instance, protective effects of breastfeeding were only found in infants breastfed for longer than three months (Grummer-Strawn & Mei, 2004). Likewise, others claim that it is the duration and exclusivity of breastfeeding that matter, not just the initiation of breastfeeding (Wolf, 2003). These studies indicate that the effects of breastfeeding are a complicated area to research and much is still unknown about the protective benefits of breastfeeding.

Another concern is that material published in medical journals is limited, both in terms of length and content. A thorough search of journals will reveal “contradictory

conclusions about the impact of breast-feeding,” with some finding a correlation with better health while others find it to be irrelevant, weakly significant, or tied to other, immeasurable variables (Wolf, 2007). Journals often limit article length, and this could lead to omitting nuances of the interpretation of findings. Additionally, negative results are rarely published, and this could limit the amount of information available about the effects of breastfeeding (Labbok, 2001).

Despite these research limitations, breastfeeding is the currently recommended method of infant feeding, mainly for the previously mentioned health benefits. However, in addition to these purported health benefits, there is interest in increasing breastfeeding rates because of social benefits. For one, if infants have increased health because of increased rates of breastfeeding, parents would be absent from work less often and there would therefore be an increase in employee productivity as well as a decrease in family income lost from missing work. Likewise, if breastfeeding rates increased, there is “the potential for decreased annual health care costs of \$3.6 billion in the United States.” In addition to these economic factors, increasing breastfeeding rates would benefit the environment by reducing the amount of formula cans and bottles being disposed (AAP, 2005).

### **Breastfeeding Behaviors**

Despite the widespread dissemination of the “breast is best” message, rates of breastfeeding continue to fall below national goals. According to the Breastfeeding Report Card published by the Centers for Disease Control and Prevention’s, women in the United States are not meeting Healthy People 2010 goals. As of writing, it seems as though Healthy People 2020 goals related to breastfeeding are to increase breastfeeding rates while retaining the specific benchmarks of Healthy People 2010.

Table 2-1 compares Healthy People 2010 goals with national and Florida rates of breastfeeding behaviors. Approximately 74% of women ever breastfeed their children, while only 43% of six month olds and 23% of twelve months olds are breastfed. Thirty-three percent of mothers are exclusively breastfeeding at three months, and this figure drops to 14% at six months (Breastfeeding Report Card, 2009). Overall, some women are breastfeeding, but rates are below official recommendations. While nineteen states meet at least one of the objectives, only ten states meet all five objectives (Breastfeeding Report Card, 2009).

Breastfeeding rates have increased in the United States since the early 1990s, both in terms of initiation and continued breastfeeding at six months. Increases have occurred in all demographic groups, but larger increases have been seen in women historically less likely to breastfeed – women who are African American, are less than twenty years old, have no more than a high-school education, are primiparous, and who are of lower economic backgrounds. These increases followed a sharp decline in breastfeeding that occurred between 1984 and 1989. Rates of exclusive breastfeeding have also increased, but not at the same rate as partial breastfeeding. This indicates that more women are using supplemental feedings (Ryan, Wenjun, & Acosta, 2002), and low rates of exclusivity and extended duration continue to be of concern to medical and public health communities (Wolf, 2003).

It is also useful to place rates of breastfeeding in an international context. According to UNICEF's End of Decade Statistics, rates of breastfeeding increased in the developing world in the 1990s. Exclusive breastfeeding rates during the first four months rose from 48% to 52%, but the rates of continuing breastfeeding at one and two

years increased only slightly. East Asia and the Pacific have the highest levels of exclusive breastfeeding in the developing world, and Latin America and the Caribbean rank the lowest in both exclusive breastfeeding and continued breastfeeding measures. These regions have seen the greatest increases, but they still have the lowest rates in the developing world (UNICEF, n.d.).

Among the industrialized world, Sweden, Norway, and Denmark have the highest rates of breastfeeding. According to an article published in 1997, Sweden and Norway both had initiation rates of 98%, and over half of women in these countries continue to breastfeed for six months or longer. Poland, Canada, and the Netherlands also had high rates of breastfeeding initiation. Reports from the United Kingdom indicate that rates of breastfeeding there are lower than in the United States; 69% of women initiate breastfeeding and 21% continue to breastfeed at six months (kellymom.com, 2007).

In addition to national rates and trends in breastfeeding, there is also some information about breastfeeding rates on the state level. The rates of breastfeeding duration in Florida are among the lowest in the nation (see Table 2-1). According to the Centers for Disease Control and Prevention's National Immunization Survey from 2004, only 37.2% of infants in Florida are breastfed at six months, and only 18.2% are breastfed at twelve months. When it comes to breastfeeding exclusivity, only 30.7% of infants are exclusively breastfed through three months and 11.9% of infants are exclusively breastfed through six months. It is interesting to note that the rate of breastfeeding initiation in Florida is not significantly lower compared to other states; in Florida, 75.7% of women initiate breastfeeding. The rates of breastfeeding initiation in Florida are comparable with other states, but rates of duration and exclusivity fall among

the nation's lowest. These data suggest that the development of breastfeeding support programs in Florida might be especially needed (Breastfeeding Report Card, 2009).

As the data on breastfeeding initiation and duration show, there is a discrepancy between what is recommended by the American Academy of Pediatrics and what actually happens. According to the Pregnancy Risk Assessment and Monitoring System data from 2000 and 2001, women cited various reasons for stopping breastfeeding at different points. When women stopped breastfeeding within the baby's first week, sore/cracked/bleeding nipples was a problem experienced by 34% of women, and 48% cited the baby having difficulty nursing as a reason for stopping. When women stopped nursing the baby between one and four weeks old, the most common response was because they were not producing enough milk. Lastly, when women stopped nursing after the baby was four weeks old, the most common response was because the baby was not satisfied with breast milk. In addition to sore nipples and difficulties with the baby getting enough milk, many women stop breastfeeding because of work or school responsibilities (Ahluwalia, 2005).

When discussing breastfeeding cessation, it is critical to recognize that some women may unintentionally discontinue breastfeeding when they begin a de-breastfeeding process. In this view, cessation is not always completely intentional but is one of the consequences of a complex situation. For instance, one of the most often cited reasons for early supplementation is an insufficient milk supply. Studies have shown that only 1-5% of women really experience a problem of insufficient milk (Dennis, 2001), but the belief that the milk supply is insufficient leads to early supplementation. The early supplementation leads to decreased suckling, which decreases the amount of

milk produced. Then there is a real need to supplement, and this strengthens the initial perception that the breast milk was inadequate (Scavenius, van Hulsel, Meijer, Wendte, & Gurgel, 2006). This highlights the idea that breastfeeding is a complex process and that it does not just happen because of biological predispositions.

### **Correlates**

There are a set of variables that have been consistently associated with rates of breastfeeding. In addition to infant's age, the mother's age, level of education, income, ethnicity, and geographic location are correlated with the initiation and duration of breastfeeding. Mothers who are under twenty years old have the lowest rates of initiating and maintaining breastfeeding, and mothers who are over thirty years old have the highest rates. Only half of teenage mothers ever begin breastfeeding, but 77% of mothers over thirty do so. Likewise, 6% of teenage mothers are exclusively breastfeeding at six months while 17% of mothers over thirty are. Amount of education and breastfeeding are positively correlated, with those receiving more education having higher rates of initiating and maintaining breastfeeding. Sixty-four percent of those whose highest level of education is graduating high school ever breastfeed compared to 84% of those who graduate from college. Income and breastfeeding behavior are also positively correlated, with those who have higher earnings being more likely to initiate and maintain breastfeeding. Asians have the highest rates of initiating and maintaining breastfeeding, followed by Hispanics, whites, and blacks. Eighty-one percent of Asians initiate breastfeeding, and 18% are exclusively breastfeeding at six months. Only 59% of blacks initiate breastfeeding, and 10% are exclusively breastfeeding at six months. Lastly, states in the western United States have the highest rates of initiating and maintaining breastfeeding. States in the south-central United States have the lowest

rates. To sum, mother's age, level of education, income, ethnicity, and geographic location are all correlated with breastfeeding initiation and maintenance (CDC, n.d.).

In addition to demographic variables and geographic location, the role of parity in breastfeeding duration has received attention in breastfeeding research. However, the results are rather mixed. One study examining the relationship between parity and full breastfeeding at one week and six months found that multiparous women who had experience breastfeeding were less likely to be fully breastfeeding at both one week and six months compared to women who did not have breastfeeding experience, either because they were primiparas or multiparas without breastfeeding experience. A possible explanation is that caring for older children and infants is challenging, resulting in early discontinuation of full breastfeeding (Clifford, 2006). Other studies have found that women with previous experience breastfeeding are more likely to breastfeed subsequent children for longer periods of time, indicating a possible connection with social learning through experience (Nagy, 2001). It is also relevant to consider the idea that it might not just be experience, but the type of experience, that matters. For instance, if a woman tries to breastfeed but has difficulty, she might be less likely to try it again. On the other hand, she might be even more determined to do better the next time. All of these studies illustrate that the relationship between parity and breastfeeding is complicated and not yet fully understood.

A mother's employment status also influences breastfeeding initiation and duration. Most results indicate that the intention of returning to paid work after a baby is born does not influence breastfeeding initiation, but returning to work does influence breastfeeding duration. The intensity of work also seems to make a difference – women

who expected to work part-time were neither more nor less likely to breastfeed compared with those who did not expect to work, but women who expected to work full-time had significantly decreased breastfeeding durations. However, women who return to work, either part or full time, do have reduced intensity of breastfeeding, meaning that they breastfeed fewer times per day (Fein & Roe, 1998).

Maternity leave and expressing breast milk are intricately tied to employment status. Women with longer maternity leave options tend to breastfeed longer than women with shorter maternity leaves (Dennis, 2001), but other studies have found that women with maternity leave breastfeed for shorter periods than those who do not have maternity leave. A possible explanation is that women who do not have maternity leave are less likely to return to work in the first year postpartum (Fein & Roe, 1998). One study examining the relationship between expressing milk and breastfeeding duration found that mothers who expressed breast milk were less likely to discontinue breastfeeding before six months when compared to women who did not express milk (Win, Binns, Zhao, Scott, & Oddy, 2006).

Whether a woman smokes or not is also a consistent predictor of breastfeeding behaviors. Women who smoke are less likely to initiate and continue to breastfeed, and there seems to be a dose-response effect in that the heaviest smokers are the least likely to establish exclusive breastfeeding. In addition to the mother herself smoking, living in a household in which someone smokes is also correlated with shorter durations of breastfeeding. For instance, one study found that women who lived in households in which ten or more cigarettes were smoked each day were more likely to discontinue

breastfeeding earlier than were women living in nonsmoking households (Dennis, 2001).

Another area of breastfeeding duration that has received significant attention is a woman's level of both formal and informal social support. Hospital policies that encourage the initiation of breastfeeding immediately after birth, allow women to room-in and share beds with their infants, promote early mother-infant contact, allow continuous labor support, and limit early supplementation are associated with increases in breastfeeding initiation and duration. Other factors, such as the role of distributing discharge hospital packages, early hospital discharge, increased rates of c-sections, and labor analgesia on breastfeeding outcomes are inconclusive at this time. Health care professionals can also be a source of breastfeeding support, but they can negatively influence breastfeeding by giving "inconsistent, inaccurate, or inadequate breastfeeding information" (Dennis, 2001, p.19).

Informal support networks also influence breastfeeding initiation and duration. Family support is critical to successful breastfeeding, and family support is often measured by a male partner's support. After the birth of the baby, a father's favorable attitude toward breastfeeding was found to be the most important factor in the decision to initiate breastfeeding. In a study of women breastfeeding at two weeks postpartum, husbands were found to be the most encouraging source of social support. Another study found that the father's preferred feeding method was strongly correlated with the duration of breastfeeding (Bar-Yam & Darby, 1997). In addition to the male partner's influence, other non-professional support is also important. Maternal grandmothers and close friends seem to have particular importance (DiGirolamo, Thompson, Martorell,

Fein, & Grummer-Strawn, 2005). If an additional support person is a part of a woman's informal network, she is more likely to breastfeed than a woman who does not have additional support. Attitudes and beliefs of those in a woman's informal network can be more important than a professional's attitudes, especially among low-income and adolescent mothers (Dennis, 2001). Studies have shown that women who breastfeed for longer than nine months perceive a reduction in social support and more social stigma associated with breastfeeding an older infant, and the opinions of others seem to influence decisions about the continuation of breastfeeding (Rempel, 2004).

Prenatal intentions and confidence with breastfeeding also influence the likelihood of breastfeeding initiation. Studies have shown that between 50-90% of women make a decision about infant feeding either before becoming pregnant or very early in a pregnancy (DiGirolamo et al., 2005). An early decision in favor of breastfeeding is correlated with a greater likelihood of initiating and with longer breastfeeding duration. If ambivalence toward breastfeeding is expressed early in the pregnancy, there is a greater risk for weaning in the first few weeks after birth. Breastfeeding intentions related to duration are also consistently correlated – women who intend to breastfeed longer tend to do so while women who do not intend to breastfeed for extended periods of time do not. Breastfeeding intentions are a significant predictor of breastfeeding duration, even after controlling for the influence of initial breastfeeding experiences (DiGirolamo et al., 2005). In addition to breastfeeding intentions related to initiation and duration, maternal confidence with breastfeeding is also positively associated with breastfeeding duration. Women with low confidence in

their ability to breastfeed are more likely to discontinue breastfeeding than women who are very confident (Dennis, 2001).

A woman's attitude toward breastfeeding also influences rates of initiation and duration, and her perception of her partner's attitudes is also an important factor. Women are more likely to breastfeed if they believe breastfeeding is healthier, convenient, and conducive to freedom. Associating breastfeeding with lifestyle restrictions and physical discomfort is correlated with lower rates of breastfeeding (Dennis, 2001). While the breastfeeding decision is usually left to the woman, her perceptions of her partner's attitudes strongly influence the decision. For instance, women who feel that her partner has negative attitudes toward breastfeeding are more likely to plan on bottle feeding (Bar-Yam & Darby, 1997). Many women who know about the health benefits of breastfeeding still decide to bottle feed, and a large influence on this decision is the ability of the father to be more involved (Earle, 2000).

Orientation toward breastfeeding problems is another important factor in breastfeeding initiation and duration. Women who successfully breastfed considered problems to be normal whereas mothers who did not consider themselves successful were more anxious, self-doubting, and more likely to discontinue when faced with difficulties (Dennis, 2001). Other studies have similarly found a difference between women who view milk as a product and women who view breastfeeding as a process. Women who see breastfeeding as a process recognize that negative aspects of breastfeeding should be anticipated and learn what can be done to alleviate challenges, such as sore nipples. These women are committed to establishing breastfeeding as an on-going routine, and doing so requires a significant investment in time and effort. The

orientation toward recognizing breastfeeding as a process increases breastfeeding duration (Scavenius, van Hulsel, Meijer, Wendte, & Gurgel, 2006).

### **Social Context**

Social context is another important factor when discussing breastfeeding initiation, duration, and cessation. Cultural norms often override healthy activities, and there has been a shift from breast to bottle feeding that redefined what is considered “normal” infant feeding. This shift started at the turn of the century, when women began to work outside of the home and when they wanted to be companions for their husbands to a greater extent than breastfeeding was thought to allow for. Women began feeding their infants cow’s milk, but since this was before pasteurization, infant mortality rates skyrocketed. Concerned physicians “decried the trouble and dangers of artificial feeding” (Wolf, 2003, p. 2001), and two public health campaigns resulted. One involved encouraging mothers to breastfeed for as long as possible, and the other advocated for cleaner cow’s milk. Pasteurization essentially nullified the known differences between cow’s milk and human milk, and breastfeeding rates fell. While rates of breastfeeding have increased, there are still cultural norms that bottle-feeding is “normal”. Today, there is a clear habit of women introducing formula well before their baby is six months old. Medical literature clearly says that supplementation is not necessary before six months of age, but 53% of lactating mothers introduce formula to their babies before they are a week old. Similarly, while the American Academy of Pediatrics recommends breastfeeding for at least an infant’s first year, fewer than 25% of mothers do so (Breastfeeding Report Card, 2009).

One important part of social context is the acceptability of breastfeeding in public. According to the Healthstyles 2000 national mail survey, 31% of respondents felt that

one-year-old children should not be breastfed, and 27% felt it was embarrassing for a mother to breastfeed in front of others. More negative attitudes toward breastfeeding were held by people with lower household incomes and less education, and by those who were non-white and who were under 30 years old or over 65 years old (Li, Fridinger, & Grummer-Strawn, 2002). Many women do not feel comfortable nursing in public because of other people's reactions and will instead go to public restrooms, go to their cars, carefully time trips out, or give the baby a bottle when they are in public. Women who nurse older children in public are even more likely to experience a feeling of inappropriateness based on other's looks, comments, or body posture, and women have said that their experiences nursing in public have lessened the enjoyment of breastfeeding (Stearns, 1999).

Related to the acceptability of breastfeeding in public is the sexualization of breasts in the United States. Exposing breasts in public for purposes of infant feeding is not widely accepted, and women are urged to use covers and to be discreet if they nurse in public. Indeed, as Saha writes, "the exposure of female breasts is so steeped in sexual connotations in modern day Western society that the good mother has no choice but to arrange her day, her schedule, and the way she breastfeeds such that her breasts are never in view to the public" (2002, p. 66). Another aspect of the sexualization of breasts is the idea that breasts are mainly for men's pleasure. One study of advice literature for breastfeeding mothers found that one of the prevailing concerns was to reassure men that women's breasts were still primarily theirs and that their primary purpose was still for his pleasure (Saha, 2002). The dichotomy between breasts being used to deliver milk in a manner that is supposed to be asexual and

breasts being used as a sexualized object for men's pleasure presents a problem for breastfeeding promotion campaigns, but the issue continues to be largely ignored because the two competing roles are so contradictory (Saha, 20002). *Fresh Milk* by Fiona Giles (2003) is an example of a book that confronts issues of breastfeeding and sexualization straight-on, but it is one of few examples that can be found.

While bottle-feeding is widely regarded as "normal" and there are social constraints to breastfeeding, breastfeeding has also been included in models of intensive mothering. Breastfeeding is symbolic of nurturing and loving qualities that are so entrenched with meanings of motherhood. Breastfeeding problems are not often discussed in American culture, and women often experience a clash between idealized expectations and early breastfeeding problems. When women cease breastfeeding because of these early problems, they often feel a sense of failure and guilt (Mozingo, Davis, Droppelman, & Medideth, 2000).

In some respects, breastfeeding is culturally situated on rocky terrain. On one hand, public health campaigns and notions of good mothering encourage breastfeeding. On the other hand, we have discordant cultural attitudes, a cultural dualism between sexualized breasts and supposedly asexual breastfeeding, and an overwhelming lack of structural programs, such as paid maternity leave and work options, which could help women breastfeed.

### **Intervention Programs**

Because of the health significance of breastfeeding and the gap between what is recommended and what is actually happening, a number of intervention programs have been developed on international, national, and local levels. All of these programs share a common goal of increasing breastfeeding rates, but there is as of yet little information

about what interventions are most successful and why some programs are more successful than others. What follows is a review of the major international and national programs as well as some of the local-level initiatives that have received attention in academic literature.

One international-level program is the International Code of Marketing of Breast-Milk Substitutes. The World Health Assembly adopted the code in 1981 in efforts to promote breastfeeding, and resolutions have been added to the original Code in recent years. The main goals of the Code are to ensure that appropriate information about infant feeding is available and to regulate the marketing of breast milk substitutes. Stipulations in the Code include not promoting breast milk substitutes to the general public and not distributing free samples of substitutes. Sixty-five countries have enacted legislation that implements provisions within the Code and over twenty more have draft laws pending approval. Iran and Papua New Guinea are two countries that have implemented parts of the Code. In Iran, the government controls the import and sale of breast milk substitutes. Formula is only available by prescription, and all tins carry a generic label free from promotional images. Papua New Guinea controls the sale of bottles and nipples, and there is a ban on advertising these products as well as breast milk substitutes (UNICEF, n.d.).

Another international level program is the Baby Friendly Hospital Initiative. In this program, there are ten steps to successful breastfeeding that hospitals are encouraged to follow, and hospitals that meet these standards can be certified as being Baby Friendly. The ten steps for the United States include having a hospital breastfeeding policy that is routinely communicated to all health care staff, informing all pregnant

women of the benefits of breastfeeding, helping mothers initiate breastfeeding within the first hour of birth, not offering supplements unless it is medically necessary, practicing rooming-in, and fostering the establishment of breastfeeding support groups. The remaining steps are to encourage breastfeeding on demand, to not offer pacifiers, to help mothers maintain lactation even if they are separated from the infant, and to train staff in the skills necessary to be able to implement the ten steps successfully. Data clearly indicates that implementing the Ten Steps to Successful Breastfeeding has a positive impact on breastfeeding initiation, duration and exclusivity, as well as related child health outcomes (Baby-Friendly USA, n.d.).

On the national level, the U.S. Department for Health and Human Services has several documents that provide guidance for program interventions. The Health Resources and Services Administration's Maternal and Child Health Bureau published a document called *Breastfeeding in the United States: A National Agenda*. The United States Breastfeeding Committee was formed in 1998 and developed the "Strategic Plan" outlined in the *National Agenda*. This Committee is comprised of government agencies as well as educational and not-for-profit organizations that work together to protect, promote, and support breastfeeding. The goals outlined in this document are to ensure access to comprehensive, current, and culturally appropriate lactation services for all women, to make certain that breastfeeding is recognized as the normal and preferred way to feed infants and young children, to ensure that all laws support the importance and practice of breastfeeding, and to increase support for mothers in the work force. Each of these goal statements is followed by strategies and specific activities for achieving that goal (USBC, 2001).

The *Blueprint for Action on Breastfeeding*, published from the Office on Women's Health, is another significant document guiding the national agenda on breastfeeding. This document recognizes the health benefits of breastfeeding and the national goals of increasing breastfeeding rates, and it states that meeting such goals will require "the collaboration of Federal agencies, state and local governments, communities, health professional organizations, advocacy groups, multidisciplinary scientists, industry, health insurers, and the American people" (2000, 13). It includes a variety of recommendations for increasing breastfeeding rates, including training health care professionals on the basics of lactation, ensuring that mothers have access to lactation services, facilitating breastfeeding in workplaces, developing social support resources for women, and encouraging the media to portray breastfeeding as normal (HHS Blueprint for Action on Breastfeeding, 2000).

In efforts to implement some of the suggestions in the *HHS Blueprint for Action*, the National Breastfeeding Awareness Campaign was designed. The goals of the campaign were to promote breastfeeding among first-time parents who would not usually breastfeed their babies with the ultimate goal of trying to achieve Healthy People 2010 goals. The campaign includes two main components: media outreach and community demonstration projects. The media segment was developed in coordination with the Advertising Council, and includes public service announcements for television, radio, newspapers, magazines, mass transit shelters, billboards and the Internet. For the community demonstration project, sixteen cities were selected around the country to receive funding to support breastfeeding services, provide outreach to their

communities, train healthcare providers on breastfeeding, implement the media aspects of the campaign, and track breastfeeding rates in their communities (NBAC, 2009).

Another national level intervention designed to promote breastfeeding is the Loving Support Campaign which began in 1997. The program is conducted by Best Start Social Marketing as part of the WIC National Breastfeeding Promotion Project. Best Start is a non-profit organization “committed to applying social marketing principles to effective breastfeeding promotion”. The campaign uses mass media, direct client education, staff training, and community outreach in a coordinated effort to provide breastfeeding support to the WIC community. The benefits of breastfeeding, such as bonding, enjoyment, and health are emphasized throughout the program’s materials, but they also address issues such as the need for support from significant others, competing demands for a mother's time, and embarrassment about breastfeeding (Loving Support Campaign, 2005).

Given the significance of increasing breastfeeding rates, a considerable portion of breastfeeding literature examines the effectiveness of breastfeeding support programs on the local level. These programs often focus on one aspect of breastfeeding, such as social support. Some programs have focused on improving prenatal education classes so that they can more effectively support women who plan on breastfeeding (Noel-Weiss, Bassett, & Cragg, 2006), and others are designed to help women in the postpartum period. Some interventions have explored whether telephone support lines or support via the Internet would be used and, if so, if they are helpful to women (Chamberlain, Merewood, Malone, Cimo, & Philipp, 2005). Intervention programs have also focused on the pivotal role that nurses can play in

breastfeeding duration and whether or not continuing education programs for nurses influence breastfeeding support behaviors (Iker & Morgan, 1992). Peer support programs have also been implemented in efforts to increase breastfeeding rates (Morrow, 1999).

Several programs have been designed to target fathers in recognition of the important role of fathers in breastfeeding initiation and duration. One program targeting fathers focused on a corporate environment, with the idea being that corporations benefit from promoting breastfeeding through reduced absenteeism, increased productivity at work, and reduced maternal stress. In this case, the Fathering Program at the Los Angeles Department of Water and Power is aimed at helping the father recognize his role in successful breastfeeding and includes activities such as breastfeeding education classes, lactation counseling for fathers and their partners, and offering rental breast pumps for their partners to use at home or at her work site. Breastfeeding rates for infants whose fathers participated in the program were well above national rates, indicating that such programs could be important in increasing breastfeeding duration (Cohen, Lange, & Slusser, 2002). Another study found that breastfeeding initiation rates increased at clinics that used a peer dad program. In this program, selected fathers are trained to encourage and support other fathers. Training includes information about the benefits of breastfeeding, common concerns new fathers might have, and ways in which fathers can support their partners with breastfeeding (Stremmler & Lovera, 2004).

These programs all highlight the importance of breastfeeding, but many advocates suggest the need for a nuanced and culturally sensitive approach to

breastfeeding promotion. For instance, while the benefits of breastfeeding are often cited, breastfeeding also has various costs, including the potentially negative impact on family dynamics, career paths, and a woman's emotional and physical health (Wolf, 2007). Likewise, placing so much emphasis on breastfeeding as better can alienate women who choose not to breastfeed for various reasons. The National Breastfeeding Awareness Campaign has been criticized for being "insufficiently attentive to the psychological, socioeconomic, and political concerns of its intended audience" (Wolf, 2007). This program has been criticized for portraying bottle-feeding as putting babies at risk and framing not breastfeeding as a weakness in maternal character. Some women might find the demands of breastfeeding overwhelming or might not be able to breastfeed because of employment reasons, and in these cases, bottle-feeding might actually be the less risky option (Wolf, 2007). Some suggest that better information needs to be given to women about breastfeeding, including potential problems, and that women who make the decision to discontinue breastfeeding need support because the decision is not always an easy one and can involve a sense of loss and failure (Mozingo, Davis, Droppleman, & Medideth, 2000).

### **Summary**

The preceding text provided an extensive overview of the current literature on breastfeeding. It began with a discussion of the current health-based recommendations to breastfeed, the debate within health literature about the health benefits, and data regarding the extent to which breastfeeding goals are being met. Factors associated with breastfeeding behaviors were also discussed, as was social context surrounding the acceptability and normality of breastfeeding. Lastly, research on intervention

programs based in public health initiatives to increase breastfeeding rates was discussed.

This extensive background is essential in situating the current project. Chapter 3 moves into a discussion of the current project, including details about the setting, participants, and data collection as well as the theoretical and methodological backgrounds.

Table 2-1. National and state rates of breastfeeding compared to Healthy People 2010 goals

	Healthy People 2010	National	Florida
Any Amount			
Initiation	75%	74%	76%
6 months	50%	43%	37%
12 months	25%	23%	18%
Exclusively			
3 months	40%	33%	31%
6 months	17%	14%	12%

Source: National Immunization Survey, Breastfeeding Report Card 2009

## CHAPTER 3 RESEARCH DESIGN

Our goal as feminists should be to gain interpretive power over our embodied experiences, to define our own embodied wants and desires. To do this, to resist, we need to disrupt dominant metaphors and apparently fixed, seamless meanings that preempt discussion, as well as to promote institutional change.

- Blum 1999, p. 200

### **Feminist Theory and Methods**

As illustrated by Blum's quote, feminist thought provides the underpinning of this project. Feminist thought influenced the theoretical and methodological approaches that the analysis is predicated upon as well as my orientation toward breastfeeding as a specific topic deserving of more attention from a feminist perspective. What follows is a discussion of the theoretical foundation in feminist standpoint theory, the methodological implications this had, and a detailed discussion of how data collection and analysis proceeded.

Feminist standpoint theory provides the underlying theoretical framework for this project. Brooks explains standpoint by stating, "A feminist standpoint is a way of understanding the world, a point of view of social reality, that beings with, and is directly developed from, women's experiences" (Brooks, 2007). As a part of resistance feminisms, the goal of feminist standpoint theory is to listen to "women's voices and perspectives to reshape the gendered social order" (Lorber, 2005, p. 12). In feminist standpoint epistemology, the absence of women's experiences in the production of knowledge is challenged, and women's points of view and centrality to research projects is of paramount importance. Feminist standpoint theory formed the basic outline for this project in two key ways: First, the key research questions were to "see and understand

the world through the eyes and experiences of oppressed women” (Brooks, 2007, p. 55), and a further goal of this project was to apply this knowledge to advocate for social change.

This project is in line with what Smith refers to as an “alternate way of thinking” (Smith, 1990, p.20). The project does not assume the positivist notion that a fixed reality exists, that truth is waiting to be discovered, or that objective researchers and value-free tools are the only ways to build knowledge. Rather, by utilizing a feminist approach, I emphasize subjectivity, embodiment, and interpretation. Smith highlights how women’s awareness of contradictions between their own lived experiences and academic literature are often the root of new approaches to knowledge building, and this contradiction is precisely why I began this project. I did not think my experience with breastfeeding was well-represented in current research, and I wanted to learn more about other women’s experiences. The main research question centers on women’s experiences with breastfeeding; in defining the key research question in this way, I emphasize the belief that paying attention to specific experiences and situated perspectives can develop rich understandings and contribute to knowledge-building (Brooks & Hesse-Biber, 2007). The interview guide was structured in a way that emphasized women’s experiences with breastfeeding, as they experienced it. This focus on experience is a key facet of standpoint feminist theory (Brooks, 2007).

In discussing experience and what constitutes experience, many suggest that experiences consist of what women do. Women engage in many different activities as part of their everyday lives, and many feminist scholars focus on the nurturing tasks that many women engage in on a daily basis. Breastfeeding is a particularly interesting

aspect of care-work because it is an embodied process that is often connected to women's choices and responsibilities as mothers.

In using a feminist standpoint perspective, my goal is not to suggest that all women have a similar experience with breastfeeding. While some feminist standpoint theorists argue that women have a privileged understanding of society because of their oppressed position, some challenge this and argue that suggesting all women share one experience is problematic. Many contemporary feminist standpoint theorists recognize the diversity in women's experiences and standpoints. There have been two main approaches to this diversity: one suggests that some standpoints, usually those of the most oppressed, "generate more objective knowledge claims than others" (Brooks, 2007, p. 70), and the other suggests that it is in recognizing the differences in experiences that we can learn the most about larger social contexts. Instead of trying to generate universal knowledge, feminist scholars using the latter approach suggest that women's experiences need to be recognized and valued as they are. A discussion of the participants of this project occurs later, but it is important to note that I approach this project following the latter perspective.

The second critical aspect of using a feminist standpoint perspective is an emphasis on social change. Through studying women's experiences with breastfeeding, I explore "knowledge that is more useful for enabling women to improve the conditions of our lives" (Harding, 1997, p. 255). In using a feminist standpoint, I want to produce information that is useful for women, not just another report about women. This is a key part of the project, as the third research goal is to develop knowledge that could be useful for women as they breastfeed and for program

development. This theme is returned to in the conclusion, where I discuss ways in which these women's voices can be applied to create social change. Feminist standpoint theory suggests that it is only when we learn about the "intraworkings of society that we learn about which elements require modification for a more just, humane, and equitable society can be constructed" (Brooks, 2007).

Utilizing the feminist standpoint framework unites all stages of this project. When it comes to what exactly is meant by feminist methods, Lott wrote, "Feminist scholarship and empirical research have particular qualities that distinguish it from other research in its choice of problems and ultimate objectives" (Lott, in Reinharz, 1992). The overall research questions are trying to learn more about women's experiences with breastfeeding and are focused on addressing women's needs with regards to meeting Healthy People 2010 goals. The topic is a gendered topic and a topic that is not commonly talked about or widely researched. Thus, the topic and key research questions fit squarely within feminist efforts to highlight aspects of gendered issues that are commonly overlooked in mainstream research.

In addition to generating an approach that focused on women's lived experiences and social change, feminist thought also influenced many methodological decisions. The idea of separate methods that can be classified as uniquely feminist has been debated. Reinharz addresses this issue and further dissects the terminology "feminist method" in *Feminist Methods in Social Research*. In this book, she defines feminist research as scholarly work done by a person who identifies as a feminist, published in journals or books that focus on feminist work, and used in research that received awards from organizations that give awards to people who do feminist work. In terms of

methods, she defines research as “the production of a publicly scrutinizable analysis of a phenomenon with the intent of clarification” (Reinharz, 1992, p. 9). Thus, feminist methods are not necessarily a unique method, but rather a unique way of utilizing and approaching methods learned within disciplines (Reinharz, 1992). In this project, feminist approaches were significant in participant selection, insider/outsider status, sharing power, multiple interviewing, and the relationship between researcher and participant. Each of these will be discussed in the following pages.

In addition to impacting the development of research questions and the overall approach to the research, a feminist framework also offers insight to the selection of participants. Feminist research tends to focus mainly on oppressed women. At the heart of feminist research is the idea that much of sociology has been founded on the male perspective, and that the language that is used does not fit with women's lived experiences (DeVault, 1999). Too much of sociology has rested on a homogenous group of men, and because people from different positions will have different experiences and perceptions, the resulting scholarly work is biased and inadequate (Chafetz, 2004). Feminist approaches question who is usually involved as respondents in research interviews. They maintain that women's voices are traditionally silenced in social research and argue that efforts must be made to include women in research. Thus, women must be included in research, and they must be allowed to give voice to their own experiences (Holstein & Gubrium, 1995).

At first, it does not seem as though this project deals with oppressed women. However, if approached from the viewpoint that all women are marginalized to some degree, a feminist framework becomes more applicable. Especially within the current

cultural context involving ideals of intensive mothering and breastfeeding imperatives, women can be seen as marginalized from decision making processes. Women feel the need to live up to standards that they did not create, and when they do not meet these standards, they often feel intense levels of guilt and failure. In this sense, current breastfeeding recommendations do little to empower women and can even be seen as limiting women's power and authority over their childrearing practices. Participant characteristics are detailed later, but it is important to note that women in this study did not fit typical images of oppressed women. Most women who participated were White, highly educated women who could afford to remain out of the workforce after the birth of their first child. This is significant because these mothers should be the most likely to meet breastfeeding recommendations; what they say about breastfeeding and the challenges they encountered while breastfeeding can further illuminate discussions about how to best try to meet Healthy People 2010 goals. If even this group has difficulty meeting Healthy People 2010 goals, it is quite significant in terms of lived experience and achievability of national goals.

A common concern in discussions of feminist research is positionality and whether the researcher is considered an insider or outsider (Hesse-Biber, 2007). I feel it is important to note that I very much felt as though I was an insider, not only because I had recently given birth and breastfed, but also because I gave birth at the same hospital as all participants. Additionally, as an expectant mom a few years prior to the start of this project, I had attended the hospital-based prenatal classes that formed an important part of recruitment. I had experience working with the lactation office and attending the new mom's luncheons, not only in terms of this project, but in terms of my

prior experience having children and seeking assistance. Thus, when moms who participated in this project talked about the luncheons or the lactation office, I felt as though my insider status and previous experience with the setting helped me to build rapport with participants.

Power is central to feminist research, and approaching this project from a feminist perspective forced me to be aware of power differentials that existed between myself and the participants. Feminist approaches encouraged me to be sensitive to any potential harm and to incorporate practices that were more inclusive and less hierarchal. Some suggest that something should be given back to the participant or that researchers should become involved in local-level change for their participants (DeVault, 1996). In efforts to share power with women throughout this project, participants usually decided when and where to meet. Most interviews were conducted face-to-face, although some were done in computer-mediated formats to enhance convenience for mothers who wanted to participate. Conversations with one mother were not recorded because of concern regarding her accent and understandability in recordings. I did enter interviews with semi-structured interview guides, but interviews followed mothers' leads on salient topics and often involved follow-up questions from topics raised in previous interviews. All questions were open-ended in format. Additionally, I invited participants to review a draft before final submission and gave interested participants a CD with all of her interviews as well as a copy of the written product.

Multiple interviewing has also been included in discussions of feminist research methods and was an important aspect of this project in several ways. First, the project

has an intense focus on mothers' experiences over time that led intuitively to a research design that included multiple in-depth interviews. However, in addition to being able to accumulate a wealth of information from each respondent, another benefit of this research design was that an important level of rapport and trust developed over time. Lastly, some suggest that multiple interviews may be more accurate than single interviews because of opportunities to ask multiple questions and to get feedback as the project continues (Reinharz, 1992). As interviews progressed, I seized the opportunity to ask questions about topics that had arisen previously as well as to member-check some of the analytical developments.

In addition to multiple interviews, another concern with interviewing is the language that is used. DeVault argues that researchers should be aware of the use of language in all steps of the research process, including constructing topics, listening, editing, and writing. She further suggests that interview topics should not be limited by standard vocabularies and that feminist researchers must be open to interviewing on topics that are incompletely articulated. In this case, I felt that having a background in breastfeeding was extremely important. I had been exposed to a variety of experiences and languages that I might not have otherwise understood; I was familiar with the preoccupation with pumping and ounces pumped, weight charts, overactive letdown, infant distractibility, and countless other topics that came up in interviews. In terms of unarticulated concepts, I think the issue of temporary supplementation is particularly relevant (see Chapter 5 for further discussion).

One other issue raised by a feminist perspective is the relationship between researchers and those being researched. Most mothers who participated started out

being strangers, neighbors, acquaintances and friends of friends. However, as time progressed, I looked forward to meeting again with mothers, to seeing their children, and to hearing about how they were doing. As an important note, I felt that this level of rapport did not build with those moms who used computer-mediated e-mail to respond to interview questions. Being a mother of two young children, I now often run into mothers who participated in the project around town at family-centered events. This, too, struck me as a little awkward at first because I was in the process of learning how to balance research with an engaged feminist perspective. Meeting in public, with our families, seemed more 'friend-like' than researcher/subject-like. It was one of those times in which the lines were blurred and I had an awkward gut reaction. Throughout this project, I learned about the entrenched positivist notion of strict dichotomies between researcher and subject; I also learned to notice it and question its utility.

Another ethical concern with feminist research is responding to participant's questions and requests for information or help. It has been suggested that answering questions posed by the interviewee is an important way to more thoroughly include subjects and reduce power differentials (Cook & Fonow, 1990). The researcher/respondent divide is also complicated in notions of co-constructed realities; some feminist approaches view researchers as actively involved with participants, and together they are constructing answers to complex questions (DeVault, 1990). At first, I was concerned that responding to questions or offering information about breastfeeding could threaten the validity of the study by impacting women's breastfeeding behaviors. For instance, if a mother asked me about frequencies of feedings or where to find information about increasing milk supply, she might then pursue this information and

breastfeed longer than she would have had I not been forthcoming with such information. While feminist approaches encourage recognizing the oppressed nature of participants and advocate for change, many researchers using feminist frameworks are challenged by issues of whether or not to help and to respond to questions from participants. In addressing this issue, Webb states, "I as an 'expert' had access to wider information than they did, and I could not justify keeping this to myself. Therefore, I would give information and advice wherever I detected a need or opportunity during the interview" (in Reinharz, 1992, p. 31). I did not go to this extent, but I did respond to all questions. I noticed that I prefaced responses with classifiers, such as "in my experience", "others have said", or "I've heard." I also openly referred women to the lactation consultant and reminded them of her availability. I did not really want to be seen as an expert because I thought it would undermine the mom-to-mom rapport that I was trying to build, and I felt that if I was seen as a successful breaster or expert that moms might be more reluctant to tell me about their challenges. In positivist interviewing, I would have been discouraged from responding, as I should have remained a more neutral obtainer of information. However, in feminist interviewing, it is important to respond to questions sincerely in order to build a mutually involved research endeavor. I most certainly struggled with finding a balance between being sincerely and ethically responsive and concern about methodological integrity.

Questions that made me especially uncomfortable related to 'what I was finding' or 'how other moms were doing.' I wanted to make sure that mothers understood the importance of the study, but I did not want to prematurely offer suggestions as to what conclusions the study was leading to. I tried, as best I could, to answer in terms of

preliminary findings and offer space for mothers to respond. When it came to questions about how long other mothers in the study were breastfeeding for, I was uncomfortable, especially if it was from a mom who had stopped breastfeeding. I did not want to say, “You are the only one who has stopped so far” or “Most moms are making it to six months.” I did not want to add to any sense of maternal guilt or shortcomings, so while I did try to be truthful, I also wanted to reaffirm their status as experts in their mothering experience.

I was also a little uncomfortable when moms would ask me about things that I thought could potentially impact results, such as how to increase milk supply or pumping. For instance, one mom asked me about breast pumps and where to get one, but she also commented on how they really could not afford such a purchase. I suggested she try the WIC offices because I had heard they rented pumps. However, I also knew that I had a pump sitting at home and part of me really wanted to offer it to her. She was struggling with breastfeeding already, expressed that she wanted to breastfeed, and stated that the pump would really help her. On the one hand I wanted to help; on the other, I did not want to influence her experience in a way that would bring about different results.

When it comes to issues of self-disclosure, I typically only offered information about my experience in response to a mom’s question or to something that she said. During recruitment, I did tell moms that I have two young children and breastfed, but I tried to have interviews take the form of “partially structured personal conversations” that focused on the participants’ experiences. While it is important to recognize how my personal experiences influence my sensitivity to the subject and interest in completing

this project, I also wanted to “avoid substituting my own experience for that of others or failing to ask questions that would challenge my assumptions” (Reinharz, 1992, p. 27).

Feminist-informed research projects can also add stress to a project because of a concern of ethical treatment of participants and work centered on oppressive conditions. Some interviews with mothers did particularly stress me out, especially when I was still becoming comfortable with the methods. It seemed as though each interview and each mother presented unique situations that I did not know how to handle. At first, I did not know how I felt about accepting offers of food. I did not know what to do if I was sick. I did not know what to do when a mother was in tears about the end of breastfeeding. As a researcher, this project was stressful. I imagine any dissertation project would be stressful, but this was compounded by cultural ideals of good mothering and an ethically concerned feminist approach.

### **Feminist Approaches to Breastfeeding**

Feminist thought influenced the theoretical framework and methods of this project, but it also influenced my orientation to breastfeeding. Breastfeeding is a gendered experience, but yet it has received relatively little attention from feminist scholars. As one of the more outspoken feminists on the issue, Penny Van Esterik, wrote, “Lactation seems to have moved out of the consciousness of western women. It is not a central concern of women’s health clinics or reproductive rights groups, nor is it something likely to be brought up in meetings on women’s pay equity. It is surprisingly absent from contemporary feminist thought” (in Hausman, 2003, p. 190). When feminist scholars have devoted time and attention to breastfeeding, they are largely divided on the issue because it presents a challenge to the traditional difference/equality divide within feminism, and a key challenge for feminist scholars addressing breastfeeding is

how to address challenges women face with breastfeeding and work. Feminists focusing on equality see breastfeeding as a "gender difference that stands in the way of liberating women" (McCarter-Spaulling, 2008, p. 207), whereas feminists in a difference framework tend to embrace breastfeeding as uniquely feminine and seek to ensure protections for women who want to breastfeed (Carter, 1995; Galtry, 2000; McCarter-Spaulling, 2008; Van Esterik, 2006; Wolf 2006). These protections can include the right to breastfeed in public as well as work-related protections, such as access to time and space to pump or on-site childcare with time to go breastfeed directly.

Another feminist framework used to approach breastfeeding is feminist health activism. This framework recognizes the biomedical research emphasizing health benefits of breastfeeding as well as the public health research identifying some groups of women as more likely to breastfeed than other groups. The goal of this approach is recognize the need to "create the social and economic conditions that make breastfeeding possible, successful, and valued for all women" (McCarter-Spaulling 2008, p. 210). It is a critical approach that identifies structural barriers to breastfeeding and argues that educational programs by themselves will not increase breastfeeding rates among marginalized groups of women. It advocates that we need to work seriously on developing policies that address paid and extended maternity leaves, onsite child care, flexible working hours, extended break times, and adequate space for milk storage. If women are just told to breastfeed, and are told it is 'best' for their baby, but face structural barriers, it will only create feelings of guilt and frustrating experiences of mothering. A feminist health activism perspective brings structural barriers to light and advocates for change (Hausman, 2003; McCarter-Spaulling, 2008).

Feminist approaches often critique the medicalization of breastfeeding and call for initiatives to empower women regarding breasts and breastfeeding. Scholars question the historical trend in pediatrician oversight of well-baby care and medical teachings that taught women to distrust their own bodies. Hospital and medical practices that encouraged formula feeding undermined women's authority as mothers and largely destroyed mother-to-mother teaching and support. Research coming from this angle has also looked at groups, such as La Leche League, that emphasize a return to trusting women's bodies and woman-to-woman support (Blum, 1999; Hausman, 2003; McCarter-Spaulding, 2008).

Feminist work on breastfeeding, whether within the difference/equality debate or from a feminist health activism approach, does seem to have one common theme in that they recognize that decisions to breastfeed involve much more than just individual choice (Bartlett, 2005). They tend to be critical of public health initiatives that push 'breast is best' messages and advocate that breastfeeding is simply a matter of choice. Rather, feminist perspectives tend to highlight the larger socio-cultural context surrounding breastfeeding, including topics of embodied practice, workplace accommodations, breastfeeding in public, and the oppressive/liberating nature of breastfeeding.

### **Setting**

This project focuses on the experiences of twenty-one women who breastfed in the North Central Florida area, and all participants were recruited through North Florida Regional Medical Center. Any woman who was pregnant with her first child and was planning on breastfeeding was invited to participate. The project was developed in coordination with the lactation consultants on staff at NFRMC, and participants were

recruited through the lactation consultants, prenatal education classes, and physician and midwifery offices associated with NFRMC. The hospital serves primarily people in Alachua County, Florida, but patients come from surrounding areas in North Central Florida, such as Lake City.

In order to situate this area, it is useful to compare county, state, and national demographic information relating to births (see Table 3-1). In the state of Florida in 2008, there were approximately 231,417 births. The birth rate per 1000 women of childbearing age was 12.3. Alachua County, where NFRMC is located, had a birth rate of 11.8 and 2,980 births. In the county, there were 1,829 births to white mothers and 1,151 births to nonwhite mothers, 895 of whom were black. The birth rate of white mothers was slightly higher for the state than the county, but the birth rate for nonwhite mothers was higher in the county than the state. In the state, 24,445 births were to mothers who were younger than twenty years old, whereas there were only 306 births to mothers under age twenty in Alachua County. In the state, 180,484 births were to unmarried mothers; in the county 1,334 births were to unmarried mothers (Florida Statistical Abstract, 2007).

Florida's birth rate, 12.3, is slightly below the national birth rate of 14.3. On a national level, the median age at first birth is 25.2, and 56% of mothers remain in the labor force the year their baby is born. Most first births occur to those who have graduated high school, followed by those who have a bachelor's degree. Most mothers are between the ages of 30-44, with 451,000 births occurring to teens in 2009 (Statistical Abstract of the US, 2009).

North Florida Regional Medical Center is a proprietary hospital that is part of the HCA health network. It has approximately three hundred twenty-five beds and is Joint Commission accredited. In 2008, 185,509 patients were treated at the hospital. Patients with Medicaid numbered 16,969 and an additional 18,309 patients who did not have insurance were also treated (2009 Community Report).

North Florida Regional Medical Center offers a unique setting for several reasons, including the fact that there are breastfeeding support programs in the hospital and the community, the hospital is not considered baby-friendly, and little is known about rates of breastfeeding duration and exclusivity among the women who give birth at this hospital. First, NFRMC has a number of breastfeeding support services already implemented. For instance, the education office offers a prenatal education class about breastfeeding and there are several lactation consultants on staff. The lactation consultants make an effort to visit every woman who wants to breastfeed her newborn before discharge and are available to meet with moms who are having trouble breastfeeding while they are still in the hospital. After discharge, the lactation consultants are available either by phone or through office visits, both of which are free services. Additionally, the hospital offers new mom postpartum luncheons that are also free. While these are not specifically about breastfeeding, one of the lactation consultants usually attends and there is often time for moms to ask questions or to voice concerns about breastfeeding.

The local area also includes breastfeeding support, including an active La Leche League group and the Center for Breastfeeding and Newborns. La Leche League is a pro-breastfeeding group that focuses on mom-to-mom support and has local groups

across the world. In the local area, key support activities include monthly meetings and the availability of leaders for assistance with breastfeeding concerns. The other key local support, the Center for Breastfeeding and Newborns, provides advice for things such as sore nipples, low milk supply, overactive letdown, mastitis, yeast infections, latch issues, reflux, colic, and poor weight gain. Services provided are covered by insurance companies and Medicaid, and the goal of the Center is “to provide consultative, support, and educational services that enhance the health of breastfeeding families” (Center for Breastfeeding and Newborns, 2010). While neither the Center nor the La Leche League is directly related to NRFMC, they are community resources that are available to mothers in the area.

Second, while the hospital does have a number of breastfeeding supports, they are not considered a baby-friendly hospital. This is most likely due to the level of unnecessary supplementation that occurs in the hospital despite written breastfeeding policies. The breastfeeding policy includes supporting rooming in, advocating for skin-to-skin contact, and avoiding early pacifier use. It also indicates that “no supplemental water, glucose water or formula will be given unless specifically ordered by a physician or nurse practitioner or by the mother’s informed and documented consent” (Breastfeeding Policy, 2007, p. 3). The policy also advocates for avoiding feeding time limits, educating mothers about breastfeeding, and offering mothers contact information for breastfeeding supports in the community (Breastfeeding Policy, 2007).

Third, although rates of breastfeeding at discharge are relatively high, indicating high levels of breastfeeding initiation, little is known regarding rates of duration or exclusivity. Based on people who call the lactation consultants, it is thought that

breastfeeding stops fairly quickly. Thus, while there is strong breastfeeding support from the education office and lactation consultants, there is also resistance from some to follow the Breastfeeding Policy. There is no systematically collected information regarding how long women who give birth at NFRMC breastfeed for or about their experiences breastfeeding beyond NFRMC.

### **Participants**

As mentioned previously, twenty-one mothers participated in the project. Only one mother was lost due to follow-up problems; the remaining twenty remained with the project until breastfeeding stopped or the baby was one year old. The characteristics of the participants varied somewhat (see Table 3-2). Women ranged in age from 19 to 36, but most were in their late twenties and early thirties. There was also significant variation in education. Two of the women were in high school at the start of the study, but twelve participants held advanced degrees. Most participants were Caucasian, but the sample also included three women who identified as Hispanic, one African American, two women from India, one woman from Germany, and one woman from England. Annual household income ranged significantly, with three women living in households that made less than \$25,000 annually and five women living in households earning more than \$85,000. Most women were married; only one was single and three were partnered.

The mothers in the sample came from a variety of occupations and had a variety of plans for maternity leave (see Table 3-3). Seven of the mothers stayed home after the birth; two of these mothers were actively looking for jobs almost immediately after the birth. The other mothers took a range of leaves: one mother returned to work

responsibilities almost immediately after the birth while six mothers took the full twelve weeks allowed by their employer.

The participants were not recruited to fulfill a random sample; rather, as described above, a convenient sampling strategy was used in recruitment. The goal of the project was to gather information about women's experiences with breastfeeding, the challenges they face, and how breastfeeding mothers could be provided with more support. These questions do not inherently require a representative and random sample; rather, qualitative research like this usually uses a more purposeful sampling strategy designed to gather input from key persons. In this case, my key recruitment criterion was the desire to breastfeed. It was important to include a diverse sample of women, but gathering a base of information about breastfeeding experiences over time was the ultimate goal of this project.

Recruitment took much longer than expected, and this gives me reason to think that participants are an especially selective group of women. This adds to the value of the project in that if these are highly motivated women who are willing to participate in the study, one would hypothesize that they should be the most likely to be able to meet current breastfeeding recommendations. While this study was open to any mother who gave birth to her first child at NFRMC, most mothers who participated in this project also utilized other services, such as the New Mom Luncheons or the lactation support office. If even these women fall short of goals and face considerable challenges, then their voices need to be heard, especially considering a general lack of attention given to this group in breastfeeding research.

## **Data Collection and Analytical Strategy**

Data was collected through interviews with mothers at several points in time. I met with mothers prenatally in the last trimester, as well as around 4 weeks, 8 weeks, 12 weeks, 6 months, 9 months, and 12 months after the birth. We met for the last time when breastfeeding stopped or when the baby was one year old, whichever came first. I went over the details of the study before participants agreed to continue and signed the informed consent form. I met with mothers at a place of their choosing; interview locations thus varied and included their homes, their offices, coffee shops, restaurants, the mall, and outdoor locations. Interviews were digitally recorded and transcribed for analysis. Each interview lasted between half an hour and an hour and a half, but most averaged about forty-five minutes. Occasionally interviews were truncated because of squirmy or fussy babies, and while each interview was shorter, I met with some mothers for six hours because of the longitudinal nature of the project. Mothers were given a five dollar gift card each time we met.

Oftentimes in qualitative work, what is planned is not necessarily what happens, and there were several aspects of data collection that are important to reflect upon. First, there was a time when I was hesitant to meet with women face-to-face because I was sick. I was trying to build rapport with these women and to develop a relationship in which we could meet repeatedly over a period of time. I did not want to run the risk of getting a new mother or a newborn ill, and I did not want them to think I was being irresponsible for meeting with them while I was sick. At the same time, the research design was time-sensitive and I did not want to put the whole project on hold. It was at this time that I requested IRB approval to do some interviews via e-mail.

While some could argue that computer mediated communications and data gathered from face-to-face meetings should not be compared in the same study, I felt it was necessary to do so for several reasons. One, as already mentioned, dealt with health and not wanting to spread illness. Another was that recruitment was particularly challenging and a few women voiced preference to communicate through e-mail. Having this option was also convenient when my dad was hospitalized because I was able to continue the project despite physical distance from participants.

Analysis proceeded by using grounded theory methodology. Data collection and analysis occurred simultaneously in order to strengthen the interview guides and to further develop ideas during continued data collection. Using grounded theory necessitated that I did not rely solely on the literature about breastfeeding for my analytical concepts or theoretical frames. While there is certainly a great deal of information about breastfeeding, and while I am sensitized to those concepts present in the literature, I wanted to be open to possibilities that emerge from conversations with women. In this way, existing literature will be used “as a source of questions and comparisons rather than as a measure of truth” (Charmaz, 1983).

In order to effectively analyze the data collected, a number of processes were used, including transcribing, writing contact summary sheets, coding, and memoing. First, all interviews were digitally recorded and transcribed. While transcription is not necessary, I felt it would be useful for me to have the interviews transcribed into text for purposes of analysis. Field notes were also taken in order to gather information on the context of the interview and to try to retain elements that might be lost in the

transcription. These field notes were then written up and attached to each transcribed interview.

Contact summary sheets were used to develop an overall summary of a particular contact with a respondent. In this way, the main themes and questions from each contact were recorded and used for future referral. This was particularly helpful given the longitudinal nature of the study. These sheets also helped me keep track of when I needed to meet with different respondents and what topics I wanted to be sure to touch upon with each respondent. Information on summary sheets included main issues raised in the interview, a summary of information gathered (or not gathered), any salient points about the contact, and new or remaining target questions. These sheets were filled out within a few days after each contact, but not immediately after the contact so as to allow for some processing time (Miles & Huberman, 1994).

Coding was used to categorize and sort the data in the transcriptions. According to Charmaz, codes are the “fundamental means of developing the analysis” and are used to “pull together and categorize a series of otherwise discrete events, statements, and observations” (Charmaz, 1983). Codes came both from ideas I brought into the study as well as in-vivo codes that were used by respondents. Coding followed two phases: initial and focused coding. In initial coding, I studied the emerging data. The main objective was to look for what could be defined and discovered in the data and to create order from the different accounts. Focused coding took the process to an analytical level rather than the level of summarizing and organizing the data. In this stage, a useful, limited set of codes that were developed in initial coding were applied to larger amounts of data. Whereas initial coding involved labeling topics, focused coding

involved developing and clarifying categories. Focused coding examined the data that categories covered as well as variations from it. Subcategories and properties of categories were used to define the category, delineate its characteristics, and demonstrate the conditions when the category developed. It is important to recognize how categories are connected, and engaging in these steps helped to lay the groundwork for developing explanations in later analysis.

Memo writing was also done throughout the research process, and memos guided subsequent data collection and pointed to areas to explore in future data collection. Additionally, memos helped to connect the coding stage of analysis and the final written reports. In initial memo writing, I named the category and described its defining features. If the category involved a pattern, the conditions under which it operated and varied were included. Memos helped to build a “more integrated understanding of events, processes, and interactions” in the data (Miles & Huberman, 1994).

These methodological tools helped to gather information from women about their experiences with breastfeeding and to analyze the data in systematic and informed ways. Using these tools and the feminist standpoint approach gave the project a solid base for analysis. Before turning to analytical findings, it is important to discuss the conceptual definition of breastfeeding that I used in this project.

### **Conceptual Definition**

Breastfeeding is generally not very well defined in research. I think for the most part, it is assumed that everyone knows what breastfeeding is. However, this lack of clarity creates unclear interpretations and makes synthesis of varied research findings problematic. For instance, not all research discusses the level of breastfeeding. If a

mother only breastfeeds once a day, is she grouped in with a mother who breastfeeds at every feeding? In medical studies about the health implications of breastfeeding, this distinction becomes especially relevant. A second problem with defining breastfeeding comes from the distinction between bottle-feeding and breastfeeding. Some articles use bottle-feeding in opposition to breastfeeding. However, in medical research about breastfeeding, it is breast milk that is emphasized, not feeding at the breast. Breast milk can be expressed and given to an infant in a bottle, thus complicating the use of bottle-feeding as the opposite of breastfeeding. An additional historical concern of definitional issues related to breastfeeding was the use of wet nurses. Again, if the essential aspect of breastfeeding is the milk, then this is very different than if the central aspect is the embodied practice of maternal breastfeeding. These three things - the extent of breastfeeding, the distinction between bottle and breastfeeding, and the tension between breastfeeding as product or practice - are core tensions in defining breastfeeding.

While breastfeeding has not been well defined historically, several attempts have been made to create comprehensive guidelines for definitions of breastfeeding. The Interagency Group for Action of Breastfeeding tried to offer guidelines for defining breastfeeding. They sub-divided breastfeeding into the following categories: exclusive, almost exclusive, full breastfeeding, full breast milk feeding, partial, and token. Exclusive breastfeeding occurs when "no other liquid or solid from any other source enters the infant's mouth" (Labbok, 2000). Full breast milk feeding is used to incorporate the fact that some infants still only receive breast milk, but the source includes both the breast and bottle, and partial and token are used to refer to women

who still breastfeed but whose infants also receive other sources of nutrition. The World Health Organization has also issued statements defining breastfeeding, using the subcategories of exclusive, predominant, full, complementary feeding and bottle-feeding (Labbok, 2000).

In general, my research falls under the general question of "What do women experience as they breastfeed?" and I define breastfeeding as a process of producing and giving breast milk to an infant. In most cases, giving any amount of breast milk to an infant in any manner counts as breastfeeding. For instance, if a mom was only pumping once a day and the baby was getting one bottle of breast milk each day, that mom would still be included in my study. Women exit the study when they completely stop breastfeeding. I included a phrase about producing milk in my conceptual definition because a mom who pumped breast milk and has a large supply stored in the freezer, but has subsequently stopped pumping or nursing at the breast, would not continue to be included in the study. The baby is still receiving breast milk, but the mother is no longer producing milk. To me, the baby is still breastfed, and possibly receiving important health benefits from milk as a product, but the mother is not still breastfeeding. This conceptual definition arises out of my interest in women's experiences with breastfeeding. Thus, I distance myself somewhat from medical approaches that value milk as a product in favor of cultural and feminist approaches that recognize the context and embodied nature of breastfeeding.

Additionally, I worked to find a definition of breastfeeding that women in my study understood and that resonated with them. For instance, if I went into the study and asked women "Are you breastfeeding? Is it exclusive, full, complementary, partial, or

token?", it just would not work. Very few, if any, of the women I'm working with would have understood the nuances between those labels. Most moms do understand exclusive breastfeeding, and I think we all shared an understanding that breastfeeding was a process of producing and giving milk to an infant. Infant feeding did not have to take place at the breast to be considered breastfeeding.

As far as measuring breastfeeding, I am more concerned with lactation and processes of feeding an infant breast milk than with quantifying how many times a day the baby nurses at the breast. I know lactation and breastfeeding are typically separated, but if we think of lactating as producing milk and as breastfeeding as feeding a baby, we miss the process that happens in between the two, and that's what I want to study. I do not want the milk product, I do not want the physiology of producing milk, I do not think breastfeeding has to happen at the breast - I want to understand the processes and experiences that women go through as they try to get the milk they produce to the baby they want to feed.

Through an interview process built upon feminist theoretical and methodological insights, and in joint efforts with those who participated, what follows is an analysis of our experiences and suggestions for helping others meet current recommendations for breastfeeding behavior.

Table 3-1. County, state, and national characteristics of births

	National		Florida		Alachua County	
	Number <sup>2</sup>	Rate <sup>3</sup>	Number	Rate	Number	Rate
Live Births	4,317 <sup>1</sup>	14.3	231,417 <sup>5</sup>	12.3	2,980	11.8
Race <sup>4</sup>						
White	3,310	13.7	167,487	11.0	1,829	9.7
Black	666	16.8	51,362		895	
Other	288		12,049		256	
Nonwhite			63,411	17.4	1,151	17.8
Age of Mother						
Under 20	451		24,445		306	
20-24	1,083	106.4	59,661		752	
25-29	1,209	117.5	63,553		839	
30-34	962	99.9	50,018		699	
35-39	500	47.5	33,294 <sup>6</sup>		376	
40-44	105	9.5				
45-49	7	0.6	437		8	
Marital Status						
Unmarried	1,642	50.6	108,484	46.9	1,334	
Educational Attainment						
Not high school graduate	12,882		45,472		426	
High school	15,010		71,878		666	
Some college	12,953		42,719		547	
Associate's degree	5,115		19,859		277	
Bachelor's degree	11,094		35,058		583	
Graduate or professional	4,638		14,869		480	

<sup>1</sup> 2007 preliminary data

<sup>2</sup> Births in thousands. 4317 represents 4,317,000

<sup>3</sup> per 1000 population

<sup>4</sup> 2006 data

<sup>5</sup> 2008 provisional data

<sup>6</sup> Ages 35-44

Source: Florida Statistical Abstract, Statistical Abstract of the United States

Table 3-2. Participant characteristics

Participant	Age	Education	Race/Ethnicity	Income	Relationship
Amanda	34	college	White	\$45,000	married
Amy	34	advanced degree	German	\$45,000	married
Angela	30	advanced degree	White	\$85,000	married
Ashley	30	advanced degree	White	\$75,000	married
Caitlyn	32	college	White	\$55,000	married
Claudia	27	some advanced degree	Hispanic	\$65,000	married
Courtney	27	advanced degree	Hispanic	\$65,000	partnered
Denise	33	some college	White	\$45,000	married
Emily	30	college	English	\$85,000	married
Grace	28	advanced degree	White	\$55,000	married
Jackie	36	advanced degree	White	\$85,000	married
Jasmine	29	college	White	\$85,000	married
Katie	27	advanced degree	Hispanic	\$25,000	married
Kim	20	high school	White	>\$25,000	partnered
Laura	30	advanced degree	White	\$25,000	married
Leah	34	advanced degree	Indian (Asian)	\$85,000	married
Mary	19	some college	White	>\$25,000	single
Melanie	31	advanced degree	White	\$45,000	married
Patty	23	advanced degree	African American	\$25,000	partnered
Samantha	36	high school	White	\$55,000	married
Sara	33	advanced degree	Indian (Asian)	>\$25,000	married

Table 3-3. Participant occupations and maternity leaves

Participant	Occupation	Return to Work
Amanda	teacher	6 weeks
Amy	---	stayed home
Angela	pharmacist	12 weeks
Ashley	registered nurse	12 weeks
Caitlyn	sales support administrator	stayed home
Claudia	marketing	stayed home
Courtney	lawyer	4 weeks
Denise	accounting clerk	12 weeks
Emily	accountant	12 weeks
Grace	veterinarian	looking for work
Jackie	veterinarian	8 weeks
Jasmine	sales associate	stayed home
Katie	research scholar	12 weeks
Kim	student	stayed home
Lauren	librarian	12 weeks
Leah	research scientist	10 weeks
Mary	customer service	2 weeks
Melanie	graduate student	immediate
Patty	sales associate	4 weeks
Samantha	insurance underwriter	12 weeks
Sara	environmental scientist	looking for work

## CHAPTER 4 EXCLUSIVITY

It was difficult not knowing how much he was eating. The first week I was nursing exclusively and we found out he wasn't gaining his weight back so we had to supplement.

- Samantha

I was really against giving supplements. I wanted to fully breastfeed her, but really, that didn't happen.

- Sara

So they told us we were going to have to supplement, which I didn't want to have to do, but at this point, whatever we needed to do to make sure the baby didn't die.

- Courtney

Current breastfeeding recommendations include exclusively breastfeeding for the first six months of an infant's life (WHO, 2009). According to the World Health Organization, exclusive breastfeeding is when babies receive only "breast milk without any additional food or drink, including water" (WHO, 2009). As indicated earlier, Healthy People 2010 goals include having 40% of three month old infants and 17% of six month old infants breastfed exclusively. The 2005 revisions to the American Academy of Pediatrics' statement "Breastfeeding and the Use of Human Milk" also include recommendations to exclusively breastfeed for approximately the first six months (AAP, 2005). As stated in the Breastfeeding and the Use of Human Milk policy statement:

Human milk is species-specific, and all substitute feeding preparations differ markedly from it, making human milk uniquely superior for infant feeding. Exclusive breastfeeding is the reference or normative model against which all alternative feeding methods must be measured with regard to growth, health, development, and all other short- and long-term outcomes.... Exclusive breastfeeding is defined as an infant's consumption of human milk with no supplementation of any type (no water, no juice, no nonhuman

milk, and no foods) except for vitamins, minerals, and medications. Exclusive breastfeeding has been shown to provide improved protection against many diseases and to increase the likelihood of continued breastfeeding for at least the first year of life. (AAP 2005).

In light of the gap between public health initiatives to increase breastfeeding exclusivity rates and women's behaviors, greater understanding of breastfeeding behaviors is needed. Based on the 2009 Breastfeeding Report Card, in the state of Florida, only 30.7% of women are exclusively breastfeeding at three months and only 11.9% are exclusively breastfeeding at six months (Breastfeeding Report Card 2009). What follows is an exploration of when and why mothers supplemented, temporary exclusivity, the embodied nature of breastfeeding, and how women responded when they supplemented earlier than they had intended.

### **When, What, and Why**

The focus of this section is Healthy People 2010 goals for exclusivity and how the behaviors of the mothers in this project compared to those goals. Among the mothers in this study, only three (14.2%) were exclusively breastfeeding at six months (see Table 4-1). Eleven mothers (52.3%) exclusively breastfed through three months.

Healthy People 2010 goals for exclusivity are to have:

- 40% of mothers breastfeeding exclusively at three months
- 17% of mothers breastfeeding exclusively at six months

In this project,

- 52.3% of mothers breastfed exclusively at three months
- 14.2% of mothers breastfed exclusively at six months

A few points on the timing of introducing supplements are significant. First, nine mothers in this study supplemented with formula within the first week after the birth.

Out of a total group of twenty-one mothers, this means that 42.8% of the sample used

formula within the first week. A second point worth noting is that eight mothers started supplementing during the fourth and fifth months. If those who began supplementing at five months had waited until six months, 47.6% of the sample would have been exclusively breastfeeding at six months and the sample would have far surpassed the Healthy People 2010 goal.

Supplementation took two forms: formula or baby cereal. For eleven mothers, the first supplementation was formula. Except for one mother, supplementation with formula began in the first month. For the other ten mothers, the first supplementation was baby cereal. Those starting cereal typically did so between four and six months, although two moms did not supplement with cereal until six and a half months.

In a few cases, formula was introduced later than it is typically assumed to. For instance, most research on breastfeeding focuses on the early supplementation with formula that occurs in the first few weeks after birth. Exclusively breastfeeding at six months is not well-researched, and at this age, it is generally recommended to begin feeding cereal and other baby food. However, I was surprised by the number of mothers who first started to use formula between six and twelve months. If part of the argument in support of breastfeeding is that formula is artificial and unhealthy, the late onset of formula use deserves more attention. For some, the first supplementation was cereal, but they also started to supplement with formula between six and twelve months.

Additionally, it is important to note that six mothers in this study combined breast milk and formula for extended periods of time. Most research on breastfeeding assumes an either/or dichotomy. Mothers are either breastfeeding or they are formula feeding. This glosses over the details of lived experiences and ignores women who

combine breast milk and formula for extended periods of time. For instance, some babies are given one bottle of formula at night every night, but all other feedings are breast milk.

Numerous reasons for supplementation were given, but one of the largest contributing factors was a belief that the baby was losing too much weight. Inverted nipples were another common reason, and several babies were given formula because of health problems the mothers were encountering. Reasons of weight loss and insufficient milk supplies were given by seven of the mothers when they were sharing details about using formula. When first supplementation was cereal around six months, there was a general assumption that the baby was now old enough and should be receiving nourishment other than just breast milk.

### **Decision-Making**

The women in this project clearly conveyed that pediatricians played an important role in decisions to supplement. There is conflict between Healthy People 2010 goals and recommendations and actions that some doctors and nurses make. If we really are to meet Healthy People 2010 goals, women need support from medical professionals. Wright and Schanler (2001) discuss the importance of appropriately trained physicians to efforts to increase breastfeeding rates. Many physicians do not have training in breastfeeding as part of their medical education, they are not prepared to help women make informed decisions regarding breastfeeding, and they often rely on their own experience in assisting women with breastfeeding. Additionally, a great deal of the breastfeeding materials provided through pediatrician offices are donated by formula companies and often include free samples and coupons for formula. Pediatricians have had a conflict-ridden history with breastfeeding, including a time when efforts to promote

scientific infant feeding included strict timings of feedings and the inclusion of formula as safer to breast milk because of reduced possibilities of milk that was inadequate or too thin (Simonds, Rothman, & Norman, 2007). The historical tensions tend to continue, although the American Academy of Pediatrics includes a section about the role of pediatricians in supporting breastfeeding through clinical practice (American Academy of Pediatrics, 2005).

In this study, some women very much wanted to exclusively breastfeed, but actions within medical establishments undermined their efforts. Sara, facing the situation in which her daughter had lost 14% of her birth weight, was told to supplement each feeding with formula. However, she then began to give three bottles to the baby every night and tried to breastfeed during the day, but stopped breastfeeding completely around five months. Once bottles were introduced, she says, “I got lazy. It was easy to say just one more, just one more. If I hadn’t started giving formula I probably would have been breastfeeding more. Now I feel ‘Okay. We are already giving formula three times, one more time is okay.’ ” Perhaps if more effort had been made to help Sara with breastfeeding, rather than immediately suggesting formula, breastfeeding would have continued longer.

Breastfeeding does require a great deal of effort, and when formula is seen as ‘easy’ and doctors legitimate the use of formula, it opens doors for reducing breastfeeding. Offering free formula was also significant. Access to formula impacted several decisions related to supplementation. While some women held onto free samples but did not use them, other mothers did use the samples that were given to them. Several other mothers received the formula they used through Women, Infants,

and Children food vouchers. While it is impossible to say what would have happened had formula not been so readily accessible, it is important to note that access to formula is important when women face challenges and are making decisions related to supplementation.

While not all mothers used the supplies that were given to them, it is significant to note that many mothers did not actively pursue formula. For instance, Grace explained her experience in the hospital and responded to my question of whether the baby was given formula by saying “They talked about it just cause he was jaundiced, but he was constantly feeding, so they gave me the option and they gave me everything you do it with when they sent me home.” When I asked her what she meant by “everything,” she explained that they gave her formula and the tubings that you can use while breastfeeding. Mary also stated “While the pediatrician is glad I am breastfeeding, he did offer me sample bags of formula in case I need to supplement.”

Katie told a similar story, in which the visiting pediatrician told her to supplement with formula after each feeding. Her baby dropped almost 10% of birth weight while they were in the hospital after the birth. In her words, she said, "So the doctor came in, and he didn't put it this way, I'm sure I'm being melodramatic, but it translated to, 'If you don't supplement, your baby is going to die'. He didn't say that I wasn't making enough milk, but he wasn't gaining weight, but he did tell me to supplement." Here, as in Sara's case, the supplementation began because of doctor recommendations.

Sometimes supplementation happens without the mother's awareness or agreement. When I asked her about her hospital stay and supplementation, Katie told me an interesting story. The nurses insisted on taking the baby to the nursery at night

so that she could rest. Katie told the nurses not to give the baby pacifiers or formula, but she knew that her baby had been gone too long and that there should have been a feeding. Another mom echoed this by saying, "They didn't tell me supplementation had happened, but I noticed a check next to it on his chart." This mom was not particularly upset because it did not seem to interfere with breastfeeding, but she had not given her consent to give the baby formula. Kim was more vocal about her displeasure that the nurses supplemented with formula without her consent. She said, "That made me mad because I didn't actually give them permission to do that. They just wanted to and took it upon themselves." In these cases, as in Laura's situation mentioned earlier, nurses were an important source of supplementation.

Through actions such as feeding the baby formula, offering free formula and bottles, or using an authoritative position to suggest that supplementation is necessary, doctors and nurses hinder breastfeeding exclusivity. However, it is important to realize that not all doctors and nurses engage in such behaviors and that mothers have agency in such situations. Some mothers described very supportive pediatricians, and other mothers simply did not listen to the advice of the pediatrician.

For instance, one mother was concerned because her baby was not staying on the breast for the ten minutes that is commonly recommended in books about breastfeeding. When she brought this up at a pediatrician visit, her pediatrician told her not to worry about it. When discussing this story, the mother said the pediatrician said to "just feed him what he wants to eat and don't worry about how long it takes." Another mom mentioned that when discussing introducing baby cereal, her pediatrician was very vocal about waiting until six months. Melanie also told a story of supportive

pediatricians when discussing her baby's nine month check-up. The baby was in the fourth percentile for weight and had gained only one pound since the six month visit. Melanie was sure the pediatrician would encourage her to start using formula, but instead, the pediatrician encouraged her to stop worrying about the numbers and focus on developmental benchmarks, such as eye contact, babbling, sitting up, and crawling. The baby was meeting these benchmarks, and when the baby was charted on the WHO's growth charts, it fell in the twentieth percentile for weight. While this story does not relate specifically to breastfeeding exclusivity within the first six months, it offered a poignant example of how pediatricians can and do act in ways to support breastfeeding.

Mothers also do not always listen to the advice of the pediatricians. For example, one pediatrician told a mother that putting the baby at the breast too often could dry out her supply. She knew breastfeeding works on a demand and supply process, and so she said, "I'm not paying much heedance to it. I'm kind of selectively ignoring that he said that." Another mom was discussing breastfeeding past a year with her pediatrician, and the pediatrician seemed negative about it. The mother responded in this way: "I'm not sure where she's coming from. In the beginning, she was pretty big on only 10-15 minutes. She's very pro-breastfeeding, but in a kind of old-school way." While mothers who participated in this project seemed to value the input from the pediatricians, some also questioned the advice they were given regarding breastfeeding.

While pediatricians, nurses, and the availability of formula influenced decisions related to supplementation, fathers also played a key role in decision-making related to supplementation. While families in this study did not use formula for the explicit

purpose of increasing father involvement, fathers were very involved in the decision to supplement with formula or not. For instance, Amy's family was involved in the dilemma of how to include a father who wanted to be involved in the care of their newborn son. Amy was concerned about her milk supply, and there were a few occasions in which the baby was refusing to latch on. In these instances, they offered the baby formula. Amy was a little sad that the father is not more involved, and the father commented to me, "I must admit, those three times we offered formula, I was behind it." Another father impacted supplementation perhaps inadvertently when he requested his wife go with him to an out-of-state football game. She explained the situation this way: "If my husband had his say about it, he would much rather that I pump and she get breast milk, but he would rather me go with him to the game most of all." The mother did not particularly enjoy pumping (an issue I return to later in this Chapter), and the baby was given formula for two days.

Other fathers voiced hesitation about introducing formula and encouraged the continuation of exclusive breastfeeding. One of the times we were talking, Courtney told me a story of conflict that arose when she misspoke and said she was going to exclusively formula feed the baby the next day. Her fiancé became very quiet and seemed a little offended that he was not involved in this decision. He requested that she try to pump and put that in a bottle (which is what she had meant). Courtney said, "He would prefer me to breastfeed exclusively. He hasn't put any pressure on me to do that because he knows how difficult it would be, but the more breast milk he can get, the better he feels about it."

Caitlyn's story illustrates how crucial a partner's support can be during breastfeeding. The baby was cluster feeding to the point where she felt she had been breastfeeding for ten straight hours. She was tired and her nipples were sore. They had free samples for formula in the pantry; she had received them while she was pregnant and held onto them just in case breastfeeding did not work out. Caitlyn suggested that next time the baby wants to eat they use formula. She continues to tell the story by saying, "He was like 'No, we're not going to do that 'cause I don't even know how to do it, how much to give.'" When they called pediatrician and lactation offices, they received mixed feedback: two people recommended supplementing with formula and two recommended avoiding supplementation. After receiving advice to use formula, Caitlyn says, "me and my husband, we're like ehh, if we start doing that then we really don't want to go on the path of not breastfeeding and we really weren't sure how that was going to mess things up." One of the lactation consultants explained that babies digest formula differently and that using formula could impact milk production. This reaffirmed Caitlyn and her husband's belief that using formula, even just a time or two, could "open up a whole bunch of other problems for us." In this situation, her husband was a critical source of help – he discouraged the use of formula, encouraged her to make it through the tough times, helped set up meetings with the lactation consultant, and accompanied her to the lactation consultant's office.

### **Temporary Supplementation**

Defining and achieving common understandings of breastfeeding exclusivity is complicated terrain. For instance, if a mother used formula for a week, but then stopped, would that baby be considered exclusively breastfed? Would they be categorized the same way as a baby who was consistently given formula several times

a day? This is a question that must be addressed, especially given the fact that most information about breastfeeding is coming from large national surveys. Exclusivity rates might actually be lower than indicated because women believe that they are exclusively breastfeeding. For instance, when I asked a mother if she was exclusively breastfeeding, she responded, “Oh yes, we’re only breast milk. Except at night.”

For the purposes of this project and the analysis presented here, I followed the WHO’s definition of breastfeeding. Babies are considered exclusively breastfed as long as they were receiving only breast milk, regardless of whether this was expressed breast milk given in the bottle or breast milk directly from the breast.

One of the key themes that emerged from talking with women is the challenge in defining exclusivity. Several women I spoke with supplemented for short times but then stopped. Often, this was due to some type of life emergency or short-term recommendation to supplement feedings. Once it was established that both mom and infant were healthy, supplementation faded out and breast milk was the only food given to the infant.

Lauren and Ashley were two such cases. Lauren was concerned that her baby had not been latching on correctly and eating sufficiently while in the hospital. Upon discharge, one of the nurses gave her formula and bottles. The parents began supplementing with formula to make sure the baby was getting something to eat. Then, two days after being discharged, Lauren was admitted to the emergency room because of low iron levels. Then, a week after the birth, she was hospitalized again because of an infected gall bladder. While in the hospital, Lauren demanded access to a breast pump so she could maintain her supply. By the time we talked at four weeks, the baby

was back to receiving only breast milk. Ashley was also hospitalized for her own health reasons and the baby was formula fed for two and a half days. After she was released, she went back to just breastfeeding.

Another example is Katie's experience. Katie was very frustrated with her early breastfeeding experience. Her first night home, the baby cried for five consecutive hours, and when they went to the pediatrician, she was told that she had an inverted nipple which made it hard for the baby to latch on. Katie said, "We had to start immediately with formula because she was at risk for being dehydrated". However, a nurse spent hours working with Katie at breastfeeding, and after four days, the baby was being fed only breast milk.

This was my own experience as well. My son and I were discharged 24 hours after the birth, but he had slightly elevated bilirubin levels. I was sent home with instructions to supplement every feeding with two ounces of formula. The hospital provided all the bottles, nipples, and formula we would need, and then we were told to visit the pediatrician in the morning. The pediatrician told me, "You know breast fed babies take longer to recover from jaundice." I told her that I was aware of that, but the way she said it made me feel as though she thought that I should give formula to help speed recovery. However, I knew my milk supply was being established and did not want to compromise that process. We did supplement with formula for a few days, but stopped as soon as the jaundice was no longer a concern.

These examples illustrate how exclusivity is not a simple, clearly defined, unidirectional issue. In some cases, babies receive formula supplementation for a short period of time but then return to receiving only breast milk. This adds complexity to

statistics about breastfeeding exclusivity; while some babies might have at some point been given formula, at the time of data collection they might be exclusively breastfeeding.

### **Embodied Breastfeeding and Father Involvement**

Breastfeeding is a gendered and embodied act, and several aspects of breastfeeding need to be noted when discussing breastfeeding exclusivity. First, breastfeeding poses a challenge to ideals of shared care-giving. It has been suggested that mothers pump breast milk so that fathers can be more involved in infant feeding, but the mothers in this project offer significant opposition to this way of negotiating both breastfeeding and father involvement.

An important aspect of exclusivity that must be dealt with is the desire for fathers to be involved. While caregiving activities for young children are often considered women's work, there has been increased acknowledgement of involved fathers. A model of a nurturing father was emphasized beginning in the 1970s and stressed that fathers should be active, nurturing parents who are involved in the day-to-day activities of caring for their children (Lamb, 2000). Some research on breastfeeding behaviors indicates that women start to use bottles because of a desire for increased father involvement. In a review of research about fathers and breastfeeding, Bar-Yam and Darby state, "Just as fathers' support for breastfeeding helps mothers initiate and continue breastfeeding, their lack of support can be a risk factor leading to increased incidence of bottle feeding" (1997, p. 47). Earle also expresses this line of thought, although she takes an even stronger stance saying, "The data suggest that the bottle-feeding participants did not only wish to involve the baby's father in feeding the baby to relieve the 'daily grind', but also as a means of ensuring paternal involvement...It has

been argued that contemporary child-rearing manuals....'warn' mothers against monopolizing the baby and excluding the father....Thus breastfeeding can be perceived as a dangerous form of possessiveness which is to be discouraged" (2000, p. 328). Jordan and Wall suggest that breastfeeding extends the mother/infant relationship exclusivity and that feeding someone is a significant symbolic action. Feeding is often perceived by parents as one of the most meaningful interactions a parent can have with an infant, and thus, many parents attempt to involve fathers in feeding despite intentions to breastfeed (1990). Most of this research fails to take into account the distinction between formula in a bottle and expressed breast milk in a bottle. For the mothers in this study, father involvement in feeding was not a factor in reducing exclusivity, but fathers' involvement in decision making regarding breastfeeding did influence whether or not exclusivity was maintained.

None of the mothers in this study used formula solely for the purpose of increasing father involvement. When asked about fathers and father involvement, many mothers said that their husbands or partners wanted to be involved and that they were planning on pumping so that the father could be more involved in feeding in the early stages. A few of the respondents pumped breast milk with the intention of allowing others, especially the fathers, to be more involved with caring for the baby. One mom said, "Yes, I pump so that I am not solely responsible for feeding her." Another responded, "I'm planning on pumping so he can, so there'll be some bottles around. It'll make life easier if I'm not the one who has to be constantly around." Some moms phrased this in that it was relieving pressure for them, while others more explicitly mentioned the importance of allowing fathers to be more involved. For instance, Caitlyn

said, “And I probably will [pump], just to kind of give myself a break sometimes. If it’s on a Saturday, to be able to say to [husband], Can you do this one? I’m going to sleep in.”

Despite an intention to pump so that others could be involved, many mothers discussed pumping in negative terms. Many mothers put off pumping, did not enjoy pumping, and did not pursue their plans to pump as much as they had anticipated. Pumping was also described as being a hassle, and many mothers became frustrated when they could not pump much milk. Caitlyn explains that her lack of follow through with pumping was due to two factors: breastfeeding at the breast had been challenging and she and the baby had just gotten the hang of that. Additionally, she didn’t

feel like learning something new...It’s like having to go back to the drawing board to figure out the pumping and how much to pump and when’s the best time to pump. And cleaning the bottles and stuff, it’s just more time consuming....I didn’t know what to do and I wasn’t really all that excited.

When I asked how she felt about pumping, she didn’t like it and said, “sitting there pumping and then you have to clean the whole machine and you put it in the freezer....it was just very mechanical.”

Even though women expected to be pumping and bottle feeding the baby to be an important aspect of father involvement, several did not carry through with this plan. Many of the women did not enjoy pumping and found it bothersome, and some women who did not have to pump because of work schedules did not follow through on plans to pump. For example, Angela said, “If I don’t have to pump, I’d rather just feed him.” Some women simply did not like pumping. Emily said, “I don’t know why I have such a problem with it, but it really gets me upset and depresses me. You just spend so long doing it and you don’t seem to get very much.” When we were talking about pumping, Melanie said, “Something about it is off-putting to me. It’s weirdly distant, but it’s

important because you're still getting all the benefits of breast milk. I can honestly say it does not have the same connotation for me as natural breastfeeding does."

For others, pumping was not necessarily a negative experience, but it became evident that pumping was not the cure-all it had been expected to be. For example, Caitlyn explained her experience with pumping by saying.

I kinda put it off and I did try, I would get about an ounce each time and we tried a few evenings where [husband] would give him the bottle. But he would suck the bottle down, and it wasn't a problem of him feeding, but when he was done he was still mad because I think half of the feeding now for him is that he's lying there on the Boppy, he's close to me and he has that cuddle time while he eats and with my husband it's not the same....So we were just like, I was going to go back to work, but I'd be working from home, so why force the whole bottle issue?

Emily also described how the baby complicated plans for the father to be involved through feeding pumped breast milk. She said, "Getting her to take the bottle seems to be a bit of a challenge. And he's having to, she'll suck on his finger but she won't really suck on the bottle, so he's having to stick his finger in and then kind of do the switch...she definitely prefers breastfeeding." Grace also experienced a change of plans regarding pumping. She, too, had planned on pumping because the father wanted to be involved in feeding. She said, "He was really gung-ho about wanting to do some bottle feeding, but now that it's here, he sees it's more of a pain than anything. There are other ways he can be involved, so he's not so adamant about that." These examples illustrate that sometimes bottle-feeding is not as accepted by the baby, and other times the parents realize that pumping entails a lot of work and that there are other ways for fathers to be involved.

In these situations, new fathers became involved in a variety of different ways and mothers did not have the impression that the fathers felt that the breastfeeding

relationship or not being able to feed the baby hindered the father/infant relationship. For instance, Lauren, mentioned earlier, spoke candidly about her husband's involvement. He had been the one responsible for the baby while she was hospitalized, and after they returned to breastfeeding, he asked to be involved in specific ways. For instance, he specifically asked to be the one who burped the baby after eating. Emily also talked about this by saying, "Well, I always get thirsty, and I always forget to get something before I sit down. So he'll always be bringing me something to drink." Many mothers commented that fathers were involved through various other means, including getting water for the mother, bringing the burp cloths, taking the baby out while the mom slept, and cooking meals. Emily explained her husband's involvement by saying, "He's always jumping around for me. At least I get to just sit there while I do it!" She went on to say, "He's quite happy just to walk her around and hold her a lot. He does so much with her that it's not like I'm gaining one up on him or anything." Angela's husband was also very active in changing the baby, burping the baby, and watching the baby while Angela napped.

Pumping was an aspect of breastfeeding that many mothers, whether they were working or not, had at least thought about. As mentioned above, pumping is sometimes promoted as a way to maintain exclusivity while also encouraging father involvement. However, few fathers in the sample regularly fed infants with bottles of breast milk and this did not seem to hinder father involvement. However, father involvement was limited by two other factors. First, while they are often quite involved in the first few weeks, fathers often returned to work before mothers. Second, several mothers noted that fathers simply cannot replace a breastfeeding mother.

Many fathers had to return to work quickly after the birth, and some mothers found that work and daycare arrangements limited a father's involvement with feeding.

For instance, Lauren said,

We don't need him as much anymore because he doesn't have to help me get her to latch on or have to get me anything. It's just primarily us that do it now, but he's happy for us. A lot of it is us alone a lot more now because he's back at school. So there aren't as many opportunities for him.

Denise explained her husband's involvement in similar terms when she said,

And then, for my husband, he's been having a hard time. For the first three weeks, he was here, and now he's not able to be here, and doesn't feel the same attachment. He wants to be more helpful...having such limited capacity to soothe him or help him....that can be frustrating.

Other fathers, who had been involved in feeding, became less so after the baby entered daycare. For instance, when we were talking about her husband's involvements, Angela said "He doesn't really [give any bottles], because it's mainly the daycare."

For mothers in this study, father involvement was more limited by the father's return to work than by breastfeeding. Another limiting factor was biology. Several mothers pointed out biology inherently limited father involvement and level of understanding of the issues they were going through. No matter how much help they offer the mother, a father cannot replace a breastfeeding mother. Consider the following quotes from mothers:

I wish my husband had breasts also.

At the end of the day, it was my decision. I got the breasts, sorry.

He's about as supportive as a guy can be about something he knows nothing about and can't experience.

Sometimes I get frustrated. You just ate! What in the hell kid! Because I'm the only one that can do that. It's not something that he can help me with.

Your husband only wants to hear it so long, or if you have a question about breastfeeding or during the day, you have someone who 110% completely understands what you're saying.

You're the one that has the milk supply.

While most moms wanted fathers to be involved and did not want breastfeeding to hinder the father's relationship with the infant, many found fathers limited for others reasons. Fathers tended to go back to work before mothers did, and this limited their interactions with the baby. Additionally, many mothers expressed the opinion that fathers were limited in terms of how much help and understanding they could offer because of simple biological differences.

When it comes to breastfeeding and father involvement, there seems to be an over-reliance on pumping. For those who breastfeed, pumping disembodies a very embodied aspect of motherhood and the mothers in this project seem to resist that disembodiment. Most mothers in this project did not enjoy pumping and did not do so unless they had to. Additionally, many fathers found other ways to be involved and did not feel slighted that they were not able to be involved in infant feeding during the first few months. However, returning to work and differences based in breastfeeding as a gendered process are significant factors that alter father involvement.

### **Negotiating Supplementation**

All the women who participated in this project wanted to breastfeed. Many mothers faced challenging times when formula was introduced earlier than they had wanted. Research on breastfeeding has indicated that mothers experience a great deal of guilt and stress when breastfeeding stops. While I noticed this to some degree when formula was introduced, the mothers were quite adept at reframing the situation. For the moms who were adamant about their desire to breastfeed, their acceptance of

supplementation seemed to progress through stages. Many women were upset, frustrated, or disappointed when supplementation first occurred. Then, many rationalized the situation and came to accept supplementation. Many also re-negotiated their sense of good mothering that had previously been dependent on breastfeeding exclusivity. Consider the following descriptions of supplementation:

When we realized that she was so fussy because she was just hungry, I was relieved to know that's what it was. But I was kind of disappointed, too.

There was a crying episode because I felt like she was saying that I'd be hurting my child if she wasn't eating something.

Oh, it was horrible. I was literally on the phone on the verge of crying. The reason we gave him that bottle was because we didn't have enough milk to make it through the day at daycare.

The first week I was nursing exclusively and we found out he wasn't gaining his weight back so we had to supplement. We just wanted to feed the baby.

It's not our fault. We have to go back to work. Breastfeeding will become secondary, because we have another option, giving formula.

Looking back on things, I wish they had not introduced the bottle so quickly. But the way I see it, if I can give him any breast milk, that's what counts and I give him as much as I can so I'm good with that. I wish I could do it more, but I have to work. I don't pump as much during the day as he eats. The overwhelming principle throughout the whole thing has been for him to be fed. I just want him to be well.

For these moms who wanted to breastfeed, using formula was often a challenging experience. What is remarkable in their stories is the level of re-framing that occurs. While some moms might have felt upset about not breastfeeding, they quickly re-framed this. Many expressed that the bottom line was that the baby was healthy and happy, and a hungry baby is neither healthy nor happy. Some also pointed to work and stated that perhaps if they had not had to work then maybe formula would not have been necessary. Others pointed out that it was not really a decision that was in their control

(ie – we had to supplement). While I am not trying to dismiss the fact that using formula when it is not desired is a challenging experience, I am trying to point out that many mothers engage in strategies to re-frame the situation.

### **Summary**

Feminist standpoint theory encourages researchers to listen to women's voices and to see how their perspective might be different than what is typically presented in research reports. When specifically focusing on breastfeeding exclusivity, these women's voices offered important insight into several topics. First, their experiences highlight the complexity of defining breastfeeding, especially in regards to temporary supplementation and long-term combinations of formula and breast milk. Second, the emphasis on pumping and father involvement is in conflict with embodied aspects of breastfeeding. Lastly, responses to supplementation are more varied than what most research suggests.

The exhortations to breastfeed, and to breastfeed exclusively, are wrought with tensions when carried out in the lives of individuals. These tensions include definitions of exclusivity, medical advice and actions, and the inclusion of fathers in infant care and feeding decisions. While breastfeeding recommendations are founded on the ideal of improving national health statistics, they must take into account the lived experiences of new families. Such experiences must be reflected in both public health recommendations and support programs designed to help people meet such recommendations, a topic I return to in Chapter 6.

Table 4-1. Details of supplementation among participants

Participant	What	When	Why
Amanda	formula	1 week	inverted nipples/milk supply
Ashley*	formula	1 week	mother hospitalized
Courtney	formula	1 week	weight loss
Katie*	formula	1 week	inverted nipples/dehydration
Kim*	formula	1 week	inverted nipples/didn't like pumping
Lauren*	formula	1 week	baby not eating/mother needed surgery
Patty	formula	1 week	milk supply
Samantha	formula	1 week	weight loss
Sara	formula	1 week	weight loss
Amy	formula	4 weeks	fussy baby/milk supply
Mary	cereal	4 months	
Claudia	cereal	5 months	baby got teeth; was big enough for food
Jasmine	cereal	5 months	
Leah	formula	5 months	in case of emergency
Caitlyn	cereal	5.5 months	
Grace	cereal	5.5 months	
Melanie	cereal	5.5 months	baby's interest in food
Denise	cereal	5.5 months	
Emily	cereal	6 months	
Angela	cereal	6.5 months	
Jackie	cereal	6.5 months	

\*Participants used formula for a limited time and returned to only breast milk.

## CHAPTER 5 DURATION

I feel like I had lofty ideals but when it comes down to it you do what you have to do to make your child ok.

-Lauren

I really wish I could have breastfed until she was one year old. Setting such a goal was an unrealistic thing.

-Katie

Current breastfeeding recommendations include breastfeeding for at least the first year of an infant's life (AAP, 2005). The 2005 revisions to the American Academy of Pediatrics' statement "Breastfeeding and the Use of Human Milk" state, "Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child" (AAP, 2005). The World Health Organization suggests "continued breastfeeding along with appropriate complementary foods up to two years of age or beyond" (WHO, 2009). As indicated earlier, Healthy People 2010 goals include having 50% of six month old infants and 25% of twelve month old infants breastfed.

Based on the 2009 Breastfeeding Report Card, in the state of Florida, only 37.2% of women are breastfeeding at six months and only 18.2% are breastfeeding at twelve months (Breastfeeding Report Card, 2009). All mothers who participated in this study wanted to breastfeed and did initiate breastfeeding. The remainder of Chapter 5 explores factors related to breastfeeding duration, including disconnects between expectations and experiences, decision-making processes, changing challenges over time, and de-breastfeeding cycles.

## When and Why

Mothers stopped breastfeeding at a variety of times and for a variety of reasons. Because one mother was lost during follow-up, I only have information regarding duration for twenty mothers. Of those twenty, six mothers stopped before six months (30%), and another four stopped between six and nine months (see Table 5-1). One mom stopped breastfeeding at eleven months, and the remaining nine moms breastfed for twelve months or longer. Three moms, who had breastfed for a least a year, were still breastfeeding at the time of writing. To summarize, Healthy People 2010 goals for duration are to have:

- 50% of mothers breastfeeding at six months
- 25% of mothers breastfeeding at twelve months

In this project,

- 65% of mothers breastfed at six months
- 45% of mothers breastfed at twelve months

As a group, the mothers in this project met Healthy People 2010 goals for duration. Their stories offer important insights into why mothers stop breastfeeding and what aspects help mothers continue breastfeeding. Nine of the mothers breastfed up to or past twelve months; this percentage of mothers who breastfed for twelve months is almost double the level that is desired by Healthy People 2010 goals. Reasons for cessation depended on when cessation occurred. Most of those who stopped before their goals stated they did so because of reasons associated with milk supply issues. For those who stopped at or around twelve months, key reasons for cessation were meeting the goal and baby-led weaning.

## **Expectations and Goals**

This section explores connections between expectations and experiences as well as goals for breastfeeding duration. More specifically, issues related to stated goals, qualifying goals, disconnects between stated goals and actual duration, and the connection between longer goals for duration and longer duration will be discussed.

Previous research has explored the role of expectations in breastfeeding duration. For example, Binns and Scott state, “The impact of breastfeeding problems on duration may be related more to unrealistic expectations of women rather than the severity and nature of breastfeeding problems” (2002, p. 17). They go on to discuss how the ‘breast is best’ message is often intertwined with a message the breastfeeding is ‘natural’; some women believe that breastfeeding just comes naturally, when in fact many women experience breastfeeding as a process that is learned. Binns and Scott further suggest that women may not stop breastfeeding so quickly if they are aware of potential problems and are given appropriate information and encouragement to be able to handle difficulties when they arise (Binns & Scott, 2002).

Others suggest that a lack of exposure to newborn babies results in unrealistic expectations more generally. Many first-time mothers are unfamiliar with how often a newborn eats, the fussiness so infants exhibit, and the nuances of breastfeeding. When mothers encounter unfamiliar situations, it can lead to questioning and stress related to not knowing if everything is okay. Some mothers then experience a sense of failure and a loss of control. They lose confidence in their abilities and switch to formula in efforts to increase control of the situation (Hoddinott & Phil, 1999).

Women in this study had a variety of expectations related to breastfeeding. Consider the following descriptions from mothers about their expectations and experiences:

I was not prepared for the real thing at all. I had to work hard at the beginning and I thought it would be a breeze. I had no idea there could be so many difficulties with it. (Katie)

It's hard work. It's hard even to get enough food for myself. (Amy)

I expected it to work out perfectly from day one, and it didn't. (Lauren)

It's very demanding. I think you don't realize how much of a 24 hour job it is. (Angela)

I thought it was going to be so second nature. When he's hungry, he'll feed, he'll be done, he'll be happy. I thought I was going to be a lot easier than it is. (Courtney)

Most women found breastfeeding more challenging than they had expected (see Table 5-3). Some did not expect to have any problems with latch, and some were not expecting breastfeeding to be quite so time consuming. Many did not feel prepared for difficulties and were caught off guard when their infants did not follow the textbook examples of how often an infant should eat, when they should sleep, or how often they should have a bowel movement. Several mothers felt that breastfeeding was better than they had expected because they had close friends or relatives who had negative experiences with breastfeeding.

Some mothers in this study worried when they did not immediately feel the blissful mother/infant bond that they were expecting based on some books about breastfeeding. The first few weeks of breastfeeding are often a challenging time in which women's nipples are sore, they are extremely tired, and they are recovering from labor themselves. Emily explains her experience this way: "That first week nearly put me off.

A lot of the books I read said, 'Oh, it's such a bonding moment.' Blah, blah, blah. I was worried I was not quite feeling that." Caitlyn expressed similar sentiments when she said,

It is not, at least for me, this like beautiful bonding experience because it's work, it's exhausting, and it's sore and it's constant and it's not relaxing. I almost feel bad because I don't like to breastfeed. It's like God, you're sucking the life out of me. You don't want to think about it that way, but you think this is a job I need to do, and I need to get through this.

When asked how they would describe the breastfeeding experience, women offered a variety of responses (see Table 5-2). While many women did enjoy breastfeeding, they also nuanced this by voicing how much work they put into breastfeeding. Grace stated, "Sometimes it's a positive bond and sometimes it's a negative frustration. I've come to realize it's more of a decision for his benefit rather than because you're going to be blissful every three hours breastfeeding." While many mothers noted negative aspects of breastfeeding, such as how much work it is, how time-consuming it is, how challenging cluster feeding can be, how challenging sleep deprivation was, and difficulties encountered when infants are distracted, many also noted that breastfeeding was an enjoyable experience. Several mothers explained a sense of accomplishment and wonder at the fact that their infants were gaining weight and thriving when their only nourishment was breast milk. Other mothers noted that being able to calm a fussy baby down was a benefit of breastfeeding. Only one mom noted that there was nothing positive about breastfeeding. Thus, while breastfeeding was described as challenging and hard work, many mothers also enjoyed the experience.

An additional issue related to expectations is that while many mothers seemed to have received the 'breast is best' message and wanted to breastfeed, their goals for

breastfeeding duration did not correspond to current recommendations regarding breastfeeding duration (see Table 5-1). The AAP recommends breastfeeding for at least the first year and encourages women and infants to breastfeed as long as it is a mutually agreed upon situation. In this study, seven mothers stated that their goal duration was less than one year; six stated they only wanted to breastfeed for six months while another stated she wanted to breastfeed for nine months. Eleven mothers wanted to breastfed for a year, one mother wanted to breastfeed for two years, and two others stated they wanted to breastfeed as long as possible. This indicates that while the women in this project were well-educated about the importance of breastfeeding initiation, they either did not know or did not internalize recommendations regarding breastfeeding duration.

It is interesting to note that among the mothers who stated that they wanted to breastfeed for a year, several of them added interesting qualifiers onto their goal. For instance, Samantha said she wanted to breastfeed for a year “if I can” while Sara was adamant that a year was the absolute longest she would breastfeed. For Jasmine and Melanie, a year was the minimum amount of time that they wanted to breastfeed, and Mary expressed her goal duration by saying, “definitely until he’s at least 6 months, but I am sure I can make it until he’s a year old.” Thus, there is a great deal of variety in terms of what women perceive to be the ideal age to stop breastfeeding.

Among these mothers, there was a disconnect between their goals for duration and the actual length of time for which they breastfed. Only eight mothers met their anticipated goal for breastfeeding duration, and the two mothers who stated they wanted to breastfed as long as possible both breastfed for more than a year. Assuming

those two mothers would be satisfied breastfeeding as long as they had, only half of the mothers in this project met their breastfeeding goals.

I expected mothers who had greater goals for duration to breastfeed for longer periods of time. For this group of mothers, no one breastfed much beyond their goal. Only two mothers breastfed past their goal; Angela exceeded her goal by two months and Melanie exceeded her goal by four months. However, Angela's initial goal of six months was under AAP recommendations for breastfeeding duration, and Melanie was clear that her goal of twelve months was a minimum (she wanted to breastfeed for at least twelve months). Additionally, all of those who breastfed for at least a year had wanted to breastfeed for a year. In this sense, there is congruence between breastfeeding for at least a year and having had a goal of breastfeeding for a year. However, there were also those who had wanted to breastfeed for longer and stopped short of their goal. Three mothers who wanted to breastfeed for a year stopped before or at six months, one mother who wanted to breastfeed for a year stopped at eleven months, and one mother who wanted to breastfeed for two years stopped at six months. Among the seven mothers who had goal durations of less than a year, only one of them exceeded her goal. All others stopped before their goals. Thus, it seems as if having a longer goal is related to breastfeeding for a longer period of time.

## **Decision-Making**

### **Conversations**

Another area that has received attention in breastfeeding literature is fathers and their influence on breastfeeding duration. Jordan and Wall state, "Fathers impact duration by serving as key supports or deterrents to breastfeeding by the mother" (1993, p. 31), and others suggest that fathers are "the strongest indicator of whether a woman

will choose to breastfeed and how long she will breastfeed” (Stremler & Lovera, 2004, p. 417). In surveys and interviews with mothers about social support, fathers are often named as significant sources of support. Other studies have indicated that breastfeeding duration is associated with the father’s preferred feeding method (Bar-Yam & Darby, 1997)

Mothers in this study often discussed fathers as important factors in efforts to breastfeed and mentioned a variety of ways in which fathers influenced duration: some requested mothers to breastfeed and encouraged them to keep going, others were important actors in highly emotional decision-making processes, others took more of a back seat to the whole thing, and others requested the mothers stop breastfeeding.

A few mothers described fathers who were not very involved in breastfeeding. Sara was one such mother and she described her husband as largely removed from breastfeeding and decisions related to breastfeeding. When we talked about the decision to breastfeed, she said, “I haven’t talked to him about that. He knows I’m going to. He’s pretty much ok with everything I decide. He doesn’t influence any of my decisions.” While she was breastfeeding, he would help by bringing her pillows and sitting with her, and as they switched to formula, he would help prepare the bottles, feed the baby, and wash the bottles. However, when we discussed the end of breastfeeding and what could have helped her meet her goals, Sara expressed the opinion that it might have helped “if a person would have encouraged me at home.”

While some mothers felt that decisions related to cessation were theirs to make, a few of the mothers told poignant stories of their husband’s involvement in breastfeeding cessation. For instance, Amy was experiencing a very challenging time when her dog

was ill. Amy stated, “If you want to breastfeed and realize you can’t, you feel bad and you do what you can.” Her husband helped her through this time by assuring her that it was okay to give the baby formula and that things were not her fault. Katie’s husband, while he also was also supportive of breastfeeding for health reasons, was ultimately the one who asked her to stop breastfeeding. Katie says, “He saw what I was going through and asked me to stop. I could not have made that decision myself. I would feel guilty.” Kim’s fiancé strongly encouraged her to breastfeed, but when he saw that she was miserable, he said, “I told her it was completely up to her because I don’t want her to be uncomfortable doing it because she was miserable pumping.” These examples illustrate that while fathers can be an important source of support for mothers who are trying to breastfeed, and while they can encourage mothers to continue breastfeeding because of health benefits to their child, often the father’s ultimate allegiance is to the mother.

While less common, several mothers talked about how pediatricians impacted decisions to stop breastfeeding. For instance, while Kim’s pediatrician was supportive of her pumping in order to keep giving breast milk to the baby, Kim spoke candidly of her conversation with her pediatrician about stopping breastfeeding. “She said to me it didn’t really matter whether or not I quit, it was up to me. She kind of encouraged me to quit I think.” Other mothers, however, discussed how their pediatricians encouraged them to keep breastfeeding even though they were having challenges.

Some mothers also talked about discussions with their mothers about stopping breastfeeding. For instance, Mary said that her mother “was proud I made it so long and thought it was an okay time to stop.” When discussing how breastfeeding stopped,

Leah describes talking to others about stopping breastfeeding. She said that she wished that someone had encouraged her to keep going, but instead, everyone said that going for six months had been good. Thus, many women do not make decisions to stop breastfeeding in isolation. For many, decisions to stop are impacted by conversations with the fathers, their pediatricians, and sometimes their mothers and other new moms.

## **Plans**

Breastfeeding cessation happened in a number of ways. Some mothers had a very detailed approach to gradually reducing the number of feedings per day. Many began by eliminating the feedings during the night and then gradually reduced the numbers of feedings during the day. For instance, here is how Grace described a gradual weaning process and cessation:

I started weaning a week or two before his first birthday by slowly introducing cow's milk in a sippy cup at snack time. At the time of his first birthday he was taking one mealtime feeding of cow's milk also. I sequentially dropped mealtime feedings very slowly so that he was still getting his bedtime feeding from me about a month later (because we were going out of town and I worried about putting him to bed somewhere strange at the same time as dropping that feeding). By 13 months (possibly plus a week or so) we stopped altogether. I just kind of did it to my comfort level. If I felt engorged, I'd feed him even if it was supposed to be a cow's milk feeding. At the end I fed once every other day, then once every 2 days....and that was it.

## **Non-Decisions**

For some mothers, stopping breastfeeding was not much of a decision at all and they did not feel in control of the situation. Often, once supplementation begins, it continues or even becomes more prevalent in an infant's diet. Scavenius, van Hulsel, Meijer, Wendte, & Gurgel (2007) describe this as a de-breastfeeding process, in which supplements are given even when a mother wants to breastfeed, thus decreasing the

amount of breast milk produced and creating a need for continued supplementation. Some women I talked with did indeed find themselves in this de-breastfeeding process (mothers who did supplement but did not are discussed in Chapter 5). Many women described the cessation of breastfeeding as just happening, almost as though they had little control over the process and were disappointed when breastfeeding ended earlier than they had wanted.

For Amy and Sara, it seemed like the use of formula just kept building until eventually breastfeeding stopped. For both mothers, formula was given at night, then once during the day, and then gradually more and more until no breast milk was being given to the baby. Both started using formula because they questioned if their milk was providing enough nourishment for the baby. Leah had a similar experience, and she said, “I never really sat down and deliberated about this decisions, it’s just the way things went and I let it go.”

Amanda and Patty are two other mothers who did not discuss cessation in terms of conversations or deliberateness. Amanda began supplementing with formula within the first week after the birth because her milk never came in. She was disappointed that breastfeeding was not going to work, but for her, there was no decision to be made because her milk never came in. Patty also expressed a situation in which breastfeeding simply stopped when she said, “Stopping wasn’t really a decision but just a result of my life at the time. My milk dried up when I continued classes and working.”

For other mothers, cessation depended on the child and the child’s readiness to stop. For instance, Melanie described cessation when she said,

As for breastfeeding, he very suddenly stopped breastfeeding at 16 1/2 months. I’m pregnant (another boy!), and my supply had slowed down a

little bit. He started to not nurse as much, and then right around the middle of 16 months, he suddenly looked at my breast in a really contemplative way, put his mouth on it, immediately pulled off, and said, "Yuck!" After that he would occasionally put his mouth on the nipple, but again immediately pull off and say "Yuck!" For awhile he was obsessed with twiddling my nipples, but he never really tried to nurse. That's about it. I had no plans to wean him. It was all him.

Caitlyn echoed the sentiment of leaving it up to the child when she said, "He went right to bed and never cried or fussed. He was ready to be done." Lauren also spoke about the baby's involvement in cessation. She said, "I haven't stopped breastfeeding yet. I've sort of decided to let her lead the way and she's shown no signs of wanting to quit. She still eats solids all day while I'm at work, but when I'm around she still nurses quite a bit." Melanie, Caitlyn, and Lauren's stories all remind us that infants are also involved in breastfeeding behaviors. The tendency is to focus on the mother, and sometimes the mother's social situation. However, research and programs related to breastfeeding rarely take into account the infant as an active agent.

### **Changes over Time**

While some women felt prepared for the first few weeks and had encountered information about how challenging establishing breastfeeding can be, they found less information available to them about changes over time. Much more information was available to them about challenges in the early weeks of breastfeeding, such as sore nipples, latching, cluster feeding, and adequate supply. As breastfeeding duration increased different concerns and challenges arose.

Overall, most mothers said that breastfeeding became easier with time. Lauren explains it this way: "First, it's like you want it to go right and so you're worried every time it's not going exactly right. Now since every time is pretty much no problem, then I get to enjoy the little things like her playing with my necklace or when she looks up at

me or pats my back.” Angela also expressed the sentiment that breastfeeding got easier with time when she said, “It’s gotten easier for me. The baby and I have learned how to do it well.” However, Katie said “It is not that easy, even after the first weeks. It is too demanding. I am still breastfeeding with no supplements because I know it is better for her health, but for me, it is a sacrifice.” Katie expected things to get better after the first month, but then found herself dealing with different challenges, such as saggy breasts. Time, and changes over time, is not adequately reflected in research about breastfeeding behaviors and goals. While most educational efforts are geared towards pregnant women, relatively little attention has been given to efforts to encourage the continuation of breastfeeding once it had been initiated. The following section explores four major aspects that mothers discussed: returning to work, teething, nursing in public, and sexual relationships with their partners.

### **Returning to Work**

While many mothers did work before the birth of the baby, returning to work and combining breastfeeding was stressful for many women. Some women got caught up in their work and realized hours later that they missed a time to pump, and others had difficulty finding private places to pump. Three of the mothers still breastfeeding at a year returned to work quickly after the birth, and these mothers were adamant about their need to space to pump and worked in positions where frequent pumping was possible. No mother said she quit explicitly because of returning to work, but returning to work required dedication to pumping and often brought challenges.

Angela adeptly describes the level of worry-work that was associated with her return to work. She says, “It’s an adjustment just trying to get everything ready and get there and then try and not worry about him during the day. It [pumping] is hard. I have

to ask all these people in one office to leave so I can use their office to pump. I feel kind of bad but I'm like 'Well, I have to do it.' You know, if I want to keep breastfeeding."

Later in the conversation when we were talking about the hardest part of breastfeeding at the moment, she said,

The whole, getting ready, getting him ready for work, trying to feed him that one last time, trying to time it in the morning, figuring out if I have to feed him at eleven thirty or eleven fifteen. Should I try to feed him again depending on when he wakes up, when to fit in another morning feeding, of just feed at ten thirty and then me not do anything until three when I pump at work. That's what I'm struggling with.

Courtney discusses her return to work and efforts to pump at work, saying, "There's no real privacy for me. The bathroom is right next to my boss's office, like there's actually a door from the bathroom leading to my boss's office, so I don't really feel comfortable taking twenty minutes in there." Later, she added, "I didn't ever really ask or say anything because I didn't want to make a big production of it." In addition to space to pump, time to pump was also problematic for Courtney. She said, "I remember getting carried away doing whatever I was doing and suddenly looking at the clock on my computer and saying, 'Wow. I just missed a feeding by three hours.' I say it out loud, and I'm like, 'How did I miss that time?' But it happened on more than one occasion."

Leah had a similar issue when she returned to work. For her, pumping was "going fine because I have my own office and I can lock myself in and pump whenever I want to, so that's not an issue. But the problem I'm finding is that I'm not very disciplined in doing it." She often only pumped once while at work, and this led her to

panic because I have only gotten just enough, like ten ounces from one pumping, and that's about it for the next whole day, which is not enough. He needs twenty ounces at home...Because of my laziness, or because I forget, or I just get busy, that I have dangerously come close to not having

any milk for him at home. Maybe it hasn't hit me seriously because I keep thinking, 'Oh, I can always use formula if worse comes to worst'.....I really shouldn't be complaining. I'm not on a time schedule for anybody. Really, there's no excuse, but I notice that I'm getting very lazy with it.

## **Teething**

For the most part, women in this project thought teething would be a larger concern than it actually was. When we discussed future concerns or their goals for breastfeeding, it was common for mothers to express worry about teething. Some mothers stated that they might have to rethink their goals for duration if biting became a problem. However, when the time came, most responded either that it was not a problem at all for them or that the baby only bit once or twice. Denise did discuss teething in more detail and said, "Every once in a while, he decides to bite because he thinks it's funny. It's an on and off thing. And I'll put him down, and I'm like crying, 'Oh, that hurts so bad!' and he's there like, 'Ha ha ha.'"

Melanie was another mother who did have significant issues with teething. Here is how she described her experience:

They all came in at once, one right after the other. He started biting. He skinned me. I was in tears. I was really worried I would have to stop because it was so incredibly painful because he would just chomp down. He would use me as a teething ring, and I tried all those things they say to try. But all of the sudden, he just stopped.

Denise and Melanie both experienced teething as a difficult time. They both were brought to tears because of the pain of a teething infant biting their breasts, but yet both kept breastfeeding. In advice literature about breastfeeding, it is relatively common to see advice about how to stop a biting infant. I expected teething to have a larger impact on breastfeeding duration; however, similar to returning to work, no mother stopped breastfeeding because of teething.

## **Nursing in Public**

Some researchers have suggested that a hostile public attitude is a significant part of breastfeeding experiences and that some women use bottles while in public in order to avoid the negativity associated with breastfeeding in public. Scott and Mostyn (2003) discussed how women would time trips out, pump and give bottles of breast milk, or give bottles of formula to avoid breastfeeding in public. Stearns (1999) also explores what she labels a “hostile environment” (321) for breastfeeding in public. She suggests that for breastfeeding women, a major goal is to “avoid exposure and consequent embarrassment” (314) and that breastfeeding in public was challenging because of the potential for exposing nipples, unsolicited comments from others, and because it opens the possibility of unwanted male gazes. She also states that breastfeeding in public is especially problematic when the infant is older. She, too, proposes that women engage in a variety of actions to avoid breastfeeding in public, including breastfeeding in dressing rooms and cars, staying home, and timing trips out.

None of the mothers in the study personally experienced negative interactions while breastfeeding in public (except for in the hospital), but many did consider other people’s reactions when deciding where to feed their babies. Lauren stated, “I don’t want to make other people uncomfortable. That’s the kind of person I am. So I don’t like noticing other people when they are uncomfortable with me. The drink guy isn’t bringing you a drink because he’s freaking out.” Courtney also separated herself while visiting at her in-law’s house. When I asked why she went to a different room, she responded, “I just didn’t want to feel inappropriate.” Others, however, felt quite comfortable breastfeeding in public and did so frequently. Lauren commented, “People just look at me more. They are trying not to look at you but they are looking at you from

the corner of their eye, so it's like I feel like I'm on display, and I go, 'What? She needs to eat to!'"

While some mothers did go to separate places to feed their babies because of the presence of others, for other mothers, the decision to breastfeed apart from others was more out of convenience. Lauren described her decision to go to a separate room to feed by saying, "I thought for one thing there was a lot of activity in the other room, so I thought it'd be easier for her in there. But I thought I could go out there and use a cover but it's more of a hassle." Angela's thoughts about going to a separate room to feed are similar: "I have a gliding rocking chair in there and a place to set my water. Everything is there....I have a nice place to get away." In another conversation with her, she said, "I feel like he [the baby] needs quiet time and just less distractions. Just to have a calm, peaceful environment for him." Courtney also commented that she had to find quiet places because "He doesn't like to breastfeed when it's too noisy or crowded." While many did consider what other people may be thinking, this did not seem to prevent mothers from breastfeeding in public. For many of the mothers in this study, larger concerns were leaking milk, being able to find places to sit, and whether or not the baby would focus on eating.

Concern with nursing in public varied with time. In the beginning, mothers were concerned that they and the baby were both still learning how to breastfeed. The process was already difficult enough that many did not even try to breastfeed in public. I expected breastfeeding older infants in public to be an even larger concern, but this was not this case. Many mothers stated that breastfeeding in public became a non-

issue once the baby could eat some finger foods. Usually, infants could be given finger foods while they were out and about, and breastfeeding would occur at other times.

While mothers in this study did often use their cars to breastfeed or timed trips out, or in other ways avoided breastfeeding in public, their stories did not reflect the overwhelming negative atmosphere Stearns describes. Rather, mothers used their cars because they knew they could find a place to sit and timed trips out in case they became covered in milk in the process of feeding. Mothers in this study did not seem to avoid public breastfeeding because of a hostile environment; rather, the motivating factor was convenience. For this group of women, public attitudes toward breastfeeding had little to nothing to do with breastfeeding duration. Again, this was somewhat of a surprise given the prominence of breastfeeding in public in current research.

### **Sexual Relationships**

As I talked with mothers over time, another concern that came up was sexual relationships with their partners. This is generally not a concern in the early post-partum period as most women either do not want to have sex or they are discouraged from doing so until they are cleared at their six week post-partum visit with their obstetrician. However, a few women commented that they were concerned at later times because they still were not interested in sex or because they were still experiencing vaginal dryness that made sex uncomfortable. One mother commented that she did not know if it was directly related to breastfeeding, but that if it was, “I’m not sure I can do this a year.” When Angela and I were discussing this when the baby was around three months old, she commented, “He’s definitely more interested in doing that than I am. At this point, I think , ‘Well, maybe it will come back.’ I’m not sure how long it will take before I’m really into that again. I think it has to do with hormones and breast

feeding and just being pregnant and everything.” Denise also touched on this subject when she said

I think my husband is probably tired of me breastfeeding. You never feel ownership of your body for so long. I don't know if this is TMI, but I still haven't had a period. I mean, he's nine months old! When you're in a relationship for long, you develop patterns, and one of the things that was nice for him was my breasts. So to not have access to them for so long, I think that can wear on you after awhile. But he is still really, really supportive. He recognizes that it's not all about him, there are bigger things now.

For some women, breastfeeding for extended periods of time could have a negative impact on their relationship with their husbands or partners. Again, no mother in this project stopped breastfeeding explicitly because of an impact on sexual relations with their partners, but this is an issue related to breastfeeding duration that should be explored in more detail.

I expected changes over time, and continually changing challenges, to be more directly connected to cessation. I thought there would be a more dramatic drop in breastfeeding rates as teething, returning to work, and breastfeeding in public became more salient issues. I was not expecting sexual relationships to be a salient issue, but mothers in this project brought up that topic. Perhaps in the wider population these issues are more directly related to cessation, but among this sample, it is clear that breastfeeding is an ongoing process and that different challenges arise as breastfeeding continues.

The mothers who met their breastfeeding goals were more likely to have an attitude that encouraged them to work through difficult times. The mothers who breastfed for longer periods of time had a strong personal resolve to succeed at breastfeeding. Caitlyn phrased it this way: “I'm more confident now because it's not like

I'm going to give up when I've made it through those first three weeks. I don't want to be a quitter." Melanie also expressed this attitude when she said,

'This, too, shall pass' has become my motto. You know when you're in high school and everything seems so horrible? And you get out of high school, and you're like 'Oh.' You know those kids who committed suicide, and you're like, if only they had just held on two more months, they would have been fine. I'm just like, this part sucks. This is not fun. But it will be over and it will get better. And it always does. This totally taught me patience and stick-to-it-iveness.

Other mothers also expressed this desire to succeed at what they had decided to accomplish. They felt as though they could achieve their goals and approached new challenges as bumps in the road that could be overcome. This approach to breastfeeding and to challenges over time should be explored in more detail. However, it should also be noted that many of these women had access to resources to help them overcome those bumps in the road. Whether it was access to the lactation consultant, to reliable information, to high quality pumps and work accommodations, or to supportive family members, many of the women in this project had a number of resources available to them that helped them continue breastfeeding despite ever-changing challenges.

### **Negotiating Cessation**

For some mothers, the end of breastfeeding was a relief of sorts and they felt proud of themselves for breastfeeding for as long as they did. Especially for those who made it to their goals, cessation was a positive experience that was accompanied by a sense of accomplishment and pride. Some mothers look forward to the end of breastfeeding. For example, Grace said, "I look forward to being able to sleep in and not having to be the one waking up." Although they enjoyed aspects of being close to

the baby and the quiet time it offered, many mothers also looked forward to not having to think about breastfeeding.

Mothers who stopped before their goals had a harder time with cessation. Some mothers, such as Kim and Amy, reframed the experience by focusing on how long they did breastfeed for and by focusing on the health of the infant. For example, although Kim had wanted to breastfeed for at least six months, she stopped at three months. Reflecting on her experience, she said, “And then when it actually came around to me doing it and they told me I had inverted nipples and I couldn’t really get him to latch on, I got really frustrated, so I felt like giving up. It’s kind of what I did but I don’t really feel like I quit because I at least pumped for three months.” She continued by saying, “I was really ready for the longest time, but then I was like, “Oh, I’m going to do it one more month because I think one more month will help and I did it for two more. It was pretty miserable, but I knew he was getting good stuff.” Amy also stopped before her goal, but she said, “But it’s okay. Your mom [referring to herself] got bottles and she’s a nice person.” Thus, these two moms offer examples of the agency mothers have in reframing cessation. By focusing on how much effort they put into breastfeeding and on formula as a suitable alternative, they come to accept breastfeeding cessation.

However, others had a harder time negotiating the end of breastfeeding. Katie described the end of breastfeeding as devastating. For her, “the hardest part was knowing that breast milk is the best for our child and having to face that I couldn’t do it anymore.” When discussing cessation, especially if it occurred before their breastfeeding goals, many mothers expressed a lack of control or a disappointment in their bodies. Their stories reflected a sense of powerlessness and an intense amount of

negative emotions. Many seemed to recover quickly by pointing out how happy and healthy the child seemed, but this sense of powerlessness is an important issue.

### **Summary**

The women in this project highlight several important facets of breastfeeding duration. First, babies are active agents in breastfeeding behaviors. Most breastfeeding literature and promotion programs focuses solely on the mothers or might also include other adults such as fathers and grandmothers, but little focus on the infant as an active agent. Second, issues related to de-breastfeeding cycles and women's negotiation of breastfeeding cessation are other important topics of future research.

The mothers who participated in this project offer several insights into meeting goals of breastfeeding duration. First, if women are to be encouraged to meet goals for breastfeeding duration, they must know what those goals are and have realistic expectations about breastfeeding. Second, fathers must be included in intervention and education efforts, as they are a key source of information and advice for mothers. Third, efforts to increase breastfeeding duration need to recognize that challenges with breastfeeding change over time and that just because a mother is doing well at initiation does not mean breastfeeding will continue effortlessly. While mothers in this project did not explicitly stop breastfeeding because of key issues that arise over time, these issues should continue to be explored in research on breastfeeding duration. Perhaps more important than the challenge itself is the mother's approach to the issue and the level of available resources to help her overcome such challenges. Lastly, efforts to help women avoid de-breastfeeding cycles by promoting exclusivity would be another important aspect of programs to encourage meeting Healthy People 2020 goals.

Table 5-1. Participant goals and durations of breastfeeding.

Participant	Goal Duration	Actual Duration	Reason for Cessation
Goal < 12 months			
Amanda	6 months	2 weeks	milk supply
Amy	6 months	3 months	milk supply
Kim	6 months	3 months	did not like pumping
Patty	6 months	4 months	milk supply
Angela	6 months	8 months	
Ashley	6 months	--	
Leah	9 months	6.5 months	milk supply
Goal ≥ 12 months			
Samantha	12 months ("If I can")	3 weeks	milk supply
Katie	12 months	5.5 months	exhaustion
Sara	12 months (max)	6 months	milk supply
Mary	12 months	11 months	milk supply
Claudia	12 months	12 months	
Denise	12 months	12 months*	
Caitlyn	12 months	13 months	
Emily	12 months	13 months	
Grace	12 months	13 months	
Jasmine	12 months (min)	13 months	
Melanie	12 months (min)	16 months	
Courtney	24 months	6 months	milk supply
Lauren	as long as possible	18 months*	
Jackie	as long as possible	18 months*	

\*mother still breastfeeding at time of writing

Table 5-2. Participant descriptions of breastfeeding.

Participant	Descriptions of breastfeeding	Challenges	Rewards
Amanda	disappointing	latching	closeness with baby
Amy	hard work	latching	natural wonder
Angela	job you're doing every day	lack of sleep	feeling close to baby
Ashley	time consuming	reflux, colic	being able to calm baby
Caitlyn	relaxing after time	cluster feeding	makes baby happy
Claudia	awesome	cluster feeding	easier than formula
Courtney	it's not a walk in the park	not knowing amount of milk	health benefits
Denise	a lot of work	frequency, sore nipples	health benefits
Emily	satisfying	pain, spitting up	being able to calm baby
Grace	fulfilling	leaking milk	keeping baby close
Jackie	rewarding	trying to feed distracted baby	bonding
Jasmine	enjoyable	cluster feeding	cuddle time
Katie	not that easy, too demanding	inverted nipples, supply	being able to calm baby
Kim	inconvenient	uncomfortable; pain	it's better than formula
Lauren	like second nature	chapped nipples	weight gain from milk
Leah	it's great, personal time	pumping and work	healthy, bonding
Mary	painful; hard work	milk supply; yeast infection	knowing it's the right choice
Melanie	paradoxical situation	baby freaking out	sense of accomplishment
Patty	personal and very focused	flat nipples; milk drying up	bonding
Samantha	complicated	awkwardness	didn't enjoy anything
Sara	boring, like a monotonous job	not knowing amount of milk	regular bowel movements

Table 5-3. Comparison of expectation and experience.

Participant	Compared to expectation
Amanda	didn't really have expectations
Amy	harder than thought
Angela	harder than thought
Ashley	harder than thought
Caitlyn	did not follow textbook examples
Claudia	not too different, but didn't expect cluster feeding
Courtney	expected it to be a lot easier
Denise	expected it to be difficult, but wasn't sure why
Emily	better than expected
Grace	didn't have any complications
Jackie	thought it would be more intuitive
Jasmine	expected challenges
Katie	thought it would be easier with time
Kim	thought latching would be easier
Lauren	did not expect so many difficulties
Leah	does not always work the way you want
Mary	didn't realize how much of a job it is
Melanie	expected challenges
Patty	more positive and rewarding
Samantha	not prepared for problems
Sara	more time consuming

## CHAPTER 6 CONCLUSION

To conclude, I return to the basic premise of feminist standpoint theory: to make mothers visible and to use women's voices to inform social change. Healthy People 2010 goals include specific desired outcomes in terms of breastfeeding initiation, exclusivity, and duration, and these goals remain in Healthy People 2020. All women in this project wanted to initiate breastfeeding, and my central concern was with women's experiences with breastfeeding and whether or not they met Healthy People 2010 goals. On a national level, rates of breastfeeding exclusivity and duration continue to fall below recommended levels. In proposing and conducting this research, I argued that we need more information about women's experiences with breastfeeding, especially with an awareness that experiences change over time.

### **Women's Experiences**

Chapters 4 and 5 provided analysis of key issues related to breastfeeding exclusivity and duration. While Chapters 4 and 5 detailed women's experiences with Healthy People 2010 goals, three key points warrant further discussion: (1) breastfeeding is challenging, (2) women are socially situated, and (3) breastfeeding is an embodied process.

The women in this study were quite clear that breastfeeding is challenging. It is not always an automatic, blissful bonding moment. Many women did have positive experiences with breastfeeding, but others said that breastfeeding was challenging, harder than they expected, time-consuming, and stressful. Most women described their experiences as a combination of positive and negative aspects. Overall, there is a general reluctance to discuss negative emotions associated with mothering behaviors,

and this is true of breastfeeding behaviors as well. Most materials that promote breastfeeding emphasize breastfeeding as a natural process, as beneficial for both mother and child health, and as a positive bonding experience. Some materials do offer information about difficult times, such as sore and cracked nipples, but very little information exists regarding negative emotions that are experienced during breastfeeding. As these women express, breastfeeding can be positive. However, breastfeeding is not always a positive experience, and more attention should be given to this issue.

Second, women are socially situated. Current public health promotion efforts related to breastfeeding tend to rely on knowledge and choice rhetoric. When asked why they wanted to breastfeed, most mothers responded because it was best for the baby. When I asked why it was best, most offered health reasons but could not give too many specifics. Choice rhetoric has been widely critiqued, but I argue that it is also misleading for well-positioned women who have more options than others. Arguing that breastfeeding is a choice disguises the fact that women are embedded in a variety of social situations, including work, school, family, and public circumstances. While most people assume that breastfeeding is a woman's individual choice, the women in this study explained how their decisions were impacted by their husbands or partners, individual characteristics of their babies, and work circumstances.

Lastly, breastfeeding is an embodied process that unfolds over time. Breastfeeding is not a one-time decision. Current efforts to increase breastfeeding rates tend to focus on spreading information about the health benefits of breastfeeding and encouraging women to make the decision to breastfeed. While this is certainly

important, the women in this project knew of the health benefits and made the decision to breastfeed. However, they seemed less clear about guidelines for breastfeeding exclusivity and duration, and breastfeeding decisions were made continuously, not just before the birth. Mothers had to continually decide what to do in certain situations, such as if the baby seemed fussy immediately after nursing at the breast, and these decisions tended to have long-term consequences for breastfeeding exclusivity and duration.

These ideas that breastfeeding is challenging and socially situated and that breastfeeding decisions occur over time have important implications in terms of social change and program development. The following section explores how the voices of the women in this project can inform breastfeeding support programs.

### **Implications**

Feminist research is often explicitly connected to calls for social action. Reinharz argues that feminism is “change-oriented by definition” and therefore all feminist research has action components (Reinharz, 1992, p. 196). Given the connections between this project and national breastfeeding policy, I find it imperative to offer specific suggestions for breastfeeding support services and as well as to offer a new theoretical approach to breastfeeding.

### **Program Development**

The *Blueprint for Action on Breastfeeding* highlights the multifaceted nature of efforts to increase rates of breastfeeding. The *Blueprint* recommends steps that could be taken in domains of health care systems, workplaces, and families and communities. In the *Blueprint*, it states

Achieving an increase in the proportion of mothers who breastfeed their babies will require the collaboration of Federal agencies, State and local governments, communities, health professional organizations, advocacy groups, multidisciplinary scientists, industry, health insurers, and the American people.

Breastfeeding is certainly a complex issue that can be approached from a variety of levels, and the *Blueprint* is significant in that it recognizes that breastfeeding support needs to come from a variety of areas. Figure 6-1 offers a conceptual model of factors that impacted the breastfeeding behaviors of the mothers in this project. The stories and experiences these mothers shared with me offer important insights into breastfeeding as lived experience and offer suggestions for helping others meet Healthy People 2020 recommendations. While these women did meet some of the Healthy People 2010 recommendations, there is a gap in the rate of exclusivity at six months and the stated goal. While breastfeeding exclusively at six months was the major indicator in which there was a gap in which outcomes were below recommendations, the following suggestions could be relevant for increasing rates of both duration and exclusivity. The following section expands upon the following suggestions:

- Continuing current programs and building new support programs
- Including fathers in educational efforts
- Expanding educational efforts to include exclusivity and duration
- Offering educational materials to OB and pediatrician offices
- Helping mothers understand their rights in the workplace
- Assisting mothers experiencing physical challenges
- Building efforts to help women build trust in their bodies

First, NFRMC offers many breastfeeding support programs, and mothers in this study spoke highly of those programs. Many of the mothers who participated in this project went to the prenatal breastfeeding class and the new mom luncheons and did

utilize the lactation office at NFRMC if they felt they needed to. Many spoke highly of these services and stated that the programs did help with breastfeeding.

While current programs are laudable, they could be expanded in several ways. First, even though they had attended the prenatal breastfeeding education class, many mothers felt unprepared for what breastfeeding was actually like. Many of the mothers commented that breastfeeding was harder than they expected. While many expressed that the breastfeeding class did help them, perhaps it would be useful to incorporate mom-to-mom support before birth from women who have recently breastfed. Perhaps part of the breastfeeding class could be a panel of mothers who recently breastfed who could answer questions and share their stories. This could help about-to-be mothers recognize the diversity in breastfeeding experiences and hear from other mothers about their experiences.

Also, some moms seemed unwilling to reach out and access the services available. For some, perhaps a check-up call in the first few days after the birth could be significant. In current lactation support programs, there is very little follow-up after the birth. While this would be more labor-intensive than other suggestions, following-up with mothers would be an important part of meeting Healthy People 2020 goals because it would offer mothers an important opportunity to voice questions and concerns when they might not otherwise reach out to available services or search for accurate information.

Additionally, the current breastfeeding class focuses almost exclusively on breastfeeding initiation; there are many questions that mothers have that are relevant at later times. Perhaps having a class about breastfeeding when babies are three months

old or mailing out information when babies would be about that age could help. This information could be geared more towards exclusivity and duration recommendations. While this information is certainly available in other places, many mothers commented that there is too much conflicting information about breastfeeding. Having materials come from the lactation office at NFRMC, a source the women trust, might be helpful.

Fathers are important to breastfeeding duration and exclusivity. Many of the mothers who participated in this project did not explicitly engage in discussions with their husbands regarding breastfeeding initiation, but many fathers were more involved in decisions related to duration and exclusivity. Educational efforts more directed towards fathers could be another important part of helping reach Healthy People 2020 goals.

Most women who participated were highly educated and did seek information regarding breastfeeding. Many of these women were highly motivated to breastfeed their infants, but while the 'breast is best' message seemed well-ingrained, the importance of breastfeeding exclusivity and duration did not seem as well-known. To address this, accurate information regarding duration and exclusivity recommendations, and the basis for such recommendations, should be incorporated into educational efforts already in place.

Many women commented that their doctors never said much about breastfeeding. Prenatally, many of their physicians or midwives asked if they were planning to breastfeed, and if they responded affirmatively, that ended the discussion most of the time. I think this is a missed opportunity to talk to women not only about breastfeeding initiation, but also about exclusivity and duration. Post-natally, most women commented

that the pediatricians wanted to know how the baby was fed and focused on weight gain. Few mothers had extended conversations with the pediatricians about breastfeeding. I was not altogether surprised by this, as it was my own experience as well. However, I believe that opening lines of communication with doctors, and increased training for doctors regarding breastfeeding to ensure they have accurate information, is an important component to meeting Healthy People 2020 goals. To address this, perhaps the education office at NFRMC could supply OB and pediatrician offices with pamphlets about breastfeeding initiation, duration, and exclusivity.

What is stunning about this study is that almost half of the mothers used formula within the first week after the birth. Some of this occurred within the hospital, and at least a few times, it occurred without parental permission. Sometimes it occurred upon doctor or nurse recommendations, and sometimes it was parent-initiated. Educational efforts aimed at doctors and nurses might help; efforts that incorporate ways to support breastfeeding through initial challenges, weight loss, and milk supply concerns would be particularly relevant.

Support services also need to target working mothers. The new mom luncheons occurred on weekdays at lunchtime and many moms who returned to work commented that they could not attend the lunches after they returned to working. However, perhaps a larger issue is the over-reliance on pumping as the solution to the mother who is breastfeeding and working. Several mothers commented that they did not have an appropriate place to pump, that they had to ask others to leave their offices in order to pump, or that the room that was established for pumping did not have a lock. Some felt uncomfortable asking for time and space to pump, especially if the boss was a male.

Others said that the nature of the workday simply did not leave time for pumping. These are critical issues that should be addressed, but we should also envision circumstances in which pumping was not the only solution to combining working and breastfeeding. On-site childcare, flexible workdays, and work-from-home options could be alternative models.

Some women do have a physical limitation that interferes with breastfeeding success. Several mothers in this project were hospitalized with health issues of their own, and, although this was not true of any infants in this study, some infants have health concerns that prevent latching at the breast. In terms of social change and support programs, it is important to reach out to these mothers and to support breastfeeding efforts if they desire. Even though the mother may have medical contraindications for a period of time, she could pump milk to maintain her supply until it is safe to offer the breast milk to the infant. Although this would not help with exclusivity, it would help with breastfeeding duration and helping mothers meet their breastfeeding goals. Likewise, the association between emotionally difficult times and milk supply should be further explored. Ensuring that mothers have support to help them do what is best for them in the situation is critical. Here, too, follow-up phone calls might help identify women going through particularly challenging times and would offer an opportunity to remind them of support services available in the community.

One of the things that stood out to me the most was the amount of worry and stress that breastfeeding mothers endured. Some almost constantly questioned the amount or quality of milk their bodies produced. A large amount of supplementation occurred within the first month after birth, which is an incredibly stressful time for any

new mother. Almost all mothers want what is best for their baby, and for some mothers, that means feeding the baby formula when they do not seem to be producing enough milk or when the baby is not latching on to eat. Educational and support programs need to empower women to resist recommendations to supplement early and to trust in their bodies. I try to say this without sounding essentialist or by supporting claims that breastfeeding is a natural and simple process; rather, I am saying that breastfeeding mothers worry about the amount of milk they produce. It would be quite liberating to be able to trust the body to produce the milk it needs to. Distrust of the body's ability to produce enough milk is a key factor in early supplementation and cessation.

As illustrated in the conceptual model in Figure 6-1, issues related to support services, support of close family members, knowledge of current recommendations for breastfeeding exclusivity and duration, supportive nurses and doctors, work circumstances, physical challenges, and trust in bodies are significant in promoting breastfeeding behaviors that meet Healthy People 2010 and 2020 goals. While this section focused on the practical and pragmatic implications of this project, the following section explores the theoretical implication.

### **Theoretical Orientation**

The conceptual model shown in Figure 6-1 is a visual display of factors that influence breastfeeding behaviors. Rather than thinking about successful breastfeeding as needing all of these factors, or about breastfeeding behaviors that do not meet goals as lacking all these factors, I suggest we think about breastfeeding behaviors as an accumulation of dis/advantage.

Theories about breastfeeding are under-developed. Most of the time, it is assumed that knowledge will lead to motivation, which will lead to breastfeeding. The

other aspect of breastfeeding that has been theorized is de-breastfeeding processes, which were discussed previously. This project offers a conceptual model that can add to theoretical developments regarding breastfeeding behaviors.

Thinking about breastfeeding in terms of cumulative advantage could help explain patterns of breastfeeding. For instance, it has been established that those who are wealthier, better educated, and older are more likely to breastfeed for longer periods of time. I suggest that women who are more likely to breastfeed have more available resources. For instance, they have more knowledge about breastfeeding, they have workplace flexibility, and they have supportive doctors and nurses. Conceptually, as women have more supportive resources, they should be more likely to meet breastfeeding goals. Fewer supportive resources would lead to reduced chances of meeting national breastfeeding goals.

An additional aspect of this conceptual model that should be explored is thresholds. Perhaps there is a threshold that impacts breastfeeding behaviors. For example, women might need at least three aspects to act in favor of breastfeeding behaviors to counter other negative aspects. To be more specific, perhaps a belief in body, knowledge, and motivation would counter negative information from doctors or negative work circumstances. Perhaps women who have only one positive resource are outweighed by other negative resources. Women in this study have shown that they can overcome negative circumstances, while others stopped short of their breastfeeding goals. This clearly illustrates that breastfeeding is more than knowledge and choice. The issue of when and what circumstances are overcome needs further

exploration, but I suggest that the issue of thresholds could be significant in explaining why some women stop while others keep breastfeeding.

### **Limitations and Future Research**

The key limitation of the project was the sampling strategy and final sample. Recruitment relied on a convenient sampling. Women who were pregnant with their first child, gave birth at NRFMC, and planned on breastfeeding were eligible to participate. Aside from those criteria, I relied on women to volunteer to participate. Based on the resulting sample and the fact that some mothers ended up as members of the same mother's groups, I suspect that this was a highly selective group of women.

Despite this limitation, the project design of following women over time was quite useful in terms of generating a great deal of data and being able to see how a mother's breastfeeding story unfolded over time. This data makes a strong contribution to breastfeeding research because it focused on longitudinal experiences and on the experiences of those who are most likely to meet breastfeeding goals. Meeting with women for face-to-face conversations was quite useful in developing rapport and generating data, but it was also quite time-intensive and limited the feasible number of participants. Future methods should incorporate various methods in order to achieve wider samples, but the value of hearing women's voices should also be retained.

Future research should focus on other groups of mothers, cumulative dis/advantage, and breastfeeding as process. Related to Healthy People 2020 goals, more research needs to be conducted regarding the rates of breastfeeding initiation, exclusivity, and duration among all mothers. While this study provided important insight into the experiences of a select group of women, their rates of exclusivity and duration most likely do not reflect those of the larger population of breastfeeding women.

Additionally, more thorough analyses should be done that consider the differences between those who utilize services and those who do not. Future research should also consider multiparous women.

This project highlights the elusive nature of a single characteristic that indicates which mothers meet Healthy People 2010 goals and which do not. Not all mothers who met the goals had completely supportive partners, not all stayed home, not all took extended maternity leaves, not all were highly educated, and not all were wealthy. Not all seemed completely comfortable with breastfeeding, breast milk, or talking about their bodies. More research should reflect ideas of cumulative dis/advantage. This is a useful way to approach breastfeeding behaviors in that it moves away from simplistic choice rhetoric and recognizes the social context in which breastfeeding women are embedded.

Lastly, future research should focus on breastfeeding as a process rather than a one-time decision. Mothers were continually challenged by different issues: cluster feeding during growth spurts, returning to work, and teething are only a few issues that mothers in this project spoke about. All mothers were firm in their desire to breastfeed and did not give much thought to breastfeeding initiation. For many, the decision to breastfeed was not really much of a decision at all; more complicated situations were encountered while breastfeeding was progressing. Emphasizing breastfeeding as a process rather than a decision should be a significant aspect of program development aimed at meeting Healthy People 2020 goals.

### **Conclusions and Reflexivity**

Reinharz suggests that in the process of feminist research, there are three key areas in which learning should take place: the person, the problem, and the method. I

have already discussed what I learned with regards to methods in Chapter 3, and Chapters 4 and 5 as well as the beginning of Chapter 6 highlighted what I learned about the problem. I would like to now discuss how I was changed throughout this research process. Talking with these moms and writing this analysis fundamentally challenged me to develop and to be aware of my personal stance on the issue of breastfeeding and breastfeeding promotion.

Writing this conclusion was by far the most difficult for me. I thought the concluding chapter would be the easiest, but I was fundamentally challenged by this project, the voices of the women, and what conclusions I felt comfortable stating. I became acutely aware of “letting the data” speak for itself, but I was fearful of developing a position that could be interpreted as essentialist or maternalistic, but at the same time, I wanted to avoid choice rhetoric. In fact, the project did not really begin with such a strong feminist presence but rather as a more atheoretical needs assessment. However, the more I grappled with it, the more I knew that a feminist approach provided an essential framework for the project.

Part of the challenge for me was my personal experience with meeting Healthy People 2010 goals while not really enjoying the experience. Another level of challenge came when I was confronted with the issue that some scholars question the research that provides the very basis for current breastfeeding recommendations. What is the point of helping mothers breastfeed if some do not like it and the research is shoddy? Is it a lost cause? I was confronted, mid-project, with serious doubts about the significance of the topic, especially given that the goal was not to dispute current recommendations. Why would I be doing a project about trying to better understand

women's experiences with breastfeeding over time, in order to inform support programs, if I did not even believe in the underlying assumptions that breastfeeding is good?

I found solace in the fact that we do have national breastfeeding goals. Regardless of the research upon which such goals are built, I wanted to know about women's experiences while trying to meet these goals. The research purpose was not to contest the policy, but the purpose was to learn about women's experiences trying to meet the goals. A policy built upon scientific research but without basis in lived experiences is going to be extremely challenging to fulfill. I hoped the project would help illuminate the challenges women have with breastfeeding over time in order to inform support programs. If we know what the situational complexity looks like, perhaps policy and support programs can better address current shortcomings.

However, after completing this project, I realized that perhaps the goals should be questioned. As I said before, this was not a goal of this project, but I think it is important to critically analyze why we have proposed the goals we have. I suppose that many would suggest that we want to increase breastfeeding rates so that babies and mothers are healthier. However, as already discussed, this 'fact' is more contested than most suggest. Additionally, perhaps if we considered other aspects of health, such as stress, breastfeeding would not always have a health-protective impact. Some women have a challenging time meeting the goals, in both physical and psychosocial facets, and we do not currently have appropriate social support systems for breastfeeding women. I think we need to build support programs dramatically, rethink the goals and public health initiatives, or perhaps engage in a combination of both. As this research suggests, carrying on as usual will not get us very far.

Where, then, do I personally stand on the issue? I am not suggesting this as the standpoint of the women in the project; rather, I write this in an effort to explain my own position that developed throughout this project. I grappled with my opinion continuously while writing. I do not think that efforts to increase breastfeeding rates are entirely misplaced. While I do not unquestionably accept health science research, and while I did not always enjoy breastfeeding, I think breastfeeding can be an important and positive experience for women and their babies. As many of the women in this project said, breastfeeding can be an enjoyable, satisfying, and rewarding experience. Some mothers feel a sense of pride and empowerment through breastfeeding. Here, then, is my stance based on my reading of the literature, my own experience, and the voices of the women in this project shared with me: We need to be realistic about breastfeeding promotion efforts and helping women meet breastfeeding goals. Educational efforts that involve simple re-iterations of “breast is best,” relentless choice rhetoric, and emphasis on pumping simply will not cut it.

If we want to focus on helping women meet Healthy People 2020 goals, two main things need to happen: women need to be able to enjoy breastfeeding and they need to feel as though such goals are realistic, achievable, and worthwhile. If breastfeeding is not enjoyable, and if new mothers feel as though breastfeeding is something that they must do in order to be good mothers, national goals run the risk of being quite oppressive. Women need to have access to resources in order to make breastfeeding less stressful. Mothers need to have access to reliable materials to increase knowledge about breastfeeding, to support services, to supportive doctors and nurses, to resources that will emphasize a belief in bodies, and to appropriate workplace accommodations.

In addition to access to resources, mothers also need to feel as though the goals are realistic and worthwhile. Especially with regards to breastfeeding exclusivity and duration, more information is needed about the goals and why the goals are what they are. It is problematic if mothers do not know the goals or do not think they are important or achievable, and this would present an immense barrier to meeting national goals. Encouraging breastfeeding can be a positive movement, but women need to support the goals and must have access to appropriate supports.

Returning to the feminist framework of the project, there are three key areas that need to be kept in mind. The first is that breastfeeding inherently relies on the mother. This seems to be a contradiction to emphases on shared housework and efforts to increase men's share of child care. The way around that issue has been to promote pumping, but there are serious concerns related to disembodiment and the long-term impact of pumping on milk supply. Another key concern is the sense of duty that many mothers feel about breastfeeding: it is not really a choice; in order to be considered a 'good' mother, you will do what is best for your baby. While these two concerns pose immense challenges to feminist thought on breastfeeding, I think the larger issue is social conditions surrounding breastfeeding. If we work for appropriate social changes, such as making resources available to all mothers, this will alleviate both the guilt factor and the over-reliance on pumping. Feminists can offer a very important voice to efforts to change social conditions in order to help women who want to breastfeed and to help women enjoy and take ownership of breastfeeding.

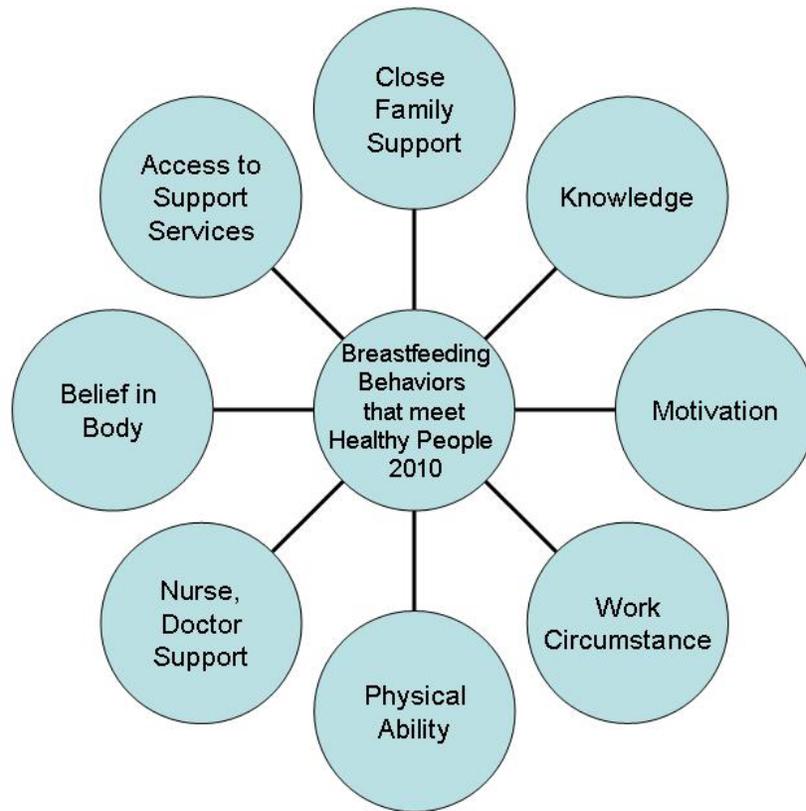


Figure 6-1. Conceptual Model of Influencing Factors

APPENDIX A  
RECRUITMENT FLYER

Are you pregnant with your first child?

Are you giving birth at NFRMC?

Are you planning on breastfeeding?

If you answered **YES**, then you're eligible to participate in a study about women's experiences with breastfeeding.

For more information, contact Jeanne Holcomb at  
holcombja@gmail.com  
352-214-9917

**You can earn up to \$35 in gift cards!**



APPENDIX B  
INFORMED CONSENT FORM

**Protocol Title: Women's Experiences with Breastfeeding:  
Challenges, Support, and Suggestions**

**Please read this consent document carefully before you decide to participate in this study.**

**Purpose of the research study:** The purpose of this study is to explore what women experience as they attempt to breastfeed.

**What you will be asked to do in the study:** You will be asked to discuss your experiences with breastfeeding. Specifically, we would like to know information about challenges you encounter with breastfeeding and support services you use while breastfeeding. You do not have to answer any question you do not wish to. I will be the only researcher present for the interview.

**Time required:** It depends on the interview, but approximately half an hour to 1 hour for each interview. We would like to follow you over time, so at most you would be asked to participate in six interviews during your baby's first year of life. However, the last interview will be whenever you stop breastfeeding. Interviews will take place at a location that is of convenience to you, whether that's your home, my office, or a mutual meeting place.

**Risks and Benefits:** There are no known risks or immediate benefits.

**Compensation:** You will receive \$10 for each completed interview, plus an additional \$10 for continuing with the project until you stop breastfeeding or until your baby is twelve months old, whichever comes first.

**Confidentiality:** Your identity will be kept confidential to the extent provided by law. The interviews will be tape recorded, but those tapes will be accessible only by me and my supervisor. At the end of the project, the tapes will be erased. Additionally, your information will be assigned a code number. The list connecting your name to this number will be kept in a locked file in my faculty supervisor's office. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report.

**Voluntary participation:** Your participation in this study is completely voluntary. There is no penalty for not participating.

**Right to withdraw from the study:** You have the right to withdraw from the study at anytime without consequence.

**Whom to contact if you have questions about the study:**

Jeanne Holcomb, MA, Graduate Student, Department of Sociology , 3219 Turlington Hall, jholcomb@soc.ufl.edu.

Barbara Zsembik, PhD, Department of Sociology

**Whom to contact about your rights as a research participant in the study:**

IRB02 Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone 392-0433.

**Agreement:**

I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.

Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_ Date: \_\_\_\_\_

APPENDIX C  
DEMOGRAPHIC INFORMATION SHEET

Date of Birth \_\_\_\_\_

Baby's Date of Birth \_\_\_\_\_

Race \_\_\_\_\_

Ethnicity \_\_\_\_\_

City of Residence \_\_\_\_\_

Type of community (urban, suburban, rural) \_\_\_\_\_

What is the highest level of school you have completed?

- \_\_\_\_\_ some high school
- \_\_\_\_\_ high school
- \_\_\_\_\_ some college
- \_\_\_\_\_ college
- \_\_\_\_\_ some advanced degree
- \_\_\_\_\_ advanced degree

What is your household annual income?

- \_\_\_\_\_ less than \$25,000
- \_\_\_\_\_ \$25,001 - \$35,000
- \_\_\_\_\_ \$35,001 - \$45,000
- \_\_\_\_\_ \$45,001 - \$55,000
- \_\_\_\_\_ \$55,001 - \$65,000
- \_\_\_\_\_ \$65,001 - \$75,000
- \_\_\_\_\_ \$75,001 - \$85,000
- \_\_\_\_\_ over \$85,000

What is your marital status?

- \_\_\_\_\_ single
- \_\_\_\_\_ partnered
- \_\_\_\_\_ married
- \_\_\_\_\_ separated
- \_\_\_\_\_ divorced
- \_\_\_\_\_ widowed

Do you live with the father of your baby?

- \_\_\_\_\_ No.
- \_\_\_\_\_ Yes.

Does anyone in your household smoke? \_\_\_\_\_

\_\_\_\_\_ No.

\_\_\_\_\_ Yes.

If yes: \_\_\_\_\_ I do.

\_\_\_\_\_ Some one in my house does.

Did you work before your baby was born?

\_\_\_\_\_ No.

\_\_\_\_\_ Yes.

If yes: Did you take any kind of maternity leave?

\_\_\_\_\_ No.

\_\_\_\_\_ Yes.

If yes: What is your planned maternity leave?

Will you work after your baby was born?

\_\_\_\_\_ No.

\_\_\_\_\_ Yes.

If yes, how old will your baby be when you first return to work?

\_\_\_\_\_

If yes, will you return to your previous job?

\_\_\_\_\_ No.

\_\_\_\_\_ Yes.

(what do you (and partner) do?)

Will your baby go to daycare?

\_\_\_\_\_ No.

\_\_\_\_\_ Yes.

Have you made plans for day care?

If yes, how old will your baby be when he or she first enters daycare?

\_\_\_\_\_

APPENDIX D  
INTERVIEW GUIDE

**Early Postpartum (within 2 weeks)**

Why do you want to try to breastfeed your baby?

How long do you want to breastfeed for?

Is your partner supportive of your decision to breastfeed? How so?

Did you seek information about breastfeeding before the birth of the baby?

Where did you go to find information about breastfeeding? (breastfeeding class)  
Did anyone in your family or any close friends have experience with  
breastfeeding? Have you talked with them about breastfeeding?

How was your hospital stay? Were the nurses supportive of breastfeeding? In what  
ways?

How often does your baby nurse?

How is your milk supply?

Are you using any supplements?

How do you feel about breastfeeding?

Do you pump milk for your baby? Why? How often? Where?  
What were some challenges to doing so?

What challenges have you encountered with breastfeeding?  
Who have you talked with about these challenges?  
What other resources have you used? (websites, books)

What resources would be helpful to you at this point?

**6 weeks, 12 weeks, 6 months**

How is breastfeeding going?

How do you feel about breastfeeding now?

Is your partner supportive of breastfeeding? How so?

How often does your baby nurse?

How is your milk supply?

Are you using any supplements? If this began since the last interview, how old was your baby when you began to use supplements? What supplements do you use? How often?

Do you pump milk for your baby? Why? How often? Where?  
What were some challenges to doing so?

What major challenges are you encountering?  
Who have you talked with about these challenges?  
What other resources have you used? (websites, books)

What resources would be helpful to you at this point?

### **9 and 12 months**

How is breastfeeding going?

How do you feel about breastfeeding now?

Is your partner supportive of breastfeeding? How so?

How often does your baby nurse?

How is your milk supply?

Do you pump milk for your baby? Why? How often? Where?  
What were some challenges to doing so?

What major challenges are you encountering?  
Who have you talked with about these challenges?  
What other resources have you used? (websites, books)

What resources would be helpful to you at this point?

### **Cessation**

How old was your baby when you stopped breastfeeding?

What influenced your decision to stop?

Was your partner involved in the decision to stop? How so?

What were some of the major obstacles or challenges you faced while breastfeeding?

Did you want to breastfeed longer than you were able to?

If you had wanted to breastfeed longer, are there things that could have been done to help you do so? What would have been helpful?

How do you feel about not breastfeeding anymore?

How would you describe your experience of breastfeeding?

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