Dueling Cultures: How Hispanic Women Reconcile Infant Feeding Options

A Thesis

Presented to

The Faculty of the Department

of Sociology

University of Houston

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

By

Angela R. Leal

May 2013

DUELING CULTURES: HOW HISPANIC WOMEN RECONCILE INFANT FEEDING OPTIONS

Angela R. Leal

APPROVED:

Samantha Kwan, Ph.D.
Committee Chair

Jennifer Augustine, Ph.D.

Elizabeth Gregory, Ph.D.
Department of English and the Women's, Gender & Sexuality Studies Program

Tatcho Mindiola, Ph.D.
Department of Sociology and the Center for Mexican American Studies

John W. Roberts, Ph.D.
Dean, College of Liberal Arts and Social Sciences
Department of English

Dueling Cultures: How Hispanic Women Reconcile Infant Feeding Options

---

An Abstract of a Thesis

Presented to

The Faculty of the Department

of Sociology

University of Houston

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

By

Angela R. Leal

May 2013

ABSTRACT

Breastfeeding has been demonstrated to be a health promoting and health protective feeding method for infants. National health statistics show that, although Hispanic women initiate breastfeeding at rates higher than the national average, there is a steeper drop in breastfeeding rates during the first six months of a child's life for this population (compared to other racial/ethnic groups). Previous breastfeeding research points to hospital experiences, social support, and work environments as explanations for decreased breastfeeding rates. For Hispanics specifically, research has linked increased acculturation among immigrant populations with a decrease in health protective behaviors. For native-born Hispanic women, dual cultural adaptation including maintaining or breaking away from traditionally gendered family structures may have more importance. Analysis of interviews with 18 Hispanic mothers showed emotional and practical support working in tandem to override the breastfeeding obstacles mothers face. Mothers with emotional support from at least one key individual in their life, backed by practical support in taking care of household or other responsibilities, allowed women to meet their breastfeeding goals. Further, dual cultural adaptation plays a complex role in breastfeeding. While adapting to a more modern American lifestyle, including two working parents, may decrease breastfeeding duration, maintaining a traditionally gendered family structure may decrease it as well.

TABLE OF CONTENTS

LIST OF TABLES

Dueling Cultures: How Hispanic Women Reconcile Infant Feeding Options

Introduction

Organizations invested in protecting public health worldwide and in the United States champion the benefits of breastfeeding. For example, both the World Health Organization (WHO) and the United States Department of Health and Human Services (USDHHS) have issued extensive documents discussing the benefits of breastfeeding and the importance of increasing breastfeeding rates as well as breastfeeding to at least six months of age (León-Cava et al. 2002; USDHHS 2011). Moreover, the American Academy of Pediatrics (AAP) states:

> exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first six months of life (AAP 2005:499)

Breastfed babies enjoy many benefits such as lowered risk of infectious diseases, infant mortality, certain types of cancer, obesity and asthma (AAP 2005:496-7). Breastfeeding mothers experience several benefits as well including reduced postpartum bleeding and decreased risk of breast and ovarian cancers (AAP 2005:497). Prolonging a breastfeeding relationship likewise prolongs or multiplies many of these benefits for both mothers and children (AAP 2005:499).

In spite of the health protective attributes of breastfeeding, rates drop dramatically by the time children are half a year old. Results from the 2008 National Health and Nutrition Examination Survey (NHNES) show, that while breastfeeding initiation rates rose from 60 percent for the 1993-1994 cohort to 77 percent for the 2005-2006, there was "no significant change" in the rate of children continuing to breastfeed at six months of age (NHNES 2008). The percentage of babies still receiving breastmilk at 6 months of

age hovered near 30 percent, well beneath the Healthy People 2010 goal of 50 percent (NHNES 2008). A more recent report distributed by the United States Surgeon General (below) shows overall breastfeeding rates for children born in the United States in 2007 dropped from 75 to 43 percent once a child reached six months of age (USDHHS 2011). While this came closer to meeting the pre-established goal of 50 percent, it still missed the mark.

Although Hispanic women initiate breastfeeding at rates higher than the national average (80.6 percent versus 75.0 percent), breastfeeding rates have a slightly steeper drop in the first six months of life for this population than any other included in the Surgeon General's racial/ethnic breakdown (USDHHS 2011). Among Hispanics, breastfeeding rates drop by 34.6 percent in the first six months of a child's life (USDHHS 2011). In comparison, the overall drop for the United States is 32 percent while the next highest decrease is essentially a tie between Non-Hispanic Whites at 31.5 percent and American Indians or Alaskan Natives at 31.4 percent (see table 1). Furthermore, although Non-Hispanic Blacks have the lowest initiation rates, their rate of decrease in the first six months is only 30.6 percent.

Sociodemographic Factor	Ever Breastfed (%)	Breastfeeding at 6 Months (%)	Breastfeeding at 12 Months (%)
United States	**75.0**	**43.0**	**22.4**
Race/ethnicity			
American Indian or Alaska Native	73.8	42.4	20.7
Asian or Pacific Islander	83.0	56.4	32.8
Hispanic or Latino	80.6	46.0	24.7
Non-Hispanic Black or African American	58.1	27.5	12.5
Non-Hispanic White	76.2	44.7	23.3

Table 1: Provisional Breastfeeding Rates of Children Born in 2007 (USDHHS 2011)

Conceptual Framework

In an attempt to understand this drop in breastfeeding rates among Hispanic women during the first six months after a child's birth, I reviewed the breastfeeding literature covering a variety of life situations with an eye towards any specifically involving Hispanic women living in the United States. Commonly occurring themes were standardized health expectations and the influence of healthcare providers, social support, work environments, and the transition from traditional Hispanic values to more mainstream American ones.

Standardized Health Expectations and the Influence of Healthcare Providers

Long before a mother faces the question of how to feed her child, the medical community may already be sending her mixed signals about what to expect from her body that she will eventually apply to infant feeding. Koerber states, "regularity and consistency have traditionally been idealized in medicine and our culture at large…(however) human milk…varies from one feeding to the next" (2005:312). A lifetime of messages telling mothers that regularity and consistency are standard and desirable expectations even from their own bodies may inadvertently send the message that a mother's milk is unreliable or at best uncomfortably unquantifiable. How mothers reconcile the aspiration towards a body that conforms with idealized expectations and the message that breastmilk is the best milk for her baby is of critical importance.

A culture of standardized expectations may inspire a common question posed by breastfeeding mothers: How will I know my baby is getting enough milk? A mother who provides infant formula for her child can easily compare the ounces in a bottle at the

beginning and end of a feeding. This makes answering the question of how much her child is consuming relatively simple. A mother who offers her breast may not have such a straightforward answer. Avishai referred to breastfeeding as a "carefully managed project" and an "anxiety-producing enterprise….deeply invested in bodily discipline" (2007:136, 139 & 149). Evidence of this may lie in diaper-charting, which involves a daily diaper count and careful examination of what is in each one. Johns Hopkins Medicine Health Library (2013) provides diaper-charting instructions listing the number of expected diapers per day of life and detailed descriptions of a breastfeeding newborn's bowel movements. Diaper-charting demonstrates and attempts to respond to anxiety new mothers feel about breastmilk consumption particularly in a culture of standardized expectations. However, it may fuel anxiety as well.

A study examining hospital practices surrounding childbirth showed that, while 80 percent of medical staff members supported a woman's decision to breastfeed, almost the same percentage of new mothers (i.e., 75 percent) was sent home from the hospital with a breastmilk alternative (Wallace and Chason 2007:428-9). The fact that mothers went on to purchase the brand provided to them by hospital staff (Wallace and Chason 2007:429) exemplifies the trust mothers place in medical professionals. On the one hand, public health campaigns beginning with the Surgeon General's office (USHHS 2011) set goals for breastfeeding making it a priority for our nation's children. On the other hand, medical staff may not always commit to breastfeeding as a priority in daily practice by making milk substitutes too readily available. These conflicting practices may unintentionally undermine both the importance of breastfeeding and the success of a mother's breastfeeding relationship with her child at a critical time.

Social Support for a Breastfeeding Mother

A mother's social support begins with the person closest to her. Partner support can be pivotal in a breastfeeding relationship and has been shown to weigh heavily on breastfeeding initiation and success (Dykes and Flacking 2010; Vaaler et al. 2010; Wallace and Chason 2007). Much of the breastfeeding literature discusses mother/father pairs and Vaaler and colleagues assert, "decisions about infant feeding are made by *both* mothers and fathers" (2010:156, my emphasis). Other studies have found however, that fathers may back away from directly taking part in infant feeding decisions because it was not their "domain" (Wallace and Chason 2007:419). However, if the father is present in the home, it would be difficult to argue that he does not impact the outcome. Stearns found, "a partner who worried about public breastfeeding could be a real deterrent to women's desire to breastfeed at all" (1999:318). Likewise, women reporting a "better relationship" (Wallace and Chason 2007:424) before the birth of their child also reported higher rates of intention to breastfeed as well as follow through. A father's absence from the home may affect breastfeeding simply by virtue of his not being there as support.

At the same time, single mothers live in a variety of situations, such as with their parent/s, with other family members or friends, or even as the only adult in a household and the absence of a partner becomes the presence of someone else, very often a family member, on whom she leans for support. Dykes and Flacking found "a combination of professional and peer support" created fertile conditions for breastfeeding to continue (2010:735) showing that in addition to encouragement from healthcare providers, just

having a solid support partner committed to helping a new mother get her footing in motherhood may be more important than that partner's specific title.

Right outside of a woman's closest supporters is the extended social environment. Mothers do not spend all of their time at home hence they will eventually need to feed their child in public making privacy and social opinion issues with which she must contend. Some researchers, such as Bartlett, have taken on privacy as a feminist issue arguing that even nicely equipped rooms set aside for mothers to breastfeed "expel" them from more public areas (2002:112). Where Bartlett argues breastfeeding mothers are being discouraged from feeding their child in public, Acker shows sexist attitudes have a significant impact on a person's view of public breastfeeding (2009:486). Additionally, both Bartlett and Davis show how women who breastfeed in public are considered deviant even as laws are enacted to protect them (Bartlett 2002:14; Davis 2004:67). With a culture such as this it would be difficult to expect mothers' breastfeeding decisions are entirely unaffected by other people's opinions whether directly or indirectly.

Work

Whether or not to work outside of the home has been a divisive issue among women for many years. In her participant observation with La Leche League International, a breastfeeding support group, Bobel found many women put a premium on staying home with their children and breastfeeding on demand while attempting to have a moment separated from your child is met with "resistance" (2001:140, 142). However, many women have no choice but to work outside of the home allowing that environment to have a significant impact on women's breastfeeding practices. Additionally, many

women discontinue breastfeeding when they return to work or shortly after. Reasons for this may vary but the absence of federal breastfeeding policies for employers in the United States is noteworthy (Vaaler et al. 2010:155). Specifically, Labbok calls this lack of formal employer support a "failure to recognize maternity rights" (Labbok 2006:283). Women with "greater paid leave" (Wallace and Chason 2007:425), which may translate to a higher status title (either because of accumulated time in the position, more education or both) including greater trust and flexibility in the work environment, are more likely to *plan* on breastfeeding, *actually* breastfeed, and do so for longer periods of time (Wallace and Chason 2007:425).

In her interviews with breastfeeding mothers, Avishai discovered that even when coworkers and bosses are cooperative, breastfeeding mothers were conflicted on their own view of pumping at work. Some women noted that pumping was "both…work, and …a maternal practice that competes with *real* work" (Avishai 2007:142, my emphasis). Her interview subjects were middle class and white-collar professionals with some measure of control in their work environment. However, such flexible work roles and/or such authoritative positions do not typify women's employment. On the contrary, Blum's research found "more rigid control of time, space and activity characterized women's work" (Blum 1993:296) making pumping on the job a near impossibility. Finally, verbal support from co-workers and bosses is important and can provide some comfort but underlying effects of time spent pumping breastmilk on other co-workers' workload at a part time job or job evaluations (Wallace and Chason 2007:425) may steer a mother away from breastfeeding her child, particularly in work settings.

Straddling Cultures

It may be that the social processes affecting breastfeeding among Hispanic mothers are the same that affect any other group of American women (NHNES 2008). Many women confront influences from medical professionals, as well as opinions of friends and relatives when making their infant feeding decisions. In addition, many women must negotiate time at work to pump milk or meet with their child to breastfeed. However, a review of the research regarding breastfeeding and the Hispanic Paradox—a situation in which Hispanics fare better than expected health wise considering a number of sociodemographic factors (Kimbro, Lynch and McLanahan 2006:184) hints that there may be more culturally unique influences acting upon whether or not a woman breastfeeds and, if so, how long.

While some research has pointed to acculturation as an explanation for the decline of positive health behaviors including breastfeeding among Hispanic immigrants, it is difficult to pin down a firm definition of acculturation. For example, some researchers point out church attendance as an outstanding component of "cultural engagement" indicating a firmer grasp on tradition and less acculturation (Kimbro et al. 2008:188). Language has also been used to determine level of acculturation with speaking only Spanish or showing a strong preference for Spanish as markers of being less acculturated (Gorman et al. 2007:311). However, while the intricacies of daily life assist quantitative researchers looking at clusters of behaviors, qualitative research benefits from a more behind the scenes view to uncover the social forces driving individual decisions.

In this case, moving from a more immigrant-focused approach like acculturation towards the concept of "dual cultural adaptation" (Knight et al. 2010:468) may provide a

more accurate indicator of how people are making decisions particularly when studying an American born population. Knight and his research team describe dual cultural adaptation as the merging of "mainstream (American) values and…Mexican American values" adding that the "incongruence…may become more salient to Mexican Americans born in the United States" (Knight et al. 2010:468). Reconciling the incongruence between cultures may cause conflict when it comes to positive health behaviors because each culture's approach to health and their bodies may differ.

Additionally, a part of what causes the steep drop in breastfeeding rates among Hispanic mothers during the first six months of children's lives may lie somewhere in Hispanic family structure, often characterized by a highly gendered division of labor (Knight et al. 2010; Lorenzo-Blanco 2012). Women bogged down with all the responsibilities of homemaking and childrearing may find it impossible to add on time to breastfeed as well, particularly if they work outside of the home on top of it all. Further, Rafaelli and Ontai found parents reinforce gendered roles, characteristic of Hispanic families, by socializing their children into them (2004:297). These traditionally gendered parenting roles include fathers modeling behaviors for children while mothers shape them more interactively (Knight et al. 2011:922). This increased interaction between mothers and children puts Hispanic mothers in a potentially powerful and influential, if not burdensome, position.

In light of the themes that emerged during my literature review—individual health and the influence of healthcare providers, social support, work, and the integration of traditional Hispanic values with more mainstream American ones, including the expectation of a gendered roles within Hispanic family structure—this research attempts

to discover if and how these issues shape infant feeding decisions among Hispanic mothers particularly in the first six months of their children's lives.

Study Design

Concepts: Breastfeeding and Bottle-feeding

Because breastfeeding is rarely an all or nothing decision, it is important to clarify how I conceptualized breastfeeding and bottle-feeding mothers for this study. A bottle-feeding mother is one who either never offers her child breastmilk or someone who did not offer breastmilk past the child's first six weeks of life. In contrast, a breastfeeding mother is one who continues to offer her child breastmilk past the first six weeks of her child's life including women who incorporate formula into their child's diet.

Sampling and Recruitment Strategies

This study, approved by the University of Houston's Committee for the Protection of Human Subjects (CPHS), began as a project aimed to learn about breastfeeding among American born Mexican mothers in the US. However, research was expanded to include Hispanic woman of any origin in order to better match participants to women included in USDHHS data regarding breastfeeding rates during the first six months of life. As such, the most basic inclusion criterion each participant was to be a Hispanic mother. Due to time constraints and CPHS restrictions, women included in this study were required to be at least 18 years old. I placed a soft restriction on the age of their children. My preference was to speak with women within five years of bottle or breastfeeding an infant (child under one year old). The purpose of this limitation was to maximize the possibility of more detailed recall by the mother of occurrences leading up to the birth of her child

and their breastfeeding experiences. I expected that while mothers may clearly remember the larger situations playing into their early infant feeding decisions, many details of their daily experiences might be lost with time. This concern was confirmed through interviews with women who had children on the older side of the group as well as those with multiple children. While they were able to share quite a bit of information about their experiences, they often expressed irritation with themselves at sometimes not remembering the first hours of their children's lives very well.

Health statistics show that a majority of women *do* try to breastfeed their newborns. Regardless of education level, at least 66 percent of women attempt breastfeeding (USDHHS 2011) and more than 70 percent of women eligible for the Supplemental Nutritional Assistance Program for Women, Infants and Children (WIC), a program focused on providing nutritional assistance to low income women, initiate breastfeeding with their children (USDHHS 2011). For Hispanic women specifically, the Centers for Disease Control and Prevention show 80.6 percent of women initiate breastfeeding (USDHHS 2011).

Keeping in mind that few women never breastfeed, it is not really practical to seek out a group of women who have never attempted breastfeeding. Because this research examines social processes that contribute to the drop in breastfeeding rates in the first six months of a child's life, strictly including a group of women that have never breastfed is not required. On the contrary, including women who have at least tried to breastfeed and for a variety of reasons did not continue is important. As a result, purposeful selection was chosen as the most effective strategy "to illuminate the reasons

for differences between individuals" (Maxwell 2005:90). Specifically, I worked to recruit a group of women who breastfeed[1] their children, as well as women who do not.

I used four methods of recruiting participants. First, I created fliers soliciting participation by Mexican American women (the originally intended population for this project) in a research project about infant feeding (available in the appendix). I posted these fliers on the University of Houston campus in designated posting sites outside of classroom buildings and accepted an offer from an acquaintance to post a flier in the lobby of the Houston Food Bank. This method was unsuccessful and yielded no responses. Second, I asked listserv administrators to share my information and request for participation on their listservs. These listservs were strategically chosen because of their potential to reach women who match my intended research participant profile. They included the Center for Mexican American Studies, the Women's Resource Center, the University of Houston Childcare Center, and the Women's Studies Department. Together these listservs potentially reach hundreds of people. This method yielded one participant. The third method I used was one of the more successful, direct contact. I asked people I personally know who also fit the criteria if they would be willing to speak with me about infant feeding as a part of the research I was working on to complete my master's degree. Direct contact yielded four participants. By far the most successful method was the fourth strategy, referral. I spoke with people I know about my project and the inclusion criteria and asked them to send me as many people as they could who fit the profile. The referral method generated thirteen participants or 72 percent of the mothers I spoke with for this project.

[1] In the interest of simplicity I use present tense when discussing infant feeding. However, mothers in this study have children in a range of life stages. Therefore present tense does not capture each current circumstance.

In addition to recruiting participants through fliers, I had planned to recruit through snowball method but this did not work. Even when the women I spoke with took the initiative to offer sharing my contact information with people they know before I made the request myself, I received no contacts this way. The best method was referral. There are two possible, somewhat related explanations for this. First, the bulk of this research was conducted in January right on the heels of the biggest holiday season of the year including Thanksgiving, Christmas and celebration of the New Year. As such many people are getting back to work from time off and many mothers are sending their children back to school or going back to school themselves. Therefore it may be a particularly busy time. The data show the women in this study self report as very busy and often overwhelmed. A request to add a research interview to their schedule may be out of the realm of possibility for many women. However, even incredibly busy women are often inclined to help someone they personally know and that seems a reasonable explanation for how I was able to get as many participants as I did.

The bulk of the women I interviewed were either women I already knew and have known for many years or women who were close (and in several cases related) to people I know and have known for many years. This could potentially be seen as a bias if the women were very similar in ideology or demographic characteristics. However, the characteristics of the sample group show how varied the life experiences of the women in this study actually are. This benefits a study like this one seeking to represent a diverse set of experiences within a culturally defined group of women. Additionally, having an established rapport with several of the women I interviewed made our discussions flow more easily all the while paying keen attention to professionalism. Infant feeding may

initially either seem like a relatively benign topic or an exciting topic giving a mother the opportunity to talk about her children. The discussion can become a sensitive one however, when specifically talking about infant feeding choices with a researcher. Having either an established relationship or common acquaintances can ease a research participant's potential concern that her choices are being judged harshly therefore helping her feel more at ease to open up during an interview. Also, when speaking with someone I already knew, I kept from responding with lengthy personal stories or offers of advice as I might in a less formal conversation. I also kept the conversation focused on informing the research question rather than allow it to diverge onto other paths that may hold personal interest but shed no light on how Hispanic women make infant feeding decisions. Perhaps one of the most important issues in this particular study was to emphasize the confidentiality of our discussions since I have several personal connections in common with the research participants.

Sample Size and Sample Demographics

The total number of women interviewed for this project amounted to 18. Some observers, such as Kvale, note that "common interview studies" include 15±10 participants, making a rather large range of between 5 and 25 interviewees (2007:1171). He further notes that many may benefit from having fewer interviews allowing more time to focus on preparation and analysis (Kvale 2007:1171). That was the case here as my smaller sample size allowed me, as an independent researcher with no assistants, to spend more time doing both. Rather than spend additional time recruiting during the interview phase of my project, I listened to each interview several times before conducting the next one. This allowed me, as a fledgling interviewer, to refine my interviewing technique

along the way. I learned new ways of phrasing questions and importantly, when to stop talking and let the interviewee take the lead. Through listening to each interview several times, I also learned some general rules about interviewing. I became increasingly able to pick up on non-verbal cues such as tone of voice and body language which helped me determine better ways of approaching each topic or when to move on to the next one. This time spent reviewing the recordings and reflecting on the interview which, as Kvale states, "provides richer access to the subjects' meanings" (Kvale 2007: 1385). I also began working on analysis sooner giving me time to delve into the responses deeper.

Although all of the women who participated in this project are Hispanic mothers of young children, they varied greatly in other socio-demographic characteristics representing a broad spectrum of life experience (see table in the appendix). The youngest participant was 19 years old and the oldest was 52. Their mean and median ages were both 32 while the mode was 31. The ages of the children spanned from one week and 3 days old to 34 years old. The mean age of the children whose mothers interviewed for this study is six years old while the median is five and the mode is two. The number of children each woman has ranges between one and four. The mean, median and mode of the number of children the women have are two. I did not control for level of education, occupation or income. Further, I did not include restrictions on marital status or number of children each woman has. Of the 18 women interviewed six completed high school, three reported completing some college, one completed an associate's degree, one completed technical training in the military, six women earned bachelor's degrees, and one has a master's degree. The participants' occupations included one full time student, one who works from home but travels frequently for her

job, one elementary school teacher, one who works part-time in a retail store, one waitress, four stay-at-home mothers, one engineer and eight who work in a professional offices in positions ranging from administrative assistant to senior management. All of the women work outside of the home full time unless otherwise noted. I did not inquire about their income levels or the income levels of their spouses. All but two of the women participating in this project are in committed heterosexual relationships and living with their partner both now and at the time of their children's births. Two of the women are single and were also single at the times of their children's bottle and/or breastfeeding. Although it was not a requirement for participation in this study, all of the women gave birth in a hospital. All of the mothers in this study gave birth to one child at a time. I did not have the opportunity to interview any mothers of multiples.

Of the 18 mothers I interviewed, five breastfed each of their children, twelve in all, for at least six months. Nine mothers either did not initiate breastfeeding or breastfed for less than six weeks for a total of twenty-six children who bottlefeed. The remaining four breastfed at least one child for six months but did not breastfeed the other/s as long. One woman breastfed her first child but not the second because she became ill and was put on a medication that is incompatible with breastfeeding. Another woman breastfed her first two children but not the third due to a personal health issue. One of the women in the study was incarcerated at the time of her first child's birth (through the child's first year of life) but not at the time her second child was born allowing her dramatically more say in how her second child is being fed. Two other moms breastfed their first born for exactly six months and their second for five. One of them cited illness as a cause and the other could not continue because of the specific circumstances of her paid employment.

Three of these children stopped breastfeeding right at six months of age and one of them went on to breastfeed until she was twenty months old or a year and eight months. Although the idea has been previously alluded to, it is important to emphasize that circumstances change with each child. While one child in a family may breastfeed for six months or longer his or her sibling/s may not breastfeed at all. Each of these situations is discussed further in the findings section.

Interview Guide and Conducting the Interviews

Blum states in breastfeeding research "we need women's voices…to articulate needs" (1993:306). Articulating needs can only happen when women have the opportunity to speak about their experiences. Sometimes we may not even be fully cognizant of our own needs until we are offered the opportunity to share our experiences with someone willing to give us their full attention. In sociological research, this happens during in-depth interviews and that is why interviews with mothers form the foundation of this qualitative study.

This interviews in this study served to gain insight into the social processes responsible for the drop in breastfeeding rates between birth and six months of age reported by the Centers for Disease Control and Prevention (USDHHS 2011). A semi-structured questionnaire was developed based on a review of relevant literature. The questions were designed with several goals in mind. The first step was to establish relevant demographic information from participants. This was accomplished either by asking the participant to complete a demographic information sheet (available in the appendix) or in the case of phone interviews asking them the questions on the form. The qualitative portion of each interview began with a request for the participant to describe

the first time they fed their oldest child. Since all of the women in this study gave birth in hospitals this provided the opportunity to begin assessing their interactions with medical staff including obstetricians, nursing staff and pediatricians. Questions regarding interactions with medical staff before the birth of their child/children and immediately surrounding that time as well as during the first year of life followed. Beyond the line of questioning relating to medical influence were questions about where they learned the bulk of their child feeding information and the opinions and influence of their family, partners and friends. Prompts to initiate discussions about breastfeeding management in situations involving family and friends, as well as breastfeeding in public, came next. For the women who work outside the home, I asked about the support or lack of support they perceived in their work environment. One last assessment of what guided these women's infant feeding processes was a question about weaning. I asked them to describe how they went about weaning and then followed up with questions about how they decided on which steps to take and when. Each interview concluded with the opportunity for them to add anything they might like me to know or ask questions about my research including questions about the interview. Each question posed, as CPHS agreed, minimal psychological harm to participants. A copy of the interview guide is available in the appendix.

Interview locations and times varied. I conducted interviews in sandwich shops, restaurants, one participant's office and another's home. I also spoke with several on the phone, commonly the case with women who either live outside of Houston or work more than 40 hours a week. For in person interviews, consent forms were handed to the participant and I verbally reiterated the information on the consent form before the

interview began. In the case of phone interviews, consent forms were sent through electronic mail before the scheduled interview. One consent form was sent via postal mail because the participant did not have access to a printer and scanner. In this particular case, I included a self addressed stamped envelope to return the consent form. When discussing the consent form I specifically reminded each participant that her privacy would be protected and pointed out the option not to answer any question and the freedom to discontinue the interview at any time. Another key element of the informed consent form was the request to digitally record the interview to which all participants agreed. At the conclusion of each interview I thanked each participant and asked her if she knew anyone else that might be willing to speak with me. Some offered before I asked but as previously mentioned no participants were generated through this method. I sent a thank you card to each participant within a week of our interview.

Data Analysis

Digital recordings of each interview were saved in MP3 format and transferred through USB connector to a specific file on my MacBook Pro. The computer itself is password protected and I am the only one with access to the computer and the password. I listened to the interviews on ITunes while I transcribed them. After transcribing the interviews, I printed them to make them easier to work with during analysis.

Although I had listened to each interview several times and transcribed them myself, I read through the transcripts in their entirety before beginning to code them. As I read through them comparing them to the literature review I had already conducted, my research question began to take shape. I began to recognize patterns in the transcripts that had been reported in quantitative research. For example, most women I spoke with

did initiate breastfeeding. Many started and stopped right in the hospital after giving birth while others continued for a few days, weeks or months. Seeing this pattern prompted me to refer back to the *Surgeon General's Call to Action to Support Breastfeeding* (2011) because it gives recent data about breastfeeding rates over time broken down into racial and ethnic groups. This allowed me to make the connection between data showing many women discontinue breastfeeding in the first six months of their child's life and participants in this study. Maxwell points out "well-constructed, focused questions are generally the *result* of an interactive design process" (2005:66, my emphasis) and this is precisely what happened in my research. Going into interviews with knowledge garnered through a literature review but openly receiving participants stories lead me to ask: which social circumstances shape Hispanic mothers' infant feeding decisions? I also took the inquiry one step further to find whether or not there are culturally influenced circumstances leading to the drop in Hispanic breastfeeding rates between birth and six months of age.

Although some researchers may handle this entire process on a computer, physical copies allowed me to actually get my hands on the documents and made them more convenient to carry around as I read through them anytime I got the chance. In addition to physical copies of each transcript, I used a notebook to memo and organize the developing codes and memos.

Coding and memoing involved several stages of refinement. Matthews has said, "accurate interpretation of behavior and words requires knowledge of the context" (2005:800). Because I listened to each recorded interview several times during the interview phase of my project and transcribed each of them myself I was familiar with

how each conversation went. As a Hispanic mother just above the median age who is also a wife, student and works outside of the home with two children who were primarily breastfed, one of which was also offered infant formula, I have a good grasp on the challenges and triumphs each woman grappled with. Therefore, developing interpretive codes, which rely more on "research insight" than literal replication of what each participant says (Hesse-Biber and Leavy 2006:352), was my first step when engaging in the actual coding and memoing process. The validity of these codes were confirmed through a comparison with existing research as well as the repetition of these themes throughout the interviews. Sometimes the codes did in fact match mothers' words directly. However, some mothers articulated the same ideas in a more roundabout way.

When I began to code I wrote a two to three word interpretation of main ideas in the margins. For example, if I came across an example of a mother having difficulty breastfeeding her child for the first time but receiving instruction or assistance from nurses, I wrote "learning curve, medical staff practical support" in the margin. I coded each of the transcripts in this manner and was able to quickly divide the preliminary codes into factors that hinder breastfeeding and those that enable it. The lists below show the results of this first stage of coding.

Breastfeeding Hindrances

- Unsupportive medical staff
- Physical challenges (health problems-mom and baby)
- Busy home life (too busy doing it all-housework and childcare)
- Family is negative about breastfeeding
- Friends and coworkers are negative about breastfeeding
- Workplace is unsupportive – no place to pump milk
- Uncomfortable with breastfeeding (ie. Rather pump than breastfeed)
- Is the baby getting enough milk?
- Mom's emotions affect baby
- Breastfeeding is physically painful

- Hospital Staff "pushes", "forces" breastfeeding
- Bottle feeding is easier
- Breastfeeding restricts diet
- Breastfeeding restricts activity
- Breastfeeding is frustrating
- Medical Staff supports formula feeding
- Social awkwardness/Breastfeeding is not normal
- Mom's self care: food/rest/proper nutrition

Breastfeeding Enablers

- Armed with information (medical and anecdotal)
- Confidence
- Commitment to breastfeeding
- Belief in healthfulness of breastfeeding
- Breastfeeding is nice/bonding
- Breastfeeding is easier
- Breastfeeding is not restrictive
- Breastfeeding is cheaper
- Coworkers/Managers are supportive (emotional and practical)
- Family is supportive (emotional and practical)
- Partner is supportive (emotional and practical)
- Personally experienced
- Supportive healthcare workers

After developing these codes and dividing them into hindrances and enablers it was necessary to further organize them while also making some theoretical connections. I sorted the codes into three categories collapsing or dismissing them when they did not pertain to my core research questions. Several codes were dropped because they did not provide any answers to why women stopped breastfeeding. I derived the codes in table 2a and table 2b during this stage.

Categories	Focused Codes: Breastfeeding Hindrances
Health	Medical Staff: Pro-formula, Negative
	Learning Curve (Latch/Position)
	Is the Baby Getting Enough?
Work	Heavy Schedule
	No Place to Pump at Work
	Unsupportive Environment
Personal	No Time for Self Care
	Unsupportive Family and Friends
	Busy with Household Chores/Other Children

Table 2a: Breastfeeding Hindrances

Categories	Focused Codes: Breastfeeding Enablers
Health	Medical Staff Educates Mom
	Medical Staff Encourages Mom
	Medical Staff Creates Opportunity to Breastfeed
Work	Supportive Work Environment
	Time and Place to Pump Breastmilk
Personal	Husband/Family Provide Emotional Support
	Husband/Family Provide Childcare/Mom Care

Table 2b: Breastfeeding Enablers

The Findings

Breastfeeding mothers need support. All but one woman in this study expressed a desire to either breastfeed or breastfeed longer. When keeping in mind the question of why mothers do not continue breastfeeding, support is key. Although all of the mothers in this study professed that breastfeeding is the healthiest way to feed an infant, they did not all continue. Therefore it did not matter that they were educated on breastfeeding. Many times other social circumstances prohibited a mother from continuing to breastfeed even if she wanted to do so. Even the most ardent breastfeeding advocates must sometimes make choices out of alignment with their idealized goals when confronted with social circumstances too overwhelming to tackle alone. Nearly 35 percent of

Hispanic mothers who begin breastfeeding their babies in the hospital abandon the practice by the time their children are less than six months old (USDHHS 2011). The question is: why do these women intend to breastfeed and begin, only to discontinue within the first six months of their child's life?

While all of the issues mentioned in previous research (i.e., health, support, work and possibly dual cultural adaptation and gendered family structure) affected the women interviewed for this study, the specific reasons each woman cited for discontinuing breastfeeding relationships varied. Thirteen of the mothers I spoke with discontinued breastfeeding at least one of their children before the six-month mark. Only five, or just over one-third, found it possible to continue for at least six months and as much as twenty months. The following excerpts from my interviews help shed light on what enables and what hinders breastfeeding for at least six months.

Self-Educating on the Health Benefits of Breastfeeding

The hospital was the first place each of these women first fed their children and throughout the interviews health issues abound. The women in this study, both breast and bottle feeding moms, tout the health benefits of breastfeeding. Breastfeeding moms cite it as their guiding force in choosing to begin or continue breastfeeding. Bottle-feeding moms often began for the same reason going on to seek out infant formulas that in their estimation mimic breastmilk as closely as possible when they discontinue providing milk themselves or simply chose not to offer it at all. Either way health issues and healthcare workers influenced the infant feeding decisions of all of the mothers I spoke with, confirming the need to spotlight health in this research.

Mothers consistently said they wanted to follow recommendations based upon medical advice. Before their children are born, especially first children, many women reported deciding to at least try breastfeeding. As early as several years prior to the birth of their children or as late as the third trimester of their pregnancies, the women in this study reported a dedication to learning all they could about their infant feeding options. They educated themselves seeking out information through classes and pamphlets recommended by their healthcare providers, on the Internet, and in books.

Liz (age 29, mother of two) began pursuing infant feeding education through the prenatal classes provided by the hospital at which she planned to give birth and was convinced to try breastfeeding her two boys. "When you go to those prenatal classes… they always talk about breastfeeding…I mean it's pretty much everywhere so I was just like…it's the best route." In addition to prenatal classes many mothers self teach about breastfeeding through reading materials available in their doctor's and other healthcare offices. Similarly, when asked where she got her information about breastfeeding, Anne (age 19, mother of two) says, "Oh, they give pamphlets whenever you're pregnant like everywhere (like) at WIC [Special Supplemental Nutrition Program for Women, Infants, and Children]."

Many women told me they, like Mandy (age 41, mother of two), "went online and researched the benefits…and all of those factors played into" their decisions. Even beyond the initial decision however, some mothers found solace or even medical advice about breastfeeding difficulties online. Mary (age 36, mother of two) was able to self diagnose her mastitis (a painful condition commonly experienced by breastfeeding mothers) by reading through the "forums of people posting" common symptoms. This

led her to realize what was happening, get help quickly and continue breastfeeding her child. In addition to looking to the forums for other mother's opinions, they often tempered this advice with information garnered through conversations with acquaintances and family members, often their mothers. Cassie (age 23, mother of two) mentioned that although she relied on "baby websites" for some of her infant feeding information, she "leaned more towards (her) mom… because you know…she raised (her)" and on the websites "there's different people that write them (the websites) and some of them are not even parents." Most of the women I spoke with coupled this Internet research with reading *When You're Expecting* (2008). This was cited by almost all of the women as a resource they depended upon heavily because as Delia (age 31, mother of one) stated when asked where she got her breastfeeding information, "I was reading that book everybody reads…*What to Expect When You're Expecting*…that book…I read it all in there."

Zeroing in on Health

An emphasis on the health impact of breastfeeding available in several of these classes and reading materials may have an unexpected side effect, an overemphasis on nutrition which may concurrently promote and conflict with breastfeeding. Conscientious mothers direct dedicated focus on the nutrition their newborns will receive whether it comes from their bodies or a bottle. All of the breastfeeding mothers in this study were well versed in breastfeeding benefits both nutritionally, knowing the difference between the nutrient rich colostrum breastfed babies partake of in the first days of life and immunologically, reciting research claiming breastfed babies get sick less often. They even added reading that breastfed babies are "smarter" (Marie age 32,

mother of 2; Beatriz age 27, mother of two). The breastfeeding mothers unanimously named health reasons as their number one motivation for choosing to give their babies their own milk. However, this does not mean bottle-feeding moms did not know about claims that breastmilk provides children with better health outcomes. They all talked about how healthy breastfeeding is too. However, since breastfeeding did not work in their lives, moms who offered their babies infant formula, whether after hours, weeks, or months or even those who never breastfed combed through websites and read cans on the grocery store shelf to find formula that, in their determination, "have all the vitamins inside that breastmilk does" (Marie, age 32, mother of two) or have extra nutrients like iron (Nancy, age 34, mother of two). On the other hand, confirming the idea that women place their faith in medical professionals, many give their children the formula the doctor recommends or even provides for them. Jenny (age 34, mother of one) said when she started talking to her pediatrician about switching her son to formula "she sent (her) home with like six cans of free stuff."

Further, an outlook narrowing the focus of infant feeding to its nutritional element may have the effect of women seeing breastmilk as merely a disembodied product provided by mothers for the nutritional benefit of their children. No one exemplified this ideology more than Marie (age 32, mother of two). She made the choice to almost exclusively pump her breastmilk beginning the day her first child was born. She insisted on breastmilk for her child but did not physically offer him her breast for more than two weeks. Marie reasoned "the most important thing was the actual milk…my milk…it didn't really matter either way how the baby go the milk."

A nutritionally fixated view may also lead very conscientious women to question the sufficiency of their own milk. Five of the eighteen mothers with whom I spoke cited a health related reason as responsible for the end of their breastfeeding relationship. Consider Elsa's (age 35, mother of three) decidedly empirical approach to feeding her daughter:

> I felt like she wasn't gonna get enough or that it wasn't going to be nutritious enough or maybe I was scared I wasn't eating the right things… I just felt that if I'm giving her the bottle…I know she's eating…just knowing that the bottle's empty…okay, I know she had her milk. With breastfeeding…How do I know she's got enough? …I didn't physically see something to know she's got it.

Two of the five mothers who discontinued breastfeeding before the six-month mark mentioned illnesses as the catalyst. Both of these women have older children who were breastfed for at least six months intensifying the emotional dimension of their decision to begin offering formula. Cassie (age 23, mother of two) told me,

> I felt like a bad mom for switching her to formula. I really wanted to breastfeed her and to see her drinking out of a bottle and knowing that it was formula…it just made me kind of sad like oh I'm not gonna have that bond with her like I had with Jacob.

In total three of the five mothers who stopped breastfeeding a child due to a medical reason breastfed at least one child for a minimum of six months. This suggests they may have continued breastfeeding if they believed they were physically able.

Early Postpartum Interactions with Hospital Staff

Educational materials distributed and often developed by healthcare professionals should facilitate smooth communication between medical staff and new mothers. However, preparations prior to giving birth may be eclipsed by what actually happens

during the critical first moments and days of breastfeeding. Therefore, to learn more about why women start breastfeeding then stop in the first six months of life, the search for answers should involve women's descriptions about what happens immediately after their babies' birth.

Supportive Hospital Experiences

When talking about the nurses attending to her just after her daughter's birth Beatriz (age 27, mother of two) highlighted their harmonious relationship, "I think they have the same mentality too, you know…keep breastfeeding your child as long as possible and if they make it easy for you…it will help you to continue doing it through the months." Nurses might be the most important staff members a new mother sees in the hospital. They walk women through the birthing process and visit them the most, essentially representing an entire medical community when they walk into their recovery rooms. The practical support they provide can act as a catalyst for the beginning of a great breastfeeding relationship. Several of the women I spoke with talked about simple things the nurses they encountered did to make breastfeeding possible. Marie (age 32, mother of 2) noted that even though she had a C-section the nurse brought her baby to her in "less than an hour" to be breastfed. Others met with lactation nurses to help their baby's latch, learn to position them properly or get confirmation that they were on track while learning this new skill. Jenny (age 34, mother of two) whose son was jaundiced talked about meeting with a lactation nurse "that first week…probably like every other day or so" until they made breastfeeding work. Delia's (age 30, mother of one) son had to be whisked away to the Neonatal Intensive Care Unit as soon as he was born due to a congenital heart defect. Without practical support from the hospital nursing staff she may

have never been able to give her son breastmilk and discontinue the formula they necessarily had to feed him just after he was born. She said the nurses "taught me and my husband how to feed him…while he was in ICU…for two weeks," eventually taking him from a feeding tube to direct breastfeeding by the time she and her husband took him home.

False Starts: When Hospital Staff Negatively Impact the First Days of Breastfeeding

However, medical professionals are not universally committed to facilitating breastfeeding and several of the women I interviewed described nursing staff who were neutral about how they fed their babies which can either ease pressure on a mother, make her question the importance of breastfeeding or even make her feel unsupported in her decision to breastfeed if that was her original intention. One particularly unsupportive nurse explicitly discouraged Nancy (age 33, mother of two) from breastfeeding. She advised her to give her son infant formula instead because she "felt that he wasn't gonna latch on…to the breast and that (Nancy) was gonna get frustrated." Direct instruction on how to feed your child can weigh heavily on a first time mother who relies upon medical advice. Additionally, women may be more vulnerable than usual immediately postpartum because the process of giving birth is physically and emotionally draining. Nancy did end up bottle-feeding her two children but not all women adhere to the advice of their nurses so readily.

Outside of technical advice backed by a nurse's hunch about how breastfeeding might go for a new mom, the emotional backdrop of their interactions with mothers trying to breastfeed for the first time can set the tone of the experience. Melissa (age 31,

mother of two) described her first breastfeeding experience with her daughter, who was slow to take the breast, as:

> Frustrating…but even more heartbreaking 'cause I'm a first time mom …everything's supposed to be perfect for the baby so it was hard in that sense…the nurse yelled at me because I wasn't feeding the child…I heard that if you give them formula from a bottle then that's it…I would do my best to just try and nurse her and…the nurse yelled at me…I started crying. My mom took her. That was the first time I fed my daughter.

Sandra (age 24, mother of three) said she felt the young medical assistant attending to her seemed "kind grossed out about it…that's what I thought because she didn't help me as much as the older lady did with my first child." Both Melissa and Sandra found the emotional and practical support they needed among their respective family members to go on and meet their breastfeeding goals.

When a new mom's expectations do not match their realities of breastfeeding, they may opt for bottle-feeding on their own before even leaving the hospital. Most of the women I spoke with described their first moments and even days of breastfeeding their babies as a "struggle" (Jenny 34, mother of one) or even more frequently "frustrating." January (age 41, mother of two) made it clear that she "didn't lose (her) patience…(she) wanted to keep trying and ….he was okay… he woke up and he started (to breastfeed)." However, Liz (age 29, mother of two) attempted to breastfeed her son and found he "was not latching up…he was getting frustrated…I was getting frustrated…so I just went the easier route and I was like let's just give him the bottle and that worked out perfect for everybody."

One Key Supporter

Looking at the overall picture, encounters with hospital staff or medical professionals are influential but fleeting while personal relationships and circumstances remain fairly constant sources of strength or impediments preventing people from reaching their goals. Once women get home with their new babies balancing breastfeeding with other obligations further complicates things. In my interviews the importance of social support from at least one close person emerged as a deciding factor in women's continuation of breastfeeding. Social support beginning with the person to whom we are closest is potentially the most pervasive force in a woman's life. For the women in this study this was often the father of their child. In the absence of the child's father the mother's own mom usually stepped in to help care for her grandchildren.

When I asked the mothers in this study if their husbands supported their infant feeding decisions they universally said yes. Not a single woman in this study said her husband was anything less than completely supportive of her infant feeding choices. However, "supportive" seemed to take on different meanings for different women. Active support comes in two complementary and necessary forms, emotional and practical. Verbally cheering on a new mother to breastfeed yet offering little support with childcare, self care or housework does not really enable breastfeeding. In fact, it might only make a woman feel worse if she is unable to continue with her ideal plan of breastfeeding her child since verbal support may highlight the goal while losing sight of the needs of daily life that must be fulfilled in order to make it happen.

Trying to Balance It All

Missy's comment (age 31, mother of two) illustrates how breastfeeding without practical support in handling basic needs can seem impossible. "I felt like I didn't even have time to feed myself…that's the reason why I wanted to bottle feed him… how was I gonna give him…my breastmilk…if I didn't eat right?" Gee (age 52, mother of four) echoed her sentiment. "When you're (breast)feeding them…you couldn't do much of anything else…their dad didn't care either way…I mean it was up to me 'cause I'm the one that's gonna have to do it." Liz's (age 29, mother of two) words then sound very familiar.

> By the time you think you can take a nap or take a break its like he's crying to be fed…trying to adjust to a baby (long pause) it was difficult…it was very difficult…to try to sit there and really like let me take time and see if we can breastfeed…it's just too much.

Bolstered By Support

Emotional support can be critical in the moments and days right after giving birth. Cassie (age 23, mother of two) felt herself slide into postpartum depression following the birth of her daughter and "confided in (her) husband." She remembers feeling as if her daughter "didn't want (Cassie) to hold her…that she didn't love (her) and maybe that's the reason why she didn't wanna latch." However, after talking with her husband she says, "he made me feel a whole lot better and I don't think my…my postpartum depression…even lasted more than a month."

When the anxiety-ridden first days of a child's life melt into a new daily routine however, practical support can act as the crucial link between a mother's breastfeeding goals and her ability to meet them. All of the married and partnered women in this study

concluded that as the father became more involved with childcare, including feeding, he also became more connected with his child. Mandy (age 41, mother of two) described her family's overnight feeding routine referring to the trio of herself, her husband and their daughter as a "tiny team." Further, when asked who helped her with her children the most, January (age 41, mother of two) immediately named her husband.

> He was very caring … he was always there if I ever needed anything...making it as comfortable and as peaceful for me as possible so if I needed some blankets or needed *anything*…he was always there to say don't worry about it, I got it…I didn't need to struggle or do I have this? Or do I have…he had everything pretty much…(he) took care of me that way.

Not all women have such supportive husbands. In fact, some do not have a husband at all but that was not necessarily a barrier to breastfeeding for the single women in this research. Each of the single mothers I spoke with met their breastfeeding goals with the help of close family members. Sandra (age 24, mother of three) told me that in addition to convincing her to breastfeed her children and providing her with plenty of information about its benefits, her mother would bathe the kids and "feed 'em in the morning…she was probably more … like their dad I guess."

Married women are grateful for emotional support and guidance from parents as well and often prioritized their mothers' advice over what they read on the Internet, in books or materials from healthcare providers. Jenny's (age 34, mother of one) parents went beyond emotional support to provide a level of practical support many mothers might only hope to have. "They were staying with us for the first…six to eight weeks…they would…take him immediately (when she finished breastfeeding) and burp him (so Jenny) could go straight to sleep."

Back to Work

Support in the home is critical but the work environment can influence and even determine how often or how long a mother offers breastmilk to her child. Four of the eighteen women in this study specified it as a reason to stop breastfeeding.

Work/Life Imbalance

Some women who work outside the home talked about how in spite of supportive colleagues or designated places to pump breastmilk, other problems prevented them from actually following through with breastfeeding. Jill (age 33, mother of three), for example, felt that although her workplace officially provided space to breastfeed her "work schedule" did not permit it. Other women like Lena (age 32, mother of two) felt that when they returned to work their supply diminished.

Mary (age 36, mother of two) had two very different experiences providing milk for her children when she returned to work. She says that when she returned to the office after giving birth to her first child, "there was a lot of support" at work and she found it easy to pump when others would take "a smoke break." Her experience breastfeeding her second child did not go as smoothly though. Since her company was going through lay offs there were few people she needed to communicate with in her office, affording her the opportunity to work from home. Ironically, instead of making breastfeeding easier, she "felt like she should always be doing something" related to her paid job and ended up weaning her daughter sooner as a result.

Obligations to earn a living often supersede the desire to provide breastmilk for a child especially when breastfeeding or pumping bring emotional and practical challenges.

It can make purchasing and offering infant formula seem like a godsend. This can be the case in the best of circumstances but if a work environment seems less than supportive breastfeeding may seem uncomfortably out of reach. Melissa (age 31, mother of two) described her workplace as having a very strict culture overall that was very tied to the clock. As a result she pumped her milk in ten-minute breaks scattered throughout the day. When I asked her if she let her boss know she was a breastfeeding mom she said she was afraid:

> He would think that I'm using it as an excuse for sympathy…as a woman, that's why I didn't wanna say: oh I'm breastfeeding so you need to give me more time…Does that make sense? It was my *job*. I had been laid off for thirteen months. I was not trying to lose this job. I (was) going to do whatever I have to do to make it work…and I just did.

Melissa is surprisingly the type of woman who might be expected to have more autonomy than most in her job. She is a college-educated woman working in a high paying technical field. However, she noted she "was the only woman in the building" which can make women particularly leery of bringing breastfeeding into the picture for the same reasons some women may still be slow to mention being pregnant during a job interview. It is not to say men are inherently unsupportive of breastfeeding (or pregnancy). It is just to say that women have dealt with so much inequality in the workplace they may feel disempowered by emphasizing any part of their lives that reminds the men around them that they are different.

When Breastfeeding Works at Work

Work is not always detrimental to a breastfeeding relationship but when it is the cause can generally be attributed to support in the workplace. Most often moms who

continued to breastfeed for at least six months and worked outside of the home simply had the opportunity to pump milk at work. Moreover, mothers who continued to breastfeed for at least six months had supportive bosses and/or coworkers in common. In addition to supportive coworkers, Beatriz (age 27, mother of one) noted, "they have our own little breastfeeding room where you can bring your child and go in there and feed…or pump. They have a refrigerator, little bags, everything. So, it's nice." Some, like January (age 41, mother of two) had the benefit of locking the door to her "own office" allowing her the freedom to avoid speaking about it "to (her) manager" or any other man in her "primarily male dominant" office. Instead, she asked a female administrative assistant "not to have anybody come in (to her office)…during lunchtimes."

Some women do not choose whether or not to share this information because their bosses actually approach them. Cassie (age 23, mother of two) was working as a waitress and although this is typically a job people might expect to have less autonomy she believes if she had "worked anywhere else it wouldn't have been so supportive because breastfeeding is not…normal to bring up in the workplace." When her boss asked her why her shirt was wet one day. She divulged that although she had been on her shift for "six, seven hours" and had not pumped yet. He offered her the use of his office and she never suffered through the pain of being overfull or the potential embarrassment of leaking through her shirt at work again.

Making Sense of a Hispanic Cultural Inheritance

While a few of the women I spoke with had some inherited familial, ethnically specific, knowledge regarding childbirth and infant feeding; most of them did not.

Evidence of this came when I asked them if they knew how they were fed as babies. The majority of them were unsure at best. Rather than follow in their mothers' footsteps, they went straight for published information in its various forms. The women who did know how they were fed or had information passed down to them from their mothers or other older relatives or Hispanic friends reacted to advice with decisively mixed reviews. These mixed reviews are perhaps the clearest example of dual cultural adaptation since Knight and colleagues described this as the merging of "mainstream (American) values and…Mexican American values" (Knight et al. 2010:468).

Technical Advice

The mothers I spoke with greeted traditionally-flavored advice with a range of reactions from outright skepticism to appreciation. Melissa (age 31, mother of two) called her mother-in-law's advice of staying home for an extended period of time after the baby was born an "old wives tale" and said that instead she "did (her) best to stick to science." In attempting to recall the advice as clearly as possible, Melissa guessed her mother-in-law told her to stay home for about three months. However, it is more likely she was referring to the *cuarenta*, a period of forty days immediately following the birth of a child during which a Mexican mother devotes her time primarily to the baby and little else including household chores, errands or outside work.

Liz (age 29, mother of two) was offered some advice just in case she decided to breastfeed and comments, "I've thought to myself you know maybe they're just myths….but I believe it because that's how I was raised and…many of my Mexican family and friends…that's what they do and it's true, you know." Beatriz (age 29, mother of two) also leaned more toward acceptance and appreciation of traditional advice.

She mentioned learning through her family members' experiences that there is a "hot chocolate that is…homemade that has a lot of corn and other things in it" that helps a mother make more milk. While Liz was convinced to try breastfeeding she decided not to continue after trying it in the hospital. Beatriz however, breastfed her daughter for eight months. This may be due to the type of advice the women received. Liz's family and friends provided a laundry list of dietary restrictions. In contrast, Beatriz's family took a more constructive approach offering her a way to make breastfeeding work.

Merging Identities

In addition to technical advice dictated by older relatives and absorbed through immersion in stories shared by Hispanic friends, there is the need to integrate incoming information into one's own life. This is where dual cultural adaptation takes place on a grander scale, outside of the details but driving them at the same time. Some of the strongest pressure shows itself in the form of a gendered family structure and a new mother's access to practical support with household responsibilities.

Although being a stay-at-home mother can mean a tremendous amount of often unrecognized work, married couples who adhere to traditional roles in which the father takes on paid employment and the mother stays at home to handle housekeeping and childrearing, can make breastfeeding work with outside help. Delia (age 30, mother of one), a breastfeeding stay-at-home mother, named her mother-in-law as a huge help. She said,

> She's constantly calling me to see if I need anything. She comes over maybe two or three times a week to help me take care of him (her son)…she lets me go off, run errands so that she can spend time with him…she'll bring me food. She's always making sure I'm fed. She does the dishes like every time she's here.

Two of the other three stay-at-home mothers also reported having a significant amount of help with household responsibilities from at least one other person. Further, the women who reported having plenty of help also breastfed at least one child for a minimum of six months.

When the Merge is More of a Clash

Mothers grappling with the combination of the American standard of a dual income family and the Hispanic tradition of a gendered family structure are less likely to breastfeed at all much less for six months. Three of the mothers, whether they worked outside of the home or not, named an incompatibility between household responsibilities and breastfeeding. Of these three mothers, not one continued to breastfeed past six weeks. This demonstrates the negative impact both dual cultural adaptation and gendered family structure can have on breastfeeding. Only one of these mothers is a full time stay-at-home mom, Gee (age 52, mother of four). However, she pointed out, " You go from just you to always having to have somebody…you always have to carry them around with you when you're feeding them. You couldn't do too much of anything else."

Stories shared by other moms whether they work outside of the home or not confirmed the importance of a helping hand in "being able to balance the work and the home life" (Lena age 32, mother of two). However, they often had to achieve this balance on their own. Missy (age 31, mother of two), a mom who works outside of the home, tried to breastfeed both of her sons, setting her goal for her second child as simply "going longer" because she "felt bad that (she) didn't continue longer with (her) first" child. She did breastfeed her second son twice as long but still found could not continue

past six weeks because "as far as breastfeeding" she was "pretty much on (her) own." When asked what would have helped her continue breastfeeding Missy said all she really needed was "help making meals." Liz (age 29, mother of two), who bottlefed both of her sons, had a different experience and described her role as taking care of all the childcare and housework as a stay-at-home mom when her children were under a year old. "I was kind of like the mommy and daddy duty for a while." She called this situation "overwhelming."

Discussion

This research set out to discover what social circumstances shape Hispanic women's infant feeding decisions. A review of breastfeeding literature led to several arenas of life that were important to explore in the interviews conducted to answer this question: influence of the medical community, partner and family support, work environments, the integration of traditional Hispanic values with more mainstream American ones, including the expectation of traditional gendered roles within Hispanic family structure.

The findings of this study show that women who breastfeed for at least six months are those receiving the most active support. Active and effective support has two components: emotional and practical. Although emotional support can create a safe environment to push forward and achieve predetermined goals, practical support is essential to allow those goals come to fruition. The first moments of a child's life can fill a new mother with anxiety and self doubt but active support can alleviate so much of this.

Also demonstrated through the words of the women who participated in this study is that this active support does not always need to come from the same person. Previous research has demonstrated the importance of nursing staff in imparting information to new mothers (Paço, Gouveia and Duarte 2010; Wallace and Chason 2007). In the case of learning to breastfeed this was certainly true for the women in this study. However, a woman's partner can provide unmatched emotional support, which can be "a significant factor in mothers' decisions to breastfeed" (Vaaler et al. 2010:149). The combination of a nurse's practical support and a partner's emotional support can enable a woman to be well equipped to overcome the challenges that accompany breastfeeding and meet her personal goals.

Once a woman leaves the hospital and begins life at home with her baby she continues to need complete support from her closest parenting partner whether that person is a husband or other family member such as the woman's mother. Blum has said "breastfeeding can be more autonomy-compromising than pregnancy" (1993:301). Dealing with this decreased autonomy in the midst of other responsibilities in the household can put a damper on a woman's enthusiasm for breastfeeding leaving her to outsource the feeding of her infant in order to take care of other things such as housework, other children or even herself.

For women working outside the home an emotionally supportive work environment including a supportive boss can make all the difference in how long a woman continues to breastfeed her child once returning to work. While practical workplace support such as a designated place to pump breastmilk may encourage a woman to continue breastfeeding (Balkam, Cadwell and Fein 2010: 682), these types of

facilities are rare and only two women in this study mentioned mother's rooms at their workplace. Further, regardless of what is available to them some women see "pumping (breastmilk) as a scheduling problem and as a time-consuming activity that interferes with the 'real work' that goes on" in the workplace (Avishai 2004:141) be it at home or in an office building. It can also be an uncomfortable situation for some women to approach their male bosses about "engaging in a process that involves partial undressing" while at work (Avishai 2004:145).

Dual cultural adaptation seems to be less about deciding whether to follow traditional technical advice or modern medical advice and more about merging traditional lifestyles with more modern ones. While the mothers interviewed for this study might say they have essentially eschewed traditional ways by leaning more on modern science, they may be overlooking the ways in which a tradition of gendered familial expectations impede achieving their breastfeeding goals. Less traditionally gendered family arrangements were associated with increased breastfeeding success in that men who take an active role in childcare show support for their wives both emotionally and practically at a critical and possibly particularly vulnerable time. Conversely, more gendered family structures often leave women no choice but to drop breastfeeding in favor of completing other household chores especially if they also work outside of the home, which the majority of the women in this study do.

Conclusion

Motherhood is filled with challenges. Infant feeding, particularly in American culture where the message that "breast is best" surrounds us, can be a divisive and emotionally draining issue during a time of increased vulnerability. Just as friends and

relatives support each other during any number of major life changes, the threshold into motherhood should not be crossed alone. In answering the question of why women discontinue breastfeeding in the first six months of life, the simple answer is support, while the more developed answer points out both practical and emotional support as necessary pieces of the puzzle. This support does not all have to come from one person such as the father; it can come from a variety of sources but both types of support are vital for a mother to achieve her breastfeeding goals.

In asking whether or not there are any culturally specific reasons Hispanic women's rates of breastfeeding drop more than any others in the first six months, the answer may be more about overall influence than direct impact. Dual cultural adaptation on infant feeding may insinuate for instance the merging of culturally inherited advice about what not to eat or drink when breastfeeding with current scientific findings. Further, it could suggest the rejection of such limitations by reducing breastfeeding duration or choosing not to breastfeed at all.

More commonly dual cultural adaptation becomes apparent in the merging of a woman's role in a more traditional Hispanic family with the role of a modern American woman. For example, if women spend more time participating in the paid workforce more often in the United States versus Spanish speaking countries where women are more likely to breastfeed (Gibson-Davis and Brooks-Gunn 2006:642), then a traditionally gendered family structure would interfere with breastfeeding by putting additional restraints on a woman's freedom to pursue her goals including breastfeeding her child. When speaking with Mexican immigrant women in an ESL (English as a Second Language) class, Warner and Leidy (2008) found that although they agreed with a more

egalitarian ideology; in their words, "the majority are still the sole caregivers of their children, do not have a career, and believe they are managing a large percentage of the housework" (2008: 116). Families who broke with this more traditionally gendered division of labor enabled mothers to achieve more success in reaching their breastfeeding goals. This success ultimately contributes to the entire family's wellbeing physically and potentially emotionally. Making infant feeding a family affair rather than a responsibility solely relegated to the mother creates an opportunity for a father to demonstrate his active support for his wife and to bond with his baby.

It is noteworthy that while a gendered division of household labor may not be particularly unique to Hispanic households, the goal of this project is not a comparison with any other racial or ethnic groups. The data collected in this project does not permit a comparison of Hispanic women's explanations for the drop in breastfeeding rates with any other group. On the contrary, this study only attempts to explain the drop in breastfeeding rates *among* Hispanic women. Although many women of any race or ethnicity may contend that the burden of household duties tends to fall heavily on women, this research suggests that this may account in part for the a decrease in breastfeeding duration among Hispanic women, even if Hispanic women are not the only women affected by this work imbalance.

This study has ethnic, geographic and demographic limitations. One such limitation is the inclusion of primarily Mexican American women native to south Texas. Research has shown that Hispanic women are "less likely to be married…and more likely to have younger children at younger ages outside of marriage" (McLoyd, Cauce, Takeuchi and Wilson 2000:1072). However, when this same research pries Mexican

Americans out of the larger Hispanic population this does not hold true. For example, Mexican Americans are shown to be half as likely as Puerto Ricans to have a female head of household and are more likely to have children within the confines of a married relationship (McLoyd et al. 2000:1072). Therefore, a more ethnically diverse study representative of variations within the broad umbrella category of "Hispanic" would be needed to see if the conclusions reached here can be extended beyond these participants. Further, this study did not account for father's nativity, cultural background or other demographic characteristics, which may exercise influence over his feelings regarding breastfeeding. For the women who were not involved with the father of their child or children, the characteristics of their primary support were not taken into account either. This may be important because a supporter who does not work outside of the home may have more time to devote to helping to care for another woman's children. Future research should not only aim to include a more representative sample but also seek out more information about a mother's closest supporters.

References

Avishai, Orit. 2004. "At the Pump." *Journal for the Association for Research on Mothering* 6(2):138–149.

_____. 2007. "Managing The Lactating Body: The Breast-Feeding Project and Privileged Motherhood." *Qualitative Sociology* 30(2):135–152.

Bartlett, Alison. 2002. "Scandalous Practices and Political Performances: Breastfeeding in the city." *Continuum* 16(1):111–121.

Bobel, Christina G. 2001. "Bounded Liberation: A Focused Study of La Leche League International." *Gender and Society* 15(1):130–151.

Blum, Linda M. 1993. "Mothers, Babies, and Breastfeeding in Late Capitalist America: The Shifting Contexts of Feminist Theory." *Feminist Studies* 19(2):290–311.

_____. 2000. *At the breast : ideologies of breastfeeding & motherhood in the contemporary United States*. Boston, Mass.; Enfield: Beacon ; Airlift.

Davis, Joanna R. 2004. "Bad Breast-feeders/Good Mothers: Constructing the Maternal Body in Public." *Berkeley Journal of Sociology* 48:50–73.

Dykes, Fiona, and Renée Flacking. 2010. "Encouraging breastfeeding: A relational perspective." *Early human development* 86(11):733–736.

Gibson-Davis, Christina M., and Jeanne Brooks-Gunn. 2006. "Couples' Immigration Status and Ethnicity as Determinants of Breastfeeding." *American Journal of Public Health* 96(4):641–646.

Gorman, Jessica R, Debra J Jackson, Theodore G Ganiats, and Eyla Boies. 2007. "Early Postpartum Breastfeeding and Acculturation among Hispanic Women." *Birth* 34(4):308–315.

Hesse-Biber, Sharlene Nagy, and Patricia Leavy. 2006. *The practice of qualitative research*. Thousand Oaks: SAGE Publications.

Johns Hopkins Medicine. n.d. "Breastfeeding: Getting Started with Breastfeeding." *Health Library*. Retrieved March 22, 2013 (http://www.hopkinsmedicine.org/healthlibrary/).

Kimbro, Rachel Tolbert, Scott M. Lynch, Sara Mclanahan. 2008. "The Influence of Acculturation on Breastfeeding Initiation and Duration for Mexican-Americans." *Population Research Policy Review* 27:183-199.

Knight, George P., Nancy A. Gonzales, Delia S. Saenz, Darya D. Bonds, Miguelina Germán, Julianna Deardorff, Mark W. Roosav, Kimberly Updegraff. 2010. "The Mexican American Cultural Values Scale for Adolescents and Adults." *The Journal of Early Adolescence* 30(3):444–481.

Knight, George P, Cady Berkel, Adriana J. Umaña-Taylor, Nancy A. Gonzales, Idean Ettekal, Maryanne Jaconis, Brenna M. Boyd. "The Familial Socialization of Culturally Related Values in Mexican American Families." *Journal of Marriage and Family* 73(5):913–925.

Koerber, A. 2005. "'You Just Don't See Enough Normal': Critical Perspectives on Infant-Feeding Discourse and Practice." *Journal of Business and Technical Communication* 19(3):304–327.

Kvale, Steinar. 2007. *Doing interviews*. London: SAGE Publications.

Labbok, M. 2006. “Breastfeeding: A woman’s reproductive right.” *International Journal of Gynecology & Obstetrics* 94(3):277–286.

Lee, Helen J, Irma T Elo, Kelly F McCollum, and Jennifer F Culhane. 2009. “Racial/Ethnic Differences in Breastfeeding Initiation and Duration Among Low-Income Inner-City Mothers.” *Social Science Quarterly* 90(5):1251–1271.

Léon-Carva, Natalia, Chessa Lutter, Jay Ross, and Luann Martin. 2002. *Quantifying the benefits of breastfeeding: a summary of the evidence*. Washington DC: PAHO.

Lorenzo-Blanco, Elma I., Jennifer B. Unger, Lourdes Baezconde-Garbanati, Anamara Ritt-Olson, and Daniel Soto. 2012. “Acculturation, Enculturation, and Symptoms of Depression in Hispanic Youth: The Roles of Gender, Hispanic Cultural Values, and Family Functioning.” *Journal of Youth and Adolescence* 41(10):1350–1365.

Matthews, Sarah H. 2005. “Crafting Qualitative Research Articles on Marriages and Families.” *Journal of Marriage and Family* 67(4):799–808.

Maxwell, Joseph Alex. 2013. *Qualitative research design : an interactive approach*. Thousand Oaks, Calif.: SAGE Publications.

McDowell, Margaret M., Chia-Yih Wang, Jocelyn Kennedy-Stephenson. 2008. “Breastfeeding in the United States. Findings from the National Health and Nutrition Examination Surveys, 1999-2006.” National Center for Health Statistics Data Brief (5). Retrieved August 27, 2012 (http://www.cdc.gov/nchs/data/databriefs/db05.pdf).

McLoyd, Vonnie C., Ana Mari Cauce, David Takeuchi and Leon Wilson. 2000. “Marital Processes and Parental Socialization in Families of Color: A Decade Review of Research.” *Journal of Marriage and Family* 62(4):1070-1093.

Murkoff, Heidi Eisenberg, and Sharon Mazel. 2008. *What to Expect When You Are Expecting*. New York, NY: Workman.

Paço, Arminda, Ricardo Rodrigues, Paulo Duarte, Paulo Pinheiro, José Martinez de Oliveira, Marta Soares. 2010. "The role of marketing in the promotion of breastfeeding." *Journal of Medical Marketing* 10(3):199–212.

Raffaelli, Marcela, and Lenna L. Ontai. 2004. "Gender Socialization in Latino/a Families: Results from Two Retrospective Studies." *Sex Roles* 50(5/6):287–299.

Section on Breastfeeding. 2005. "Breastfeeding and the Use of Human Milk." *Pediatrics* 115(2):496–506.

Stearns, Cindy A. 1998. "Breastfeeding and the Good Maternal Body." *Gender and Society* 13(3):308–325.

U.S. Department of Health and Human Services. "The Surgeon General's Call to Action to Support Breastfeeding". Washington, DC. Retrieved November 15, 2011. (http://www.surgeongeneral.gov).

Vaaler, Margaret L., Brian C. Castrucci, Sharyn E. Parks, Jamie Clark, Julie Stagg, Tracy Erickson. 2010. "Men's Attitudes Toward Breastfeeding: Findings from the 2007 Texas Behavioral Risk Factor Surveillance System." *Maternal and Child Health Journal* 15(2):148–157.

Wallace, Lora Ebert, and Holly Chason. 2007. "Infant feeding in the modern world: Medicalization and the Maternal Body." *Sociological Spectrum* 27(4):405–438.

Warner, Beth, and Cara Leidy. 2008. "Latina women's perception of gender equity in house-hold labor and its relation to marital satisfaction." *Human Service Education* 28(1):110-121.

Wolf, Joan. 2010. Is Breast Best? ; Taking on the Breastfeeding Experts and the New High Stakes of Motherhood. New York University Press.

Appendix

Interview Guide

Healthcare influence/experience and privacy issues.

Please describe the first time you fed your baby.

Hospital, home or birthing center?
Staff management of feeding?
Personal management of feeding?
During visits?

Did it turn out the way you planned? How so?

Accumulation of health knowledge

Do you know how you were fed as an infant?

Has that influenced your choices with your own child? In what ways?

Did you seek out information about infant feeding options before your baby was born?

When did you start thinking about how you would feed your baby?
How did you decide what information to listen to and what to ignore?
What or who influenced you the most? Why?

How much of a role did lifestyle considerations play in choosing how to feed your baby? In what ways?

Implementation of health knowledge.

Regarding daily care for your child including feeding, who do you feel supports you the most?

(Spouse, mother, mother in law?)
If BF – stories of enabling or obstacles.
If Bottle – if and how things might be different if they bf.

Please describe a typical infant feeding situation at home when things are really busy.
Then an ideal time when everything's working smoothly.

mixed family living situations
feeding your child when you are out
at friend or family parties
if bf - managing public breastfeeding and/or breastfeeding as a working mom

Please describe the weaning process.

How did you decide when to wean and how did you make it happen?

Moms,

If you have a child up to 6 years old and are…

***Mexican American and born in the United States**

***willing to participate in a brief one on one discussion about breast or bottle feeding**

***at least 18 years old**

Please contact Angela at: aleal3@uh.edu

This project has been reviewed by the University of Houston Committee for the Protection of Human Subjects (713) 743-9204.

Infant Feeding Study Participant Biographical Information

Date _____ **Time** _____

Alias _____

Age _____

Occupation

Full Time or Part Time _____

What Generation American are you? _____

Highest Level of Education Completed _____

Married, Partnered, Single _____

If Yes, Ethnicity of Partner/Spouse _____

Total Number of Adults in Household _____

Number of Own Children and Their Ages _____

Total Number of Children in Household and Their Ages ___

Thank you!

Respondent Pseudonym	Age	Marital Status	Generation American	Education	Occupation	Child	Duration of Breastfeeding
Anne	19	S	2nd	High School	Stay-At-Home Mom	1st 2nd	Once 1 week+
Beatriz	27	M	2nd	Some College	Administrative Asst.	Only	8 months
Cassie	23	M	3rd		Stay-At-Home Mom	1st 2nd	6 months 3 weeks
Delia	30	M	2nd	Bachelor's	Stay-At-Home Mom	Only	7 months
Elsa	35	M	2nd	Bachelor's	Administrative Asst.	1st 2nd 3rd	Once None None
Gee	52	M	2nd	High School	Stay-At-Home Mom	1st 2nd 3rd 4th	None None 2 weeks None
January	41	M	1st	Bachelor's	Engineer Tech	1st 2nd	10 months 11 months
Jenny	34	M	3rd	Bachelor's	In Compliance/Travels	Only	6 months
Jill	33	D	3rd	Some College	Sr. Financial Analyst	1st 2nd 3rd	3 weeks None None
Lena	32	M	4th	High School	Sr. Budget Analyst	1st 2nd	4 months 3 months
Liz	29	M	1st	High School	Financial Coordinator	1st 2nd	Once Once
Mandy	41	M	4th	Master's	Teacher	1st 2nd	6 months 20 months
Marie	32	M	4th	Associate's	Full-Time Student	1st 2nd	6 months 5 months
Mary	36	M	2nd	Bachelor's	Senior Manager of E-Commerce Operations	1st 2nd	6 months 5 months
Melissa	31	M	5th	Bachelor's	Engineer	1st 2nd	4 months 5 months
Missy	31	P	1st	Some College	Administrative Asst.	1st 2nd	3 weeks 6 weeks
Nancy	33	M	3rd	Military Training	Retail Sales	1st 2nd	None None
Sandra	24	S	3rd	High School	Waitress	1st 2nd 3rd	11 months 11 months None

Table 3: Participant Demographics

Key
S: Single
M: Married
D: Divorced
Generation American: The number of generations of a respondent's family who lived in the United States before them.
Duration of Breastfeeding: Describes how many times a mother breastfed; children breastfed for less than one year were offered infant formula until approximately one year of age.