

1-1-2013

What Matters Most? An Examination Of Breastfeeding Support For African American Mothers

Kanika Littleton
Wayne State University,

Follow this and additional works at: http://digitalcommons.wayne.edu/oa_theses

Recommended Citation

Littleton, Kanika, "What Matters Most? An Examination Of Breastfeeding Support For African American Mothers" (2013). *Wayne State University Theses*. Paper 235.

This Open Access Thesis is brought to you for free and open access by DigitalCommons@WayneState. It has been accepted for inclusion in Wayne State University Theses by an authorized administrator of DigitalCommons@WayneState.

**WHAT MATTERS MOST? AN EXAMINATION OF BREASTFEEDING SUPPORT
FOR AFRICAN AMERICAN MOTHERS**

by

KANIKA A. LITTLETON

THESIS

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

MASTER OF ARTS

2013

MAJOR: SOCIOLOGY

Approved By:

Advisor

Date

DEDICATION

This thesis is dedicated to the strong women in my life, who have encouraged me to be the very best woman that I can be. Thank you to my mother who taught me how to stay the course, and to never give up on my dreams. You have always believed that I could accomplish anything, even when I didn't believe in myself. To my mother-in-law, thank you for sharing your wisdom, love of family, and love of God, with me. Finally, thank you to my late grandmother. You were always there for me when I needed you. I was your first and special granddaughter. You never let me forget that. Thank you.

ACKNOWLEDGMENTS

First and foremost I would like to give thanks and acknowledgement to God. Through him all things are possible. I would like to acknowledge my loving husband for all of the support and encouragement that he has given me over the years. We both have experienced this journey together and I'm happy to share this experience with you. I would like to acknowledge Dr. Janet R. Hankin and Dr. Heather E. Dillaway for all of their help with completing this thesis. You both were very patient and understanding as I worked on this project. I would also like to acknowledge Dr. Zachary Brewster for serving on my committee. Finally, I would like to acknowledge all of the women who participated in this study. You allowed me to come into your homes and share in your experiences. Without all of you, this study would not have been possible. Thank you all.

TABLE OF CONTENTS

Dedication.....	ii
Acknowledgements.....	iii
List of Tables.....	v
Chapter 1: Breastfeeding in the United States.....	1
Chapter 2: Literature Review.....	8
Chapter 3: Research Design and Methodology.....	37
Chapter 4: Results.....	46
Chapter 5: Discussion.....	82
Chapter 6: Conclusion.....	93
Appendix A: Breastfeeding Interview Guide.....	98
Appendix B: Breastfeeding Demographic Questionnaire.....	100
Appendix C: Research Information Sheet.....	101
Appendix D: IRB Approval.....	103
References.....	105
Abstract.....	111
Autobiographical Statement.....	113

LIST OF TABLES

Table 1: Descriptive Participant Characteristics.....	39
Table 2: Participant Breastfeeding Information.....	40
Table 3: Summary of Breastfeeding Support by Type of Support.....	77

CHAPTER 1: BREASTFEEDING IN THE UNITED STATES

According to the Centers for Disease Control and Prevention (2012), breastfeeding provides many health related benefits to mothers and infants. Breast milk is easily digested and also strengthens the immune system because it contains maternal antibodies. These antibodies assist in protecting children from a range of illnesses, including asthma, Type 1 and Type 2 diabetes, respiratory and gastrointestinal diseases, and childhood leukemia (USDHHS, 2010). Additionally, breastfeeding is attributed to an overall reduction in infant mortality. Breastfed infants become sick less often than bottle fed infants, and the illnesses they do acquire are generally milder in comparison. Breastfeeding assists with maternal weight loss after pregnancy and helps to shrink the uterus back to its normal size. More importantly, women who breastfeed may have lower rates of premenopausal and ovarian cancer (AAP, 2005). Breastfeeding also offers economic benefits to families and society overall. Breastfeeding is a cost-effective alternative to bottle feeding. In addition, societal benefits include a reduction in healthcare costs, as well as a more productive workforce due to breastfeeding mothers needing less time away from work to care for sick children (AAP, 2005; Witters-Green, 2003).

The U. S. Department of Health and Human Services (2000) states that successful breastfeeding is essential for infants, mothers, and overall public health. The CDC has adopted a new health plan for the United States known as the *Healthy People 2020 Initiative*. Breastfeeding guidelines and goals for initiation, duration, and exclusivity are included in this plan. Breastfeeding refers to any breast milk that is fed to the child, including milk that is expressed from the mother and fed through a bottle. Initiation is defined as the start of breastfeeding for any amount of time. Breastfeeding duration refers to the length of time from initiation until the infant

receives no breast milk (including pumped milk). Exclusivity is defined as the amount of time the child is exclusively breastfed without any other diet supplements, such as solid food or other liquids (Arlotti et al., 1998; CDC, 2012). The CDC would like to see 81.9 % of American mothers initiate breastfeeding, 60.6% breastfeeding at 6 months, and 34.1% of mothers breastfeeding at 12 months postpartum. Additionally, exclusivity goals at 3 and 6 months are 46.2% and 25.5%, respectively (USDHHS, 2012).

Although health organizations continuously advocate breastfeeding, many American women have not met the breastfeeding goals set forth by the CDC. While nearly half of all U.S. states have achieved the previous *Healthy People 2010* objectives for breastfeeding initiation, duration and exclusivity, rates continue to remain lower than the *Healthy People 2020* recommendations. In 2008 breastfeeding initiation rates were approximately 74.6%; however 6 month and 12 month continuation rates were approximately 44.4% and 23.4%, respectively. Exclusivity rates were approximately 34.3% at 3 months and 14.6% at six months. The most current rates for children born in Michigan show that around 65% of infants born in 2006 were ever breastfed, while approximately 32.2% and 16% were still receiving breast milk at 6 and 12 months, respectively. (CDC, National Immunization Survey, 2012). These statistics illustrate a need for better understanding of the persistent barriers that affect breastfeeding rates.

Research shows that African American women have the lowest breastfeeding rates in the United States. The National Immunization Survey conducted by the CDC for children born in 2006, shows some significant differences in breastfeeding rates of African Americans, when compared to other races or ethnicities. Breastfeeding initiation rates for African American infants were approximately 59.7%, compared to 76.6% of Whites, 81.2% of Hispanics and 83.7% of Asians. Breastfeeding rates for 6 and 12 months postpartum were significantly lower than other

groups, as well. At 6 months African Americans had a breastfeeding rate of approximately 30.5% compared to 45.5% for Whites, 47.6% for Hispanics, and 57.2% for Asians. Finally, at 12 months 13.4% of African American infants were breastfed, compared to 23.9% of White infants, 25.6% of Hispanic infants, and 36.1% of Asian infants (USDHHS, 2012). According to the United States Department of Health (2012), African Americans are at higher disadvantage for suffering from many problems, including infant mortality, which is the number of deaths of children under the age of 1 per 1,000 live births. In 2010 the African American infant mortality rate was 11.61, compared to 5.19 for white Americans (Murphy et al., 2012).

Many studies (Hannon et al., 2000; Johnston-Robledo and Fred, 2008; Li et al., 2004; Wallace and Chason, 2007) have uncovered barriers relating to breastfeeding rates for African American women. These studies reflect that African American women have lower intentions to breastfeed because of negative perceptions towards breastfeeding, concerns about others not being able to feed the baby, low levels of confidence with breastfeeding, fear of self-objectification and concerns over employment. In addition, African American women, particularly those with low-income, show higher concern for pain or discomfort, embarrassment, and how other people perceive breastfeeding (Chezem et al., 2004). Research examining breastfeeding barriers for low-income African American women often study rates for women enrolled in programs such as Women, Infants and Children (WIC). In addition to supplemental and nutritional needs, this program for low-income women offers information and support for breastfeeding mothers. WIC serves nearly half of all babies born in the United States. While WIC advocates breastfeeding, women enrolled in WIC do not initiate breastfeeding as often as women who are not enrolled in the program (Chezem et al., 2004). In 2006, 67.1% of women receiving WIC initiated breastfeeding, compared to 74.1% of those eligible but not receiving

WIC, and 82.4% of women ineligible to receive WIC (USDHHS, 2012). Although programs such as WIC offer information to women on the health benefits of breastfeeding, breastfeeding initiation, duration and exclusivity rates are influenced by many factors beyond personal knowledge of these benefits. WIC also offers free infant formula to women, which may influence the infant feeding decisions of women enrolled in the program.

Social relationships have been shown to affect health outcomes in numerous ways. The quantity and quality of these relationships may positively or negatively affect an individual's overall health. Social relationships have been shown to influence health behaviors, mental and physical well-being, as well as mortality risks. In fact, social relationships play a role in health outcomes for individuals across the lifespan, with certain relationships being more influential at specific times throughout life (Umberson & Montez, 2010).

Several studies (Chapman et al., 2004; Ekstrom et al., 2003; Mitra et al., 2004; Wallace and Chason, 2007) have explored a connection between social support and infant feeding decisions. Social support may be provided through various social relationships. Hughes (1984) cites the theoretical definition of social support as containing three aspects, 1) emotional: interactions which convey caring, trust, or love, 2) instrumental: task-oriented behaviors that directly assist the person, 3) informational: knowledge-sharing behaviors. In their guide to breastfeeding for African American women, the United States Department of Human Health and Services (2006) suggests that adequate social support will positively influence breastfeeding rates for African American women. The USDHHS (2006) strongly suggests that breastfeeding support should come from the community networks and interaction with those close to the mother, including: friends, spouses, mothers, grandmothers, or other relatives.

Comprehensive sociological consideration has not been given to which types of social support (emotional, instrumental, and informational) are most significant to the breastfeeding experiences of African American women. Furthermore, not enough attention has been given to the role of male partners, female relatives and friends on infant feeding decisions. There are still questions as to how and why support from these groups may affect breastfeeding initiation, duration and exclusivity. As previously discussed, these people are instrumental in providing an encouraging environment that will lead to breastfeeding success.

Rationale

Social scientists should focus research on specific ways to increase breastfeeding initiation, duration, and exclusivity in the groups with the lowest rates. Increasing breastfeeding rates may have a positive impact on the health of women and children. Improving breastfeeding rates among ethnic minorities, particularly African Americans, may be especially helpful in promoting good health. These groups and their infants are at a particularly high risk for health complications. Women's social networks can be influential in infant feeding decisions. It is imperative to identify how these social networks encourage breastfeeding in women with the lowest rates of initiation, continuation and exclusivity.

As previously stated, rates of breastfeeding vary by ethnicity. Data from the CDC's National Immunization Survey (2012) suggest that African American women are the least likely to breastfeed. Research shows that even after controlling for such variables as education, income, and marital status, African American mothers are 2 ½ times less likely to initiate breastfeeding than White mothers (Forste et al., 2001).

This study sought to uncover support networks that are most important to breastfeeding African American women. This study has policy implications for the development of strategies

that work best for educating members of support networks that can encourage breastfeeding initiation, continuation, and exclusivity among African American women.

Specific Aim

The primary purpose of this study was to examine the breastfeeding experiences of a diverse group of African American women, in order to better understand what social networks encouraged or discouraged breastfeeding initiation, continuation, and exclusivity. Close attention was given to the type of support (informational, emotional, and instrumental) provided by support systems to positively influence breastfeeding in this group of women. The study sought to understand in detail how those closest to the mother encouraged or discouraged breastfeeding. According to the women, the people closest to them were spouses or male partners, female relatives, and friends. Lastly, this study sought to uncover the meaning of adequate breastfeeding support as perceived by the women in the study. During this study the women discussed specific actions that constituted adequate support from the members of their support networks, as well as how these actions shaped their breastfeeding experiences. This thesis concludes with policy recommendations about the possible role of these support networks in breastfeeding education.

Originating Questions

The following questions were developed to guide this study:

- 1) What social networks are most encouraging to breastfeeding initiation, increased duration, and exclusivity for a diverse group of African American mothers?
- 2) How do spouses or male partners encourage or discourage breastfeeding initiation, increased duration, and exclusivity in this group of African American mothers?
- 3) How do female relatives and/or friends encourage or discourage breastfeeding initiation, increased duration, and exclusivity in this group of mothers?
- 4) What types of support (informational, emotional, and instrumental) do these women perceive

as most important for reaching their breastfeeding goals? 5) What is the perceived meaning of adequate breastfeeding support for this group of African American mothers?

CHAPTER 2: LITERATURE REVIEW

Medical sociologists and feminists theorists have examined infant feeding decisions from a historical viewpoint of traditional female knowledge and practices to the medicalization of pregnancy, childbirth and infant care. Medicalization is often attributed to the ideologies of the patriarchal medical institution (Wolf, 2006). Theorists have also examined the economic benefits of breastfeeding for employers, and overall society. Breastfeeding is viewed as a cost effective feeding choice because it is readily available from the mother, leads to less frequent illnesses in the infant, and generally requires less time away from work for employed mothers, due to less time spent caring for sick children.

A great deal of literature has addressed social support in relation to health. Social relationships may have a negative or positive impact on health and health behavior. Breastfeeding is a health behavior that is positively affected by satisfying social relationships. However, rather than examining the role of social relationships, the literature primarily addresses factors that discourage breastfeeding initiation, continuation, and exclusivity. Some of these discouraging factors include a lack of confidence, self-objectification, hospital practices that encourage formula feeding, employment concerns, and overall social environments that hinder breastfeeding success. To a lesser extent, research has examined the role of medicalization on attitudes and policies regarding breastfeeding. This thesis will discuss literature concerning social relationships and general health, social support and breastfeeding, as well as barriers to successful breastfeeding.

Background: Social Relationships and Health Behavior

Social relationships have been extensively studied by social scientists as a factor in health related issues. Umberson and Montez (2010) describe the nature of social relationships in four

distinct categories: social isolation, social integration, quality of relationships, and social networks. According to Umberson and Montez (2010), social isolation is the absence of any social connections, social integration is involvement with informal and formal relationships, quality of relationships includes positive and negative aspects of relationships, and social networks include all social relationships. The authors suggest that all of these relationships affect health in three ways: behavioral, psychosocial, and physiological.

Umberson et al. (2010) suggest that people are affected by social relationships in different ways, depending on the stage of their life. For example, parental relationships are generally the biggest social influence on the health of children, while peer relationships are more influential for adolescents. Marriage and other intimate relationships seem to be the key social connections for adults. Overall, the major way in which social relationships impact health is by influencing health behavior (Umberson et al., 2010). Umberson et al. (2010) state that, “health behavior refers to a range of personal actions that influence health, disability, and mortality” (p. 140). Poor health behaviors contribute to around 40 percent of illnesses, disabilities, and deaths in the United States (McGinnis et al., 2002).

Social relationships may influence behavioral health by establishing social norms and creating symbolic meaning around health behaviors (Durkheim, 1897; Bachman et al. 2002; Williams & Collins, 1995). An example of this may be family eating habits. Additionally, religious connections may be instrumental in encouraging healthy behavior through teachings and messages (Strawbridge et al., 2001). For instance, certain religious groups do not drink or smoke. In addition, religious groups have been associated with positive physical health through the promotion of exercise (Idler & Kasl, 1997). Social relationships may positively affect psychosocial health by reducing stress and enhancing emotional well-being. Physiological health

is also impacted by a reduction in stress, which decreases the risk of certain health problems such as hypertension.

Social Support and Breastfeeding

Umberson and Montez (2010) define social support as “the emotionally sustaining qualities of relationships, or the sense that one is loved, cared for, and listened to” (p. S56). This reflects the emotional type of support described by Hughes (1984). As previously mentioned, there are two other types of social support: informational, such as giving advice, and instrumental, which is task-driven (Hughes, 1984; Umberson & Montez, 2010). Social networks vary greatly and may include family and friends, peer group counselors, religious institutions, and healthcare professionals. As stated, social networks impact health in several ways. Social networks impact preventive health through the influence of health behaviors. For instance, social networks providing informational support may promote breastfeeding initiation by providing knowledge about health benefits for mothers and infants. Additionally, providing emotional support may encourage breastfeeding continuation in spite of any challenges breastfeeding may present. Finally, social relationships providing instrumental support may promote breastfeeding through participation with feeding infants expressed breastmilk.

Breastfeeding may be considered a preventive health measure because it has been associated with the prevention of several health disorders. Breastfeeding success has been linked to a woman’s perceived support during the breastfeeding process. Mitra and colleagues (2004) found that social networks may either encourage or impede breastfeeding. In their study, 694 pregnant women receiving WIC assistance completed a self-administered, closed-ended questionnaire, which collected data on demographics, breastfeeding knowledge, breastfeeding intentions, breastfeeding barriers, and self-efficacy. The women with greater intention to

breastfeed perceived themselves as having a high level of support. On the other hand, lack of social support was a strong predictor of low breastfeeding intentions among the group of low-income women. This study revealed that social support may influence breastfeeding intentions, however, because there was no data collected postpartum, there is no way to conclude if the women with greater intentions, actually initiated breastfeeding, and if so, for how long.

According to the CDC (2009) peer support is invaluable to women's breastfeeding success. Peer counselors generally have prior breastfeeding experience and are typically from the same socioeconomic backgrounds as the women they assist. Peer counselors are specially trained to teach women about breastfeeding, help manage breastfeeding, and assist with any problems that may arise during the process.

Chapman and colleagues (2004) conducted a study of breastfeeding peer support effectiveness on a group of low-income, predominantly Latino women. Participants were recruited from an urban hospital, and randomly assigned to receive either routine breastfeeding education (control group) or routine breastfeeding education and peer counseling (intervention group). The sample included 165 women (90 in interventions group, 75 in control group). The hospital was designated as "Baby-Friendly", which is a classification given to healthcare settings which are part of the Baby-Friendly Hospital Initiative, developed by the World Health Organization (Merewood et al., 2005). In order to be labeled "Baby-Friendly", a hospital or birthing center must implement a plan which consists of 10 steps to encourage breastfeeding. The breastfeeding peer counseling services included a 1 month prenatal home visit, daily perinatal visits, 3 postpartum home visits, and telephone consultations, as needed. The researchers examined breastfeeding rates at birth, 1, 3, and 6 months postpartum. Participants were interviewed monthly until they stopped breastfeeding or for a maximum of 6 months.

Results indicated that the women in the intervention group were more likely to initiate breastfeeding and continue breastfeeding at 1 and 3 months postpartum. The effect of the peer counseling was less apparent at 6 months postpartum. The rate of exclusive breastfeeding was not impacted by peer counseling. Based on their results, the researchers concluded that peer support may be a cost effective approach to promote and support breastfeeding for women of all socioeconomic backgrounds. The results of this study are encouraging; however, using a Baby-Friendly hospital as the source of respondents may limit the generalizability of the results. Research indicates women delivering at Baby-Friendly hospitals generally have higher rates of breastfeeding initiation and continuation, even among low-income women.

Research likewise suggests that family support is influential in breastfeeding decisions. Arora and colleagues (2000) studied factors influencing breastfeeding rates in a group of 123 women recruited from a family medicine practice housed in a community-based hospital. The women completed a 28 question mail-in survey designed to evaluate a range of issues including feeding methods, reasons for breastfeeding or bottle feeding, and sources that would have encouraged bottle feeding mothers to breastfeed.

The researchers found that the most common reasons for bottle feeding were the mother's perception of the father's attitude regarding breastfeeding, uncertainty about their milk supply, and returning to work. These mothers stated that factors that would have encouraged them to breastfeed included gaining more information from prenatal classes, television, books, and magazines, as well as more support from the father and maternal grandmother. The researchers concluded that a supportive family environment may be important to initiating and sustaining breastfeeding.

While this study provided insight into factors that may encourage bottle feeding mothers to breastfeed, the sample in this study was predominantly White and may not reflect the attitudes and behaviors of underrepresented groups. In addition, the women were recruited when their children were between the ages of 6 months and 3 years old. Women with older children may not have accurately recalled their feelings and actions from when their child was first born. Also, their perceptions may have changed over time.

A similar study conducted by Ekstrom and colleagues (2003) found that a close, satisfying relationship with the male partner correlated to longer breastfeeding durations. The study was based on mothers' perceptions of breastfeeding support received from their partners and mothers. The sample included 488 women (194 primipara [first-time mothers], 294 multipara [women with a previous delivery]) recruited from a hospital. The women received and completed questionnaires when their children were 9 to 12 months old. The women were asked to provide information about breastfeeding history, perceived and overall breastfeeding support, and their confidence during the breastfeeding process.

The results indicated that breastfeeding duration for first time mothers was closely related to the amount of time spent with their partners following delivery. In addition, support from the baby's father through active participation in the breastfeeding decision, showing a positive attitude, and possessing knowledge about breastfeeding benefits were all shown to increase breastfeeding initiation and duration. The women who continued to breastfeed at 9 months had a better relationship and were more satisfied with the emotional support received from their husbands, than women with shorter breastfeeding durations. The researchers also found that women with longer durations were happier with their relationships with their own mothers and the emotional support they provided. Based on their results, the researchers suggest healthcare

providers utilize grandmothers and partners in the promotion of breastfeeding. This study suggests that perceived adequacy of support may be instrumental in breastfeeding decisions.

Breastfeeding Barriers

Confidence

Lack of confidence with breastfeeding has been linked to low rates of initiation and early weaning in breastfeeding women. A lack of breastfeeding confidence may result in depression and insufficient milk supply. Some reasons for lack of confidence are pain associated with breastfeeding, insufficient time to breastfeed, and absence of healthcare provider encouragement (Dunn et al., 2006; Schwartz et al., 2002).

In their study of the relationship between vulnerability factors and breastfeeding outcome, Dunn et al. (2006) conducted a secondary analysis of a cross-sectional telephone survey at 6 weeks postpartum for a sample of 526 Canadian women. The data used in this study came from the Family-Centered Maternity Care (FCMC) survey conducted by the Ottawa-Carleton Health Department in 2001. Vulnerability factors included: confidence with breastfeeding, supplementation, post-partum depression, and perceived adequacy of support. A stratified bivariate analysis was used to determine a relationship between each of the four factors and breastfeeding outcomes.

After controlling for age and education, their analysis indicated that postpartum depression and lack of maternal confidence with breastfeeding were related to early weaning (Dunn et al., 2006). In this study, the primary reason for breastfeeding cessation was due to a loss of confidence over the first 6 weeks postpartum. However, the women surveyed were asked to recall their level of confidence about breastfeeding when they were discharged from the hospital. The women may have either overestimated or underestimated their confidence levels at

the time of discharge. Also, the study does not take into account other factors that may have led to a lack of breastfeeding confidence over the six week period. Since the study is based on secondary analysis of existing data, the researchers had no way of inquiring further into the factors that led to the women's lack of confidence, and ultimately breastfeeding discontinuation. Nevertheless, the study is based on a large and fairly diverse sample, which suggests that lack of confidence may have a strong relationship to early breastfeeding termination.

Lack of confidence was also found to be a mitigating factor in early weaning in a study conducted by Schwartz and colleagues (2002). In a prospective cohort study of 946 breastfeeding women in Michigan and Nebraska the researchers examined factors associated with weaning in the first 3 months postpartum. Telephone interviews were completed at 3, 6, 9, and 12 weeks postpartum. The objective of the interviews was to assess the demographic, behavioral, and clinical factors associated with weaning.

Low confidence in breastfeeding technique and performance was associated with the delayed onset of milk production (according to the mothers), as well as the mother's perceived inadequacy in milk supply. The study found that insufficient milk supply was cited as the number one reason for breastfeeding cessation during the first 4 through 6 weeks postpartum.

While this study was based on a large sample of women in two different cities, not all of the women participated in all four of the interviews. Some of the women were only able to be interviewed once. Only 658 of the 946 women in the sample completed all four interviews. The four telephone interviews were fairly short, lasting 20 minutes or less. The women were asked to recall their breastfeeding experiences and health issues over the previous 3 weeks. Women who discontinued breastfeeding were asked to choose from a list of predetermined reasons for discontinuation. This method of gathering information does not allow for the participant to fully

explain their experiences or any factors that caused them to wean their child from breastfeeding. There is no way of determining how and why the mothers associated lack of confidence with insufficient milk supply.

In a smaller study, Wallace and Chason (2007) assessed infant feeding decisions, medicalization and social support. Thirty-one women were recruited from local hospitals prior to the birth of their child. The women completed a quantitative questionnaire discussing numerous topics such as healthcare, social support, and infant feeding plans. Women were then interviewed on three separate occasions during the first twelve months postpartum.

In agreement with Dunn et al. (2006) and Schwartz et al. (2002), lack of confidence in breastfeeding was cited as a main reason for breastfeeding termination. Participants in this study indicated that lack of confidence was primarily the result of problems with techniques, insufficient milk supply, and pain during breastfeeding. The women also noted an incompatibility with social life and work schedules as a reason for discontinuing breastfeeding.

While this study employed a method which allowed for a great deal of information to be collected from the participants, the sample was small and homogenous in race, educational, economic, and marital status. Of the 31 women that participated, 30 were White and one was Hispanic. Most of the women held at least a bachelor's degree, were married, and had household incomes above the national average. The results do not reflect factors that affect early weaning for women belonging to more diverse groups, such as low-income women, unmarried women, or women of color.

Self-Objectification and Embarrassment

The female breast is often perceived as a sexual object, particularly in the male dominated Western society (Wallace and Chason, 2007). Feminist theorists and other social

scientists suggest that women often face conflict between the sexual role of their breast and the nurturing purpose of providing nourishment to a child. A great deal of theoretical research has examined the relationship between the sexual objectification of the breast and the medicalization of infant feeding. This research suggests that the perception of the breast may play a significant part in women's conflicting attitudes about breastfeeding (Stearns, 1999; Schmied and Lupton, 2001). Additionally, women may feel embarrassed by the very act of breastfeeding, whether privately or in public.

These conflicting feelings and subsequent embarrassment have had a negative impact on breastfeeding initiation and continuation rates, as Bramwell (2001) suggested in her theoretical discussion of the negative construction of women's bodily fluids. She suggests that these negative perceptions may undermine women's belief in their ability to feed their infants from their own bodies. Similarly, Bartlett (2002) theorizes that the conflicting perceptions of the breast as a sexual object and the medicalization of the breast as an instrument for infant nourishment, may negatively impact a woman's physical ability to breastfeed. The feelings of anxiety or embarrassment may interfere with a woman's let-down reflex, which is imperative to successful breastfeeding (Bartlett, 2002).

In concurrence with these theorists, Stern (1999) found that sexualization of breasts and embarrassment has a negative effect on women's breastfeeding experiences. In this study, a qualitative analysis using in-depth interviews was used to gain insight on the breastfeeding experiences of 51 women living in California. The interviews lasted an average of 90 minutes and covered a range of topics including the women's perception of the breasts and their breastfeeding experiences. The sample of women was diverse in age and occupation. The age range of the women was 18 to 43. Some of the women held professional positions, such as a

physician or a lawyer, while others did not work and received welfare. Although there was some racial and ethnic diversity in the sample, 82% of the respondents were White, and the sample included no African American women. The findings of this study revealed that many of the women were conflicted with the purpose of the breast. A majority of the women in this study reported feeling uncomfortable with the notion of breastfeeding being perceived as a sexual act, rather than maternal nurturing. Consequently, the women were reluctant to breastfeed in front of men, and had negative perceptions of breastfeeding in public. Many of the women reported receiving negative feedback from family members and friends while breastfeeding in public, however none of the women were sanctioned by strangers. Despite the perception of a hostile environment for public breastfeeding, the women in the study enjoyed the experience, but chose to treat breastfeeding as a private act.

The method utilized in this study allowed for a great deal of information to be gathered from the women. A list of topics was covered during the interviews, however in no particular order. The women were not given predetermined questions, and were allowed to introduce new topics that they wished to discuss. This may have introduced discrepancies in the consistency of data collected and subsequent data analysis, as some of the women may not have fully discussed the same topics. This makes it difficult to extrapolate emerging patterns from the data. In addition, this sample did not include any African American women, and therefore, cannot give any insight into African American women's perception of the breast.

In agreement with Stern (1999), Johnston-Robledo and Fred (2008), found that women concerned with self-objectification, were less likely to breastfeed in public. In their study of low-income women's attitudes about public breastfeeding, the researchers found that women were also very concerned with the impact of breastfeeding on their bodies and sexuality. The

sample included 52 women recruited from a prenatal clinic in northeastern United States. All of the women were enrolled in the WIC program. The age range of the participants was 18 to 30. White women comprised 89% of the sample. Over half of the women were either married or in a committed relationship. In regard to education, 60% had a high school diploma or less, while only 8% reported having a college degree. Close to half of the women were employed at the time of the study. The women participated in 30 minute phone sessions to complete several survey instruments which measured demographics, feeding plans, breastfeeding concerns, breastfeeding attitudes, and self-objectification. The instruments used during the study included the Iowa Infant Feeding Attitudes Scale (IIFAS; De La Mora, Russell, Dungy, Losch, & Dusdieker, 1999) and the Objectified Body Consciousness Scale (OBCS; McKinley & Hyde, 1996).

Overall, the results of the study showed that breastfeeding decisions for most women in the study were not impacted by negative perceptions of their body or sexuality. However, the women who showed weaker intentions to initiate and continue breastfeeding, scored higher on the personal and structural restriction concerns and were less comfortable breastfeeding in public, due to breast shame and embarrassment.

The results of the study were unable to show a strong correlation between self-objectification, embarrassment and early breastfeeding termination. Furthermore, the women were unable to fully explain how self-objectification and embarrassment over public breastfeeding impacted their decisions regarding breastfeeding initiation or duration. Also, the sample was very homogenous in terms of race, educational, economic, and marital status. These findings may not reflect the attitudes of women from different racial, ethnic, educational, or economic backgrounds.

As Johnston-Robledo and Fred (2008) suggest, self-objectification or sexualization of breast may lead to a woman's concern about the physical appearance of her breast. This concern may be shared by the woman's romantic partner, which can create tension and stress on the relationship. As previously discussed, Wallace and Chason (2007) conducted a study of 31 breastfeeding women, assessing breastfeeding experiences and decisions. The results of their study revealed a negative correlation between concern over breast appearance, confidence to breastfeed, and intent to breastfeed. The results of their study also show that concern over breast appearance inhibited breastfeeding and caused marital or relationship stress because partners were unhappy with the appearance of the breasts.

Although these results coincide with the notion that breast appearance is a concern for breastfeeding women, many of the women reported that it was not enough to make them discontinue breastfeeding. Although some of the women in the sample reported a lack of partner support, low relationship satisfaction and a lack of partner happiness with the appearance of their breast, other confounding factors which may have led to negative partner attitudes about breastfeeding were not considered.

Finally, there was a negative correlation between educational level and household income with the negative perception of breast appearance, which suggests the sexualization of breast was impacted by socioeconomic status in this sample. However, the researchers were unable to clearly examine the impact of this on infant-feeding practices.

Medicalization, Hospital Practices, and Health Care Providers

Peter Conrad defined medicalization as, "defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it" (Conrad and Leiter, 2004, p.3). Research on the social influences of infant feeding decisions has examined how the

medicalization of women's reproduction, sexualization of the breast, and increased medical interventions before, during, and after birth have created a medical environment which is unsupportive of breastfeeding (Wallace and Chason, 2007).

Caesarean births, other medical interventions, and medications may interfere with breastfeeding, often due to the delayed time between the birth and the initiation of breastfeeding. In addition, the mother may have physical issues which prevent her from immediately holding the infant (Wallace and Chason, 2007).

Hospital practices may influence infant feeding and success. In 1991 the World Health Organization (WHO), along with the United Nations Children's Fund (UNICEF), launched the global Baby-Friendly Hospital Initiative (BFHI). As previously stated, Baby-Friendly hospitals or birthing centers must implement a plan which consists of 10 steps to encourage breastfeeding. According to the plan, hospitals can assist with successful breastfeeding by implementing a rooming-in policy, not giving breastfed babies formula, as well as ensuring prompt and proper latch-on after the baby is born (Merewood et al., 2005).

Rowe-Murray and colleagues (2002) examined how cesarean deliveries and other medical interventions affect breastfeeding initiation. The research was based on hospital implementation of step 4 of the Baby-Friendly Hospital Initiative, which recommends that breastfeeding is initiated within the first hour after birth. Participants were recruited from four hospitals, one of which was designated as Baby-Friendly. The sample included 163 women who recently delivered full-term babies. The women were interviewed in-person at 2 days postpartum and contacted again at 8 months postpartum, when they completed a mailed questionnaire. The women provided demographic information, details about labor and delivery, first infant-mother contact, and first breastfeed. In addition, the labor and delivery information was compared with

medical records. Women who completed the entire study were older, higher educated, held better occupations, and were more likely to have health insurance, than those who completed only the first part of the study. For analysis, women were grouped by mode of delivery (caesarean, instrument assisted vaginal delivery, and spontaneous vaginal delivery), as well as which hospital they delivered their baby.

Results indicated that skin-to-skin contact immediately after birth was common practice only within the Baby-Friendly hospital, and this was the only hospital in the sample where mothers who delivered by c-section were offered skin-to-skin contact with their babies. Additionally, the women who delivered by caesarean experienced longer periods between birth and the initiation of breastfeeding compared to women who delivered vaginally. Women that received instrumental assistance during vaginal delivery also experienced delays in breastfeeding initiation.

Merewood and colleagues (2005) conducted a study of U.S. breastfeeding rates among Baby-Friendly hospitals. The objective of their research was to determine if breastfeeding rates were different among Baby-Friendly hospitals, when compared to average U.S. hospitals. Moreover, the study examined barriers to implementing the Baby-Friendly Hospital Initiative. Data was collected from the 29 existing U.S. hospitals and birthing centers designated as “Baby-Friendly” in 2003. The sample included a total of 34,365 births. The researchers interviewed the Baby-Friendly coordinator from each hospital, to obtain information on breastfeeding initiation and exclusivity rates, breastfeeding data collection methods, hospital demographics, and barriers to obtaining a Baby-Friendly designation. Demographic information was obtained from medical records, billing data, or annual reports. Simple linear regression was used to evaluate associations between hospital and patient characteristics and the rates of breastfeeding initiation

and exclusivity. Twenty-eight of the hospitals provided initiation rates, either from birth certificates or medical records. Sixteen of the hospitals were able to provide exclusivity rates.

The results of the study show that the breastfeeding initiation rates for the Baby-Friendly hospitals was 83.8% compared to the national rate of 69.5%. The mean exclusivity rate during the hospital stay was 78.4%, compared to the national rate of 46.3%. The researchers found that the breastfeeding initiation rates were positively associated with the state in which the participants resided. Also, freestanding birthing centers had higher initiation rates when compared to community hospitals, academic teaching centers, and the single district and military hospitals. None of the birthing centers had pediatricians or obstetricians on staff. Statistically significant associations were observed in lower breastfeeding rates at the Baby-Friendly hospitals with increased caesareans, and those having pediatricians, obstetricians, or family practitioners on staff. Furthermore, African American patients in all of the hospitals had lower rates of breastfeeding exclusivity during their hospital stay. However, low-income was not associated with lower rates of exclusivity.

This study's findings convey desirable breastfeeding rates among Baby-Friendly hospitals. In addition, among the Baby-Friendly hospitals and birthing centers, low-income women in this study showed higher breastfeeding initiation and exclusivity rates when compared to the national average among women in the hospitals without Baby-Friendly status. Still, African Americans in Baby-Friendly hospitals did not show a significant difference in relation to women giving birth in non-Baby-Friendly institutions. The researchers were unable to obtain information about race or demographics beyond medical records or insurer status. In addition, the methods for collecting breastfeeding data differed among the institutions. Only around half of the institutions provided information on exclusivity. The data collected from the Baby-Friendly

institutions was largely obtained from medical records and the breastfeeding coordinators, while the national data used for comparisons was based on mothers' answers to the Ross Mother's Survey. This survey is a longstanding national survey used to assess breastfeeding rates before the CDC's National Immunization Survey became the main source of breastfeeding trends for the United States.

While the results from this study show that breastfeeding initiation and exclusivity rates were higher among Baby-Friendly hospitals, the study only examines data from the time of the hospital stay. The researchers have no way of knowing whether these breastfeeding trends continued once the mothers and babies were discharged. The results bolster the need for further examination to determine why the disparities in breastfeeding rates still existed among the African American women in the study.

In a similar study conducted by DiGirolamo and colleagues (2008), the Baby-Friendly Hospital Initiative was examined in regard to breastfeeding duration. Specifically, the study assessed the impact of "Baby-Friendly" practices and other maternity care practices on breastfeeding duration. The researchers did an analysis of data from the Infant Feeding Practices Study II, a longitudinal consumer survey conducted by the Food and Drug Administration (FDA). The women in this survey were sent a total of 11 questionnaires (1 prenatal and 10 postnatal) to provide information on infant feeding practices. This study focused on mothers in the survey who initiated breastfeeding and prenatally intended to breastfeed for greater than 2 months. The sample included 1907 women. Analysis was completed on data from the prenatal and 1 month postnatal questionnaires, along with data on actual breastfeeding durations. Six of the ten Baby-Friendly hospital practices were considered as predictor variables, along with other maternity care practices. The main outcome variable was breastfeeding termination before six

weeks postpartum. The study also controlled for a number of demographic, behavioral, and attitudinal variables. Statistical analysis included frequencies, chi-square tests, and logistic regression. The six Baby-Friendly practices included: initiating breastfeeding within one hour of birth, only providing breast milk, rooming in, no pacifiers, breastfeeding on demand, and providing information on breastfeeding support. Results of the study revealed strong associations between experiencing all six of the predictor variables and breastfeeding beyond six weeks. Mothers who experienced none of the predictor variables were 13 times more likely to discontinue breastfeeding early. One-third of these women discontinued breastfeeding before six weeks. The type of delivery, for example caesarean or vaginal was not associated with shorter durations; however receiving pain medication during labor was associated with shorter breastfeeding duration.

The results of this study are consistent with the literature; however, the data analyzed is based on a consumer mail-in survey. The results may not be representative of lower socioeconomic mothers or racial and ethnic minorities. In addition, the associations made between hospital practices and early weaning may have been affected by factors that were not measured in the study. Still, this study makes a strong case for the effectiveness of Baby-Friendly hospital practices increasing breastfeeding duration.

While research indicates that healthcare practices which have adopted the Baby-Friendly Hospital Initiative have had success in improving breastfeeding initiation and durations, many providers still lack the ability to encourage or support breastfeeding. Several studies (Dennis, 1999; Dunn, 2006; Ekstrom, 2003; Tarkka et al., 1998) have noted the impact of healthcare provider (HCP) support on breastfeeding outcomes. These studies suggest that HCP lack knowledge, training, and an overall willingness to support breastfeeding.

Dillaway and Douma (2004) conducted a study on the meaning of breastfeeding support, and how this concept is perceived by breastfeeding women and their healthcare providers. Participants were recruited from 3 primary care offices affiliated with a pediatric practice at a large university based hospital in the Midwest. One of the clinics was located in an urban location and the other two clinics were located in suburban locations. The study involved 394 women who completed questionnaires, 16 women who participated in 3 separate focus groups and 21 healthcare professionals who participated in individual interviews. The questionnaires asked the women to provide information regarding several breastfeeding topics, including initiation, duration, supplementation and weaning, and types of support. Focus group members discussed similar issues, as well as a broader perception of what support means to them. The healthcare providers were asked to provide information about breastfeeding attitudes and support in their clinics. Questionnaire data was analyzed using SPSS, while focus group and interview data were analyzed using qualitative methodology.

Results were reported only for focus group data, as the questionnaire data was part of a larger ongoing study. Results of the study indicated that the healthcare providers generally felt that their clinics and staff were supportive to breastfeeding mothers. On the other hand, the women felt that their healthcare providers could have been more encouraging about breastfeeding. While the majority of the women did not feel that the providers were deliberately discouraging, there was a subtle dissuasion in their demeanor or statements. The women felt that their questions and concerns regarding breastfeeding were not adequately addressed. In addition, some mothers reported receiving inaccurate information from their healthcare providers, which suggest a need for more training. There were clear discrepancies in the perceptions of support between the mothers and the healthcare providers. Although, the focus groups took place in 3

separate clinics serving a diverse population, the participants in the focus groups were not racially diverse. Among the 16 participants, 1 participant was African American and 15 were white. Therefore, the researchers were unable to draw any conclusions regarding racial differences and perceived support. Nevertheless, this study suggest further research on the concept of “support” and how different interpretations may affect the quality of care and guidance that breastfeeding women receive.

Taveras and colleagues (2004) found similar results in their study of healthcare provider opinions regarding breastfeeding duration and exclusivity. This was a prospective-cohort study of mothers and infants and a cross-sectional study of healthcare clinicians at a multidisciplinary provider group in Boston. The mother-infant pairs were linked with their obstetricians and pediatricians through medical records. The sample of 288 women was racially, educationally, and socioeconomically diverse. The majority of women were educated beyond high school, and nearly all of the women lived with the infant’s father.

Telephone interviews were completed by the mothers at 4 and 12 weeks postpartum. The interviews consisted of close-ended questions to discuss infant feeding decisions, problems with feeding, support barriers, and breastfeeding services. Healthcare provider surveys consisted of closed-ended questions, which were mailed. The sample of healthcare providers included 121 (87% White) obstetricians, pediatricians, nurse midwives, and nurse practitioners. Most (76%) of the providers had more than one child and 90% of them indicated that their children had been breastfed. The surveys asked about breastfeeding attitudes, healthcare related supports and barriers to promoting breastfeeding, and management practices. Specifically, the providers were asked to provide their recommendations on exclusive breastfeeding and formula supplementation, as well as, barriers to giving parents advice about infant feeding, and their own

level of confidence in managing breastfeeding concerns. Data analysis included Chi-square test for categorical variables and the Wilcoxon rank-sum test for ordinal and continuous variables used to identify predictors of breastfeeding continuation at 12 weeks postpartum. Logistic regression with generalized estimating equations was used to account for correlated values among the mothers' and providers' responses and to assess the individualized effects of the predictors on exclusive breastfeeding at 12 weeks.

Results showed that of the 288 mothers that were breastfeeding at 4 weeks, 152 were exclusively breastfeeding at 12 weeks, 102 were breastfeeding with supplementation, and 34 has discontinued breastfeeding. The researchers found notable results on the healthcare providers feeling regarding breastfeeding. Although the majority of the providers had indicated that their own children were breastfed, many of them felt that exclusive breastfeeding for 6 months (as recommended by AAP) was unrealistic for their patients. In addition many of them felt that their advice on breastfeeding was unimportant to the patient and there was not enough time during healthcare visits to provide information or offer advice. Many of the physicians, especially the obstetricians and pediatricians, felt less confident about teaching breastfeeding techniques or resolving issues of inadequate milk supply and breast pain. When the two samples were linked, there were strong association between not exclusively breastfeeding at 12 weeks and the healthcare provider recommending formula supplementation because of low weight for the baby or providers feeling that their advice on breastfeeding duration was unimportant to the patient. The results of this study suggest a lack of communication and understanding between healthcare providers and patients, regarding breastfeeding. In addition, healthcare providers may benefit from more training on breastfeeding techniques and resolving problems that may arise.

This study used a number of methods to gather comprehensive data from breastfeeding women and their personal healthcare providers. Overall, the results are encouraging; however many of the women had personal factors which may have bolstered their success in increased breastfeeding durations and exclusivity. A majority of the women were educated and had partner or spousal support. These factors likely increased their ability to sustain exclusive breastfeeding over a longer period of time.

Although many healthcare providers agree with the benefits of breastfeeding, the previous studies suggest the some providers lack the training and confidence necessary to encourage and assist with successful breastfeeding. Haughwout and colleagues (2000) addressed these issues and implemented a study on training medical residents to improve breastfeeding assessment skills. The study consisted of two groups of second and third year family medicine residents who were assigned to either a control group or an intervention group. The sample was comprised of 23 (10-control, 13-intervention) residents recruited from a hospital affiliated with a major Wisconsin university. Both groups completed baseline written examinations and Objective Structured Clinical Examinations (OSCE). The OSCE were completed at the beginning of the study, and again after 60 days. The intervention group also attended a 4 ½ hour workshop. The workshop consisted of didactic presentations, time working with a lactation consultant and standardized patients trained to present hypothetical breastfeeding problems. Data analysis included: *t*-test, two-sample *t*-test, Fischer's exact test, and regression analysis.

There were significant differences between the OSCE scores of the intervention and control groups, after the intervention workshop took place. The intervention group did particularly well in the areas assessing proper latch position and evaluation of sore nipples. There

was also improvement for this group in assessing low milk supply. In addition, the intervention group felt more confident in their ability to solve breastfeeding problems.

This study concurs with other studies which suggest healthcare providers need more training and confidence when caring for breastfeeding patients. While the intervention workshop was successful in increasing knowledge and confidence among the residents, this study should be replicated with a larger sample in order to see if similar results are observed. These types of interventions may be helpful for healthcare providers to improve the quality of care provided to breastfeeding women.

Employment

Employment concerns are a notable barrier to breastfeeding continuation among American women. According to the U.S. Department of Labor (2011), 54.5% of employed women have a child less than 3 years old. In their study examining 20 years of breastfeeding research, Wambach and colleagues (2005) found that employment was one of the most important factors relating to breastfeeding duration. Similarly, Johnston and Esposito (2007) suggest that time required on the job may influence breastfeeding duration. In their examination of twenty large studies on breastfeeding women in the workforce, part-time workers consistently had higher rates and longer breastfeeding duration than those working full time. While research has shown that mothers who work full-time outside of the home have breastfeeding initiation rates similar to stay-at-home mothers, their breastfeeding duration is shorter (Johnston and Esposito, 2007). Ethnicity and socioeconomic status may also impact breastfeeding duration for working women. According to data from the Fragile Families and Child Well-Being Study of 2005, racial and ethnic minorities, along with socioeconomically disadvantaged mothers had 32% higher odds of terminating breastfeeding within the first month of returning to work than a comparative

group of stay-at-home mothers (Kimbrow, 2006). In the previously discussed study by Wallace and Chason (2007), the researchers found that mothers with lower education and income had jobs with less paid maternity leave. The women with lower socioeconomic status also had less accommodations or flexibility at their jobs, which would allow them to stay at home and breastfeed for longer durations.

Many women may perceive difficulty in continuing to breastfeed after returning to work. Witters-Green (2003) conducted an extensive study on employment concerns for breastfeeding mothers. In the study, 4 focus groups with a total of 13 pre-partum and postpartum women in were held in three different counties. All of the women were recruited from WIC. Interviews were also conducted with 14 employers about their policies and attitudes toward breastfeeding. The employers were selected from the type of sites the women in the focus groups reported working, such as grocery stores, dentists' offices, and restaurants. Finally, 423 prenatal WIC clients completed surveys regarding breastfeeding intentions, as well as employment plans after delivery. The women were allowed to write-in questions on the survey, as well.

The researchers found that mothers with more flexible employment were able to breastfeed longer. For example, a self-employed mother was able to feed her baby and pump in private. Another mother was able to feed her child at the daycare facility, on her lunch break. Some of the women in this study reported that a supportive partner, encouraging family members, and friends enabled them to continue breastfeeding during employment. In addition, having friends or family members with prior breastfeeding experience contributed to their success.

The majority of the women who completed surveys intended to discontinue breastfeeding prior to employment, because of the perceived difficulties. The women believed that pumping,

storing and transporting milk may be burdensome. Some also stated that childcare providers may feel uneasy about feeding the baby pumped breast milk. A number of the women also stated that family and friends with negative attitudes toward breastfeeding interfered with breastfeeding continuation once they returned to work. In fact, some family members fed babies formula while the mother was working.

The employers interviewed did not have any policies regarding breastfeeding, however about half knew of an employee that was breastfeeding. Many of the employers were uninformed about the benefits of breastfeeding and did not see a strong need for women to breastfeed as opposed to formula feed their children. Still, all of the employers agreed that they would not have an issue with the women pumping milk or taking time out to breastfeed, as long as their work was completed.

This study provided valuable information about employment concerns for breastfeeding women, as well as employer perspectives. However, the sample of women was overwhelmingly composed of low-income, low-educated, and unmarried women. These women have confounding factors which make breastfeeding continuation difficult, in spite of employment status. Also, the occupations these women are likely to have are often in environments or settings that are not conducive to breastfeeding or pumping milk. These women are not likely to have autonomy at their workplace, which would allow for more flexibility in pumping or feeding. Additionally, while the survey method was useful in gathering information from a fairly large sample, allowing the women to write-in questions may cause inconsistency during data analysis.

Literature suggests that the type of occupation a woman has may impact breastfeeding continuation. Kimbro (2006) conducted a study of breastfeeding initiation and duration for a sample of working, low-income women. Data was extracted from the Fragile Families and Child

Wellbeing Study, a U.S. study which followed a cohort of new, (mostly) unwed parents and their children, for a period of 5 years. The study sample included 4,900 mothers who provided information about breastfeeding. The researcher used logistic regression for the first analysis done on mothers who initiated breastfeeding (n=4,331), and a discrete-time logit model for the second analysis conducted on breastfeeding duration. The second sample included only those mothers that provided information about when they returned to work (n=2,466).

The results of the study indicated that while stay-at-home and working mothers had the same rates of duration, mothers with administrative or manual occupations had 34% and 35% higher odds of terminating breastfeeding, respectively. Mothers with professional and service occupations did not differ from stay-at-home mothers in their rates of breastfeeding continuation. This is likely due to more flexibility in daily schedules for these occupations (Kimbrow, 2006).

While this study yielded interesting results describing the impact of occupation on breastfeeding duration, the sample included a fairly large amount of immigrants, which generally have longer breastfeeding durations than native-born Americans before assimilation (Singh et al., 2007). Immigrant status was not strongly considered during analysis; however, the results for this group may have involved other factors (such as cultural practices) independent of occupation.

Working mothers who wish to continue breastfeeding may face issues with time constraints and the physical demand to maintain an adequate milk supply. For these women, pumping milk may be a viable option. High quality electrical breast pumps produce more milk in a shorter amount of time than nonelectrical pumps. Therefore, pumping is more productive and the women are able to store a greater amount of milk, which can be fed to the child by someone

other than the mother. Nevertheless, quality breast pumps are not always available to certain groups of women.

In their study on breastfeeding duration among working mothers, Ortiz and colleagues (2004) found that pumping milk is a significant way to increase breastfeeding duration after returning to work. The researchers reviewed data on 462 women who were enrolled in an employer-sponsored lactation program. The women were employed by five different corporations. The sample was racially diverse, most of the women worked full-time, and there was nearly an equal amount of salaried and hourly employees. The lactation program included a class on the benefits of breastfeeding, services from a certified lactation consultant, and a private room in the workplace equipped with hospital grade pumps. Data were retrieved from the lactation consultants' charts. Information from the charts was entered into a database for analysis. Several variables were examined, including breastfeeding initiation, expression of milk at work, duration of milk expression at work, part-time employment and full-time employment. Comparison of groups was done using two-tailed *t*-test and ANOVA. Chi-square analysis was also performed.

Women in the study had longer durations (57.8% at 6 months and 18.5% at 1 year) than the average working woman in the U.S. (36.2% at 6 months and 17.2% at 1 year). The mean age of the babies when mothers discontinued pumping was 9.1 months. There was no significant difference in breastfeeding rates among part-time and full-time employees. Also, no significant difference was seen among salaried and hourly employees. In addition, race and ethnicity did not affect pumping duration.

This study occurred over several years and included a fairly large sample, which provided a great deal of information. However, the study lacks a control group and therefore cannot draw

definite conclusions as to the effectiveness of pumping at work and the association with breastfeeding duration. Women who were not enrolled in the employee lactation program should have been included in the study, in order to draw comparisons. Women without such favorable work conditions and support may not have displayed similar success with breastfeeding continuation.

Gaps in Existing Research

The studies reviewed in this thesis address several issues relating to social support and breastfeeding, as well as the common barriers to breastfeeding initiation, sustained duration, and exclusivity. Many of these studies have employed quantitative methodologies to find out what factors influence breastfeeding outcomes. These studies primarily focus on low-income women and generally use convenience samples of women enrolled in the WIC program. Few studies have examined the breastfeeding experiences of educated or middle-income African American women. In addition, these studies often center on factors that lead to low rates of breastfeeding initiation or factors influencing breastfeeding cessation. Many of these studies do not provide great detail on the type of support networks that women perceive to be most important in encouraging breastfeeding. Researchers should evaluate the specific types of support that encourage breastfeeding initiation, increase duration, and increase exclusivity rates. Additionally, previous research on breastfeeding support typically examines only emotional support, not informational or instrumental. These types of support may be equally influential in supporting breastfeeding mothers. Moreover, many studies examine social support as a general aspect of infant feeding decisions. Few of these studies specifically examine the father's role in breastfeeding decisions, nor the role of female relatives and friends.

Using a qualitative methodology of semi-structured interviews, this study sought to understand the breastfeeding experiences of a diverse group of African American women. The women in this study came from diverse educational and occupational backgrounds. Qualitative methodologies are helpful in gathering a great amount of descriptive information concerning particularly hard-to-define concepts. This type of methodology is useful in gaining and understanding of the concept of support and how it specifically relates to breastfeeding decisions. This study sought to gain insight on what type of support (emotional, instrumental, and informational) that their male partners and female relatives or friends gave to encourage breastfeeding initiation, duration, and exclusivity. In addition this method was used to understand what support networks the women perceived as most important to their breastfeeding success, as well as what the women perceived as adequate breastfeeding support.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

Sampling Strategy

This study employed a purposive non-probability sampling method. A total of 15 African American women participated in this study. Of the 15 participants, 10 were currently breastfeeding at the time of participation, while 5 of the women had discontinued breastfeeding within two months of participating in the study. All of the women were recruited in southwest Michigan. Eight of the women were recruited from the Breastfeeding Assistance Program (pseudonym), which is a collaborative partnership between the Michigan Department of Community Health and Michigan State University. This program offers trained breastfeeding peer counselors to WIC eligible women. Seven of the women were recruited from the breastfeeding center located in Greatview Hospital (pseudonym). The women were recruited through the placement of flyers at the two sites, referrals from breastfeeding counselors or lactation consultants, and snow-ball sampling. Five women, who originally agreed to participate in the study, later contacted the investigator to cancel their interviews due to scheduling conflicts. Three of the women who canceled were recruited from the Breastfeeding Assistance Program, while two were recruited from Greatview Hospital.

- Inclusion criterion for this study included:
 - 1) African American women 18-40 years of age
 - 2) Singleton Birth
 - 3) Breastfeeding their child or discontinued breastfeeding within 2 months of study participation.
 - 4) Able to read, speak, and understand English
 - 5) Currently married or in a relationship
- Exclusion criterion for this study included:

- 1) Women with children that have spent time in the NICU
- 2) Women with HIV/AIDS or other communicable diseases
- 3) Women who have given birth to multiples

Women with the above issues were excluded due to great difficulty or inability to breastfeed in these situations. Children who have spent time in the NICU have special challenges with initiating breastfeeding, while women with HIV or other communicable diseases are unable to breastfeed their children, due to the safety risks of the child contracting the infection or illness. Women giving birth to multiple children also face unique challenges with breastfeeding initiation, duration, and exclusivity, which are not shared by women giving birth to singletons.

Sample

The age range of the women in this study was 22 to 32 years. All of the women had at least a high school education, while several held a bachelor's degree or higher. All of the women were either married or living with their male partner. Among the women, five were employed full-time, three were employed part-time, and seven were stay-at-home mothers. Participants held a variety of occupations, such as a pianist, a therapist, two daycare providers, a secretary, a receptionist, and two retail workers. Two of the women were students at the time of the study. The number of children for each woman ranged from one to six. The age range for the breastfed child was 2 weeks to 10 months. Detailed participant characteristics are shown in Table 1. Participants' names are pseudonyms assigned by the investigator in order to preserve confidentiality and anonymity.

Table 1: Descriptive Participant Characteristics (n=15)

Participant	Age	Education Level	Employment Status	Student Status	Relationship Status	Number of children	Delivery Method
Jaime	24	Some College	Stay-at-home	No	Married	1	C-section
Lisa	24	Master's Degree	Part-time	No	Married	2	Vaginal
Tiffany	32	HS/GED	Full-time	No	Engaged	6	Vaginal
Alexis	31	Some College	Full-time	No	Living with partner	3	Vaginal
Stephanie	22	Some College	Stay-at-home	Yes	Living with Partner	1	C-section
Brittany	26	HS/GED	Stay-at-home	No	Married	2	C-section
Jennifer	25	Some College	Part-time	Yes	Living with Partner	1	Vaginal
Alisha	25	Bachelor's Degree	Stay-at-home	No	Married	2	Vaginal
Mary	27	Bachelor's Degree	Stay-at-home	No	Living with Partner	2	Vaginal
Estelle	27	Master's Degree	Full-time	No	Married	1	C-section
Julie	28	Some College	Part-time	No	Married	3	Vaginal
Annette	28	Some College	Full-time	No	Living with Partner	2	C-section
Yvette	28	H S / G E D	Full-time	No	Living with Partner	2	C-section
Courtney	31	Bachelor's Degree	Stay-at-home	No	Married	1	Vaginal
Kate	31	Some College	Stay-at-home	No	Married	3	Vaginal

Table 2 illustrates how participants received breastfeeding information, reasons for breastfeeding, breastfeeding durations, and exclusivity.

Table 2: Participant Breastfeeding Information (n=15)				
Participant	Breastfeeding Knowledge	Reason for Breastfeeding	Breastfeeding Duration	**Breastfed Exclusively
Jaime	Internet, Books, Brochures, WIC	Health, Bonding	9 Months	Yes (4 Months)
Lisa	Internet, Books, Brochures, WIC	Health, Saves Money, HCP & WIC Advice	9 Months	No
Tiffany	HCP, WIC, Family/Friends	Health, Bonding	8 Months*	Yes (3 Months)
Alexis	HCP, Family/Friends	Health, Bonding	1 Month*	No
Stephanie	Internet, Books, Brochures	Health, Saves Money	2 Weeks	Yes (2 Weeks)
Brittany	Internet, Books, Brochures, WIC	Health, Bonding	4 Months	Yes (3 Months)
Jennifer	HCP, Family/Friends	Health, Saves Money	7 Months	No
Alisha	Internet, Books, Brochures	Health, Bonding	9 Months	Yes (4 Months)
Mary	Family/Friends	Health, Family/Friend Advice	4 Months*	Yes (2 Months)
Estelle	HCP, Internet, Books, Brochures	Health, HCP Advice	6 Months*	No
Julie	Internet, Books, Brochures	Health, Bonding	5 months	Yes (3 Months)
Annette	Internet, Books, Brochures, WIC	Health, Saves Money	6 Months	No
Yvette	WIC, Family/Friends	Health, Bonding, Saves Money	10 Months*	No
Courtney	HCP, Family/Friends	Health, Family/Friend Advice	6 Months	No
Kate	Internet, Books, Brochures	Health, Bonding, Saves Money	8 Months	Yes (3 Months)

* These women were not breastfeeding at the time of the study

**Length of time participant breastfed without formula supplementation

. Data Collection

This study was submitted and approved by the Wayne State University Institutional Review Board prior to any data collection. The study was also approved by Greatview Hospital Institutional Review Board prior to participant recruitment from this site. This study employed a qualitative research design using semi-structured in-depth interviewing. According to Esterberg (2002), this type of interview allows participants to express ideas and opinions in their own words. Therefore, the researcher may gain a better understanding of their perspectives. Potential participants completed an initial phone screening in order to determine eligibility for the study. After eligibility was determined, an interview time was scheduled with each participant. Each of the participants met with the investigator one time. The purpose of the interviews was to ascertain the mother's perspectives on breastfeeding experiences and support systems. Some of the topics discussed during the interviews included breastfeeding support networks, daily infant-care, employment, breastfeeding problems, and coping mechanisms. The participants were also asked to discuss future plans involving caring for their child.

All of the interviews took place in the participants' homes. All of the interviews were conducted only with the women; however two of the women's male partners were home during the interviews. The men remained in separate rooms during the interview. Five of the women also had their children at home during the interview. Prior to beginning the interview, participants received a Research Information Sheet which described the study in detail. The information sheet explained that by completing the interview, they were agreeing to participate in the study. All of the women that began the interview completed it. The interviews lasted from 45 minutes to 1 hour and 5 minutes. All interviews were recorded with a digital voice recorder. Participants also filled out a demographic questionnaire after the interview. The questionnaire

consisted of 11 questions and took 5 to 10 minutes to complete. All of the women completed the questionnaires and answered all of the questions. At the conclusion of the interviews, each participant was compensated with a \$25 gift card to a local department store. The women were also provided with a list of referrals for parenting support, breastfeeding support, and domestic violence support. In order to maintain anonymity, all interview materials (audiotape recordings, interview guides/notes, questionnaires) were coded with a number and placed in separate envelopes at the end of each interview. All materials were kept in a locked file cabinet inside the investigator's home.

Data Analysis and Interpretation

Taped interviews were transcribed verbatim. The interviews generated a total of 216 pages of transcripts. Initial procedures of data analysis included memoing and preliminary coding after each interview. Memoing consist of jotting notes that helped to further understand the data as it is collected (Esterberg, 2002). Memos were written documenting the interview itself, including where it took place and any interesting or unusual reactions of the participants. Memos were also written to describe my own thoughts about the data being collected, as well as the participants, and the home environment. Saldana (2009) suggest preliminary coding while collecting data by writing down any preliminary words or phrases that may generate codes during data analysis. This was done during and after the transcription of each interview, after reading through the transcript. The preliminary words and phrases were generated based on the number of times they were mentioned throughout each interview. Words, phrases or ideas that were mentioned numerous times during an interview were recorded as preliminary codes.

Interview data was analyzed using the software program QSR *NVIVO*, which is designed to assist in analysis of qualitative data. This program assists in coding for patterns, themes, and

meanings that will arise in the data. The data was organized categorically and chronologically based on emerging themes. The transcripts were reviewed repeatedly and continually coded using as many categories as possible. Initially thirty categories emerged from the data. Categories were based on commonalities among the interview data and frequency of appearance within the transcripts.

The interview data was coded in four cycles which consisted of different coding methods. The first and second cycles of coding employed attribute, In Vivo, values, and emotions coding. The purpose of these coding methods was to organize the data, describe the contents of the data, and describe participant perspectives. Particularly, attribute coding assisted with data management. In Vivo coding allowed me to become familiar with commonalities in the participants' language by using their exact words during the coding process (Saldana, 2009). Values and emotions coding is used to assist with exploring "aspects", as described by Lofland et.al (2006) as cognitive aspects or meanings and emotional aspects or feelings. This type of coding was particularly useful to analyzing this type of data, specifically because many of the themes that emerged were based in part on the women's emotions or feelings attached to a particular aspect of their experience. For example, the emotional impact of isolation during breastfeeding. Another example of the cognitive aspects included the participants' ideologies about adequate support. Emotional aspects also included parental-role satisfaction, as a majority of the mothers equated breastfeeding with being a "good mother", as they were providing the best nourishment to their child. The third and fourth cycles of coding included pattern, focused, and elaborative coding. The third and fourth cycles of coding assisted in further analysis to generate the final themes, concepts, and meanings. During this process, the original codes were condensed into seventeen themes that were meaningful and consistent among all of the interview

data. These themes led to assertions about this group of breastfeeding mothers. The themes were grouped into five descriptive categories. The demographic data was organized using the software program Statistical Package for the Social Sciences (SPSS). This program assisted with the basic organization of participant demographic data including age, education, marital status, number of children, and breastfeeding durations.

In order to increase internal validity and reliability of the findings, the following strategies were employed: inter-coder agreement, comprehensive data treatment, and peer debriefing. Corbin & Strauss (2008) describe inter-coder agreement as using another analyst to review data and create codes. The other coder used for this purpose was a doctoral candidate from the sociology department at Western Michigan University. The coder reviewed each of the transcripts and generated codes which were then discussed and compared to my own codes. The two sets of codes were then combined to create the seventeen main themes. The themes were grouped into four types of support. The purpose of this process was to evaluate if there was agreement on how the data was being interpreted. According to Corbin and Strauss (2008), comprehensive data treatment involves “giving a more detailed analysis of the data in order to sort ‘fact’ from ‘fiction’” (p.271). The transcripts were repeatedly inspected until generalizations could be applied to all of the data collected. Finally, according to Creswell (2003) peer debriefing is the process of locating a person who will review the study and ask questions so that the conclusions from the data will resonate with people other than the researcher. In this study the peer debriefer was a doctoral student in the department of counseling psychology at Western Michigan University.

Confidentiality

All of the demographic questionnaires and interview protocol sheets were coded with a number before distribution to participants. No identifiers were used on any of the forms. Participants filled out the demographic questionnaires using blue or black ink. The questionnaires and interview notes were placed in an envelope upon completion of the interview. In addition, all taped interview sessions and transcripts were identified by a number corresponding to the code number provided on the demographic questionnaires and interview notes. No names were used on any of the interview materials or to identify any of the recordings. Lastly, the participants were given research information sheets that did not require a signature. The research information sheets provided complete anonymity and confidentiality for the participants. All of the research materials were kept in a locked file cabinet at the investigator's home. Only the investigator had access to the material. The transcripts and final study write-up were provided to the inter-coder and peer-debriefer. However, all documents were examined at the investigator's home and securely locked in the file cabinet upon completion of the reviews. All data were destroyed upon completion of the study.

CHAPTER 4: RESULTS

The main goal of this study was to examine the breastfeeding experiences of a group of African American women, in order to determine what types of support encouraged breastfeeding initiation, continuation, and exclusivity. This study focused on support provided from male partners and female relatives and/or friends of the women. In addition, this study sought to gain insight on which type of support was most influential to breastfeeding success, as well as how the women defined adequate breastfeeding support. All of the women in the study reported receiving some form of what Hughes (1984) describes as “social support”. This support was in the form of emotional, informational, and instrumental support during their experiences with breastfeeding. However, the support was not limited to partner or female relative/friend support. The women also reported receiving support from other sources, such as breastfeeding counselors, lactation consultants, teachers, coworkers, and internet chat groups. Support for these women came from what Umberson and Montez (2010) describe as “the social network”. Their support came from all of their social relationships.

While the main objective of this study was to gain insight on breastfeeding support, all of the women had significant problems during their breastfeeding experiences which hindered their breastfeeding success. Additionally, several of the women reported being discouraged about breastfeeding at some point during their experiences. Discouragement came from partners, family members, friends, and healthcare providers. This discouragement made it difficult for some of the women to continue breastfeeding, and in some cases to breastfeed exclusively. These challenges are discussed in addition to the types of support the women received, as the problems were an integral part of all of the women’s breastfeeding experiences. The findings of this study are organized into five categories including: breastfeeding challenges, emotional support,

informational support, instrumental support, and adequate support. Each support category illustrates how the women were encouraged or discouraged during their breastfeeding experiences. The results are elaborated by excerpts from the women describing their breastfeeding experiences. Pseudonyms are used to maintain anonymity.

Breastfeeding Challenges

This section discusses breastfeeding challenges encountered by the women in this study. Challenges with breastfeeding were an aspect of each woman's experience. Themes reflecting the breastfeeding challenges of these women include:

- *Lack of confidence*: feeling of uncertainty with breastfeeding performance or ability to breastfeed
- *Time constraints*: time conflicts with school, work, and social life
- *Pumping problems*: problems related to the time and technique required to express milk, as well as the amount of milk expressed
- *Lack of healthcare provider encouragement*: issues concerning communication with healthcare providers about breastfeeding
- *General breastfeeding stress*: issues causing stressful breastfeeding experiences

Several of the women also experienced problems with intimacy, which will be discussed in the section on emotional support. The difficulties encountered during breastfeeding made it imperative for the women to receive support from their social networks.

Lack of Confidence

All of the women in this study reported feeling confident about breastfeeding prior to initiation; however, six women described a decrease in confidence after breastfeeding initiation. Reasons cited for lack of confidence included concerns about improper technique, milk

production, and sufficient milk intake for the baby. The following excerpt is an example given by Jaime, a 24 year-old, married, first-time mother. Jaime indicated that she had trouble with getting her baby to latch on properly during the first months of breastfeeding. Jamie revealed that she was worried about her breastfeeding performance, even before initiation, and once she began it was more difficult than she anticipated. She stated that her inability to properly latch-on her son lowered her confidence with breastfeeding:

I didn't know he wasn't latched on properly...So he started losing weight, I had no confidence what-so-ever and every single day and every single time I fed him I was worried...is he getting enough...so like I said, the first few months was very stressful and my confidence was very low in it, but I knew it was best for him so I kept doing it.

Brittany, a 26 year-old, married mother of two children said that she chose to breastfeed her child because of the health benefits and the bonding experience. Brittany did not breastfeed her first child. She stated that she was somewhat confident with breastfeeding before she began. However, it became challenging once she began the process. In the following statement, Brittany described how the frequency of breastfeeding, along with her lack of confidence made it difficult, although she knew it was best for her child:

And, um the frequency of it, um that's pretty much it, but I mean it's like it's very sweet, you know I liked it because I knew, you know that he was getting the best nutrition and it was a bonding between me and him, but also it was just...I don't know...I just felt that it was just hard, it was challenging...and I think it was just my lack of confidence in it that made me not, you know, like it.

These statements suggest that for women who have initiated breastfeeding, the bonding experience between mother and child, along with the health benefits, may overcome a woman's lack of confidence. All six of the women with confidence problems decided to continue breastfeeding because of the health benefits for their child. Still, this issue caused the women to

question their decision to initiate breastfeeding. These women indicated that they needed support in order to bolster their confidence and continue to breastfeed.

Time Constraints

Time constraints of breastfeeding were a major concern for many of the women in this study. Nine of the women in this study cited time constraints as a deterrent for breastfeeding continuation. Among the five women who had terminated breastfeeding at the time of the study, three cited time constraints as a reason for breastfeeding cessation (the other two women cited self-weaning). The women reported that breastfeeding often required a great deal of time, which conflicted with their work and personal schedules. Alexis, a 31 year-old mother of 3 children stated that she did not have the time required to continue breastfeeding her son. Alexis breastfed all 3 of her children, though she revealed that she did not reach her goals with her two youngest children. She was able to breastfeed her first child for 6 months, but only breastfed her daughter for two weeks. Alexis stopped breastfeeding her youngest son after 1 month. Alexis worked full-time at a daycare center. She said that her job did not influence her decision to stop breastfeeding because she was able to keep her baby at work with her. She simply felt that breastfeeding was too inconvenient at this point in her life. In the following statement Alexis described the moment she decided to discontinue breastfeeding her son:

It was just inconvenient. The last straw was, I was at Wal-Mart and he was hungry...like super, super upset, and um...and I had to go into a bathroom stall and breastfeed and it was gross, it was disgusting and I was like I can't do this anymore. It was sad, like my heart was broken; I really wanted to keep breastfeeding but I couldn't do it all the time.

Mary, a 27 year-old mother of two children also felt that breastfeeding was very time-consuming. Mary did not breastfeed her first child. She chose to breastfeed her youngest child because of the health benefits. Mary was a stay-at home mother who graduated with her

bachelor's degree prior to giving birth to her son. Mary indicated that breastfeeding made her feel too confined. She terminated breastfeeding after 4 months. In the following statement she described why she stopped breastfeeding:

It was just a lot of selfish reasons, I didn't want to feel...what's the word...like just being able to go, yeah get up and go. With breastfeeding, you're just a little more confined to one area...unless you pump, and I didn't like pumping, I didn't like that at all.

A majority of the women who were concerned with time constraints were able to continue breastfeeding in spite of the time requirements. Tiffany, a 32 year-old mother of six children described herself as a veteran breastfeeder. She breastfed all of her children for at least 6 months. Tiffany worked full-time at a daycare center and was able to take her baby to work with her. She indicated that pumping was useful when she needed other people to feed her baby. Tiffany was able to breastfeed her youngest son for 8 months. In the following statement she suggests that breastfeeding should be a priority in spite of the time demands:

Um, you have to make it a priority if you want it to keep on going you know...um no matter what else you have to do. Yeah it [breastfeeding] takes up time, but I would suggest pumping a lot so other people can feed the baby when you have something to do... or if you just need a break. I have a lot of other things going on besides breastfeeding or pumping my breast but I did it cause I really wanted to keep on breastfeeding as long as I could.

These women's statements reflect the sentiment that breastfeeding is a time consuming task which requires total commitment. The three women, who stated time constraints as the reason for breastfeeding cessation, described feeling an overall inconvenience with the frequency of feedings and a sense of confinement.

Pumping Issues

Eight of the women pumped milk during their breastfeeding experience. All of the women who pumped milk described having a problem with pumping. The reasons for pumping problems included: improper technique, pumping was too time consuming, pumping did not

produce enough milk, the baby would not take a bottle, and lack of equipment to pump and store milk. Lisa, a 24 year-old married mother breastfed both of her children and was breastfeeding her 9 month old daughter at the time of the study. Lisa had recently completed a master's degree. She was also employed part-time as a pianist and accompanist. Lisa expressed milk in order for her husband and mother-in-law to feed the baby while she was away. She felt that pumping milk was very time consuming. In addition, she stated that her daughter did not like to drink anything out of bottles, including breastmilk. However she indicated that she pumped milk because she wanted to continue exclusively breastfeeding her daughter. In the following statement, Lisa described her concerns with pumping:

I pumped at school sometimes...it was just really, it was really hard during that time, it did become stressful because I was exclusively breastfeeding so...if she were to get fussy...like my husband didn't really know what to do or how to calm her and she especially didn't like bottles even if it was breastmilk in the bottle. She just wanted me to be there. So that was a bit stressful...and I did think quite a few times that it would be so much easier if I just switched over to bottles, but I did it as long as I could and I'm still doing it with her. She gets less now...but little is better than none. It's just hard to find time to pump when you're not at home.

Lisa's statement suggests that the time commitment required to express milk may become stressful for some mothers. In addition, a child's aversion to drinking from a bottle may create difficulty for others to feed the baby. However, Lisa implies that a commitment to continue breastfeeding may overcome these difficulties. Tiffany also felt that time was an issue with pumping milk. She discussed having challenges while pumping at work. Tiffany also felt uncomfortable with pumping because she was unsure of her technique. She had not pumped with her previous children. In the following statement she described her difficulties with pumping:

Well by me working at the daycare...my kids were there...it was gettin' kinda complicated like when people wouldn't show up to work, cause I was told that I would have my fifteens or whatever to either pump milk or feed him, but it was getting kinda frustrating for me as well as the baby because I ended up not having

time to pump enough milk because the manual pump was really slow. So he was missing a feeding and my boobs would get full and I was like I can't do this anymore...pumping with that breast pump was getting too overwhelming cause it wasn't fast enough, but I ended up getting an electric one. I did well with that but I had to get help because I didn't never really have to pump with the other kids. I was a stay-at-home mom off and on, so it was just new to me when I was pumping when I was with my last baby.

The challenges Tiffany faced using a manual breast pump illustrates the importance of women to have electric pumps in order to produce a sufficient amount of milk in less time. The women agreed that being able to pump milk fast enough was an incentive to continue pumping, which allowed the women to provide their children with breastmilk for longer durations. Yvette, a 28 year-old mother of two children breastfed her son for 10 months. Yvette worked full-time at a retail store. She stated that pumping allowed her to continue breastfeeding but she had difficulties with it in the beginning. In the following statement, she described her problem with pumping a sufficient amount of milk:

At first I did have problems with pumping because something about the way that the pump went, to me it just seemed like it wasn't coming out...I wasn't producing enough for the pump. I mean with him, I could see he was full, I could tell he was content...but when I actually seen the ounces coming out...like I'd be pumping for like 25 minutes and here, I only have 3 ounces. It just seemed like it wasn't happening fast enough. I don't know if it was the way that it was latched on to me, or I'm not really sure.

The responses of the women indicate that successful pumping required time and knowledge of proper technique. The women were able to receive help from various sources in order to address their challenges with pumping. None of the women cited pumping problems as a reason for breastfeeding cessation.

Healthcare Providers

Eight of the women in the study felt that their babies' healthcare providers did not actively encourage breastfeeding continuation or exclusivity. Julie, a 28 year-old married mother

of three, stated that her baby's pediatrician did not encourage breastfeeding during visits. Julie had not breastfed her first two children. She decided to breastfeed her youngest son because of the health benefits. Julie exclusively breastfed her son for 3 months, and then began supplementing with formula. In the following statement, she indicates that her son's pediatrician did not encourage her to continue breastfeeding:

When I go to his pediatrician he just ask me "Do you breastfeed or formula feed?, Oh how much does he take?, How long does he nurse off each side?, okay"...just the technical stuff, nothing to keep encouraging me to breastfeed him, not like "oh you're doing so good"...like his pediatrician office, they don't care if he gets formula or not...like last time I told them he's on formula, too... "Okay, well how much does he take?"...and that's it, they just want to know how much he's getting. So, but no...he isn't really supportive.

Brittany shared a similar account, stating that her baby's doctor caused her to lose confidence with breastfeeding her child because of his discouraging attitude:

Yeah, because it's like the doctor is the biggest problem because it's like I'm only getting negative feedback... "oh he's losing a little weight, you might need to go get yourself checked to make sure you're producing enough milk for him on each side"...and every time I am, it's just what he's taking. They always make me feel like, you know...that everything has to be so by-the-book, like the problem is my problem...but it isn't a problem, it's just what he eats and what he wants to do. So they really lowered my confidence in breastfeeding him.

Stephanie, a 22 year-old first-time mother, felt that both her healthcare provider and her baby's pediatrician approved of her breastfeeding, however they offered no encouragement. Stephanie had been breastfeeding for only 2 weeks at the time of the study. In the following statement she indicated that she did not discuss breastfeeding in detail with her healthcare providers:

So neither one of them talk to me about it, I mean they asked, "Are you breastfeeding?" and I said "yeah" and that was pretty much it, and they said, "good job" and that was it. They don't really say why I should keep doing it.

These statements reflect the sentiment that their babies' healthcare providers were often more concerned with certain aspects of the babies' health, such as weight gain and growth, rather than how the babies were being fed. The women felt that their breastfeeding efforts were largely ignored. The mothers often referred to the healthcare providers as "technical" or "by-the-book". These terms suggest a lack of personal connection between the mothers and the healthcare providers.

Breastfeeding Stress

Stress with breastfeeding was often addressed by the women in this study. Eight women reported that breastfeeding was a stressful task. Causes of stress included: depression, pain, and feelings of uncertainty in being able to provide an adequate milk supply. Jaime described feeling depressed every time she had to breastfeed her son:

Um, knowing that I had to breastfeed him again, it was just...I didn't always look forward to it. Yeah. That was the biggest stress, so I really dreaded breastfeeding at first, you know after I had started and I was really depressed over it. That lasted for a couple of months.

Similarly, Julie felt depressed but decided to continue breastfeeding because of the health benefits:

Even though I was stressed and depressed ...like even, even at every breastfeeding that I did you know, even though I didn't want...wasn't looking forward to it, when I did it, I'm like you know well this is why I'm doing it...I'm doing it for his health, and that's another thing that you know, kept me going.

Alisha, a 25 year-old married mother of two children also described feeling stress during her experience with breastfeeding. Alisha had to have a medical procedure and was unable to breastfeed for three days. She began to feel stress over her ability to maintain her milk supply during the interruption in breastfeeding. The hospital where her procedure was done was able to

provide her with donated breastmilk until she could nurse again. In the following statement Alisha described her ordeal:

They had to do a CT scan and they told me I couldn't breastfeed for three days... I was balling my eyes out because I'm like he needs milk to breastfeed...and um they gave me some donated milk and I was fine with it. I was fine with it just because that's what I had to do, but I was really upset. I didn't want my milk to start drying up.

Her statement addressed an important way that healthcare providers can promote and encourage breastfeeding. The availability of donated breastmilk may allow women that are unable to breastfeed, the opportunity to provide breastmilk to their babies. This practice is used in some healthcare settings to accommodate women with certain illnesses, as well as mothers having medical procedures that would temporarily interrupt breastfeeding.

Three of the women in the study stated that they experienced pain during breastfeeding. Estelle, a 27 year-old married mother of one child, discussed having pain the first few weeks of breastfeeding her son. In the following statement, she described wanting to stop breastfeeding because of the pain:

My nipples...oh my god, they cracked, they bled, it was just too painful, every time he latched on, I would just cringe. It was really stressful... at first the pain was too much cause I didn't know what I was doing. I just wanted to give up and be done with it [breastfeeding].

Estelle later discovered that she was experiencing pain because her son was not properly latched-on to her breasts. She received assistance with proper breastfeeding technique and was able to continue breastfeeding for 6 months. In a similar account, Yvette described experiencing pain during breastfeeding. Yvette also felt that her son was not properly latched-on to her breasts. In the following statement she described experiencing breast engorgement (breasts become hard, swollen, and painful):

I don't think he was latched-on good, and my breast kept getting full and hard. That made it even harder for him to latch on! It was so painful at times I couldn't stand it. I had to get help to latch him on good.

Breastfeeding seemed to stimulate stress for several mothers in this study. Five women revealed feeling depressed at some point during breastfeeding, although none of the women were able to elaborate on why they felt depressed. It was uncertain if the depression was caused by breastfeeding or other factors such as some form of postpartum psychological distress. Other women felt that pain or perceived inadequacy of milk production was the source of their stressful breastfeeding experiences.

Each of the mothers indicated that they experienced one or more of the previously described breastfeeding challenges. However, some problems were more common for certain women. For instance, while the group of mothers that reported experiencing issues with time constraints included employed and unemployed women, all of the women had more than one child to care for. In addition, women using manual pumps had more problems with expressing breastmilk. Finally, depression and pain associated with breastfeeding was more common among first-time breastfeeding women.

Breastfeeding Support

The following section discusses breastfeeding support received by the women in this study. This section is divided into four categories including: emotional support, informational support, instrumental support, and adequate support. Each type of support is described in terms of the major themes that emerged during discussions with the mothers, what support groups provided each type of support, and the mothers' perceptions of how this support affected their breastfeeding experiences. Each category also includes any way in which the women felt unsupported by members of their social network.

Emotional Support

As previously stated, Hughes (1984) described emotional support as interactions that convey caring, trust, and love. All of the women in this study reported receiving emotional breastfeeding support. The following themes emerged reflecting emotional support:

- *Encouragement*: encouraging the mothers to initiate and continue breastfeeding
- *Comfort*: providing care and love as the women encountered difficulties with breastfeeding

The women perceived breastfeeding initiation and duration to be impacted most by emotional support. The women did not perceive emotional support to have a significant affect on exclusivity. The emotional support the women received is categorized below by the source of support.

Spouse/Partner Support

Ten women reported receiving emotional support from their spouse or partner during their breastfeeding experiences. Jaime stated that her husband attended a breastfeeding class with her in order to learn about the benefits of breastfeeding. She said that once he knew more about breastfeeding, he felt that it was the best feeding choice for their son. Jaime indicated that her husband was influential in her decision to breastfeed. In the following statement she described how her husband encouraged her decision:

He appreciated that I made the decision to breastfeed because I talked to him about it...talked to him about the health benefits, plus we had took a course before we had him so he knew all the benefits of breastfeeding. He was happy to participate in it and learn more, he was all for it. So, we talked about it and both decided that it was best for the baby.

She suggested that her husband's knowledge of the benefits of breastfeeding enabled him to be a part of the decision-making process and encourage breastfeeding initiation. Alexis also stated

that her partner encouraged her decision to breastfeed their son. Alexis said that her partner insisted that she breastfeed, even though he wasn't fully aware of the benefits. In the following statement she described discussing breastfeeding with her partner:

We had discussions about the whole breastfeeding thing in the beginning, and I knew that I wanted to breastfeed and he was totally against me bottle feeding, even though he really didn't know about the benefits of breastfeeding. He just heard that it was best. So...I mean he did have an influence in some way.

Julie expressed that her husband encouraged her to continue breastfeeding when it became stressful for her. She felt that he was able to provide comfort and encouragement without pressuring her to continue breastfeeding. In the following statement, she illustrates how he was able to comfort her:

Breastfeeding started off to be very, very depressing and stressing for me, but he was always there to comfort me and to stick to...well to keep me going... he would say if it's so stressful for you I wouldn't mind if you did switch him to formula...so he was supportive of whatever decision I was to make, but encouraged me to keep going, and I did.

Kate, a 31 year-old married mother of three children, revealed that she often felt overwhelmed with breastfeeding and thought about quitting several times. She felt that her husband encouraged her to continue breastfeeding. In the following statement, Kate argued that married women likely breastfeed longer than single women because they usually have more support:

I guarantee you a single woman versus a married woman, the married woman would probably breastfeed longer, you know what I mean. They have more support. I've seen single women try to get through it and it's harder for them because they don't have that emotional support. When it gets hard, you need someone telling you that you can do it. It's about a mindframe. Breastfeeding takes a lot of dedication...you have to really, really want it to work, for it to work...and if you don't want it to work...it's just not gonna. My husband really did help me. He kept telling me not to give up. When he saw that I was frustrated, he was there to make me feel better.

The women's statements reflect their need for partnership during the breastfeeding process. These women felt that their partners were influential on their breastfeeding decisions

and positively affected their breastfeeding experiences. Specifically, spouses and partners were supportive by engaging in communication about breastfeeding initiation and by offering encouragement and comfort when breastfeeding became challenging.

Some of the women in the study felt that spouses or partners were unsupportive in various ways. Five women reported that their spouses or partners showed a lack of emotional support. The following themes emerged:

- *Discouragement*: discouraging the mother from breastfeeding, encouraging the mother to formula-feed
- *Intimacy problems*: frustrations with lack of intimacy, feeling uncomfortable during intimate situations

Lisa explained how her husband's discouraging comments affected her breastfeeding experience:

It was discouraging um.....I don't really feel that he was trying to be outright discouraging about the breastfeeding, but it was discouraging none-the-less...like I said that it did seem to get a little bit burdensome with my schedule and knowing that I was trying to be in all kinds of places at once...and so sometimes my husband was like, "you gotta do something else, you gotta pump more or you gotta choose for her to have formula" because he just didn't really know other ways to calm her besides feeding her, basically. So, it was just pressure to make sure I had enough milk pumped up or I would have to stop.

Courtney, a 31 year-old first-time mother also felt that her husband was discouraging. Courtney experienced pain during the first couple of weeks of breastfeeding. In the following statement, she explains how her husband attempted to encourage her to formula feed:

He would just say things like, "You know you can use formula, if it's bothering you that much, then why don't you just use formula? Babies who get formula turn out just fine!" he knew I wanted to breastfeed, so I don't know why he said that stuff. I mean I know he was looking out for me, but it was still discouraging.

Jennifer, a 25 year-old first-time mother discussed having intimacy problems with her partner. Jennifer pointed out that she was uncomfortable with having her breasts touched. She indicated that her partner was frustrated with not being able to touch her. Jennifer felt that his frustration was discouraging because it affected their romantic relationship. However, she does explain that her partner did not explicitly discourage her from continuing to breastfeed. In the following statement, she described her concerns with intimacy:

You know at first it was awkward for me because I did not want that part of my body touched, it just felt uncomfortable...I just was like “that doesn’t feel good”...but at the same time, men are visual and they want to touch, so they don’t really understand and he would get frustrated and I’d be like “I’m sorry, I just don’t like it...just please don’t do that right now”...but yes, it did affect our relationship. I did start to think that maybe I could just use formula... I don’t know...it still felt important to be romantic and to have a relationship...but I decided to keep breastfeeding. It’s gotten better.

Estelle also had problems with intimacy because she was uncomfortable with her breasts being touched. Estelle felt that her husband had a discouraging attitude because he could not understand why she did not want to be touched. She indicated that her husband should have been more supportive because the baby was the first priority. In the following statement, she discussed how breastfeeding affected intimacy with her husband:

He knows I’m really blunt so it doesn’t matter...well cause he’s like a breast man so he’d get frustrated cause he kept wanting to try and touch me and I’m like, ‘no, when the baby’s done’. I still am not like 100 percent...I don’t like him touching my breast. It’s getting there, like if me and him were intimate, it would be a no-go...like don’t touch...yeah, but his little attitudes were discouraging, cause he didn’t get it...like the baby comes first.

Annette, a 28 year-old mother of two children, also talked about how breastfeeding affected intimacy. Annette revealed that she physical issues which made being intimate uncomfortable. She explained that her sexual drive had diminished since she began breastfeeding. In addition, her breasts would leak breastmilk during intimacy, which made her feel awkward. Annette did

not believe that her partner was purposely trying to discourage breastfeeding, but she felt frustrated by his lack of understanding. In the following statement, she expressed her concerns:

I don't think he gets it! It's kind of hard to feel sexy and take someone seriously as being sexy when you have milk squirting all over you! That's just awkward...but he always says...he always tries to ignore it...I'll be like "I'm sorry" and he's like "don't worry about it", but it's weird at times. It does affect our sexual relationship and I feel bad about that...but right now I want to keep breastfeeding, so he'll have to deal with it.

The women's responses are similar to the findings of Wallace and Chason (2007) that breastfeeding may negatively impact a woman's sexuality. However, in this study, the women and their partners were not concerned over breast appearance. Instead, the women felt physically uncomfortable with their partners touching their breast, as well as the leakage of breastmilk during intimate activity. Consequently, these issues caused strain on their romantic relationships.

Female Relative/Friend Support

Five of the women in this study reported that their female relatives or friends were emotionally supportive of breastfeeding. Estelle explained that she had doubts about breastfeeding once she returned to work, but ultimately decided to continue. She pumped milk in order for others to feed her child and to maintain her milk supply. Estelle indicated that her mother and sister were supportive of her decision. She felt that they were respectful of her wishes by not trying to dissuade her from breastfeeding. In the following statement, she described their support:

They did understand what I was going through and they did support my decision by not telling me to stop or trying to discourage me by saying "she needs to be on bottles right now", or something like that...no that never happened...and if it did, I wouldn't have cared cause I was set in my decision.

Jennifer gave a similar description, of the support received by her female relatives and friends. She stated that although her female relatives and friends did not have experience with

breastfeeding, they were emotionally supportive of her decision to breastfeed. In the following statement, Jennifer indicated that her female relatives and friends encouraged her to make her own decisions about breastfeeding:

I'm sure if the women in my family had more experience and if my friends had more experience, then they would have been able to understand a lot more...but just by encouraging me to do what I really wanted to do...you know...that was helpful and I am appreciative of that.

Jaime and Julie both indicated that their female family members did not have experience with breastfeeding. The children in their families were all bottle-fed. However, both women stated that they received support from women in their church. Jaime and Julie expressed that communicating with friends at church encouraged them to continue breastfeeding, particularly because these women had experienced breastfeeding and understood their concerns. In the following statement, Jaime indicated that her church friends encouraged her to continue breastfeeding when she having problems:

Within my Christian congregation a lot of my friends are older than me and some of them have breastfed, they're older women...or know people that have breastfed, so...you know , they knew that I was having issues and they were encouraging to me...you know trying to encourage me to keep doing it.

In the following statement Julie described receiving support from the women in the church where she worked:

You know I do have support from the church that I work at because there are women there that share...like their breastfeeding stories with me...or um...they you know...they do offer support by listening... just being able to talk about it with older women that have done it before helps.

Lisa explained that she was adopted and had recently become re-acquainted with her biological mother. She found out that her mother had breastfed her before she went to live with her adopted mother. Lisa felt encouraged by knowing that her mother had breastfed her; however they did not have many conversations about breastfeeding. Lisa felt encouraged by other women in her life.

In the following statement, she indicated that her female teachers were encouraging, understanding, and accommodating of her breastfeeding:

Sometimes my female teachers would ask me if I had her with me, ...sometimes they would ask me “oh are you nursing?” and I would say “yeah that’s an active part of schedule”, and they would just be like astounded “oh that’s so good”...”that’s really nice”...you know and if I needed to...I don’t know, they were just encouraging in their own way...and most of my teachers were that way with both of my children...understanding and being willing to make accommodations for things and that was really nice.

These statements reflect that female relatives and friends were emotionally supportive of breastfeeding initiation and continuation. Specifically, by allowing the mothers to make their own decisions about breastfeeding, listening to concerns, and offering encouragement. Some of the women also felt that women who had experienced breastfeeding, were particularly supportive and understanding.

Six of the women reported that either a female relative or friend discouraged them during breastfeeding. In the following statement, Stephanie reflected on how her mother and friends discouraged her when she told them she wanted to breastfeed:

My mom was looking at me like I was crazy when I said I was doing it, and my mom...well, she’s my grandma, she adopted me and she’s older so she was like, “no you don’t need to do that, you better give her formula” and my friends were like, “oh you can’t go out if you breastfeed”.

Kate explained that she experienced pain when she first started to breastfeed. She felt that her sisters attempted to discourage her from continuing to breastfeed. In the following statement, she discussed how her sisters encouraged her to formula-feed her baby when she experienced pain during breastfeeding:

The baby... when she was hurting me... my sisters weren’t like, “Yeah, go go”... they kept saying, “there’s always formula if you don’t want to do it”...even those days, when I had those days like, “oh my god it hurts and I don’t want to do it”, they could’ve stepped in and said, “oh it’s alright, you can

still do it”, but they still said, “just do formula or something”, but I didn’t want that.

In a similar account, Courtney shared that her mother also encouraged formula-feeding. She said that her mother supported her decision to initiate breastfeeding. Nevertheless, after Courtney began to experience stress during breastfeeding, her mother encouraged her to stop. In the following statement, she indicated that her mother wanted her to switch to formula:

The closest member of my family is pretty much my mom, so she...um, you know...she...was happy that I decided to do it, but at the same time she saw the stress that it caused me...so she was like...”yeah, you should switch him to formula ...if it’s stressing you out this much, you should put him on formula”.

Tiffany indicated that her friends at work were initially supportive of her breastfeeding her son. Tiffany explained that she wanted to nurse her baby at work instead of pumping milk. However, when her breastfeeding demands began to interfere with her duties at work, she felt that her friends became unsupportive. In the following statement, she described how her friends at work demanded that she pump milk or stop breastfeeding:

Well they were supportive at first but it was like...they knew I had to breastfeed my baby when I’m taking care of other kids too, and I know my breast would get full and I could hear my son through the walls...and I’m like you have to find somebody so I can feed my baby and they got frustrated after a while...they were supportive to a certain extent, but then they weren’t...you know what I mean? It was like...then they were telling me, “Well you need to start pumping or you’re gonna have to stop!”... and I’m thinking, “well the boss said I didn’t have to pump...I could just breastfeed”, but...I kind of figured out after a while that it wasn’t going to work.

Brittany and Annette felt that their family and friends may have been more encouraging if any of them had breastfeed their own children. In addition, Brittany indicated that she would have felt more competent if she had witnessed women in her family breastfeeding. In the following statement, Brittany implied that she felt discouraged because she did not have any women in her family who had breastfed:

You know that if it was something that I maybe grew up around and was accustomed to seeing...you know, versus giving a baby a bottle all the time...I think it would have come natural you know for me to be able to breastfeed ...and you know if I had more support, more family members and friends doing it. They didn't offer much emotional support because they didn't really understand what I was going through.

In a similar statement, Annette explained that she was discouraged by her family's lack of encouragement:

I mean in my family and my boyfriend's family ...a lot of people would say "oh I tried but I gave up", that really didn't help me! I didn't really have too many people to go to that had actually been through it and were encouraging in that aspect.

These statements illustrate that some of the women encountered unsupportive female relatives or friends during their breastfeeding experience. The women felt that this lack of support hindered either breastfeeding initiation or continuation. Specifically, these women were discouraged from initiating breastfeeding or encouraged to formula-feed when breastfeeding became challenging. In addition, the women felt that lack of encouragement from female relatives and friends was also unsupportive.

Peer Counselor/Lactation Consultant Support

All of the women in this study had access to either a breastfeeding peer counselor provided by WIC or a lactation consultant provided by the hospital where they delivered. Fourteen women reported receiving emotional support from the peer counselors and lactation consultants. One woman chose not to utilize their services even though she was offered a counselor. None of the women reported that the peer counselors and lactation consultants were unsupportive. Lisa felt that the peer counselors were very influential on her decision to initiate breastfeeding. In the following statement, she gave an example of how they encouraged her to breastfeed:

I would talk to the counselors, they would always say “it’s so good that you’re thinking about it”, even if I didn’t commit, they would be like “it’s so good you’re thinking about it...here’s all the reasons it’s the best”, and they would tell me verbally and they would hand out pamphlets. They really helped me to make the decision.

Jaime expressed that the peer counselors’ praise felt rewarding to her and helped her to continue breastfeeding. In the following statement, she provided an example of their encouragement:

When I went to the WIC office they were like, “oh you’re still full breastfeeding...that is so good”; “you know a lot of moms don’t breastfeed this long”. That felt good to me and I wanted to keep going.

Julie, Yvette, and Jennifer felt that the breastfeeding counselors and lactation consultants were encouraging at a time when breastfeeding was difficult for them. Julie stated that she wanted to stop breastfeeding several times. In the following statement, she described how her peer counselor encouraged her to continue breastfeeding:

I had the peer counselor through WIC, she kept coming by to see me, um because it was so many times that I was going to give up, but um it was her, you know that kept encouraging me to breastfeed him, so...I kind of stuck through it, so then after a few months it started to get better.

Yvette also felt that breastfeeding had become too difficult and wanted to stop. In the following statement, she described how her peer counselor encouraged her to continue breastfeeding:

I just remember when I would go to my WIC appointments I would tell them that...you know it was getting hard for me and they’d be like...well they gave me a breast pump and...they just always made sure to call and check up on me and they just kept encouraging me like “like I know it’s hard but it really is the best and you know just try, even if you can only do a little bit, just try”, so it was encouraging. Everyone else...like no one was really going through what I was going through so they couldn’t exactly understand, especially if they had never breastfed before. WIC was definitely helpful.

Jennifer expressed that she enjoyed being able to call the hospital lactation consultants and have home visits from the WIC peer counselors. In the following statement, she explained that it was

helpful to be able to talk to someone about the breastfeeding problems she had, as well as receiving personal advice.

Having the lactation consultants there was really helpful, or knowing that they're there and I could call them if I needed to, was helpful...and even with WIC, once I found out they had them... coming out to your house was extremely helpful because you don't have to do anything, just sit there and show them what the problem was.

In the following statements, Brittany and Annette described how they felt comfortable communicating their concerns with the breastfeeding peer counselors:

Yeah, because she understood...she breastfeeds herself, her son is only like three months older than mine so I felt that connection with her and that she understood me because she was in the same position and this is her second time breastfeeding...so that's why I confided in her so much because she's been through it (Brittany).

I do think, like I said if I had more family members and stuff that could support me...that you know, knew about breastfeeding, that it would be a lot better because you know I'd have a closer bond with my family...versus you know having a stranger at first come over and tell me about breastfeeding and stuff, but eventually me and my breastfeeding counselor...we became really close...I felt okay with opening up to her about you know how I felt about the things, but she was very, very supportive, and like I said, if it was not for her...I would not be breastfeeding (Annette).

The women felt that breastfeeding peer counselors and lactation consultants were particularly supportive of breastfeeding continuation. Specifically, peer counselors and lactation consultants offered encouragement, communication, and comfort to the women. A majority of the women relied on the counselors and consultants when they encountered challenges with breastfeeding. Additionally, many of the women felt a bond with the breastfeeding counselors because they could relate to the breastfeeding experience, as all of the counselors breastfed their own children.

Informational Support

Hughes (1984) describes informational support as “knowledge-sharing behaviors”. The women in this study reported receiving informational breastfeeding support from female relatives and friends, breastfeeding peer counselors and lactation consultants, and internet support groups. None of the women reported that their spouse or male partner provided informational breastfeeding support. The women perceived informational support to be most helpful with breastfeeding initiation and continuation. The women did not perceive informational support to significantly affect exclusivity. Themes reflecting informational support included:

- *Breastfeeding knowledge-sharing*: providing informational about the benefits of breastfeeding and breastfeeding/pumping techniques, providing information on breastfeeding expectations
- *Breastfeeding problem-solving*: providing informational on solving breastfeeding problems

Female Relative/Friend Support

Twelve women reported that they were not breastfed as a child and did not know any close relative that had breastfed. Three of the women in the study were breastfed by their mothers. Five of the women knew a friend that had breastfed their baby. Five of the women in the study reported receiving informational breastfeeding support from a female family member or friend. None of the women reported that their female relatives or friends were unsupportive. Specifically, none of the women reported that they were provided with negative or discouraging breastfeeding information or advice. Tiffany indicated that she was breastfed as a child and that her mother breastfed all of her siblings. She also stated that her cousin breastfed her children. Tiffany felt that her family set a great example and were very influential in her decision to

breastfeed her children. In the following statement, she talked about receiving breastfeeding knowledge and advice from her mother and cousin:

I remember my oldest cousin, she has 11 kids, and my little cousins they were twins and she used to breastfeed both of them at the same time, I said wow! Yeah and my mom breastfed me...yep for about 8 months. They let me know about the benefits and I always got advice from them, especially when it was hard.

Alexis indicated that as a teenage mother, she attended a school that encouraged breastfeeding. This is where she got a great deal of information about the benefits of breastfeeding. In addition, she was also breastfed as a child and her mother taught her about breastfeeding. In the following statement, she described receiving information from both sources:

When I was 15, I was going to a school that was geared towards teenage mothers. They had parenting classes and they kind of taught us what was best for the baby and they did have a lot of literature on breastfeeding and things like that, so...initially when I breastfed my first son, it was from my school, and then from my mom, because my mom is an avid...you know, she's all about breastfeeding. She breastfed me and my siblings and she was there to help me with my kids.

In the following statement, Yvette explained how a friend helped her solve her problem with breast engorgement:

My friend at work was telling me to put some lettuce on my nipples, just to soak it up...I guess that was a family remedy...it worked. I was like how does that keep'em from swelling up, but it worked...it worked out great. She was always telling me something...because she had breastfed her kids.

Mary described receiving breastfeeding information from a close friend. In the following statement, she expressed how that information encouraged her to breastfeed:

A good friend of mine, she had a daughter and she breastfed her...so it just seemed like the right thing to do. She's the reason I wanted to breastfeed my son in the first place. So, anything I needed to know, I kinda got from her. I watched her breastfeed her daughter a lot of times and she gave me advice on what to do.

The women's statements indicate that female relatives and friends provided informational support specifically by providing knowledge on the benefits of breastfeeding and advice on how

to solve various problems that arose during breastfeeding. The women felt that this type of support encouraged breastfeeding initiation and helped them to continue breastfeeding when it became challenging.

Breastfeeding Peer Counselor/Lactation Consultant Support

Fourteen women received informational support from WIC breastfeeding peer counselors or hospital lactation consultants. None of the women reported that peer counselors or lactation consultants were unsupportive. Jennifer said that she received a great deal of information about the benefits of breastfeeding from WIC peer counselors. She felt that they were very influential on her decision to breastfeed. In the following statement, Jennifer described how the peer counselors encouraged her to initiate breastfeeding:

With the WIC counselors...they were extremely informational, I don't think if they would have...or if they wouldn't have been as...like, I don't want to say aggressive, but you know as proactive as they were about producing information about breastfeeding and encouraging it, explaining the benefits and handing out the literature, then I don't know if I would have been...it would have been as easy a decision for me to make, to breastfeed.

In the following statement, Annette discussed receiving advice during home visits with the lactation consultant:

When I was in the hospital at Greatview, they also gave me contacts for the lactation consultants there...so when I was having trouble, then I did call and ask for help cause I didn't want to quit...and that you know, really helped out...having someone that is there just to help with breastfeeding and is willing to come to your house and observe you...and give you feedback on how you're doing.

In the following statement, Stephanie offered a similar account of receiving information from lactation consultants at the hospital breastfeeding center:

One time I was there for like a half hour to 45 minutes and she helped me, she showed me some props and stuff, cause I have the Boppy, but I don't have...the thing that they have, it straps on you. That's where I can get a lot of information, like if I go there or I call. Even after I got home, they called me and asked me

how everything was going, and what questions I have... I can call them to get the answers to so...it's like you just have to call and ask them.

Jaime revealed that had problems with breast engorgement once she began to supplement her son's diet with food. In the following statement, she described receiving advice from the lactation consultant on how to relieve the pain and swelling:

One thing I was concerned about was getting clogged ducts, which causes swelling and that's what was happening when he stopped nursing so much because of course, I'm used to producing X amount of milk and he's not drinking it, so it causes swelling and stuff. So I did have a problem with that. The lactation consultant at Greatview gave me advice on what to do, put a hot to warm towel on you, take a warm shower... so they told me to do that...and pretty much it helped, all the stuff helped. I've never had any severe problems with my breast besides like soreness.

The women perceived peer counselor and lactation consultant informational support to be most helpful with breastfeeding initiation and continuation. Specifically, peer counselors and lactation consultants encouraged initiation by providing information on the benefits of breastfeeding. In addition, peer counselors and lactation consultants supported breastfeeding continuation by providing information on proper breastfeeding technique and problem-solving advice.

Internet Breastfeeding Support Groups

Five women indicated that they received informational breastfeeding support from internet support groups. These women suggested that the support groups offered informational support in a variety of ways, such as providing knowledge on the benefits of breastfeeding, information about the challenges of breastfeeding, and problem-solving advice. Stephanie said that she did not discuss breastfeeding with her healthcare provider. She explained that she decided to breastfeed because of the information that she received online. She then joined an

online support group. In the following statement, she talked about receiving information and advice from the online support group:

I first decided to breastfeed from researching online and then I joined a chat group. My doctors really didn't say anything about it, so I got most of my advice from researching and chatting online... like the benefits of it and everything...I got that online and from talking to the other people in the group, who had done it. I also talk to them about the problems I'm having with her latching-on and keeping my milk supply up.

In the following statement, Julie also described receiving information and advice from her online support group:

I check with the online group to see if somebody else is saying the same thing or is doing the same thing...so I'll talk about it and I'm comforted that way cause I know everybody is going through the type of thing...and some of the people talk about leaking...I did not leak before I had my baby and they tell me that it may...they don't like it, it's uncomfortable...you know.

Estelle gave a similar account of receiving information and advice from her support group:

I joined an online group and we would talk about different issues we were having. Some of the people gave advice...you know, like old wives tales on how to deal with swollen breast or family remedies for cracked nipples, that type of thing. It was helpful because I hadn't heard about some of it.

Instrumental Support

Hughes (1984) describes instrumental social support as “task-driven”. All of the women in this study indicated that they received instrumental breastfeeding support from their spouses or partners, female relatives or friends, and breastfeeding peer counselors or lactation consultants. The women perceived instrumental support to be most helpful with breastfeeding continuation and exclusivity. The women did not perceive instrumental support to significantly affect breastfeeding initiation. Themes related to instrumental support included:

- *Active participation*: participation in learning about breastfeeding, participation in feeding the child

- *Providing resources*: providing essential breastfeeding supplies
- *Teaching*: teaching and demonstrating proper breastfeeding and pumping technique

Spouse/Partner Support

Eight women reported that they received instrumental breastfeeding support from their spouse or male partner. Jaime stated that her husband was active with the breastfeeding process.

In the following statement, she indicated that her husband would assist her with feedings:

So when he's up, of course my husband is up...and he will get up some nights just to be up with me so I won't be up by myself...and if I've pumped some of the milk, he will do some of the night feedings for me.

Courtney indicated that her husband was supportive when she became "stressed out" during feedings. In the following statement, she talked about her husband's participation with feedings:

Sometimes I'm very stressed out, and my husband, he works early...but you know the times that I need him to get up and help feed... I'm like I've had it...I can't get up anymore, that's when he steps in, you know. When I'm tired and stressed, I make sure to pump so he can help me.

In the following statement, Annette discusses her appreciation that her partner took an active interest in learning about breastfeeding:

He wanted to learn about it. He talked to the counselor and asked questions about our hormones and stuff while breastfeeding... "Does it feel different than the pregnancy stage?" Yeah, he asked a lot of questions about when our breast would get full and um, was he getting enough milk with his feedings too. He always wondered that. He really made an effort to know what was going on.

The women's statements suggest that their spouses and partners provided instrumental support by being active in learning about breastfeeding, as well as participating with feedings. The women felt that this type of support helped them continue breastfeeding when they had difficulties or felt overwhelmed. In addition, spouses and partners were able to feed babies with expressed breastmilk, which helped to delay formula supplementation.

Female Relative/Friend Support

Four women stated that they received instrumental breastfeeding support from female family members or friends. Female relatives and friends provided instrumental support which according to the mothers, promoted continued breastfeeding and exclusivity, specifically by being active in feeding babies expressed breastmilk. In the following statement, Lisa explained that her mother-in-law and baby's Godmother were both active participants with breastfeeding:

My mother-in-law, who lives with us, goes out of her way to help. She helps out any way she can...with feedings, bathing, dressing, anything. Also, the baby's God-mom...she's my cousin, she's very active in feedings whenever I need to be away from her [the baby]. They did that with my son, too. So it helps me to still be able to give them breastmilk, you know...especially when I was exclusively breastfeeding.

Tiffany felt that her oldest daughter was very helpful during her breastfeeding experience. In the following statement, she described how her daughter provided support with breastfeeding and other responsibilities:

If I needed her to take over feedings, she would, or if I had to pump because I needed to be away from the baby. Most of the time after I breastfed, she got the baby and she'd bathe him so I could spend time with the other kids too. Um, she cleans...whatever I needed her to do...she'd do it for me. I think that's part of the reason I was able to breastfeed for so long. You know, I couldn't always be there to nurse him, so at least he was able to get it [breastmilk] from the bottle.

Breastfeeding Peer Counselor/Lactation Consultant Support

Fourteen women reported that they received instrumental breastfeeding support from breastfeeding peer counselors and lactation consultants. In the following statement, Jaime described how her peer counselor provided her with breastfeeding supplies that would have otherwise been a financial burden:

She brought breast pads, and she brought like the little bags that you store milk in...she brought those things for free...and she got me a free breast pump, which is very expensive, so that program really helped me a lot, encouraging me and it

covered some expenses that I would have had to pay...you know if I were not to have her or that program.

In the following statement, Mary shared a similar account of receiving equipment to help her increase her milk production continue breastfeeding:

I did call the WIC counselor when I felt like he wasn't getting enough milk ... and that's when I ended up getting that... um I got a free electrical breast pump...and I was excited about that cause I was like wow, I never used one of these before, and it was free, brand new and um...I noticed the more I pumped, the more breastmilk I would express out...so it worked out good for me to keep feeding him.

Stephanie explained that because most of her family lived in a different city, she did not have a baby shower. She stated that she didn't receive any baby supplies from her family or friends. In the following statement, she indicated that she was able to receive breastfeeding supplies from her peer counselor:

Yeah, I got the Avent pump but she said that I could get it electric, but I may not get as much formula. I was just like, "it's alright... I'll just take the manual, cause you know they do the same thing, just one is probably quicker. I don't plan on using formula, but I don't know what could happen. I'm gonna do the manual one for now. She also gave me other stuff to use for breastfeeding, like breast pads and cream, which helps since I didn't have a baby shower or get gifts.

In agreement with Stephanie's statement, four other women implied that, while WIC provides women with electric breast pumps, women who receive them will be supplied with less formula. This may be a way of encouraging exclusive breastfeeding. In addition, women who are breastfeeding receive additional food supplements to promote better nutrition and assist with adequate milk production.

In addition to supplies, the women reported that the peer counselors and lactation consultants also taught them proper techniques for breastfeeding and using breast pumps. In the following statement, Alisha discussed being visited by lactation consultants in the hospital and receiving home visits from a WIC breastfeeding peer counselor:

I got a lot of help from the hospital lactation consultants, after I had him they asked me if I was formula feeding him or breastfeeding him and I told them breastfeeding, and so when I was in the hospital, they came in pretty much every day to see if I needed help with pumping and then I found out WIC had a breastfeeding lady to come by and she stopped by when I needed her to come... probably like every week when I first had him. She showed me different ways to hold him and how to pump and store the milk.

Julie explained how she received assistance from the hospital lactation consultants when her son was having trouble feeding:

The lactation consultants at Greatview offer a program, um, if you have your baby there, you can come in anytime to get their weight checked and also see how much milk they're getting from each side, what they do is you know I'll nurse him from one side and they'll weigh him and see...and you can see how many ounces he's getting to. He was having trouble feeding at first, so I had to constantly make sure he was getting enough milk and I had to make sure I was producing enough. That program really helped.

The women indicated that breastfeeding peer counselors and lactation consultants provided instrumental support which promoted continued breastfeeding and exclusivity. Specifically, peer counselors and lactation consultants were able to demonstrate and teach proper breastfeeding technique, and assist with any problems encountered during breastfeeding. The women felt that this encouraged breastfeeding continuation, as opposed to giving up when difficulties occurred. In addition, peer counselors and lactation consultants provided the mothers with breastfeeding supplies, such as electrical breast pumps. This promoted breastfeeding continuation and exclusivity by allowing other people to feed babies breastmilk instead of formula.

All of the women in the study indicated that they received emotional, informational, and instrumental breastfeeding support from various members of their social network. Table 3 illustrates a summary of the type of breastfeeding support that the women received, as well as which support group provided each type of support.

Table 3: Summary of Breastfeeding Support By Type

	Emotional Support	Informational Support	Instrumental Support
Number of Participants*	15	15	15
Support Groups**	Spouses/Partners (10), Female Relatives/Friends (5), Peer Counselors/Lactation Consultants (14)	Female Relatives/Friends (5), Peer Counselors/Lactation Consultants (14), Internet Support Groups (4)	Spouses/Partners (8), Female Relatives/Friends (4), Peer Counselors/Lactation Consultants (14)
Description of Support	Encouragement, Communication, Comfort	Sharing-knowledge, Problem-solving advice	Active Participation, Providing Resources, Teaching
Breastfeeding Aspect***	Initiation, Duration	Initiation, Duration	Duration, Exclusivity

*Number of participants who received this type of support

**Numbers in parentheses represent the number of participants who cited support from this group

***Aspect of breastfeeding the participants perceived most influenced by this type of support

Adequate Breastfeeding Support

All of the women in the study were asked to describe what they believed adequate breastfeeding support entailed and how this support could affect the breastfeeding experience. The women indicated that having adequate support during breastfeeding could help a woman to reach her breastfeeding goals. All of the women described adequate breastfeeding support as having all three aspects of social support described by Hughes (1984), as well as the social interaction described by Umberson and Montez (2010). Themes that arose regarding adequate breastfeeding support included:

- *Positive communication*: listening to concerns, providing advice, and encouragement to reach breastfeeding goals
- *Understanding*: recognizing concerns and providing comfort and empathy
- *Active assistance*: providing assistance with breastfeeding, as well as other tasks, such as household chores and childcare

As previously stated, each of the themes that emerged from the discussions about adequate breastfeeding support, represent an aspect of social support described by Hughes (1984). Positive communication represents informational and emotional support. Understanding represents emotional support. Assistance represents instrumental support. The following statements share some of the women's perceptions of adequate breastfeeding support.

Jaime believed that adequate breastfeeding support involved positive communication by providing encouragement, offering advice, and not persuading a mother to formula-feed:

I just think that... you know having someone that can give you a listening ear...and giving you good advice...and doing things to keep pushing you, not steering you another way...you know I want to breastfeed...so let's work with breastfeeding, don't give me formula as an alternative...just give me things that will encourage me to breastfeed. So, I feel that a person that will you know, help

you reach your goal versus trying to...you know discourage you... would be the best person for you...and that's what my breastfeeding counselor did for me.

Jennifer discussed how spouses and partners could provide adequate breastfeeding support through encouragement and positive communication:

Good support is when you tell someone that you have a desire or a goal or that you want to start doing something...good support is going to help you reach and maintain your goal...so they wouldn't tell you "oh, I think that's a terrible idea to breastfeed", or "you know I wouldn't do that because...", then you know offer information that's contrary to what you want to do. I feel like it can come in all sorts of forms, like for example, if you are a man and you want to support a woman that's breastfeeding, you know just giving a call and seeing how they're doing...or saying "hey the baby looks good, you must be doing something"...you know just encouraging comments and not giving discouraging comments about the way that a woman looks, you know, that type of thing.

Courtney agreed that communication was essential to adequate support. She also stated that helping the mother with other responsibilities, such as housework, constitutes good support:

Um, just through talking to them, like "Is there anything I can do to help?" or "do you need me to clean the house so you can feed the baby?" you know, just finding ways to be useful is good support and through offering encouraging, positive words that don't go contradict the mother's wishes...and sometimes just by being there, just by being an active person, playing an active role. You don't always have to say things or do things, if you're just there, that can be supportive.

Yvette shared the sentiment that adequate breastfeeding support involved providing encouragement through positive communication. She also reflected on how her boyfriend was active in feeding the baby, which allowed her to exclusively breastfeed for a longer period:

Like someone not telling you all the bad things or disadvantages of it, but encouraging you to do it...by not thinking about what they want or what they think is best and actually listening to what you're saying and try to see both sides of it...at least support you on your decision to breastfeed and do what they can to help you reach your goal. Like my boyfriend knew I wanted to exclusively breastfeed, so he gave the baby pumped milk in a bottle when I had to go to work. Plus, that helped me to breastfeed longer.

Alisha stated that the people in her support network provided adequate support by understanding and respecting her wishes to breastfeed her children and doing whatever they could to help her reach her breastfeeding goals. She agreed with the other women that providing positive communication and helping with responsibilities is essential to adequate support. For instance, she remarked on how her family would assist with taking care of her son while she fed her daughter:

I would say the peer counselor definitely played a huge part, also family just, you know understanding that that's what I wanted to do...and they would bring the baby to me or take one baby so I could feed the other one...or if I needed to pump they would make sure that I had the time and space by myself to do that, and they were really respectful of my wishes and giving me what I needed...giving me the tools to do what I needed to do...and friends too, just by being understanding and not making inappropriate comments and discouraging comments about, "doesn't that hurt" or "isn't that weird"?

Alexis felt that adequate breastfeeding support entailed having positive people in your life in general, as well as feeling positive about yourself. She reflected on she was able to breastfeed her first son longer than her last two children because she was happier with her life at the time. With her last son, she felt anxious and confined and did not have positive people in her life. Consequently, she terminated breastfeeding after one month. Alexis shared how she was regretful of terminating breastfeeding so early because she had a goal to feed her son for 6 months. However, she did not feel that she got the support that she needed from her partner to continue breastfeeding, even though he encouraged her to initiate breastfeeding with their son:

I think that for a lot of people, well for me, breastfeeding has a lot to do with where I'm at in my life. Like at that point, if I feel good about my life, then I feel good about breastfeeding. If I feel like everything is intact, if I physically and mentally feel good, then I want to breastfeed. If I start to feel a certain type of way, like if I feel anxious or claustrophobic...it's like I gotta let this go. So I think it just has to do with people just being...positive people being in your life. I don't think there is anything that they could necessarily say to me about breastfeeding; it would just be like about how I feel about the people and the support I'm getting in my life period.

Most of the women believed that adequate breastfeeding support included emotional, informational, and instrumental support. However, emotional support was perceived to be the most influential in reaching breastfeeding goals. Specifically, all of the mothers felt that encouragement was invaluable to successful breastfeeding. All of the women sought encouragement from all of their support systems, in order to attempt to reach their breastfeeding goals.

CHAPTER 5: DISCUSSION

The purpose of this study was to examine the breastfeeding experiences of a group of African American women, in order to gain insight on the social relationships that encouraged or discouraged breastfeeding initiation, continuation, and exclusivity. This study closely focused on the types of support provided by the women's social network, in order to positively influence breastfeeding in this group of women. Finally, this study sought to understand how the women in this study defined "adequate breastfeeding support". This study employed a qualitative research design using semi-structured in-depth interviewing. The study sample included 15 African American women recruited from two breastfeeding centers in southwest Michigan.

The mothers in this study encountered several breastfeeding problems which negatively affected their breastfeeding experiences. The women utilized a number of support systems to ameliorate challenges and to attempt to reach their breastfeeding goals. All of the women reported that they received breastfeeding support from various members of their social network. Members of social networks included: spouses, male partners, female relatives and friends, breastfeeding peer counselors, hospital lactation consultants, and internet support groups. This is agreement with Umberson and Montez (2010) who suggest one's social network include all social relationships.

The type of support each woman received was consistent with each aspect of social support described by Hughes (1984). Breastfeeding support included emotional, informational, and instrumental support. The women indicated that this support positively affected their breastfeeding experiences and was influential on breastfeeding initiation, continuation, and to a lesser extent, exclusivity. The women also reported that some members of their social network were unsupportive of breastfeeding in different ways, which negatively affected their

breastfeeding experiences. These findings concur with Mitra and colleagues (2004) which suggested that members of the social network could be either encourage or impede breastfeeding success.

Breastfeeding Problems

Consistent with previous research, the women in this study encountered several barriers which hindered breastfeeding success. For instance, some women reported that their breastfeeding confidence decreased after initiation. Reasons given for this decrease in confidence included concerns with breastfeeding technique, milk production, and adequacy of milk supply. The women perceived lack of confidence to have a negative effect on their desire to continue breastfeeding. These results agree with previous studies (Dunn et al., 2006; Schwartz et al., 2002; Wallace & Chason, 2007) which proposed that a woman's lack of confidence may hinder her ability to breastfeed. However, lack of confidence did not result in breastfeeding cessation for any of the women in this study. In each case, the mothers were able to receive support which encouraged breastfeeding continuation.

Time constraints were also problematic for the mothers in this study. Several women reported that breastfeeding conflicted with their school, work, and personal schedules. Three mothers in this study terminated breastfeeding because they felt that the frequency of breastfeeding was inconvenient. In contrast to previous studies, employment or student status was not cited as a direct cause for breastfeeding cessation. Nevertheless, all of the employed women stated that breastfeeding continuation became more challenging upon returning to work because they were required to pump milk in order to maintain an adequate milk supply. As Kimbro (2006) and Witters-Green (2003) suggest, the occupations of the women in this study may have allowed for greater flexibility to either nurse their babies, or have time to pump during

breaks at work. For example, two of the women were employed at a daycare center where their children were able to attend work with them.

Several women experienced various problems with pumping milk. Mothers who used manual breast pumps felt that pumping was too time consuming and did not produce a sufficient amount of milk. In addition, some of the women had problems with their pumping technique. These findings concur with literature which suggests having high quality electric breast pumps may be a significant resource because these devices are able to express a large quantity of milk in a shorter amount of time than manual pumps. Still, high quality electric breast pumps are not available to every breastfeeding woman. Some of the women in this study who received free electric breast pumps revealed that it would have been a financial burden to purchase one. Access to electric breast pumps may lead to longer breastfeeding duration because women are able to pump and store enough milk for other people to feed their children. This is especially useful when women are employed, in school, or otherwise absent from the child.

Lack of healthcare provider support was also a concern for the mothers in this study. Similar to Dillaway and Douma (2004) and Taveras et.al, (2004), none of the mother's indicated that their healthcare providers were especially encouraging or supportive of breastfeeding. In fact, some of the mothers felt discouraged by their communication with healthcare providers, regarding breastfeeding. The women often discussed their healthcare providers as being "too technical" and they generally felt that their breastfeeding efforts were ignored. The women believed that although their healthcare providers did not deliberately discourage breastfeeding, there was a lack of emotional and informational support. Nevertheless, the mothers did not perceive lack of healthcare provider support to affect breastfeeding initiation, duration, or exclusivity.

Many of the mothers felt that breastfeeding was generally stressful. Several women discussed feeling depressed at some time during breastfeeding. The women also reported feeling anxious and uncertain about maintaining adequate milk production, as well as feeling physical pain during breastfeeding. According to the women, stress incurred during breastfeeding had the most potential to negatively affect duration. Many of the mothers indicated stress negatively affected their desire to continue breastfeeding. Umberson et al. (2010) suggest that social relationships may positively affect psychosocial health by reducing stress and promoting emotional well-being. The findings of this study agree with this assessment of social relationships. The mothers were able to receive support through social relationships in order to relieve stress related to breastfeeding. As a result, none of the mothers terminated breastfeeding because of stress. Still, some of the mothers indicated that some members of their social network were discouraging, which caused stress and negatively affected their breastfeeding experiences.

The women in this study also encountered problems with intimacy. Bartlett (2002) theorized that the conflicting perception of breasts as sexual objects and the medicalization of breast as instruments of nourishment, may affect a woman's ability to breastfeed. The mothers in this study did have conflicting perceptions of their breasts as sexual objects and a means to nourish their children. While the mothers did not perceive this conflict to affect their ability to breastfeed, many of the women indicated that they felt guilty because in their view, breastfeeding caused lack of intimacy with their partners. Several of the mothers reported that they did not want their significant other to touch their breasts. The women explained that their breasts were tender, swollen, and often leaked milk, which made intimate activity uncomfortable. As a result, their partners became frustrated. These findings suggest a need for romantic partners to become educated about the physical changes a woman may experience during breastfeeding. In return,

partners may be more understanding and avoid reacting negatively to women's concerns with intimacy.

Emotional Breastfeeding Support

All of the mothers in this study indicated that they received emotional support from members of their social network. The women perceived emotional support to be most helpful with breastfeeding initiation and duration. Emotional support included encouragement and comfort. It was expected that spouses and male partners would be most encouraging to this group of mothers by providing emotional support. However, according to the women breastfeeding peer counselors and lactation consultants provided the greatest emotional support, followed by spouses/partners, and female relatives and friends.

All but one of the women indicated that they received emotional support from a peer counselor or lactation consultant. This support group was shown to be instrumental in providing the mothers with emotional support. Participants found peer counselors and lactation consultants to be particularly encouraging when they encountered hardships during breastfeeding. In fact, many of the women attributed emotional support provided by peer counselors and lactation consultants to their ability to continue breastfeeding despite difficulties. These results are not surprising, as breastfeeding peer counselors and lactation consultants are trained to encourage all aspects of breastfeeding and to manage problems that arise during breastfeeding. Additionally, most of the peer counselors and lactation consultants had breastfed their own children. As a result, they were able to personally relate to the mothers' experiences. The women in this study found this attribute to be especially helpful.

Over half of the mothers indicated that they received emotional support from spouses or partners. The women perceived emotional support from spouses and partners to be helpful with

breastfeeding initiation and continuation. These results suggest that spouses and partners can encourage breastfeeding initiation and continuation by providing emotional support. However, the mothers did not feel that emotional support provided by spouses or partners encouraged exclusivity. In particular, spouses and partners encouraged breastfeeding initiation, provided comfort, and encouraged continuing breastfeeding despite difficulties. The findings agree with previous studies (Arora et al., 2000, Ekstrom et al., 2003) which suggest male partner support may positively affect breastfeeding. These researchers suggest that male partners may influence initiation and continuation through active participation in the breastfeeding decision, showing a positive attitude, and possessing knowledge of the benefits of breastfeeding. The women in this study asserted that male partners also provided them with comfort and encouragement during difficult breastfeeding situations, which they believed to be essential for breastfeeding continuation. On the other hand, some of the women indicated that their partners were unsupportive by encouraging them to formula-feed when breastfeeding became difficult. The mothers also indicated that their partners lacked understanding about the effects of breastfeeding on intimacy.

Only one-third of the mothers reported that they received emotional support from their female relatives or friends. According to these women, female relatives and friends were helpful with breastfeeding initiation and continuation, particularly by listening to concerns and providing encouragement. The findings show that female relatives or friends can encourage breastfeeding initiation, continuation, and exclusivity through providing emotional support. However, the women did not feel that this type of support from their female relatives and friends encouraged exclusivity. Over half of the mothers felt that their female relatives and friends did not provide any emotional support. According to these women, it was difficult for their family and friends to

provide emotional support because they did not understand the experience of breastfeeding. Only five of the women indicated that they had been breastfed or knew a family member or friend that breastfed their child. From the mothers' perspectives, lack of knowledge and experience hindered the ability of their family and friends to offer encouragement or comfort. In addition, some of the women believed that their female relative and friends were discouraging in different ways. For example, several women stated that their relatives or friends encouraged them to formula-feed, especially when breastfeeding became difficult. Overall, it seemed to be consistent among this group of women that breastfeeding was not a part of their family tradition. Previous research (Durkheim, 1897; Bachman et al. 2002; Williams & Collins, 1995) has addressed the issue of social relationships influencing health behavior by establishing social norms. While all of the women in this study initiated breastfeeding, in general their family traditions seemed to promote bottle-feeding. These results indicate a need for the women closest to breastfeeding mothers to become familiar with breastfeeding, including the benefits and how to manage problems. Therefore, even if they do not have personal experience with breastfeeding, they may still be able to emotionally support breastfeeding mothers.

Informational Breastfeeding Support

All of the mothers indicated that they received informational support. Informational support was perceived to be most helpful with breastfeeding initiation and continuation. Informational support included sharing breastfeeding knowledge and giving problem-solving advice. None of the women reported that they received informational breastfeeding support from spouses or partners. This may be a result of lack of knowledge among the male partners. Most of the women indicated that their partners did not know a great deal about breastfeeding. Therefore, they were unable to be informative or provide problem-solving advice to the mothers.

Only one-third of the women reported that they received informational support from a female relative or friend. According to these women, female relatives and friends encouraged breastfeeding initiation and exclusivity by sharing breastfeeding knowledge and advice. Interestingly, the mothers who received informational support from their female relatives and friends indicated that these women had personal experience with breastfeeding. Again, the women's perceptions were that personal breastfeeding experience allows one to become more knowledgeable and understanding of the breastfeeding process. Among the women who did not receive informational support from female relatives or friends, lack of breastfeeding experience was generally perceived to be the reason no informational support was provided. Most of these women indicated that their female relatives or friends did not possess a great deal of knowledge about breastfeeding.

All but one of the mothers in this study received informational support from breastfeeding peer counselors and lactation consultants. According to the women, peer counselors and lactation consultants encouraged breastfeeding initiation and continuation by providing information about breastfeeding benefits and technique, as well as advice on solving any problems that occurred during breastfeeding. The women perceived breastfeeding peer counselors and lactation consultants to be their main source of informational support. These findings agree with previous research suggesting that breastfeeding peer counselors and lactation consultants are a valuable source of information for breastfeeding mothers. The women in this study felt that peer counselors and lactation consultants were knowledgeable about breastfeeding than their healthcare providers and offered more informational support. The results suggest that breastfeeding peer counselors and lactation consultants may be able to provide other individuals with the necessary knowledge to provide informational support to breastfeeding mothers.

About one-third of the women reported that they received informational support from members of internet support groups. This was unexpected result, as this support system has not been thoroughly addressed in previous literature. According to the women, internet support groups were helpful with breastfeeding continuation. The women indicated that support group members provided information on the benefits of breastfeeding, as well as gave advice on how to solve breastfeeding problems. These results suggest that online support groups may be a valuable resource for breastfeeding women. These support groups may encourage initiation and continuation, particularly for breastfeeding women that do not have other sources of support. Online support groups may provide easy access to both informational and emotional support.

Instrumental Breastfeeding Support

All of the mothers reported that they received instrumental support. Instrumental support was perceived to be most helpful with breastfeeding continuation and exclusivity. Instrumental support included active participation, providing resources, and teaching. The women received instrumental support from spouses and partners, as well as female relatives and friends. The women perceived breastfeeding peer counselors and lactation consultants to be most helpful in providing instrumental support.

Around half of the women indicated that their spouse or partner provided instrumental support. Instrumental support was most often provided by participation with feedings. According to the women, this support promoted breastfeeding continuation and exclusivity because it allowed for babies to be fed breastmilk in the mothers' absence. Therefore, they did not have to implement formula supplementation. Mothers, who supplemented with formula, agreed that their partners' participation in feeding expressed milk, helped to promote breastfeeding continuation. This is consistent with literature which suggests that spouses and partners may be an important

asset to breastfeeding women through active participation in the breastfeeding process. Specifically, through participation in feeding babies pumped breastmilk, spouses and partners can positively influence breastfeeding duration and exclusivity.

Around one-third of the mothers reported that female relatives or friends provided instrumental support. Instrumental support was most often provided by participation with feedings. Again, the mothers perceived this support to be most helpful with breastfeeding continuation and exclusivity. It was expected that female relatives and friends would be essential in providing instrumental breastfeeding support. However, most of the mothers in the study indicated that their female relatives and friends did not provide instrumental support. The findings suggest that female relatives and friends should be made aware of specific actions they can do to positively influence breastfeeding initiation, duration, and exclusivity. For instance, among the mothers who indicated that they received instrumental support from family and friends, assistance with feedings was perceived to be influential on duration and exclusivity.

All but one of the mothers reported that they received instrumental support from breastfeeding peer counselors and lactation consultants. According to the mothers, instrumental support from peer counselors and lactation consultants encouraged breastfeeding continuation and exclusivity. Specifically, peer counselors and lactation consultants provided instrumental support by teaching proper breastfeeding techniques, assisting with breastfeeding problems, and providing breastfeeding supplies. According to the mothers, this support encouraged breastfeeding continuation because it allowed them to become familiar with proper breastfeeding and pumping techniques, as well as work through any problems they encountered during breastfeeding. In addition, providing the mothers with electric breast pumps allowed them to

supply breastmilk for other individuals to assist with feedings. The mothers felt that pumping milk encouraged a longer duration of exclusive breastfeeding.

Adequate Breastfeeding Support

The mothers perceived emotional, informational, and instrumental support to be essential to adequate breastfeeding support. These findings support the notion that all three aspects of social support would be perceived to be essential to providing adequate support. All the mothers agreed that adequate breastfeeding support included positive communication (emotional and informational support), understanding (emotional support), and active assistance (instrumental support). All of the mothers believed that members of their support network provided at least one aspect of social support. However, a majority of the women perceived breastfeeding peer counselors and lactations consultants to be the only group to provide all three aspects of adequate support. The women perceived peer counselors and lactation consultants to have the most positive influence on their breastfeeding experiences, as well as the most helpful in encouraging breastfeeding initiation, continuation, and exclusivity. These findings are in agreement with numerous studies which suggest that breastfeeding peer counselors and lactation consultants are a critical asset to breastfeeding women, particularly because they are specially trained to teach women about breastfeeding and to help manage and assist with any problems that may occur during the breastfeeding process.

CHAPTER 6: CONCLUSION

The Centers for Disease Control and Prevention state that breastfeeding provides many health related benefits to mothers and infants. The organization has set forth a health plan for the United States known as the *Healthy People 2020 Initiative*. This health initiative includes breastfeeding guidelines and goals for initiation, duration, and exclusivity. While many health organizations advocate breastfeeding, many American women have not met the breastfeeding goals set forth by the CDC. This suggests a need for healthcare professionals to develop a better understanding of the persistent barriers to breastfeeding, particularly breastfeeding continuation.

Research shows that African American women have the lowest breastfeeding rates in the United States. Several studies have explored a connection between social support and breastfeeding outcomes. This study sought to understand what social relationships encouraged or discouraged breastfeeding initiation, continuation, and exclusivity in a group of African American women. In addition this study sought to understand what type of support encouraged breastfeeding initiation, continuation, and exclusivity. Finally, this study sought to uncover the meaning of adequate breastfeeding support as perceived by the women in the study.

Overall, the social relationships that were most influential to breastfeeding initiation, continuation, and exclusivity for this group of women, included: spouses, partners, female relatives and friends, breastfeeding peer counselors, lactation consultants, and online support groups. In general, the mothers felt that all members of their support network promoted a positive breastfeeding experience and encouraged them to reach their breastfeeding goals. Breastfeeding peer counselors and lactation consultants were perceived to be most helpful. Emotional, informational, and instrumental support were all perceived to influence breastfeeding

initiation, duration, and exclusivity. Additionally, all three types of support were perceived to be essential components of adequate breastfeeding support.

This study has several limitations. First the sample size is very small and therefore the results are not generalizable. The findings of this study only reflect the ideas of this group of African American women. Moreover, because of the method employed, and the small sample size, no correlations can be determined between received support and breastfeeding outcomes. Instead the findings of the study reflect the relationship of perceived support and breastfeeding outcomes, according to this group of women. In addition, all of the women in this study lived with their spouse or male partner. It may be useful to conduct a study including women who do not reside with their partner, in order to draw conclusions about how influential this support group is. Furthermore, women with female partners were not included in this study. There may be different outcomes for breastfeeding support provided by female romantic partners. Additionally, all of the women had access to breastfeeding peer counselors and lactation consultants. It would be helpful to conduct a study including women without this type of support, in order to draw conclusions on how influential this support group is. Moreover, this study only included women who were breastfeeding or had recently weaned. It would have been helpful to include women who did not initiate breastfeeding, in order to draw comparisons on how influential social support was on breastfeeding initiation. Additionally, while none of the women who were employed terminated breastfeeding because of conflicts with employment, these women likely had confounding factors that were not accounted for during the analysis. Furthermore, the method used in this study made it difficult to account for factors influenced by marital status and delivery method. In addition, this study only included African American women. It may have been helpful to include a racially diverse sample, in order to draw

conclusions about components of breastfeeding support that may specifically affect African American women. Finally, both qualitative and quantitative methodologies should be employed to gain a more complete assessment of the effects of social relationships and support on the breastfeeding outcomes of African American women.

In spite of the limitations, this study was able to generate a great deal of information relating to social relationships and breastfeeding experiences. Participants discussed a wide array of topics related to breastfeeding. The women were allowed to speak freely and candidly. This allowed for a more comprehensive view of the participants breastfeeding experiences, social relationships, and perceived support. Although the study sample was small, participants were from diverse economic and social backgrounds. Overall, previous studies on breastfeeding barriers and support for African American women have focused on low-income women. This study was able to examine the breastfeeding experiences of a more diverse group of African American women, in order to get a general assessment of the type of support that these women perceived to be most influential on breastfeeding, who provided the support, and how support was provided.

This study has implications for healthcare professionals and policy makers. Policies should specifically focus on strategies that include individuals closest to mother in the breastfeeding education process. Healthcare providers, peer counselors and lactation consultants should encourage and include the participation of spouses, partners and other relatives in breastfeeding educational efforts. Specifically, through encouraging these support groups to become familiar with the benefits of breastfeeding, how to assist women with managing breastfeeding, and how to assist with any problems that may occur during the breastfeeding process. In addition, this study suggests that it may be useful to implement breastfeeding

education and support through online programs. This may make breastfeeding education more accessible, not only to mothers but to partners and other family members.

Healthcare providers, peer counselors and lactation consultants should emphasize the importance of emotional, informational, and instrumental support in encouraging initiation, continuation, and exclusivity. In addition, healthcare providers should become more aware of the importance of informational and emotional support on the breastfeeding experience, as well as how mothers perceive adequate breastfeeding support.

Taveras and colleagues (2004) found that healthcare providers were not confident in breastfeeding assessment and often did not feel the need to actively encourage breastfeeding. Moreover, Haughwout and colleagues (2000) determined that healthcare professionals who receive more comprehensive training may possess more confidence and better skills in breastfeeding assessment. The findings of the current study suggest that the women felt their healthcare providers lacked knowledge about breastfeeding, did not diligently encourage breastfeeding, and did not provide support. Women and children's healthcare professionals should receive training on all aspects of breastfeeding, including assessing and treating any problems that may occur, and teaching techniques. Additionally, these healthcare providers should receive more training and education on how to support breastfeeding patients. Finally, healthcare providers, peer counselors, and lactation consultants should be educated on the cultural influences on infant-feeding decisions and address these issues during their interaction with breastfeeding women and their families.

Future research should focus on more comprehensive methods to understand what support systems are useful in encouraging African American women to initiate and continue breastfeeding, as well as exclusively breastfeed for longer periods of time. Specific attention

should be given to how these support systems positively influence breastfeeding outcomes for African American women. In addition, this study suggests a need for further inquiry into any cultural factors that may influence breastfeeding rates for African American women, particularly initiation. Furthermore, research should explore the use of the internet in promoting breastfeeding initiation, continuation, and exclusivity, including the implementation of online support groups and breastfeeding tutorials.

APPENDIX A: BREASTFEEDING INTERVIEW GUIDE

A. Breastfeeding Information

1. Describe how you got the majority of your information about breastfeeding. (Where did you get information? From whom did you get your information?)
2. How did you decide to breastfeed your baby? (Did anyone help you with this decision? Do you know someone else that breastfed their child?)
3. How have most of the women you know fed their babies? (Do you feel that their decisions influenced your feeding choice? If yes, how?)
4. What feeding method did your mother use to feed you and/or your siblings?
5. Describe how your spouse/partner feels about your decision to breastfeed the baby. (Are they supportive, discouraging, etc? Describe how your spouse/partner has been the most supportive since you started breastfeeding. Has your spouse/partner been unsupportive in any way?)
6. How do your family and/or friends feel about you breastfeeding your child? (What type of support or encouragement have they offered you? Has anyone seemed unsupportive in any way?)
7. How confident are you about breastfeeding your baby? (Do you have any concerns? Do you have knowledge about positioning and techniques?)
8. Describe anything that would make you more confident about breastfeeding. (Do you need more information, more support, more time, etc?)
9. How long do you plan to breastfeed your baby, and why? (Do you plan to breastfeed exclusively, and for how long?)
10. What do you enjoy most about breastfeeding your baby?

B. Infant Care

11. Describe how you learned about caring for your baby. (Did anyone teach you or give advice? Did you attend an infant care class? Did you talk to anyone about infant care?)
12. Does anyone help to care for your baby? How?
13. How would you describe a typical feeding time? (Does anyone assist you with the feeding?)

C. Typical Day

14. What does a typical day look like for you? (Describe your normal routine.)
15. Tell me about the daily household work in your home. (Who does it? Who does specific tasks such as cleaning, cooking, laundry, etc.?)
16. Describe the greatest stressors of your day? (What gets you stressed out the most?)
17. How do you usually cope or deal with these stressors?
18. Who usually helps you when you're having a bad day?
19. What gives you the greatest joy during your day?

D. Support Systems

20. Tell me about your relationships with the people close to you.
21. How would you describe the support you have received with breastfeeding, so far? (What support systems do you have now?)

22. Describe what you think good support is. (What can people say or do that's most supportive for you? How can people help you the most with your daily living? How can people help the most with breastfeeding?)
23. What support systems are most important to you achieving your breastfeeding goals? (Who or what helps you the most and what specific actions are the most supportive to you?)

F. School/Work/Breastfeeding Continuation

24. Are you currently a student or working? (If not, do you plan to become a student or go to work in the near future? If answer No, skip to question 29)
25. Tell me about your plans to care for the baby after/since returning to work/school. (Do you plan to continue breastfeeding? Do you plan to use a breast pump? Who will help take care of the baby while you are away?)
26. Do you anticipate any problems with continuing to breastfeed after/since returning to work/school?
27. What type of support will you need after/since your return to work/school?
28. How can the people close to you support you the most after/since returning to work/school?
29. Do you anticipate any problems with continuing to breastfeed your child in the future?
30. How can the people close to you offer support if you choose to continue breastfeeding?

APPENDIX B: BREASTFEEDING DEMOGRAPHIC QUESTIONNAIRE

The following questionnaire will ask you about your background information. Please remember that all information given will be kept confidential and only used for research purposes. These forms will be destroyed upon completion of this study. If you do not feel comfortable answering a question, you may skip it and go to the next one. Thank you.

1. What is your date of birth?
2. Where do you currently reside? (City, Township, etc.)
3. What is your level of education?

<input type="checkbox"/> Less than High School Diploma	<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> High School Diploma/GED	<input type="checkbox"/> Some Graduate/Professional Study
<input type="checkbox"/> Some College	<input type="checkbox"/> Graduate/Professional Degree
<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Other:
4. Are you a student?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------
5. Are you employed?

<input type="checkbox"/> Yes, occupation:	<input type="checkbox"/> No
---	-----------------------------
6. What is your relationship status?

<input type="checkbox"/> Single	<input type="checkbox"/> Living with same sex
<input type="checkbox"/> Married	<input type="checkbox"/> Living with opposite sex
<input type="checkbox"/> Separated/Divorced	<input type="checkbox"/> Other:
7. How many children do you have?
8. Describe your delivery method.

<input type="checkbox"/> Vaginal	<input type="checkbox"/> Induced vaginal	<input type="checkbox"/> Elective Cesarean
<input type="checkbox"/> Cesarean (c-section)	<input type="checkbox"/> Induced Cesarean	
9. Where did you get most of your information about breastfeeding?

<input type="checkbox"/> Doctor or other healthcare provider	<input type="checkbox"/> Family and/or Friends
<input type="checkbox"/> WIC Staff	<input type="checkbox"/> Spouse/Partner
<input type="checkbox"/> Internet, books, brochures	<input type="checkbox"/> Other:
10. How do you plan to feed your baby?

<input type="checkbox"/> Breastfeed exclusively	<input type="checkbox"/> Breastfeed with formula supplementation	<input type="checkbox"/> Other:
---	--	---------------------------------
11. Why did you choose to breastfeed your baby? Check all that apply.

<input type="checkbox"/> Health Benefits	<input type="checkbox"/> Family/Friend advice	<input type="checkbox"/> Spouse/Partner advice
<input type="checkbox"/> Saves Money	<input type="checkbox"/> Healthcare provider advice	<input type="checkbox"/> Other:

APPENDIX C: RESEARCH INFORMATION SHEET**Research Information Sheet**

Title of Study: *What Matters Most? An Examination of Breastfeeding Support for African American Mothers*

Principal Investigator (PI): Kanika A. Littleton
Department of Sociology
Wayne State University
(248)579-7063

Purpose:

You are being asked to be in a research study of breastfeeding support systems for African American mothers because you are an African American woman age 18 or older that is currently breastfeeding your child. This study is being conducted at Wayne State University and the homes of participants in the metro Detroit and Kalamazoo/Battle Creek areas. The estimated number of study participants to be enrolled is 20. There will be an estimated 10 participants at Wayne State University, as well as about 10 throughout Southeast and West Michigan. **Please read this form and ask any questions you may have before agreeing to be in the study.**

The goal of this study is to understand the breastfeeding experiences of a group of African American women. In this study you will discuss many issues that have helped to shape your experience as a breastfeeding mother. You will also provide information about what you feel is most important to achieving success with breastfeeding.

Study Procedures:

If you agree to take part in this research study, you will be asked to complete a questionnaire, as well as participate in a tape recorded interview about your support systems, breastfeeding experiences, daily activities, school and/or work, and future care for your child. The study requires a one time commitment. The total estimated time to complete the questionnaire and interview is 1 to 1 ½ hours. Your participation in this study is completely voluntary. You may choose not to answer any question on the questionnaire and/or during the interview. All information given on the questionnaire and during the interview will be anonymous and confidential.

Benefits

As a participant in this research study, there will be no direct benefit for you; however, information from this study may benefit other people now or in the future.

Risks

There are no known risks at this time to participation in this study

Costs

There will be no costs to you for participation in this research study.

Compensation

For taking part in this research study, you will receive for your time and inconvenience a Target store gift card in the amount of \$25. You will receive the gift card upon completion of the interview.

Confidentiality:

You will be identified in the research records by a code name or number. There will be no list that links your identity with this code. Audiotape recordings will be identified or labeled by a code name or number. Only the principal investigator will have access to the audiotape recordings. Audiotapes will be erased upon completion of the study.

Voluntary Participation /Withdrawal:

Taking part in this study is voluntary. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with Wayne State University or its affiliates.

Questions:

If you have any questions about this study now or in the future, you may contact Kanika A. Littleton at (248)579-7063 or Dr. Janet R. Hankin at the following phone number (313) 577-8131. If you have questions or concerns about your rights as a research participant, the Chair of the Human Investigation Committee can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Participation:

By completing the questionnaire and interview you are agreeing to participate in this study.

APPENDIX D: IRB APPROVAL



HUMAN INVESTIGATION COMMITTEE
101 East Alexandrine Building
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
<http://hic.wayne.edu>



CONCURRENCE OF EXEMPTION

To: Kanika Littleton
Sociology

From: Ellen Barton, Ph.D.

Chairperson, Behavioral Institutional Review Board (B3)

Date: December 09, 2009

RE: HIC #
124909B3X

Protocol Title: What Matters Most? An Examination of Breastfeeding Support for African American Mothers

Spons

or:

Protocol #:

0912007

825

The above-referenced protocol has been reviewed and found to qualify for **Exemption** according to Paragraph #2 of the Department of Health and Human Services Code of Federal Regulations [45 CFR 46.101(b)].

- Recruitment
- Script
- Pipeline
- Advertisement

- Flyer
- Information Sheet

This proposal has not been evaluated for scientific merit, except to weight the risk to the human subjects in relation to the potential benefits.

- Exempt protocols do not require annual review by the IRB.
- All changes or amendments to the above-referenced protocol require review and approval by the HIC **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the HIC Policy (<http://www.hic.wayne.edu/hicpol.html>).

NOTE: 1. Forms should be downloaded from the HIC website at each use.

2. Submit a Closure Form to the HIC Office upon completion of the study.

REFERENCES

- American Academy of Pediatrics. (2005). Breastfeeding and the use of Human Milk. *Pediatrics*, 115, 496-506.
- Arlotti, Jean Penrose; Cottrell, Barbara Hansen, Lee, Sally Hughes; Curtin, John Joseph. (1998). Breastfeeding Among Low-Income Women With and Without Peer Support. *Journal of Community Health Nursing*, 15(3), 163-178.
- Arora, Samir; McJunkin, Cheryl; Wehrer, Julie; Kuhn, Phyllis. (2000). Major Factors Influencing Breastfeeding Rates: Mother's Perception of Father's Attitude and Milk Supply, *Pediatrics*, 106(5), 65-69.
- Bachman, J.; O'Malley, P.; Schulenberg, J.; Johnson, K.; Bryant, A.; Merline, A. (2002). *The Decline of Substance Use in Young Adulthood: Changes in Social Activities, Roles, and Beliefs*. Mahwah, NJ: Lawrence Erlbaum
- Bartlett, Alison. (2002). Breastfeeding As Headwork: Corporeal Feminism And Meanings For Breastfeeding. *Women's Studies International Forum*, 25(3), 373- 382.
- Bramwell, Ros PhD. (2001). Blood and Milk: Constructions of Female Bodily Fluids in Western Society. *Women and Health*, 34(4), 85-96.
- Centers for Disease Control and Prevention. (2012). *National Immunization Survey: Breastfeeding Among U.S. Children Born 2000-2009*. Available at www.cdc.gov/breastfeeding/data/NIS_data/. Accessed on August 21, 2012.
- Chapman, Donna J. PhD. R.D.; Damio, Grace M.S., CD-N; Young, Sara, M.S.N., RN, IBCLC; Perez-Escamilla, Rafael, PhD. (2004). Effectiveness of Breastfeeding Peer Counseling in a Low-Income, Predominantly Latina Population A Randomized Control Trial, *Archives of Pediatric and Adolescent Medicine*, 158(9), 897-902.

- Chezem, Jo Carol; Friesen, Carol A.; Parker, Catherine G. (2004). Effect of Postpartum Support on Infant Feeding Patterns Among Breastfeeding Participants in the WIC Program. *Family and Consumer Sciences Research Journal*, 32(4), 349-360.
- Corbin, Juliet, Anselm C. Strauss. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Sage Publications.
- Creswell, John W. (2003). *Research Design: Qualitative, Quantitative, and Mixed Method Approaches* (2nd ed). Sage Publications, Inc.
- Cricco-Lizza, Roberta. (2005). The Milk of Human Kindness: Environmental and Human Interactions in a WIC Clinic That Influence Infant-Feeding Decisions of Black Women. *Qualitative Health Research*, 15(4), 525-538.
- DiGirolama, Ann M PhD, MPH; Grummer-Strawn, Laurence M. PhD; Fein, Sara B. PhD. (2008). Effect of Maternity-Care Practices on Breastfeeding, *Pediatrics*, 122(2), 43-49.
- Dillaway, Heather E.; Douma, Mari E. (2004). Are Pediatric Offices Supportive of Breastfeeding? Discrepancies Between Mothers' and Healthcare Professionals' Reports, *Clinical Pediatrics*, 43(5), 417-430.
- Dunn, Sandra; Davies, Barbara; McCleary, Lynn; Edwards, Nancy; Gaboury, Isabelle. (2006). The Relationship Between Vulnerability Factors and Breastfeeding Outcome. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(1), 87-97.
- Durkheim E. (1897). *Suicide: A Study in Sociology*. New York: Free Press
- Ekstrom, Anette; Widstrom, Ann-Marie; Nissen, Eva. (2003). Breastfeeding Support From Partners and Grandmothers: Perceptions of Swedish Women, *Birth*, 30(4), 261-266.
- Esterberg, Kristin G. (2002). *Qualitative Methods in Social Research*. McGraw-Hill.

- Forste, Renata; Weiss, Jessica; Lippincott, Emily. (2001). The Decision to Breastfeed in the United States: Does Race Matter? *Pediatrics*, 108(2), 291-296.
- Hannon, P.R.; Willis, S.K.; Bishop-Townsend, V.; Martinez, I.; Scrimshaw, S.C. (2000). African American and Latina Adolescent Mothers' Infant Feeding Decisions and Breastfeeding Practices: A Qualitative Study, *Journal of Adolescent Health*, 26, 399-407.
- Haughwout, Jean C.; Eglash, Anne R.; Plane, Mary Beth; Mundt, Marlon P; Fleming, Michael F. (2000). Improving Residents' Breastfeeding Assessment Skills: A Problem-Based Workshop, *Family Practice*, 17(6), 541-546.
- Idler, E.L.; Kasl, S.V. (1997). Religion Among Disabled and Nondisabled Persons: Cross-Sectional Patterns in Health Practices, Social Activities, and Well-being. *Journal of Gerontology, B* 52, S294-305.
- Johnston, Marina L. and Esposito, Noreen. (2007). Barriers and Facilitators for Breastfeeding Among Working Women in the United States, *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 36(1), 9-20.
- Johnston-Robledo, Ingrid; Fred, Victoria. (2008). Self-Objectification and Lower Income Pregnant Women's Breastfeeding Attitudes. *Journal of Applied Social Psychology*, 38(1), 1-21.
- Kimbrow, Rachel Tolbert. (2006). On-the-Job Moms: Work and Breastfeeding Initiation and Duration for a Sample of Low-Income Women, *Maternal and Child Health Journal*, 10(1), 19-26.

- Li, R., Hsia, J., Frindinger, F., Hussain, A., Benton-Davis, S., Grummer-Strawn, L. (2004). Public Beliefs about Breastfeeding Policies in Various Settings. *Journal of the American Dietetic Association*, 104, 1162-1168.
- Lofland, John; David Snow, Leon Anderson, Lyn H. Lofland. (2006). *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis* (4th ed). Wadsworth/Thomson Learning.
- McGinnis, J.M.; Williams-Russo, P; Knickman, J.R.(2002). The Case for More Active Policy Attention to Health Promotion. *Health Aff.*, 21, 78–93.
- Merewood, Anne; Mehta, Supriya D.; Chamberlain, Laura Beth; Philipp, Barbara L.; Bauchner, Howard. (2005). Breastfeeding Rates in U.S. Baby-Friendly Hospitals: Results of a National Survey, *Pediatrics*, 116 (3), 628-634.
- Mitra, A. K.; Khoury, A.J.; Hinton, A.W.; Carothers, C. (2004). Predictors of Breastfeeding Intension Among Low-Income Women, *Maternal and Child Health Journal*, 8(2), 65-70.
- Murphy, Sherry L. B.S.; Xu, Jiaquan,M.D.; Kochanek, Kenneth D., M.A. (2012). Deaths: Preliminary Data for 2010. *National Vital Statistics Reports*, 60(4), Hyattsville, MD: National Center for Health Statistics.
- Ortiz, Joan; McGilligan, Kathryn; Kelley, Patricia. (2004). Duration of Breast Milk Expression Among Working Mothers Enrolled in an Employer-Sponsored Lactation Program, *Pediatric Nursing*, 30(2), 111-119.
- Rowe-Murray, Heather J. PhD and Fisher, Jane R.W., PhD. (2002). Baby Friendly Hospital Practices: Caesarean Section is a Persistent Barrier to Early Initiation of Breastfeeding, *Birth*, 29(2), 124-131.
- Saldana, Johnny. (2009). *The Coding Manual for Qualitative Researchers*. Sage Publications.

- Schwartz, Kendra MD, MSPH; D'Arcy, Hannah J. S. MS; Gillespie, Brenda PhD; Bobo, Janet PhD; Longeway, MaryLou MSN; Foxman, Betsy PhD. (2002). Factors Associated with Weaning in the First 3 Months Postpartum. *Journal of Family Practice*, 51, 439-444.
- Singh, G.K.; Kogan, M.D.; Dee, D.L. (2007). Nativity/immigrant status, race/ethnicity, and socioeconomic determinants of breastfeeding initiation and duration in the United States, 2003, *Pediatrics*, 119, Supplement 1, 38-46.
- Stearns, Cindy A. (1999). Breastfeeding and the Good Maternal Body. *Gender and Society*, 13(3), 308-325.
- Strawbridge, W.J.; Shema, S; Cohen, R; Kaplan, G. (2001). Religious Attendance Increases Survival by Improving and Maintaining Good Health Behaviors, Mental Health, and Social Relationships. *Annual Behavioral Medicine*, 23, 68–74.
- Taveras, Elsie M.; Li, Ruowei; Grummer-Strawn, Lawrence; Richardson, Marcie; Marshall, Richard; Rego, Virginia H.; Miroshnik, Irina; Lieu, Tracy A. (2004). Opinions and Practices of Clinicians Associated with Continuation of Exclusive Breastfeeding, *Pediatrics*, 113(4), 283-290.
- U.S. Department of Health and Human Services. (2000). *Healthy People 2010*. Washington, D.C.: Office for Disease Prevention & Health Promotion, Office of Public Health & Science.
- U. S. Department of Health and Human Services. (2010). *Breastfeeding Fact Sheet*. Washington, D.C.: Office of Women's Health. Available at www.womenshealth.gov/publications/our-publications/fact-sheet/breastfeeding.cfm. Accessed on September 30, 2012.

- U.S. Department of Health and Human Services (2012). *Healthy People 2020: Maternal, Infant, and Child Health*. Washington, D.C.: Office for Disease Prevention & Health Promotion, Office of Public Health & Science. Available at www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=26. Accessed on August 20, 2012.
- Umberson, Debra and Montez, Jennifer Karas. (2010). Social Relationships and Health: A Flashpoint for Health Policy, *Journal of Health and Social Behavior*, 51(5), S54- S66.
- Umberson, Debra; Robert Crosnoe; Reczek, Corinne. (2010). Social Relationships and Health Behavior Across the Life Course, *Annual Review Sociology*, 36, 139-157.
- Wallace, Lora Ebert; Chason, Holly. (2007). Infant Feeding In The Modern World: Medicalization And The Maternal Body. *Sociological Spectrum*, 27(4), 405-438.
- Wambach, K.; Campbell, S.H.; Gill, S.L.; Dodgson, S.L.; Abiona, T.C.; Heinig, M.J. (2005). Clinical Lactation Practice: 20 Years of Evidence, *Journal of Human Lactation*, 21, 245-258.
- Williams, DR; Collins, C. (1995). US Socioeconomic and Racial Differences in Health: Patterns and Explanations. *Annual Review Sociology*, 21, 349-8.
- Witters-Green, R. (2003). Increasing Breastfeeding Rates in Working Mothers. *Families, Systems & Health*, 21, 415-434.
- Wolf, Jacqueline H. (2006). What Feminists Can Do for Breastfeeding and What Breastfeeding Can Do for Feminists. *Signs*, 31(2), 397-424.

ABSTRACT**WHAT MATTERS MOST? AN EXAMINATION OF BREASTFEEDING SUPPORT
FOR AFRICAN AMERICAN MOTHERS**

by

KANIKA A. LITTLETON**May 2013****Advisor:** Dr. Janet R. Hankin**Major:** Sociology**Degree:** Master of Arts

Breastfeeding offers numerous health benefits to the mother, infant, and society. In the United States breastfeeding initiation rates have increased, but continue to fall short of objectives set forth by the CDC in the Healthy People 2020 initiative, regarding duration and exclusivity. African Americans have lower rates of breastfeeding initiation, duration, and exclusivity than any other racial or ethnic group in the United States (USDHHS, 2012).

The purpose of this study was to examine the breastfeeding experiences of a diverse group of African American women, in order to better understand what social networks encouraged or discouraged breastfeeding initiation, continuation, and exclusivity. Close attention was given to the type of support provided by support systems to positively influence breastfeeding in this group of women. Additionally, this study sought to uncover the meaning of adequate breastfeeding support as perceived by the women in the study.

This study employed a qualitative research design using semi-structured in-depth interviewing. The sample included 15 African American women recruited from 2 sites serving breastfeeding women in Kalamazoo, Michigan. The purpose of the interviews was to ascertain the women's perspectives on breastfeeding experiences and support systems.

Results of this study indicate that participants engaged in a number of supportive social relationships which positively affected their breastfeeding experiences. Women in the study perceived romantic partners, breastfeeding peer counselors, and hospital-based lactation consultants to be most supportive during breastfeeding. Additionally, women received support from female relatives and friends, and online breastfeeding support groups. Participants found emotional, informational, and instrumental support to be most essential to breastfeeding success.

AUTOBIOGRAPHICAL STATEMENT

Kanika A. Littleton was born in June 1981 in Detroit, Michigan. She spent part of her childhood on a military base in Berlin, Germany. Upon returning to Michigan, she attended St. Suzanne Middle School and graduated with honors from Detroit Urban Lutheran High School in June 1999. As a high school student, Kanika served as senior class president and president of the National Honor Society. She was also involved with several community organizations to promote awareness of childhood hunger in southeast Michigan. In September 1999, she began studying sociology and premedical sciences at Wayne State University in Detroit, Michigan. As an undergraduate student, she served as a volunteer working with burn patients at Children's Hospital of Michigan. In December 2004, Mrs. Littleton graduated with a Bachelor of Arts Degree in Sociology. In September 2005, she entered the graduate program in the department of sociology at Wayne State University, in order to study medical sociology. Her research interest focused on the social aspects of women and children's health, as well as the social and emotional well-being of caretakers for children with special needs. As a graduate student, she worked as a children's caretaker and teaching assistant. She has also worked with parental organizations to promote community awareness of the challenges encountered by children with special needs. Mrs. Littleton resides in Kalamazoo, Michigan with her husband and two children.