Nipple Matters: A Black Feminist Analysis of the Politics of Infant Feeding among African American Mothers

Nicole Elaine Banton

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During this unique moment of feminist inquiry wherein breastfeeding has been a focal point of interdisciplinary research, little sociological scholarship has been presented which has centered on the various meanings that African American mothers, as a diverse group, attach to their experiences with breastfeeding and/or infant formula use. While patterns of behavior have been explored in a cross-racial context, most social science studies have not focused on how the choice between breastfeeding, using infant formula, or using a combination of the two has impacted (or has been shaped by) African American mothers’ constructs of self, motherhood/mothering, their birth experiences, and their
sexuality. In order to understand the interplay of the decision-making process and these constructs, I conducted a qualitative study in which I participated in face-to-face interviews with a diverse group of thirty African-American mothers. They ranged in age from 18 years-old to 50-years-old. At the time of her interview, each mother had at least one child who was three-years-old or younger. Through our discussions, we explored how pre-pregnancy perceptions, lived experiences as a mother, familial influences, and the discourses surrounding motherhood within an African-American context affected the perceptions and experiences that the mothers in the study had with their infant feeding practice(s). Findings suggest that while African Americans mothers know that “breast is best,” that knowledge is not the only reason for their decisions. The first step in understanding why African-American mothers choose the feeding method(s) that they choose is embracing the reality that choosing is an ongoing and dynamic process which is often informed by what she does versus “is supposed to do” versus how she is portrayed weighed with the consequences of her choice(s) for herself and her family. Further, African American mothers are in the active process of negotiating an evolving definition of themselves within this post-Civil Rights, Affirmative Action context wherein choices appear abundant, but the choosing always comes with a price.
NIPPLE MATTERS: A BLACK FEMINIST ANALYSIS OF THE POLITICS OF
INFANT FEEDING AMONG AFRICAN-AMERICAN MOTHERS

by

NICOLE E. BANTON

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August 2009
For Mummy and Diaksahu
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CHAPTER 1

INTRODUCTION

Historically, African-American mothers have been at the forefront of breastfeeding (Roberts, 1997). During the Middle Passage (AKA African Holocaust), enslaved African mothers breastfed not only their own children but also the children who were separated from their biological mothers. Throughout the period of slavery, African-American mothers were forced to be wetnurses for the babies of their White enslavers. When an enslaved African-American mother could not see to the care and/or feeding of her own child(ren) because of restrictions placed upon her by her enslavers, it was common practice for another mother to take care of feeding the child (Roberts 1997, Collins 2000).

In the past half century, there has been a significant shift in the rates of breastfeeding among African-American women. According the Centers for Disease Control, African-American mothers are the least likely group to breastfeed their babies regardless of their class, age, or educational status. While 69% of all children who are discharged from the hospital are breastfed, among African-Americans, the figure is 59%. Unfortunately, by the six month mark (the duration for exclusive breastfeeding\(^1\) recommended by the American Medical Association) only 24% of African-American mothers are still breastfeeding at all. Coupled with that, African-American infants continue to have the highest infant mortality rate. The purpose of this study is to investigate why African-American women make the choices that they do regarding infant feeding method(s). The key research questions that guide this study are:

\(^1\) Exclusive breastfeeding means that the baby is only fed breastmilk.
• What factors affect the mother’s choice regarding infant feeding method? Why?
• How do internalized and externalized constructs of “good” and “bad” mothering impact the choice of an infant feeding method?
• How do the external and internalized constructs of the Black female body and Black women’s sexuality impact how a Black mother feels about (and negotiates her sexual self in relation to) her choice of infant feeding method(s)?
• How do the mothers in the study view their birth experiences and how do they affect her decision-making regarding breast and/or bottle feeding?

Why Breastfeeding?

According to Blum (1993), “breastfeeding provides a wonderful lens for magnifying the cracks and fractures in our construction of the late-twentieth-century [and early twenty-first-century] mother” (p. 291). The practice of breastfeeding has become inextricably intertwined with our cultural prescriptions for the “good” and “bad” mother. According to Hays (1996), the “good” mother follows the ideology of “intensive mothering.” The ideology is, “a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children” (Hays 1996: x). The “good” mother, usually portrayed as White and middle class, is always there and solely responsible for the health and future well-being of her children. She must breastfeed her children. In doing so, she must adhere either to the nursing duration guidelines provided by medical authorities or follow her infant’s cues. The “good” mother makes all
necessary sacrifices to ensure embodied motherhood. The "bad" mother selfishly works in the paid labor market in order to afford luxuries, ignores the cries and bonding needs of her child(ren), and employs other women (nannies or daycare workers) to care for her children (Hays 1996). This racist and classist model ignores the historical presence of non-White and poor women in the paid labor market. It also ignores their anguish at having to care for other women’s children while their own are neglected (Collins 2000; Blum 1999; Hays 1996; Walker 1983). Also, this sexist ideology reinforces the fallibility of the woman. It insists that she follows guidelines for childcare which are provided by external sources (medical professionals or the child) rather than her own internal intuition.

What of these feeding vessels, these breasts? Why is their use or unfettered presence grounds for contestation? According to Young (1998),

Breasts are the most visible sign of a woman’s femininity, the signal of her sexuality. In a phallocentric culture sexuality is oriented to the man and modeled on male desire. Capitalist, patriarchal, American, media-dominated culture objectifies breasts before a distancing gaze that freezes and masters. The fetishized breasts are valued as objects, things....

In this patriarchal society, breasts exist as objects for male consumption and possession. Breasts which are used for nursing babies are not readily available for male manipulation and/or control because of their status as feeding breasts. Also, in this society, the Madonna/whore dichotomy situates women as either sexual or maternal.

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2 Embodied motherhood requires that the mother is physically present and active in meeting the needs of her child. In this model, only the mother is able to "properly" care for the child. This model lends itself well to the practice of independent mothering wherein mothers are sole caretakers of their children.
By extension, maternal bodies are constructed as asexual. Young (1998) states, “phallocentric culture tends not to think of a woman’s breasts as hers. Woman is a natural territory; her breasts belong to others—her husband” (p.127). While some women resist this ideology, research indicates some mothers have chosen to avoid breastfeeding because of internalized norms of asexual motherhood, and concern over men’s resentment of “sharing” women’s breasts with their breastfeeding child (Guttman and Zimmerman 2000; Blum 1999; Weisskopf 1980).

Respect(able) Black Mother(hood)

Historically, for oppressed women of color, their breasts were objects to be controlled and utilized by White men, specifically enslavers. According to Barbara Omolade (1994), this is an example of “specialized commodification.” Every part of the Black woman’s body was used by her White male enslaver. Omolade goes on to state, “To him [the White man] she was a fragmented commodity whose feelings and choices were rarely considered: her head and her heart were separated from her back and her hands and divided from her womb and vagina” (p. 7). This quote exemplifies the idea that Black women, and enslaved people generally, were not acknowledged as thinking and feeling human beings. Instead they were viewed as mules. As such, they were present for labor, breeding, and always sexually available. Roberts (1997) astutely recognizes that the paradox constructed by the American institution of slavery which strove to punish and control the pregnant mother while attempting to safeguard the unborn worker was the first formulation of a conflict between maternal and fetal rights.

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3 Women of color and poor women were viewed as sexually available because of their social status in society. As a result, maternal status did not protect them from sexual assault.
Jezebel. Welfare Queen. Crack Whore. These terms stand as testament to the lasting image created by European/European-Americans, of the African/African-American's wanton, insatiable and irresponsible hypersexuality. White men were not held culpable for the massive rape and torture of millions of Black women and their daughters because the popular discourse framed Black women as impure, animalistic temptresses who solicited sex just as surely as they drank water to live (Collins 2000; Roberts 1997, Davis 1983).

The media is full of images and stories of Black and brown women around the world who are "multiplying at alarming rates." As in the case of the 1990s Benetton promotional ad showing a dark-skinned Black woman, bare-chested, nursing a White baby, Black women's breasts are still viewed as a commodity to be used, abused or objectified to sell sweaters (Blum 1999).

**Breast Is Best?**

In 1999, The New York Times ran a story which was entitled, "Mother Convicted in Infant’s Starvation Death Gets 5 Years’ Probation" (Bernstein 1999). The story centers around Tabitha Walrond, an African American mother who was accused of starving her son to death. At 15, Walrond had breast reduction surgery. After she got pregnant, her healthcare providers encouraged her to breastfeed, but she was not informed that breast reduction surgery could adversely affect her ability to breastfeed. After she gave birth to a healthy eight pound boy, Tyler, she began to exclusively breastfeeding. After she noticed that Tyler was losing weight, she attempted to take him to his doctor for a check up, but she was turned away because she did not

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4 See Appendix D.
have a current Medicaid card. Shortly thereafter, he died of dehydration. Her Medicaid card arrived after Tyler’s death.

The jury ruled that she was guilty of negligent homicide, but not manslaughter. Instead of prison, the judge gave her five years of probation. After he ruled in her case, Judge Straus said, “The mother is the bottom line. The buck stops here.” He placed the onus of the blame for the caretaking and decisions about infant feeding on Walrond. He did not openly criticize the bureaucratic medical system. In her statement to the court, Tyler’s paternal grandmother gave an impassioned speech which, among other things, questioned why Walrond did not feed the child formula.

African-American women are more likely to have greater challenges with negotiating work and breastfeeding than their European-American counterparts. This is in large part due to the effects of their disproportionate representation among those in poverty. Many African-American mothers maintain a traditional system of cooperative childcare whereby “Othermothers” are entrusted with the care of children while their biological mothers are away at work. While a study done by Guttman and Zimmerman (2000) indicated that among low-income African-American women there is a general understanding and agreement that “breast is best,” attitudes and behaviors diverge.

Infant mortality is twice as high among African-Americans in comparison to European-Americans (Centers for Disease Control and Prevention 2003). It is important to note that children who are fed with infant formula which has been prepared following the guidelines established by formula makers have a higher incidence of SIDS (Sudden
infant Death Syndrome), gastrointestinal problems, ear infections, allergies, and asthma in comparison to breastfed children (Pugh et al. 2001). In recognition of the health problems associated with using infant formula and the growing health risks that come with the practice of over dilution and usage of tainted water supplies, the World Health Organization has launched an initiative to curb the distribution of infant formula in countries around the world. Claims have been made that breastfeeding is correlated with increased intelligence, reduced obesity later in life, increased survival rates, reduced allergies and respiratory illnesses, and the list goes continues to grow (La Leche League 2004, www.cdc.gov). Recent studies have linked breastfeeding to reduced incidences of certain breast and ovarian cancer and diabetes, weight loss, and reduction in postnatal hemorrhaging (www.cdc.gov).

While scholars have explored different aspects of women's attitudes and behaviors regarding infant feeding, they have often fallen in the "Othering" trap (Guttman and Zimmerman 2000; Lothian 1994; Campen 1990; Fugh-Berman 1983; Baranowski, et al. 1983). Researchers have either compared non-White groups with Whites (primarily Black and White dichotomy) or taken for granted that low income status and Blackness are synonymous. There are a number of problems with the first approach. Primarily, binaries such as these can lead to dichotomized results which reinforce the "Otherness" of one group while promulgating the normalcy of the dominant, mainstream group. Another problem with this type of sampling is that it obscures intra-group uniqueness. Unfortunately, it is still the norm for researchers to ignore the heterogeneity within African-American
groups. This is evidenced in the general practice of recruiting low income women in studies that include or are focused on African-Americans (B Baranowski 1983, Bentley, et al 2003, Bentley, et al. 1999, Blum 1998, Guttman and Zimmerman 2000). In the research on breastfeeding, no comprehensive study of a socially diverse group of African-American women exists.

Theoretical Framework

Following the basic ground rules of Grounded theory method, I did not attempt to apply a solitary theoretical perspective before analyzing the data in this study. Grounded theory involves the discovery and development of theory from data, systematically obtained and analyzed from social research (Glaser & Strauss, 1967). Glaser and Strauss (1967) argue for grounding theory in social research and for generating theory from the data. They link this position with a general method of comparative analysis, which is strategic for generating theory that is concerned with creating and reasonably formulating many categories, properties, and hypotheses about general problems. Grounded theory requires that one’s explanatory conceptual categories be generated from the everyday social world emerge from a systematic process of data collection and because they reflect the experiences of the participants under investigation.

I used a modified form of grounded theory method, described by Straus (1987), wherein a limited review of existing literature is permitted. It is not my goal to produce a complete grounded theory.

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Socially diverse refers to a wide range of demographic characteristics which may include but are not limited to class, religion, educational attainment, sexuality, marital status, employment status, able-bodiedness, etc.
Rather, I strive to develop a conceptual framework that accounts for the following:

- why African-American women choose the method(s) of feeding that they do;
- how African-American mothers navigate the circumstances created by incorporating their chosen method(s) into their lives;
- how African-American mothers negotiate their “maternal” and “woman” identities internally during this time and externally through their interactions with others during this time.

For the purposes of this study, I utilize different theoretical perspectives to investigate the motivation, lived experience, and consequences of African-American women’s infant feeding choices. Using multiple perspectives allows for an in-depth exploration of these intertwined phenomena. Themes from Black Feminism, Womanism and Symbolic Interactionism, respectively, inform and guide the structuring of my research questions, and interviews.

**Black Feminism and Womanism**

Womanism and Black Feminism are particularly relevant to this study because both require that the researcher centralize (and reflect upon her connection to) the experiences of women of color who navigate multiple layers of oppression. According to Crenshaw, these intersectionalities color the epistemological lens through which people perceive and experience their social reality. Further, "in order to fully understand human behavior, one must understand the context within which the behavior occurs" (Bentley, et al. 1995: 1086). Cultural belief systems about parenting and child development serve as “ethnotheories” of parenting (Bentley, Gavin, Black, and Teti
These theories come out of the “cultural common sense” in which African-American women grew up. They inform the internalized normative maternal constructs, as well provide an external cultural roadmap for “best practices” for the “good mother.”


**Womanist** 1. From *womanish*, A Black feminist or feminist of color, 2. Appreciates women’s culture, women’s emotional flexibility (values tears as a natural counterbalance of laughter), and women’s strength. Committed to the survival and wholeness of entire people, male and female. Not a separatist, except periodically, for health. Traditionally universalist, traditionally capable. 3. Loves the Spirit, loves struggle, loves the folk, loves herself regardless. 4. Womanist is to feminist as purple is to lavender (Walker 1983:xi-xii).

In reflecting on some of the traditional and conventional works and “energy” of Black feminists and other oppressed people of color, Walker (1983) illuminates an inclusive perspective that negotiates the lines of resistance drawn between feminism and nationalism for many African-American women. According to Collins (1998), “many Black women view feminism as a movement that at best, is exclusively for women, and, at worst, dedicated to attacking or eliminating men” (p. 11). Womanism, with its emphasis on the “survival of women and men,” serves as a point of departure where women of color can address gender oppression without demonizing and/or abandoning their men. This ideology focuses on consciousness-raising among the people. This component allows for the recognition, inclusion, respect, and support of all peoples who are focused on the dismantling of oppressive structures within and without the political structure of the society.

According to Collins (1995), Black women have a “self-defined standpoint.” Historically, “U.S. Black women had common
organizational networks that enabled them to share experiences and construct a collective body of wisdom” (Collins 2000:24). While they faced common challenges, this by no means implies that they had the same experiences, interpreted them the same way or used the same methods to negotiate those experiences. Variations in class and sexual identification opened the door to differences in experience, interpretation, and reaction. According to Collins (2000), in order to understand the plurality of African-American women’s experiences, it is important recognize that there is no single Black woman’s standpoint; rather, there is a collective of women’s perspectives.

Although Black feminist thought is not typically recognized and acknowledged as feminist methodology (Devault, 1999), this theoretical framework has nonetheless provided valuable methodological insight to other Black women researchers and can provide a sound approach for this research project. As Collins (2000) highlights, “increasing numbers of African-American women scholars have chosen to study Black women’s experiences, and to do so by relying on elements of Black feminist epistemology in framing their work” (p.267). Central to this feminist methodology are the features of subjectivity, lived experience, dialogue, and ethics.

Joyce Ladner’s decisive work, Tomorrow’s Tomorrow, impacted sociology and feminist scholarship in innumerable ways. She conducted the first sociological study on Black women (conducted by a Black woman). In her work, she refused to pathologize Black adolescence and womanhood. Ladner’s 1971 ethnographic account of low-income Black girls in urban St. Louis was unique in that the author incorporated an innovative methodological approach to her research. Impenitently
aware of her social location as a Black woman, Ladner openly writes about the methodological conflict between what life experience taught her and what academic training required. She writes:

As I became more involved with the subjects of this research, I knew that I would not be able to play the role of the dispassionate scientist...I began to perceive my role as a Black person, with empathy and attachment, and to a great extent, their day-to-day lives and future destinies became intricately interwoven with my own...On the one hand, I wanted to conduct a study that would allow me to fulfill certain academic requirements...On the other hand, I was highly influenced by my Blackness—by the fact that I, on many levels, was one of them and had to deal with their problems on a personal level (Ladner, 1971, p.3-4).

Ultimately, Ladner resolved to conduct research outside the realm of sociological and positivist training, deciding to use her own study as a way to “decolonize social research on the conceptual and methodological levels” (Ladner, 1971, p.7). She sets the groundwork for valuable research that is sociological, yet liberated from the conventional value-free constraints of social science.

Similar to Ladner, Patricia Hill Collins (2000) “found [her] training as a social scientist inadequate to the task of studying a Black women’s standpoint” (p.252). In the ground-breaking text Black Feminist Thought, Collins carefully outlines an alternative methodological framework that she refers to as Black feminist epistemology. This methodological approach “enrich[es] our understanding of how subordinate groups create knowledge that fosters their empowerment and social justice” (Collins, 2000, p.269). Collins (2000) declares that every Black woman, whether she is in academia or the community, is an agent of knowledge; meaning and intellect can be derived by any Black woman. Lived experience, she asserts, is a worthy criterion for knowledge claims (p.257). Additionally, Collins
highlights the importance of dialogue, the ethic of caring (emotions and empathy), and the ethic of personal accountability as crucial methodological ingredients in feminist research involving Black women.

The landmark empirical example offered by Joyce Lander, and the theoretical framework set forth by Patricia Hill Collins provide concrete methodological steps for conducting feminist research grounded within the tenets of Black feminist thought.

**Symbolic Interactionism**

Symbolic interactionism is a paradigm that relies on the crucial assumption that human beings possess the ability to think and imbue their world with meaning. Individuals are viewed not as units that are simply motivated by external forces beyond their control; rather they are viewed as reflective or interacting human agents (Mead, 1934). This unique capacity for thought is shaped and refined by social interaction, which in turn is shaped by different ways of thinking.

In social interaction, humans learn the meanings and the symbols that allow them to exercise their unique capacity for thought (Blumer, 1969; Mead, 1934; Stryker, 1980). Symbolic interactionism focuses on how individuals use and interpret symbols as a form of communication. These symbols are used to create and maintain impressions of themselves and to construct a sense of self (Mead, 1934). Also, the SI paradigm elucidates how people use and interpret symbols to create and sustain what they experience. Through social interaction, people symbolically communicate meanings to the others involved and individuals behave toward symbols based on the meanings that are attached to them.
The socially constructed identity is a central concept in the SI paradigm. Consistent with ideas on the looking glass self, individuals adapt to their perceptions of how others see them (Cooley, 1902). As social beings, we see ourselves through the eyes of other people, even to the extent of incorporating their views of us into our own self-concept (Cooley, 1902). As a result, individuals come to develop an identity through either imagined or real interactions with others. Although an actor may stake out an identity claim such as “Black woman” or “good mother” the validity of the claim depends on the responses of significant others within the actor’s networks (Gubrium & Holstein, 1990). This process illuminates the phenomena of some Black women internalizing myths and stereotypes which situate Black mother(hood) as pathological, particularly along class lines.

The SI paradigm provides a lens through which I explore the presentation and performance of mother(hood) by Black mothers. I rely on West’s and Zimmerman’s (1987) concept of doing gender, which goes beyond examining the biological traits that have been used to explain gender performance and focuses on the interactional and institutional prescriptions and proscriptions for how to enact and embody gender. The focus on gender as interactional is rooted in symbolic interaction and ethnomethodology (Goffman. “A person’s gender is not simply an aspect of what one is, but more fundamentally, it is something that one does, recurrently, in interaction with others” (West and Zimmerman, 1987, p. 126).

**Methodology**

Feminist methodology steers research within the context of feminist theory (Ramazanoglu & Holland, 2002). Distinct from feminist
research, feminist methodology is dedicated to the theory about research practice, epistemology, and knowledge production (Devault, 1999). Beyond women interviewing women or utilizing a specific research technique, Devault (1999) argues that feminist methodology has the following three essential components:

- the importance of methodology as a tool of “excavation,” bringing women’s voices and experiences to the focal point of practice and method;
- the empowerment of research participants through minimal harm and control;
- the inclusion of activism, change, and transformation into research methods.

These principles differ significantly from conventional scientific research methods which are grounded in ideals of positivism. Collins (2000) notes that positivism requires a disregard of emotions and innately human values. A cornerstone of feminist research methods is that it is concerned with the advancement of the knowledge of women’s experience and gender relations as well as feminist theorizing and practice. Feminist critiques of positivism have challenged these male-biased methodological and epistemological stances, arguing that women have been excluded from traditional means of theorizing and knowledge production. Thus, feminist researchers sought to uncover facts and truths that were marginalized and excluded, and like postmodern theorists, sought to complicate the notion of objective truth. Wolf (1996) describes the advancement of feminist research methods further:

[Feminist scholars] sought to break down the hierarchical and potentially exploitative relationship between researcher and research by cultivating friendship, sharing, and closeness that, it was felt, would lead to a richer picture of women’s lives. Many feminists heeded the call of “passionate scholarship” (DuBois, 1983), joining their methods with their political sympathies (p.4-5).
To that end, feminist researchers find conventional methods, methodologies, and epistemologies inadequate and inappropriate for investigating the experiences and perspectives of women.

There are several key features that distinguish feminist research from traditional research methods. First, feminist research is grounded within feminist theory (Reinharz, 1992). Despite the multiple perspectives and standpoints that constitute a multitude of theories, a guiding principle of this theoretical framework recognizes the nature of unjust gendered relations and practices. As Naples (2003) points out, “feminist theories emphasize the need to challenge sexism, racism, colonialism, class, and other forms of inequalities in the research process” (p.13). Unlike conventional forms of research methods and methodologies that do not consider the elements of feminism, feminist research places women’s voice and experiences at the center of analysis. Marjorie Devault (1999) refers to this idea as excavation. A critical element of feminist methodology, excavation brings women to the focal point of practice and method. Ultimately, feminist theory provides a guiding framework that enables feminist researchers to study women’s lives for the purposes of understanding and ending oppression (Kelly, Burton, & Regan, 1994).

Second, feminist research acknowledges difference and diversity. Just as there is no universal feminism, there is no universal feminist method, methodology, or epistemology. Many feminist scholars maintain that there is a multitude of approaches to feminist research (Devault, 1999; Ramazanoglu & Holland, 2002; Reinharz, 1992; Smith, 1987). As Reinharz (1992) insists, “diversity has become a new criterion for feminist research excellence” (p.253). An attention to diversity
within the research process reveals the various ways in which
difference shapes a seemingly universal experience. As such, feminist
research methods can draw on differing methods, epistemologies, and
experiences to further knowledge on various issues and phenomena.
Similarly, a recognition of difference and diversity also underscores
that there is no distinct feminist method, methodology, or
epistemology (Ramazanoglu & Holland, 2002; Reinharz, 1992). As
Reinharz (1992) points out, “feminist research practices must be
recognized as a plurality. Rather than there being a woman’s way of
knowing, or a feminist way of doing research, there are women’s ways
of knowing” (p.4). Alternative frameworks, such as Black feminist
epistemology have developed in response to this criticism.

A third feature of feminist research lies in empowerment. Unlike
traditional methods that privilege the knowledge of the researcher
over participants, feminist research aims to empower the research
subjects. Devault (1999) writes that an important aim of feminist
methodology is the infusion of activism, change, and transformation
within research methods. Using feminist methods as a means of
consciousness-raising is an integral component in fostering such
change. One of my main objectives is to incorporate a feminist
methodology in order to produce culturally relevant knowledge that
will inform recommendations for both personal empowerment and social
change. One of the best ways to accomplish this is by allowing the
women who deal with the politics of infant feeding every day to have
their say in the research.

The final component of feminist research concerns the idea of
reflexivity. Although a subjective stance is not common to all
feminist researchers, many argue that personal experience and reflection are at the core of feminist methods, methodology and epistemology. As Reinharz (1992) explains,

To the extent that this is not the case in mainstream research, utilizing the researcher’s personal experience is a distinguishing feature of feminist research. Personal experience typically is irrelevant in mainstream research, or is thought to contaminate a project’s objectivity. In feminist research by contrast, it is relevant and repairs the project’s pseudo-objectivity (p.258).

Writing on the importance of positionality, Deutsch (2004) adds:

The researcher’s awareness of her or his own subjective experience in relation to that of her or his participants’ is key to acknowledging the limits of objectivity. It recognizes the bidirectional nature of research. I am subject, object, and researcher. To assert otherwise is to be disingenuous about the process of research, especially qualitative research” (p. 889)

Recognizing that reflexivity is a core element of feminist research, it is critical for researchers to position themselves within their research, by reflecting, examining, and exploring the ways in which they are impacted by the research process (Cook & Fonow, 1991).

Feminist researchers, must in fact, start with themselves at the onset of research (Reinharz, 1992). This start is particularly crucial for feminist researchers who are studying populations of which they are a part. For example, Annecka Marshall (1994) employed a self-reflective approach when writing about her experiences as a Black woman conducting research on a population that has so often been trivialized by mainstream paradigms of social science research. As a Black woman researcher, Marshall points out that she could not help but play a “dual role” as a researcher and as a participant (p.109). Similarly, other scholars, including bell hooks (1989), Patricia Hill Collins (2000) and Joyce Ladner (1971) write about the ways in which their passion and personal connection (a direct consequence of their social
location) has influenced their theorizing and research methodology. As women of color embedded within research projects on women of color, it is neither possible nor recommended to place significant distance between researcher and subjects.

**Sample**

Thirty African-American women in the metro Orlando area were recruited for this study. Each woman had at least one child who was three years old or younger at the time that she was interviewed. During the recruitment process, I placed emphasis on locating mothers who were still breastfeeding and/or using infant formula. I wanted mothers who were negotiating their infant decision-making on a regular basis because I wanted to avoid the revisionism that can occur when people have to recount what it was like to make decision(s) regarding feeding methods or recall key influences and behavioral plans. I addressed this challenge by restricting my sample to mothers who had at least one child who was three years old or younger.

There are two primary reasons why I chose to focus on African-American women. First, infant mortality rates for African-Americans are twice that of European-Americans (Forum for Child and Family Statistics 2003, Centers for Disease Control and Prevention 2007). There are abundant data to support the nutritional benefits of breastfeeding for infants. While there was a rise in breastfeeding among women in the population, African-American women are still largely choosing not to breastfeed despite research that shows that they understand and agree with the health benefits of nursing (Baranowski, David, Rassin, and Richardson 1983, Guttman and Zimmerman
Secondly, the majority of research that is done on breastfeeding practices and attitudes compares data on European-Americans and African-Americans (Van Esterik 2002). These comparisons often skew and/or obscure the within-group characteristics that are unique to that multifaceted group (Ladner 1973, Zuberi and Bonilla-Silva 2008). For example, while research indicates that European-American women are mostly influenced by male partners, African-American women’s decision-making regarding breastfeeding is mostly influenced by female family members and friends (Blum 1999; Lothian 1994; Baranowski, et al. 1983; Leeper, et al. 1983). This interesting finding tells us nothing about the differences that exist intraracially, in terms of class, educational attainment, region, etc. Such comparative practices also lead to the “othering” of African-Americans when their practices differ from the normative practices of the dominant, white population.

I recruited the participants by using snowball sampling. This method of sampling is best suited for “hard to reach” populations\(^6\). Initially, I recruited the respondents from the practice of a local African-American certified nurse midwife. She has privileges at a local hospital, a free-standing birthing center, as well as a homebirth practice. As a result, she has access to a diverse pool of African-American women. I accepted a maximum of 3 referrals of other prospective participants from the women who participated in the study. I used this practice in an effort to avoid homogeneity in the groups. During the recruitment process, I focused on including an equal number of breastfeeding and formula feeding mothers in my sample. Ultimately,

\[^6\text{Hard to reach populations are groups which are either small numerically (ethnic or racial minority), and/or a hidden group (cocaine users).}\]
I ended up with a majority of women who were (or had) breastfeeding and who had also, at some point in their child’s life, used infant formula. I did not factor the presence of other living children (siblings) or marital status into the recruitment process.

The mothers in the study ranged in age from 18-50 years old. Seventeen of the women in the study were in their 30s. All of the participants in the study identified as heterosexual. Eighteen of the respondents in the study were married at the time of the interview. Six of the mothers were single and had never been married. Two participants in the study reported that they were cohabiting, and two were divorced. Total family income ranged from less than $14,000 per year to over $100,000. One of the respondents in the study did not report her total family income. Table 1.1 shows the participants’ general demographic information. All of the names of the respondents have been changed to protect their privacy. Prior to each interview, I told each of the mothers in the study about the nature of the project, informed of her rights to confidentiality, and that choosing to be videotaped could compromise her privacy. Subsequently, the respondents chose whether or not they would be videotaped. Each respondent was asked to review and sign an informed consent form. All of the participants were informed of their right to terminate the interview at their discretion. Each of the respondents signed the consent form (Appendix A) and completed a demographic fact sheet which supplied her personal information such as age, family income, religion, as well as, information about her birth experiences and infant feeding practices.
Table 1.1
Demographic Information

<table>
<thead>
<tr>
<th>Alias</th>
<th>Age</th>
<th># Kids</th>
<th>Income</th>
<th>Marital Status</th>
<th>Religion</th>
<th># Adult In home</th>
<th>Ed</th>
<th>Job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaniqua</td>
<td>28</td>
<td>1</td>
<td>35-45K</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>BA</td>
<td>Clerk</td>
</tr>
<tr>
<td>Chelsea</td>
<td>22</td>
<td>1</td>
<td>Below 14k</td>
<td>S</td>
<td>N/A</td>
<td>1</td>
<td>Some college Ext Day Tchr</td>
<td></td>
</tr>
<tr>
<td>Hadliatu</td>
<td>26</td>
<td>2</td>
<td>35-45K</td>
<td>M</td>
<td>Muslim</td>
<td>2</td>
<td>BA</td>
<td>Full Mthr</td>
</tr>
<tr>
<td>Elaine</td>
<td>32</td>
<td>3</td>
<td>25-35K</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>AA+ yrs</td>
<td>Men, Hnth tech/Student/98% mother</td>
</tr>
<tr>
<td>Amy</td>
<td>18</td>
<td>1</td>
<td>&gt;15K</td>
<td>Sblgn</td>
<td>Christian</td>
<td>4</td>
<td>HS</td>
<td>Data Entry</td>
</tr>
<tr>
<td>Kim</td>
<td>27</td>
<td>3</td>
<td>25-35K</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>AA</td>
<td>Domestic Engineer</td>
</tr>
<tr>
<td>Diedre</td>
<td>20</td>
<td>1</td>
<td>&gt;14K</td>
<td>S</td>
<td>Spiritual</td>
<td>1</td>
<td>Some college</td>
<td>Student/Mother</td>
</tr>
<tr>
<td>Leila</td>
<td>38</td>
<td>2</td>
<td>100K+</td>
<td>M</td>
<td>Christian Baptist</td>
<td>2</td>
<td>BA</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Lydia</td>
<td>27</td>
<td>2</td>
<td>25-35K</td>
<td>S</td>
<td>Christian</td>
<td>1</td>
<td>Some college</td>
<td>Correction Officer</td>
</tr>
<tr>
<td>Yvonne</td>
<td>51</td>
<td>2</td>
<td>45-59K</td>
<td>M</td>
<td>Buddhist</td>
<td>2</td>
<td>Some college</td>
<td>Lactation Counselor</td>
</tr>
<tr>
<td>Carla</td>
<td>36</td>
<td>3</td>
<td>35-45K</td>
<td>M</td>
<td>Christian nondenom</td>
<td>2</td>
<td>BA, grad work</td>
<td>Stay at home mom</td>
</tr>
<tr>
<td>Dejoneae</td>
<td>36</td>
<td>3</td>
<td>35-45K</td>
<td>M</td>
<td>Christian Baptist</td>
<td>2</td>
<td>BA</td>
<td>Full time mother</td>
</tr>
<tr>
<td>Yvette</td>
<td>35</td>
<td>2</td>
<td>45-59K</td>
<td>M</td>
<td>Christian Catholic</td>
<td>2</td>
<td>BS</td>
<td>Stay at Home</td>
</tr>
<tr>
<td>Diana</td>
<td>40</td>
<td>3</td>
<td>60-79K</td>
<td>M</td>
<td>Baptist</td>
<td>2</td>
<td>MSW</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Nzinghha</td>
<td>34</td>
<td>3</td>
<td>35-45K</td>
<td>D</td>
<td>Christian</td>
<td>1</td>
<td>Some college</td>
<td>Billing Clerk</td>
</tr>
<tr>
<td>Cassandra</td>
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<td>2</td>
<td>No Answer</td>
<td>CoHab</td>
<td>Christian</td>
<td>2</td>
<td>Some college</td>
<td>Full time Mom</td>
</tr>
<tr>
<td>Esther</td>
<td>37</td>
<td>2</td>
<td>45-59K</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>Some college</td>
<td>Homemaker</td>
</tr>
<tr>
<td>Rachel</td>
<td>28</td>
<td>3</td>
<td>45-59K</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>BA</td>
<td>Missionary At-Home-mom</td>
</tr>
<tr>
<td>Kendra</td>
<td>29</td>
<td>2</td>
<td>60-79K</td>
<td>M</td>
<td>Baptist</td>
<td>2</td>
<td>BA</td>
<td>Homemaker</td>
</tr>
<tr>
<td>Yolonda</td>
<td>30</td>
<td>2</td>
<td>80-90K</td>
<td>M</td>
<td>None</td>
<td>2</td>
<td>Some college</td>
<td>S-A-H Mom</td>
</tr>
<tr>
<td>Monica</td>
<td>33</td>
<td>2</td>
<td>100+</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>MA</td>
<td>Housewife</td>
</tr>
<tr>
<td>Faluke</td>
<td>34</td>
<td>2</td>
<td>100+</td>
<td>M</td>
<td>Christian</td>
<td>2</td>
<td>Grad School</td>
<td>Stay-at-Home Mom</td>
</tr>
<tr>
<td>Destanni</td>
<td>31</td>
<td>3</td>
<td>60-79K</td>
<td>M</td>
<td>Baptist</td>
<td>2</td>
<td>BS</td>
<td>Occupationa l Therapist</td>
</tr>
<tr>
<td>Alias</td>
<td>Age</td>
<td>Income</td>
<td>Gender</td>
<td>Religion</td>
<td>Education</td>
<td>Occupation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Denitra</td>
<td>26</td>
<td>&gt;14K</td>
<td>S</td>
<td>NA</td>
<td>1 HS</td>
<td>Cosmetologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brihanna</td>
<td>32</td>
<td>25-35K</td>
<td>S</td>
<td>Baptist</td>
<td>1 Some college</td>
<td>Bank Teller</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melissa</td>
<td>32</td>
<td>25-35K</td>
<td>S</td>
<td>Goddess Centered</td>
<td>1 BA</td>
<td>Lactation Counselor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sholanda</td>
<td>34</td>
<td>80-99K</td>
<td>M</td>
<td>Christian</td>
<td>3 MA</td>
<td>Director Grief Prog</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juanita</td>
<td>31</td>
<td>80-99K</td>
<td>M</td>
<td>African Tradition</td>
<td>2 BA</td>
<td>FT mom Art Direct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Danielle</td>
<td>36</td>
<td>80-99K</td>
<td>D/ Remar</td>
<td>Non Denom</td>
<td>BA</td>
<td>HS Tchr</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Procedures

All of the mothers in the study participated in in-depth face-to-face interviews at a place of their choosing. The interviews lasted between 45 minutes and 4 hours. Each of the respondents in the study was asked the same core questions. The schedule of questions is located in Appendix B. Each interview session was tape recorded, videotaped, and later transcribed for analysis. I videotaped twenty-seven of the interviews. The remaining three were videotaped by a videographer. The interviews were loosely structured. I chose loosely structured interview because that format allowed me to engage the participant(s) in the study with a small list of core questions supplemented with a few probes. This framework facilitated the respondents ability to tell their stories in their own ways (Strauss 1987, Denzin and Lincoln 1994). The variation in the length of the interviews is a result of the degree of elaboration in the story that each respondent chose to provide.

Analysis

In the analysis of my data, I used modified grounded theory approach. Grounded theory is

a detailed grounding by systematically and intensively “analyzing data, often sentence by sentence, or phrase by phrase of the field note, interview, or other document; by “constant comparison,” data are extensively collected and coded”....The focus of analysis is not ordering a “mass of data,” but on organizing many ideas which have emerged from the analysis of the data (Straus 1987: 21-22).

Due to the reality that there is not an abundance of sociological literature which explores the intra-group diversity within the African-American community, it is necessary to begin from the standpoint of creating a theoretical foundation. This foundation can serve as a reference point for present and future researchers. Due to
my lived experience as an African American mother, who has dealt with infant feeding decision-making and my prior research in mothering, I entered the research process for this study with pre-existing knowledge about scholarship on mothering and infant feeding. As I am not able to erase that information, I entered this process knowing that my knowledge and experience would shape the types of questions that I asked.

The digital recording of each interview was transcribed by an external company which specializes in transcribing legal and academic interviews. In order to code the interviews, I created data trees. There are three types of coding. The first is open coding. At this (inductive) phase, every piece of data is scrutinized. My goal was to produce concepts that related to the central research questions. Concepts which were outside the purview of those questions were placed in a folder for review for another project. Through the usage of axial coding, I was able to compare, check for repetition, and ultimately create categories from the emergent concepts (Glazer and Strauss 1967). At that point, I began the process of asking “generative questions.” Through these questions, I could explore the linkages of the concepts to each other and further the movement towards developing or supporting theory. Following that process, I used selective coding to focus on identifying and fortifying the core category which would serve as my theoretical umbrella under which all of the other categories must rest. Once I realized that the same conceptual

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7 The data trees were comprised on concepts that were linked to each other. The concepts were the initial branches of trees. The branches were further broken down to indicate dimensions of the concepts. Once a core theme emerged, it became the trunk of the tree.
connections were presenting themselves, over and over, I knew that I had reached saturation⁸.

**Limitations**

While the women were aged 18-50 years old, twenty-six of the participants in the study were in their 20s [10] and 30s [16]. This concentration on a particular generation provides us with a snapshot of the pervasive ideology about infant feeding at a unique moment in time. The study would be informed by including more mothers who are under the age of twenty and over the age of forty. Also, there is a shortage of research that is specifically being done on diverse samples of African American teenage mothers and their views on infant feeding in general, and breastfeeding in particular. Also, I recruited some mothers who I knew to be a part of the sample.

My disproportionate representation of married and partnered women does not provide us with a multidimensional picture of the infant feeding experiences which are had by single, unpartnered women. All of the mothers in the study are biological mothers. Also, there were no lesbians or transgendered mothers in this study. As a result, there were no questions directed toward same-sex relationships, and/or the dynamics of negotiating infant feeding in a non-heteronormative context. This omission points to a gap not only in my research project, but also in the broader realm of research on queer black mothers and infant feeding. Further studies should consider the experiences of lesbians and transgendered Black mothers, as those

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⁸ When a category has reached saturation, it means that the repeated, multidimensional concepts which comprise the category emerge and consistently re-emerge when the data are (re)reviewed (Glazer and Straus 1967).
voices would surely elucidate the (potentially) different venues for navigating infant feeding in this subgroup of black women.

Future research should include participants who have more diverse educational backgrounds than in my sample. Arguably, since the majority of research on black women’s infant feeding practices focuses on women with little or no formal education beyond high school, this study stands as a counterbalance to their findings.

**Overview of Dissertation**

I set forth in my research for this dissertation to understand and discuss the attitudes and practices of infant feeding among African-Americans mothers. To that end, I investigated the following factors affecting infant feeding choice: perceived social norms about infant care, issues of sexuality/intimacy, body image, work in the paid labor market, social network, and medicalized experiences. I used the following four main research questions to guide this study: (1) What factors affect the mother’s choice regarding infant feeding method? Why?; (2) How do constructs of “good” and “bad” mothering impact the choosing of an infant feeding method?; (3) How do the external and internalized constructs of the Black female body and her sexuality impact her choice (and experience) of infant feeding method(s)?; (4) How do the mothers in the study view the effects of social norms and social support regarding infant feeding on the mother’s decision-making regarding breast and/or bottle feeding?

In Chapter 2, *Why We Choose*, I discuss the prominent reasons why the mothers in the study chose the infant feeding methods that they chose. While I expected to find a primary focus on economics, the
mothers focused on other issues such as agency, identity, and autonomy. Chapter 3, The Birth Connection, is focused on discussing how the experience of birth, beginning with pregnancy, affected feeding choices. Also, I examine how their birth experiences, including their interaction with birth attendants and other healthcare providers, affect the feeding method that they chose. Also, I explore how they view their options for feeding. Further, I connect these factors to what the respondents in the study think about themselves as mothers in relation to their feeding experiences. In Chapter 4, On Doing Mother, I explore how the participants’ performance of mother informs their feeding choices. Also, I discuss the ideas that the participants in the study have about their bodies in relation to feeding and sexual activity. Chapter 5, Thinking Back, Looking Forward, wraps up with a discussion of the politics of infant feeding for the mothers in the study. Finally, I make suggestions for future research.
CHAPTER 2

Why We Choose

While most babies in the United States were breastfed in the late 1800s, the act of feeding from the breast was viewed as most suitable for lower class, white women, African Americans, and other people classified as “colored.” The high incidence of using wet nurses among upper and middle class white women stands as a testament to this orientation. Within this society, breastfeeding was viewed as primitive and animal-like. When the first commercially available formula for infant food was introduced in 1867 to the European and American markets, it was embraced by the predominantly white, middle and upper class women who could afford its costly price tag. Babies who drank the product developed health problems like diarrhea, dehydration, constipation, and other gastrointestinal problems that the fledgling group of doctors who focused on children’s health (pediatricians) could treat (Blum 1999, Levenstein 1988). Mothers were marked as “haves” or “have nots” based on whether or not they could afford to purchase infant formula. Over the following decades, companies like Nestle and Mead Johnson refined their products and added ingredients which approximated some of the ingredients found in human breastmilk. As the cost of infant formula fell, which made it more accessible to greater masses of people, formula makers (supported by the medical establishment) began aggressively attacking breastfeeding, depicting female body as fallible and unsterile (Blum 1999, Levenstein 1988). Among mothers in the US, African Americans were the last group to widely use infant formula (Blum 1999). By the early 1970s, the majority of babies who were born in the US, across
racial lines, were formula fed. During that time, maternalists and other feminists who focused on women’s health began to protest the artificial infant feeding practices that were commonly enforced in hospitals in the US. As a result, a revitalization of breastfeeding was promoted among predominantly middle and upper class women (Blum 1999). By the 1990s, breastfeeding rates had begun to rise, but they remained low in comparison to breastfeeding rates in other equally industrialized nations (Blum 1999). While the latest data from the Centers for Disease Control (CDC) indicate that breastfeeding rates have continued to rise across racial lines among women in the US, African American women’s breastfeeding rates remain significantly lower than the national average. Table 2.1 outlines the feeding practices which were followed by the mothers in the study. Table 2.2 presents the frequency of breastfeeding and infant formula use in relation to the number of adults and children in the home.

In this chapter, I explore why African American mothers chose the infant feeding practice(s) that they did. To that end, I examine how the beliefs and experiences that the mothers in the study held about infant feeding prior to and during pregnancy, as well as, after the baby was born impacted the process by which they chose their infant feeding practice(s). What becomes clear is that the knowledge that something is considered best for their child(ren) is not necessarily the sole or even key factor in how the mothers negotiated feeding their child(ren).
Table 2.1
Feeding Practices

<table>
<thead>
<tr>
<th>Alias</th>
<th># Kids</th>
<th>Breast, Bottle, Both</th>
<th>Age Weaned</th>
<th># Adults In home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaniqua</td>
<td>1</td>
<td>Breast/Rice milk</td>
<td>9mths</td>
<td>2</td>
</tr>
<tr>
<td>Chelsea</td>
<td>1</td>
<td>both</td>
<td>4-5 Wks</td>
<td>1</td>
</tr>
<tr>
<td>Hadiatu</td>
<td>2</td>
<td>Both</td>
<td>15 mths/18 mths still nurse</td>
<td>2</td>
</tr>
<tr>
<td>Elaine</td>
<td>3</td>
<td>Both</td>
<td>6 wks</td>
<td>2</td>
</tr>
<tr>
<td>Amy</td>
<td>1</td>
<td>Both</td>
<td>3 mths</td>
<td>4</td>
</tr>
<tr>
<td>Kim</td>
<td>3</td>
<td>Breast</td>
<td>Still Nursing 6 wk old</td>
<td>2</td>
</tr>
<tr>
<td>Diedre</td>
<td>1</td>
<td>Both</td>
<td>&gt;2 mths</td>
<td>1</td>
</tr>
<tr>
<td>Leila</td>
<td>2</td>
<td>Both</td>
<td>3 mths</td>
<td>2</td>
</tr>
<tr>
<td>Lydia</td>
<td>2</td>
<td>Both</td>
<td>2 days</td>
<td>1</td>
</tr>
<tr>
<td>Yvonne</td>
<td>2</td>
<td>Breast</td>
<td>18mths</td>
<td>2</td>
</tr>
<tr>
<td>Carla</td>
<td>3</td>
<td>Both</td>
<td>10 mths</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>16 mths</td>
<td></td>
</tr>
<tr>
<td>Dejonae</td>
<td>3</td>
<td>Both</td>
<td>3 mths</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13 mth 8wks</td>
<td></td>
</tr>
<tr>
<td>Yvette</td>
<td>2</td>
<td>Breast</td>
<td>2 yrs 2yrs Still</td>
<td>2</td>
</tr>
<tr>
<td>Evelyn</td>
<td>1</td>
<td>Breast</td>
<td>Still 2mths</td>
<td>2</td>
</tr>
<tr>
<td>Diana</td>
<td>3</td>
<td>Both</td>
<td>10 mths</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Formula (twins)</td>
<td></td>
</tr>
<tr>
<td>Nzingha</td>
<td>3</td>
<td>Both</td>
<td>3 mths</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11mths</td>
<td></td>
</tr>
<tr>
<td>Cassandra</td>
<td>2</td>
<td>Both</td>
<td>6 mths</td>
<td>2</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Still baby</td>
<td></td>
</tr>
<tr>
<td>Esther</td>
<td>2</td>
<td>Formula</td>
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<td>2</td>
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<tr>
<td>Rachel</td>
<td>3</td>
<td>Breast</td>
<td>1 yr 11 mths still-3 mths</td>
<td>2</td>
</tr>
<tr>
<td>Kendra</td>
<td>2</td>
<td>Both</td>
<td>3 mths</td>
<td>2</td>
</tr>
<tr>
<td>Alias</td>
<td># of Kids</td>
<td>Breast, Bottle, Both</td>
<td>Age Weaned</td>
<td>Adults In Home</td>
</tr>
<tr>
<td>------------</td>
<td>-----------</td>
<td>----------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Yolonda</td>
<td>2</td>
<td>Breast</td>
<td>9 mths</td>
<td>Still-8mths</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monica</td>
<td>2</td>
<td>Both</td>
<td>1 week</td>
<td></td>
</tr>
<tr>
<td>Faluke</td>
<td>2</td>
<td>Breast</td>
<td>1 yr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Still-2mths</td>
<td></td>
</tr>
<tr>
<td>Destanni</td>
<td>3</td>
<td>Both</td>
<td>6mths, 6 mths, 12 wks</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Breast</td>
<td>1 yr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1yr</td>
<td></td>
</tr>
<tr>
<td>Brihanna</td>
<td>2</td>
<td>Breast</td>
<td>Formula</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Still-6mths</td>
<td></td>
</tr>
<tr>
<td>Melissa</td>
<td>1</td>
<td>Both</td>
<td>18mths</td>
<td></td>
</tr>
<tr>
<td>Sholanda</td>
<td>2</td>
<td>Breast</td>
<td>14mths</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Still-2mths</td>
<td></td>
</tr>
<tr>
<td>Juanita</td>
<td>2</td>
<td>Breast</td>
<td>10mths</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 yrs</td>
<td></td>
</tr>
<tr>
<td>Danielle</td>
<td>2</td>
<td>Both</td>
<td>10 mths</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>still-10 mths</td>
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Table 2.2
A Crosstabulation of Infant Feeding Practices

<table>
<thead>
<tr>
<th></th>
<th>Breastmilk Only</th>
<th>Formula Only</th>
<th>Both</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Count</strong></td>
<td>(11)</td>
<td>(1)</td>
<td>(18)</td>
<td>(30)</td>
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<tr>
<td><strong># of Adults</strong></td>
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</tr>
<tr>
<td>1</td>
<td>2</td>
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<td>7</td>
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<td>2</td>
<td>8</td>
<td>1</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>3+</td>
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<td>2</td>
</tr>
<tr>
<td><strong># of Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>6</td>
</tr>
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<td>7</td>
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</tr>
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<td>3+</td>
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<td>0</td>
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<td>8</td>
</tr>
<tr>
<td><strong>Age Weaned</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4 weeks</td>
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<td>N/A</td>
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<tr>
<td>5-8 weeks</td>
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<td>N/A</td>
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<td>9-12 weeks</td>
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</tr>
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<td>4-6 months</td>
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<td>0</td>
</tr>
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<td>7-12 months</td>
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<td>N/A</td>
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<td>4</td>
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<td>1-2 years</td>
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<td>N/A</td>
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<td>4</td>
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<td>2+ years</td>
<td>1</td>
<td>N/A</td>
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* Ten respondents reported that they were still breastfeeding their babies at the time of their interviews.
Breastmilk Is A Benz and Formula Is A Honda

All of the mothers in the study stated, at some point in their interview, that they understood the message that, “breast is best.” The Mercedes Benz has been rated best in quality and performance among cars. Breastmilk shares the same distinction among infant foods. This stamp of approval has been provided by the major medical associations. Even formula manufacturers, who are the direct competitors for infant foods, chime in to say that breast is best. Similar to the cultural capital that driving a Benz might bring/mark (higher social position and opportunities), the mothers in this study believed that feeding their babies breastmilk would bring higher intelligence, a stronger immune system, and heightened bonding. They identified these benefits as their primary reason for choosing human breastmilk over teat (breast)milk from a cow (key ingredient in infant formula). The majority of participants did not articulate any physical benefits that came to them as a result of breastfeeding. A few mothers mentioned weight loss and the fact their uterus would go back to its pre-pregnant size. While they were happy that breastfeeding would speed their return to their pre-pregnancy weight, the participants focused most on how breastfeeding benefited their children in the present and could potentially affect them in the future. So like the Benz, breastfeeding opens the door to opportunities.

To complicate matters further, she routinely traveled back and forth to her hometown so that she could benefit from the help of her mother. The stress of the keeping all of the balls in the air took its
toll. Diedre had a revelation, "It was like, yeah, I know breastfeeding is the best thing, but I need to do the bottle." After that, she opened herself up the idea of using infant formula, in effect trading in the best thing (Benz) for the utilitarian thing (Honda). Like other mothers in the study who followed this trajectory, Diedre did not articulate remorse about her decision. She tried breastfeeding because she believed that it was the best food for her child. Once she realized that it wasn’t the best for her lifestyle, and became comfortable with a food alternative, she made a change. She examined her goals and priorities. Once she began feeding her child formula, she was able to more help with child care from her family. Because she wasn’t pumping and fretting about her milk production, she was better able to focus on completing her education so that she would be better poised to take care of her family and herself.

Like a Honda, infant formula will get you to your destination. It does not imbue the health benefits to the baby that breastmilk does and there are no known health benefits to the mother. While the participants consistently spoke about health issues related to formula use like constipation, flatulence, and a higher susceptibility to illnesses, their children did not suffer from malnutrition once they found the right formula for the baby. In some instances, as in the experiences of Hadiatu, 26 years old with two children, and Leila, 38 years old with two children, using formula improved the health of their babies when they were perceived as either failing to thrive or concern over not producing soiled diapers (a measure of food intake).

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9 One of the participant’s child had an allergic reaction to each brand of over-the-counter infant formula. Another participant’s child suffered from GERD. Both children experienced vomiting which resulted in dehydration and hospitalization. As a result, each mother had to use a prescription infant formula to feed their babies.
placed their babies at risk. In this context formula, like a Honda, was viewed as reliable, consistent, and always available.

Like other participants in the study, 27-year-old Shaniqua, was not committed to a specific method of infant feeding prior to the birth of her first child. She was open to either breastmilk, formula or some combination of the two. She had not been breastfed and grew up watching cousins and children of friends be fed formula. Other participants, in the study, who shared her level of openness with either using formula or breastfeeding were most likely to have been formula fed. In our discussions, they reflected on their own good health as adults as evidence to support the claim that formula was an acceptable food for babies. According to them, they, and most of the babies that they knew of, had not experienced any ill effects from formula use. As a result, they felt no ambivalence about formula-feeding their own babies. On the other hand, participants in the study, who were breastfed, were less likely to feel comfortable with feeding their babies infant formula. They were more likely to question its nutritional value as well as to express outright condemnation of it. All of the participants talked about how formula use was normalized in this society. Mothers spoke freely about how commonplace it was to see babies fed by bottles. They assumed that formula was in the bottle. They talked about the free samples of and coupons for infant formula that they received in the baby bags that they were given by their obstetricians and midwives. Receiving these products from a healthcare provider legitimated the product (and in some instances the specific brand) for many of the mothers. They felt that
if there was something wrong with it, their doctor/midwife would not give it to them. First time mothers were most likely to feel this way.

While not all of the participants indicated that they had seen a woman breastfeeding in a public place like a park or private business like an airport, the majority stated that they had seen a woman breastfeeding a baby somewhere outside of the home. They identified the following types of spaces wherein they encountered breastfeeding women: bathrooms in department stores, family rooms in churches/temples, grocery stores and shopping malls. According to the participants, most of the women whom they saw breastfeeding were white. When the participants saw a black woman breastfeeding, some like Diedre, felt a wave of pride and happiness that she was there. They described feeling the comfort (and for some relief) of “not being the only one.” For some women like 34-year-old Sholanda, seeing other black women breastfeeding helped her to feel more at ease with her decision. While she didn’t see many women nursing (in public or private spaces) after she had her first child, she saw many more black women nursing her second time around. She felt reassured and less isolated because coming across such women reminded her that even if she was the only one among her family and friends breastfeeding, there were other black women who were doing it.

The participants spoke about the advertisements that they had seen which either specifically advertised breastfeeding or advertised formula feeding but included a statement that breastfeeding was best in the ad. The mothers agreed that when the advertisements (print and television) included a picture of a breastfeeding woman or were focused on encouraging breastfeeding, the woman and baby in the ad
were most likely to be white. Yet, when they saw advertisements for formula, women of different races were featured. According to the participants, breastfeeding was being depicted as something that white women did, while all mothers used formula. Also, males were more likely to be featured in infant formula ads. When the ads featured a man and woman, they were typically a heteronormative couple with a visible sign of marriage, like a wedding ring. Despite the inclusion of only husbands, participants said that such ads reinforced the concept that babies who were formula fed could be fed by anyone - the father, child care providers, other family, and friends. This had a special significance for them because historically, within the context of the African American family, mothering in isolation was not the norm. According to Collins (2000), the tradition of incorporating othermothers and other forms of shared caregiving can be traced back to familial structures and childcare practices found in West African societies\(^\text{10}\).

The message of “Breast is Best” resonated with the participants. They invariably brought up the slogan that is tied to the campaign which goes by the same name when I asked them about infant feeding. The mothers in the study articulated a clear understanding of the message that human breastmilk was the best food for their babies\(^\text{11}\). The foundational presumption of the campaign is that if women only

\(^{10}\) Othermothers are women (friends and family) who take on the caretaking role ascribed to mothers. They do this when the mother is present, as well as, in her absence. In some communities they are “aunties,” and other fictive kin. Women who are not able or choose not to biologically mother often receive status and recognition by acting as othermothers to black children (Collins 2000).

\(^{11}\) The Breast Is Best Campaign is a US-based public health program, aimed at increasing breastfeeding rates among women in the United States. It is tied to the Healthy People 2010 Initiative, which is “a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats” (www.healthypeople.gov).
knew the benefits of breastfeeding (to themselves and their babies), they would breastfeed. In a masterful turnabout, advertisements for formula both include an acknowledgement that breastfeeding is best, and a statement that using infant formula is a good alternative because it contains special ingredient(s) that mimic breastmilk\textsuperscript{12}. By co-opting the language of the Breast is Best campaign, formula manufacturers send the message that mothers (not doctors, fathers, friends, or family) know what was best for their babies. This tactic serves to validate the intrinsic “know how” of mothers, while reinforcing that it is alright for them to choose formula as a good, albeit not best, option for their babies. In other words, even though good was not best, it was not bad either.

A minority of mothers in the study were adamantly opposed to accepting the idea that infant formula was acceptable for their babies. For instance, 28-year-old Rachel, a missionary and self-identified Lactivist (someone who is a breastfeeding activist), believed formula was harmful to babies. Similarly, 35-year-old Yvette spoke about the inferior nature of infant formula. Both respondents, who were full-time mothers, nursed their children for over one year. These participants said that they understood why many women, and African American women in particular, chose not to breastfeed, but they wished that those same women were breastfeeding. In some instances, they consciously acted as role models for other black mothers whom they knew were not nursing their babies, as well as, support systems for mothers who were breastfeeding. They said that

\textsuperscript{12} A common ingredient is Lipil (DHA and ARA). DHA is docosahexaenoic acid and ARA is arachidonic acid. Both are long-chain polyunsaturated fatty acids that are found in human breastmilk. The fatty acids assist with brain development.
informal connections and support groups like Mocha Moms (a national network of women of color who are full-time mothers) and the African American Breastfeeding Alliance (a national organization which is focused on educating African Americans about and promoting breastfeeding) were groups which connected them with other African American mothers with small children. These groups offered the mothers outlets for working through any breastfeeding challenges as well as help when they were having problems with their personal lives. They could pass on tips and equipment as well as provide their children with opportunities to connect with other children their age and expand their network of other mothers.

_I, Me, and We_

"I am gonna do this thing!" exclaimed Juanita, a 31-year-old mother of two. A common thread in the participants’ narratives was that they were most influenced by their proclivity to act independently of those around them. In her assertion, Juanita, the director of a performing arts company, owned her decision to breastfeed. Her reference to, "doing the thing," highlights her sense of responsibility as well as her intent to control the process. According to Juanita:

I remember going to classes and I think [with] my strong personality, [I] was just, always assumed that I would nurse. . . . everybody in my family nursed, you know. You get milk to nurse, it was just like. You don’t let milk come through and not nurse the baby. It just seemed kinda abnormal. You know that’s why the milk comes, you know, because you’re supposed to nurse. So, it just seemed logical to me.

Like other participants, she spoke about the information that she gathered on the pros and cons of breastfeeding and formula use. The decision to breastfeed was hers and she claimed it confidently.
According to Juanita, breastfeeding was a common practice in her home. She observed other siblings and children being nursed as well as formula fed. Her statement, “You don’t let milk come through and not nurse your baby,” conveys the notion that it is absurd to choose not to breastfeed one’s child when one is able. The belief in breastfeeding as normative served to further validate her decision to nurse. She, like other participants, presented herself as making this decision because she considered herself to be strong enough to do what should be done. It is important to note that in her statement, Juanita, like the majority of the participants, did not indicate that there was anything wrong with using formula to supplement breastfeeding. Instead, Juanita focused on why she believed breastfeeding should happen.

Denitra, a 26-year-old mother of two, faced a different reality. While Juanita spoke about the precedent of having family members who breastfed, Denitra, a cosmetologist, shared another, more common, experience in the African-American community. She said:

Well, with my family, they're more traditional. They didn't want to do breastfeeding. They just say formula. So stick with formula, but I always try to be different, so that’s I went on ahead and tried breastfeeding. Because you can't just go by other people’s stories, you have to try for yourself. So that’s why I went on ahead and did breastfeeding.

She was the first, in her immediate family, to breastfeed. Her choice to breastfeed put her at odds with the feeding tradition among the women in her family. By choosing this act, Denitra broke the code(s) which are a significant part of how her group is defined. As a result, she chanced the possibility of losing the protection and/or connection with other members of her familial and racial group, as well as, being
alienated from her group. Denitra’s response was to invoke her agency by asserting her uniqueness. She chose to ride under the banner of difference which provided its own protection. Also, it gave her a different reference point from which she could measure her success and failure. Because she was the first person to step out and try this new thing, her personal experiences became her yardstick.

According to all of the participants, the fathers of their children were involved with the children at some point, if not all, of their lives. At the time of the interview, four fathers were not active in their child’s life. One of these fathers was in prison for fraud. Another father had been murdered in the previous year. According to the participants in the study, the fathers (when present) deferred to them to make the final decision on whether they would breastfeed or use infant formula. Among the fathers, husbands were most likely to be vocal about the choosing a feeding method(s). Both boyfriends and husbands were focused on the mother and child being “fine.” They raised their voices when things ceased to be “fine.” Fathers who were identified as “pushing breastfeeding” were men who had themselves been breastfed. None of the mothers discussed having the father of their child(ren) emphasize the benefits of formula use over breastfeeding until they expressed a challenge with breastfeeding or frustration with the process. According to the participants, once that information was given to fathers, they went from being silent and compliant to taking on a position of advocacy for supplementing breastmilk with formula or for the cessation of nursing altogether. Juanita recalled her initial discussions and the experiences that she
had with her husband before and after their first child (a boy) was born:

Umm, I don’t think my husband talked. As far as formula, I don’t think my husband- or breastfeeding, I don’t think we talked about, umm, either one. It was like, “Okay you gonna breastfeed him. Okay, that’s your decision.” You know, it was more like my decision. Up until the baby came. Once the baby came, I think that he started to feel the, umm, this is our first baby, you know. Where’s my turn to be with the baby. Cuz the baby had to be with me so much. You know, well it’s with me all day and then he got home. Then if the baby cried or was hungry, then he’d have to turn his baby over. And so, I think he felt like a little dissed. You know, like where’s my time? I want my son and that kind of thing. So I think, part of the pressure of him wanting me to go to supplement him formula was, “I can give you a break.” You know what I think he was thinking was, I want to show him I can feed him too. . . so that was a little difficult too. There was a lot of pressure, and you already trying to nurse and it’s like, “Your milk is not coming in!” So he’s like, “Let me feed the baby.” So, umm, you know. I guess we all have our selfish moments when the baby comes. Like, “Who’s gonna be with the baby?” He’s here at the house like, “Is the baby getting enough?!” You know, so then you start questioning, “Is the baby?” Well, no, because they said he’s getting enough. It’s okay. I know things are working out, right? So I did question, maybe I should be giving the baby more. But I was insistent on nursing my baby.

Juanita’s initial experience reflects the common belief that it is the mother’s job to decide what and how she is going to feed the baby. Juanita used the term “dissed,” to reflect what she believed was her husband having a feeling of being disrespected/disconnected, left out in the cold. Her husband viewed the need to “give the child up” when he was hungry as a problem because he could not meet a basic need of his child. He argued that his feeding the baby would give “her time to herself.” He did not focus on other times that he could spend time with the baby. Feeding became the most desired activity. Echoing the rhetoric of the fallible female body, he questioned her about the sufficiency of her milk supply and encouraged her to supplement with
infant formula\textsuperscript{13}. Juanita held fast to her desire to breastfeed the baby, but when her husband, the man who she viewed as partner, began to question her, she began to question herself. While Juanita chose to continue breastfeeding without adding formula, other participants in the study made the decision to either supplement or discontinue breastfeeding altogether.

When Chelsea’s recounted her breastfeeding experience, she talked about the pain of cracked and bleeding nipples, and having a strong determination to breastfeed. The 21-year-old teaching assistant described how she struggled to continue breastfeeding despite the problems that she was having and despite her husband, now estranged, telling her to use formula whenever she talked to him about any of those challenges and frustrations. After four weeks of working at breastfeeding, she decided that she was going to wean her baby. Chelsea resigned herself to her decision. She said that if she had another child, she would not attempt to breastfeed again. She said, “[They said] it will help her be healthier, and it will also give her that natural attachment to me. I figure that’s my baby; she’ll be attached period [Laughter]...I didn’t really go for that.” Chelsea reasoned that it would not be worth the stress and problems to attempt to breastfeed. The bottom line for her was that her child would be fed. She saw formula as her best option.

For the fathers who had more experience with formula feeding, like 31-year-old Destanni’s husband, supplementing or transitioning

\textsuperscript{13} According to Blum(1998), the rhetoric of the fallible female body which was used by infant formula manufacturers and medical professionals (primarily pediatricians) furthered the idea that the female body was unreliable and tainted. Its fluids were viewed as unsanitary. Pediatricians argued that the scientific “formula” could be created from substances that the doctor could control, “properly” measured, and sanitize which would be best for the health of the baby.
the baby to eating infant formula solely became a way for them to show that they could take care of their babies. Destanni’s husband had three children from a previous marriage. As a result, he was well-versed with using bottles and infant formula. He was able to take the lead with feedings and teach Destanni, an occupational therapist, what to do. It was uncommon for fathers to have more knowledge than mothers about infant feed, but using formula gave them an opportunity to learn. While some of the mothers in the study said that there were other things that fathers could do with the babies like diaper changing, or simply spending time with them, feedings took center stage. Juanita, like other participants, felt that the fathers tended to focus on feedings because they wanted to prove to the mothers of their children and/or themselves that they could take care of the baby just as well as the mothers. They wanted to feel important as parents.

**The Game Plan**

All of the mothers in this study pondered the decision of what first food would be best for their babies with some goals in mind. Some mothers believed that there was one way and one way only to feed their babies. The majority of women viewed feeding flexibly. They planned to use one method (breastfeeding), but articulated being very open to using formula if breastfeeding “didn’t work out.” They identified the following examples of “not working out”: not having enough milk; it being too painful; a belief that the baby wasn’t getting enough milk; the baby having a problem latching on; a personal dislike for breastfeeding. The participants talked about mothers they knew (or knew of) who had problems with breastfeeding. As a result of this, many were open to the possibility of initiating breastfeeding,
but not being able to meet the time table put forth by the American Medical Association (AMA). Participants whose lived reality most closely matched the plan that they had for feeding their babies were most likely to talk about their experiences in terms of success. They expressed the greatest degree of happiness. According to Brihanna,

It's beautiful...I feel like a woman, truly. That I'm able to do this, it's amazing that your body makes nourishment for your own child. It's amazing. I feel like a woman doing that and giving, the whole giving birth and everything. . . . this was the most enjoyable one because I did everything that I didn't do with Jamaal and I liked it. It was fun to experience. . . . The whole thing, it was good for me.

She attached the fullness of being a woman with being able to carry out a biological script. She connected joy and wonder with this in part because the experience was different from the one that she had with her previous child. The experience was healing and transformative for her because she controlled it and it worked out the way that she planned.

Mothers assigned the value judgments of success and failure to their infant feeding experience based on how it fit with their plan. They measured success and failure by the duration and lived experiences of breastfeeding. For some, just initiating breastfeeding marked success. For others only initiating, but not making it to the benchmarks articulated by the AMA was a failure. Participants didn’t discuss the duration of formula use in terms of success or failure. However, they did judge themselves (and others) as good or bad mothers based on whether or not breastfeeding was initiated. Breastfeeding alone was presented as a badge of honor. The longer the period of time, the more the mothers referenced it as an accomplishment. This

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14 The American Medical Association recommends exclusive breastfeeding for at least six months. They recommend breastfeeding for at least one year.
was especially true when mothers breastfed beyond one year. Mothers who breastfed for fewer than six weeks often said things like, “...at least (s)he got that much...,” or, “...at least I did that much...” These statements were commonly presented with both a sense of accomplishment and a feeling of wistfulness. The mothers who were most likely to say these things with a sense of accomplishment were also most likely to be in the paid labor market and/or in school and to not have been breastfed as children. They were stepping outside of their familial practices and breaking new ground. They had mixed support. Sometimes it was they got it from their mothers and friends, and other times they did not. From where they stood, they accomplished their breastfeeding goal, in spite of all of their responsibilities in and outside of the home. Participants who were full-time mothers and/or part-time paid workers were the ones who were most likely to judge their breastfeeding experience in terms of how long they breastfed their babies. They were most likely to be tied to breastfeeding for months rather than weeks. They were most likely to view the time that they breastfed as short, and to believe that they had somehow failed in their maternal responsibilities if they did not meet their predetermined temporal goal. Full-time mothers held the belief that even if they were not exclusively breastfeeding, they would be able to meet their breastfeeding goals because to do so was “natural.” They believed that as mothers who were committing themselves to being with their babies full-time, they were committing themselves to following a maternal instinct and/or traditional role. The participants who were able to choose whether or not they returned to paid work, and chose to remain in the home felt greater pressure to perform as “traditional”
mothers. Their choice to stay out of the paid labor market was envied and in some instances, thought to be “waste of what she could do.” Some of the mothers faced even more challenges with acceptance of their chosen role because their friends and family bought into the image of full-time mothers as women who played with children and didn’t do much with their brains.

Esther, a 37-year-old mother of 2 children who chose not to nurse after she received a diagnosis of Hepatitis C from her doctor, felt that infant formula was “poison...man-made...synthetic...not natural.” The self-identified homemaker talked about feeling guilt every time that she had to feed her baby the product. She was breastfed as a child and watched many of her other eight siblings breastfeed. She had an intense commitment to breastfeed until she received her diagnosis. She was told that there was a significant risk of passing the disease, which deteriorates the liver, on to any children that she might have, if she breastfed. She was not willing to forgo having children. Having another mother breastfeed her child was not an option that she felt comfortable choosing, and she did not have knowledge of a breastmilk bank. She believed that infant formula was the only viable option available to her. As she talked with me, her youngest daughter looked at us and laughed. Esther nuzzled her neck. She said,

I feel guilty about it. I mean, even though I know that medically and for health reasons I couldn’t do it, I still feel bad that I couldn’t because I felt like I deprived my child of something that was natural and was part of the whole process, you know… It’s a more natural process, and this is my opinion too, you feel like you bond better with your child; you have a stronger connection with your baby. And not being able to do that— and you also feel less— and this is me— I feel guilty about not being able to do it, and less of a woman because I wasn’t able to do that for my child and that’s like a natural thing, you know.
Esther connects the concept of “natural” to something that is hardwired into the biological system. Because breastfeeding is natural, as a woman, a mother, she was supposed to be “made” to do it, just like her mother before her. The inability to breastfeed caused her identity as a woman, the precursor for being a mother, to be contested. Even as her child sat before her healthy and happy, she still saw herself as a feeding failure. When she judged her motherhood, she saw it as lacking despite having made what she believed was the best choice, given her circumstances.

**Adaptive Strategies**

There were different reasons why the mothers in this study chose to breastfeed, and/or use infant formula. While the practice/culture of infant feeding has been bifurcated into mothers who breastfeed and ones who use formula, the majority of the mothers in this study breastfed and used formula at some time during the life of their child(ren). The most recent data from the CDC indicates that even though breastfeeding rates have steadily risen since the 1990s, the greater majority of mothers are not exclusively breastfeeding. Most mothers were combination feeders. They “supplemented” their breastmilk, either from the baby’s birth or from another point in time like when the mother returns to the paid labor market. In a few instances, mothers supplemented their breastmilk with soy or rice milk. In our society, supplements are constructed as added nutrients which augment our dietary regiment. In the instance of feeding babies, the formula becomes the supplement to human breastmilk until it becomes the primary food. Mothers who augment their feeding regiment generally did so because they planned to fully transition to infant
formula. Few mothers exclusively breastfed the first year of their child’s life. Those who did, expressed (pumped) their milk at some time during the infancy of the child so that s(he) could be bottle fed with the mother’s breastmilk. Esther was the only mother in the study who started off as a formula user and never breastfed her children. Mothers created adaptive strategies which they used to make the care of their babies and so that they could manage the activities in their lives, like childcare, school, work, and other social responsibilities.

Work, outside of the home, and school were the activities that were most likely to require the mothers in the study to create regular feeding routines that accommodated the absence of the respondent. According to the participants in this study, employment outside of the home was not the key indicator of whether or not the participants in the study chose to breastfeed their child. Each respondent’s decision was most influenced by her preconceived ideas about breastfeeding and formula use. Employment outside of the home did have an effect on the duration of breastfeeding. For example, Amy made sure that she weaned her child shortly before she had to return to work. Also, respondents in the study, like Chelsea, made sure that they introduced the bottle-some with breastmilk, others with formula-as a supplement to feeding from the breast because of the separation that they would face with their children once they returned to work. Also, mothers in the study, like Shaniqua were impacted by the stress of having to ensure that they expressed enough and could breastfeed and pump after and, in some cases, before they went off to work or school.
The participants in the study created breastfeeding goals based on the literature that they had read, information from media sources like magazines, and the news, the Internet, family and friends, as well as, the advice that they received from their healthcare providers. The following factors had the greatest effect on the duration of breastfeeding: status of the mother/father in the paid labor market; access to resources, e.g. breast pump, supplies, pumping space (if she worked out side of the home), availability and accessibility of formula, and social support. These factors were interrelated. For example, the amount of flexibility and control that respondents had over their work environment or the amount of power to shape policies surrounding breastfeeding in their work space impacted whether or not the mothers in the study breastfed while they were full-time workers outside of the home. During our interview, Shaniqua and I have the following exchange:

Shaniqua: My job allows breast feeding at work. Yeah, the woman who works human resources was pregnant at the same time as me. She had an office where she would pump all day. Now, I wasn’t in a position to do that because I worked in a cubicle, but she said you can go into the bathroom and do it. Actually, I think there's a regulation in regards to that. You have to be allowed to pump at work.

Interviewer: Is there a center provided? You just mentioned she had an office. You have a bathroom.

Shaniqua: Right, no.

Interviewer: But, you have to be allowed to, but it’s either you have an office or a bathroom?

Shaniqua: Right. It’s more like no one can complain that you’re pumping in the restroom.

Interviewer: But, no place is provided

Shaniqua: No. Because that regulation has been allowed, shows that somewhere someone is trying to further that cause. But, because it’s so minimal – unless you want to pump on the commode, you're pretty much not going to do it unless you have an office like Ella says she pumps in her office. She’s given the freedom to do so – no problem. Again, I guess as it goes back to economical.
Interviewer: Who is more likely to be in that position? Just looking at that idea of race again cause that’s an economic situation. Who is more likely to be in that position when you think about race to have the office versus the toilet?

Shaniqua: I know that in my work center, the women who have offices are usually white. The women who don’t are usually the ones sitting in the cubicle are usually women of color.

Interviewer: Do you think that’s an unusual situation?
Shaniqua: No, I don’t think that’s an unusual situation. I’ve been in the office where there’s only been two women in an office, and I was the one sitting at the cubicle. Statistically, chances are higher that if you’re white, you’re going to have a higher paying job.

Shaniqua, a clerk at a telecommunications company, talks about the importance of power within the workplace. The mothers who sought to pump their breastmilk at work, yet had no place in which to do so had to choose another means of expressing their milk for their babies. Or, they chose to use infant formula. Within her comment, Shaniqua highlighted the racialized structuring of her workplace. White women were more likely than women of color to have offices. As a result, women of color were more likely to have to choose between the toilet or the break room to express their milk. Neither place afforded the privacy, cleanliness, or security that an office provided. All of the mothers in the study indicated that those elements were important to them. Also, privacy when dealing with bodily fluids is a standard expectation for women. While men may be expected to have open urinals and communal showers, from the time of early childhood, girls are required to keep their bodies covered. As they age and begin menstruation, they are admonished to keep this period and their bodily fluids private and to manage them behind closed doors. While the closed stall doors in the bathroom offered some privacy, in comparison to the break room, Yvonne, a self-employed caterer, summed up the
feelings expressed by other mothers in the study when she said, “Who wants to make her baby’s food on the toilet?”

**So They Chose…**

The participants in this study were most concerned with having choices about what to feed their babies. Many of them found themselves treading new ground as breastfeeding mothers while others re-entered familiar territory. Whether they breastfed, used formula or a combination of the two, the mothers in the study were most pleased with their feeding practice(s) when their ability to control their infant feeding experience wasn’t impeded. The participants wanted to have the option to follow one practice, possibly incorporate (or totally switch to) another option without being judged. When the participants had these choices, they created fluidity in infant feeding practice which enabled them to do things like work in the paid labor market, attend school, take care of children, and/or entertain friends and family. The participants who were least satisfied with their feeding experiences were those who believed that control over the feeding event was taken away from them. They were the ones who were most likely to have regrets about the decisions that they made about breastfeeding and/or using infant formula.

The mothers in the study adapted to their final feeding practices whether or not they were what they had originally planned. Armed with the knowledge of what was good and what was best, they chose what was best, but their focal point wasn’t just their babies. They chose what was best for themselves and for the entire family, as well.
CHAPTER 3
THE BIRTH CONNECTION

In this society, baby girls who are born in hospitals are wrapped in pink. A stork carrying a baby swaddled in pink is placed on the door of the birthing mother’s room. It serves as a signifier to passers-by that a baby girl has been born. The girls’ sections at boutiques and department stores are swathed in pink. These color cues serve as an early guide for the girl child (and adults) that she is supposed to be surrounded by soft, baby things. The majority of girls are given baby dolls when they are toddlers and preadolescents. They will be shown movies, books, advertisements and everything in between with the same message, “You have to be a mother.” Another message is, “You aren’t complete until you are a mother.” Girls around the country internalize these messages and grow up into women who believe that in this day and age, they can do anything in this world, but in order for it all to matter, they must become biological mothers. Before they plan weddings, if they follow the conventionally gendered and heteronormative plan, they will think of baby names, and talk with friends and family about being a mother.

In this chapter, I will examine how the experiences surrounding the actualization of biological motherhood impact what mothers think about breastfeeding and/or using infant formula. Also, I will examine how the birth experience, whether she had vagina birth or c-section, impacted her infant feeding experience. The birth event is defined as pregnancy, the process of birth and six weeks postpartum. I include the six week postpartum period to address the recovery period for women who have c-sections. Also, the first check-up appointment that
most post-pregnant women attend falls six weeks after their babies are born. Table 3.1 is a datalist of all of the birth experiences of the mothers in the study. Table 3.2 is a frequency table of the most recent births that the mothers in the study experienced.

**Pregnant Noise**

From early childhood, girls in this society are exposed to baby dolls with bottles. They receive them as gifts, see them in stores, and are bombarded with commercials hawking them on television. The bottles are made to resemble the types of bottles that are commonly sold at stores. The bottles appear to have white liquid in them that is presumed to be infant formula. While it is possible to purchase breastfeeding dolls from specialty catalogs and stores, these toys are uncommon. The uncontested presence of dolls with bottles provides a model of the normative way to feed a baby.

During pregnancy, the buzz about infant feeding grew and surrounded the mothers in the study. In the beginning, many of them did not know exactly what method they were going to choose. As their pregnancies advanced, and the birth became imminent, all of the mothers had to make a definitive decision about what method of feeding they were going to use. Until they heard the words, “You’re pregnant,” for their healthcare providers, twenty one of the respondents assumed that they would formula-feed their babies until they found out they were pregnant\(^{15}\). They had been formula fed as babies and, in the case

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\(^{15}\) Today, many women (and girls) find out that they are pregnant from a take-home pregnancy test before they are seen by a healthcare worker. It is important to note that doctors, nurses, and midwives will not take the word of a woman (or girl) that she is pregnant. The healthcare providers will not medically manage the female’s pregnancy until their tests identify her as pregnant. This practice is part of what Rothman (1991) identifies as the medicalization of pregnancy and birth.
<table>
<thead>
<tr>
<th>Alias</th>
<th>Birth Type</th>
<th>Birth Attendant</th>
<th>Lactation Consultant</th>
<th>Birth Location</th>
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<tbody>
<tr>
<td>Shaniqua</td>
<td>V</td>
<td>Midwife</td>
<td>Y</td>
<td>Birth Center</td>
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<td>V</td>
<td>Midwife &amp; OB</td>
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<td>Hospital</td>
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<tr>
<td>Hadiatu</td>
<td>V &amp; c-sect</td>
<td>OB</td>
<td>N</td>
<td>Hospital</td>
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<td>Amy</td>
<td>c-sect</td>
<td>OB</td>
<td>N</td>
<td>Hospital</td>
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<td>Hospital</td>
</tr>
<tr>
<td>Diedre</td>
<td>c-sect &amp; VBAC</td>
<td>OB</td>
<td>Y</td>
<td>Hospital</td>
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</tr>
<tr>
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<td>V &amp; c-sect</td>
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</tr>
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<td>V</td>
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<td>Lactation Consultant</td>
<td>Birth Location</td>
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<td>----------------------</td>
<td>----------------</td>
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<tr>
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<td>Hospital</td>
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<td>Y</td>
<td>Home</td>
</tr>
<tr>
<td>Danielle</td>
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<td>OB</td>
<td>Y</td>
<td>Hospital</td>
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KEY-  V=Vaginal Delivery; C-sect= Cesarean Section; VBAC=Vaginal Birth After Cesearean; OB=Obstetrician
Table 3.2
A Crosstabulation of Birth Outcomes

<table>
<thead>
<tr>
<th>Birth Attendant*</th>
<th>Vaginal (20)</th>
<th>C-section (9)</th>
<th>VBAC (1)</th>
<th>Total(30)</th>
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<td>Midwife</td>
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<td>Lactation Consultant</td>
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<tr>
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<td>4</td>
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<td>0</td>
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N=30
* Two of the mothers in the study reported having both and obstetrician and a midwife.
of those who had younger siblings and/or cousins, had been active agents in feeding formula to their relatives when they were babies. Some participants stated that they had seen breastfeeding at stores or at church, but the women who were breastfeeding were normally white women. Only a few of the mothers in the study had friends and/or family members who breastfed. As Monica, a 33-year-old housewife, put it, “I wasn’t even thinking about it.” On the other hand, women who were breastfed as babies, indicated that before they were pregnant they, “knew that they would breastfeed.” These mothers experienced at least one of the following: they were told that they were breastfed; they listened to stories from older sibling(s) about being breastfed; they watched a younger sibling(s) being breastfed; or they spent a significant portion of their childhood in a culture where breastfeeding was normalized, e.g. Jamaica. While all of these participants now live in a larger society which privileges formula use, the normative feeding practices that they experienced in their childhood homes made breastfeeding the presumption -- a default choice. Similar to the mothers whose children were formula fed, the mothers who had been breastfed made the passive choice to continue the practice that they had experienced. Yet, the participants who chose to breastfeed followed a path which placed them in ideological opposition to the mores of the dominant society in which they lived. So, although the participants’ decision-making had a passive quality, their actions as breastfeeders were by no means passive.

The participants began to engage actively in the decision-making process about infant feeding once they realized that they were pregnant. At that point, they consciously considered the information
that they received about the benefits and challenges of breastfeeding and formula use. The majority of mothers in the study were adolescents and young adults during the height of the “Breast is Best” campaign. As a result, many women said they received a bevy of information about the benefits of breastfeeding that was validated by medical authorities. By the time that they had their babies, all of the mothers in the study had been exposed to ad campaigns which centered on the benefits of breastfeeding. Amy, an 18-year-old, first-time mother summed up the orientation of the participants in this study when she said,

   While I was pregnant, I thought breastfeeding would be very good, because it would be healthy for my baby, so as long as I stayed healthy, I would help my baby stay healthy.

Breastfeeding was something that was good for her baby, and she had control over it. As long as she cared for herself, she would be caring for her baby, which by extension is what she believed a good mother was supposed to do for her child. Like Amy, the other participants focused on the health benefits of breastfeeding for their babies. All of the mothers knew that breastfeeding was supposed to cause the breastfeeding mother to lose weight sooner than those who did not breastfeed. Also, many mothers said that breastfeeding increased bonding between themselves and their babies. A few mothers mentioned the uterus shrinking back to its pre-pregnancy size as a health benefit, but they, with the exception of the participant in the study who was a registered nurse, did not articulate the significance of that information. I asked participants about the thoughts that they had about feeding their babies with infant formula and breastfeeding
while they were pregnant. Thirty-three-year-old Monica, a mother of two at the time of the interview, said:

> When you're growing your child you start thinking about, you know, what's healthiest for them, what's going to make them stronger, and just the idea that they wouldn't get sick as much... they don't have as many ear infections, they're healthier, they're stronger, they grow faster. All these great things happen with breastfeeding.

Monica’s quote reflects her change in focus from that of an individual who is solely responsible for and accountable to herself to the new person who she is physically creating within her body. The physical changes tangibly mark her transition into motherhood. Her new identity required her to orient herself toward what she believed was the idealized best feeding method for her soon-to-be growing child. Monica, like other respondents, did not speak about how providing “the best” would affect her lifestyle or her physical and/or psychological self. She centralized breastfeeding, the idealized “best,” because of the information that she accepted from medical authorities, family, and friends that linked breastfeeding to better outcomes in health and intelligence -- key markers for success -- for her unborn child. Despite their collective focus on the laudable benefits of breastfeeding, the mothers in the study maintained infant formula as a default food because to them infant formula, like it or not, was “the option that was always there.” Juanita a 31-year-old, mother of two boys at the time of the interview talked about warming up and preparing fresh bottles of infant formula for her younger siblings. As she spoke, she sat back in her wine colored easy chair and said, “You can start off breastfeeding, but you know that no matter what happens, there’s always formula.” During their pregnancies, particularly for first time mothers, the women found comfort in
knowing that infant formula was the next best thing to breastfeeding. Mothers in the study expressed a sense of security that if for any reason they were not able to breastfeed or did not produce “enough” breastmilk that there was an alternative food available.

 Throughout their pregnancies, the participants sought information about infant feeding from various non-medical sources, e.g. books, the Internet, family, friends, and magazines. By the time that they talked to their healthcare providers, the participants had already decided what options they were willing to use. According to the mothers in the study, their healthcare providers did not discuss infant feeding options with them until after their pregnancy was verified and documented. After that point, the participants in the study who were using obstetricians (OBs) as their birth attendants said that their doctor asked what method of feeding they were going to use. In general, the participants indicated that their doctors, who were predominantly male, would acknowledge the response, but did not overtly show approval of one method over another. The respondents who birthed with midwives (direct-entry and certified-nurse midwives), indicated that the midwives were more likely than obstetricians to present overt support of breastfeeding once the respondents indicated that they planned to breastfeed. During their pregnancies, the mothers in the study received “goodie bags,” which obstetricians and midwives gave to all of the mothers. The “goodie bags” contained, among other things, coupons for and samples of infant formula from specific companies that made and distributed infant formula, e.g. Ross Laboratories, Nestlé. This silent collaboration of the healthcare
providers with formula manufacturers validated the normalcy of feeding babies, particularly newborns, infant formula.

Obstetricians and midwives giving the mothers bags with formula samples and coupons privileged infant formula as an essential item that the mothers in the study would use and/or should have on hand “just in case,” despite any statements that the participant had made about her desire/plan to breastfeed. The participants’ bags did not include breastfeeding paraphernalia like breast pads, phalanges for a manual breast pump, or nipple ointment (for sore and/or cracked nipples). Having these items in the bags that are routinely given to pregnant women would imply that breastfeeding could be an option, so supplies that support the practice should be on hand. The absence of breastfeeding accoutrements from the standard issue “goodie bags” marginalizes breastfeeding, which iterates that social norm that it is an exception not the rule.

Once the mothers in the study were visibly pregnant, “showing,” they were bombarded by advice from friends, family, and strangers. People, primarily women, talked to them about how they were feeling and the baby’s movement to their birth plans and potential names for the baby. Invariably, the topic of infant feeding came up. For some participants, the conversations and experiences that they had with mothers who had nursed (or were actively breastfeeding) opened up the door for lively conversation that validated the benefits of breastfeeding and strengthened the mothers’ resolve to “at least give it a try.” Lydia’s friends told her that it would hurt a little, but that she should do it because it “would be good.” Yolonda had an African-American friend who breastfed her baby during a visit to her
home. Her friend fielded questions about breastfeeding and physically
guided Yolonda through the process of getting her baby to latch on to
her breast. According to Yolonda, after she had that experience, she
“knew” that she would breastfeed. Prior to watching and talking with
her friend, she thought that “maybe” she would “try” breastfeeding
because of what she had learned about it from books, the Internet, and
magazines. She was excited about getting “cute little baby bottles”
because that experience was what she knew. Once Yolonda had a model of
a breastfeeding African-American woman, she was sold on the practice.
The active, joyous breastfeeding that her friend displayed
demonstrated that not only do Black women breastfeed, but also they do
it happily and comfortably. Yolanda found the social support for
breastfeeding that she did not have among members of her family and
friends.

After Yolonda found out that she was pregnant, she told her
mother that she was thinking about breastfeeding. Her mother:

wanted [her] to bottle-feed. She actually was very opposed
to me breast-feeding the entire time. I think she probably
maybe was a little offended at the notion that she bottle-
fed all of her children and all of the sudden I'm telling
her that that wasn't the best way to do it. . . . (She saw
it as) more of an attack on her parenting as opposed to a
choice I was making.

Yolonda’s mother chose to breastfeed her children during the 1970s
when the majority of African-American women made the transition from
mainly breastfeeding their babies to primarily feeding them infant
formula. As a group, African-American mothers gravitated toward a
reliance on infant formula as the primary food source for babies later
than their European American counterparts. As a result, African-
American mothers were demonized by the dominant white majority along
with poor, and other racially marginalized groups who did not embrace the product (Blum, 1999). The central use of infant formula, as the primary food for infants, was endorsed by medical authorities. The product was costly, and the glass bottles and nipples that were used to feed the babies the new infant formula were cumbersome. As a result of industrial innovations and mass production the price of formula fell. Also the wide-scale usage of plastics paved the way for the creation of newer, safer bottles and nipples (Levenstein, 1988).

During the 1950s, middle class, African-American mothers started turning away from the practice of breastfeeding and began to follow the advice of medical authorities, who continued to endorse infant formula as a superior food. Infant formula, unlike human breastmilk, was promoted as “scientifically” created. The ingredients of the product could be controlled and reproduced on demand. Pediatricians verified that infant formula was dependable, sanitary, and medically superior to human breastmilk; they framed factory production as superior to women’s bodies (Blum, 1998). Breasts had to be sucked in order for the milk to come out which meant that fluids like saliva, and milk would have to comingle. On the coattails of Freudian psychosexual analyses, the act of a baby sucking its mother’s breast was characterized as both sexual and “unclean.”

When, Yolonda’s mother chose to follow the trend of other middle-class African-American women at that time, she acted counter to the actions of her mother. She accepted the position of medical authorities over the motherwit which had sustained her through her
childhood into adulthood\textsuperscript{16}. She created a generational schism. Within the African-American community, generational continuity was the hallmark of what kept the community together through the horrors of slavery and ongoing racism. Black mothers, who were charged with the care of children and acted as the culture bearers for the community, played a significant role in keeping families and by extension communities of free and enslaved African Americans together. Within the familial expectations in Yolonda’s family, her mother’s decision to feed her children with infant formula was perceived as undermining the authority of her mother. Yolonda’s decision to breastfeed contradicted her mother’s judgment, thereby undermining her authority. Ironically, according to Yolonda, her mother asked her the following:


Yolonda’s mother racializes the decision to breastfeed. She implies that formula-feeding (the African American way) would be easier than breastfeeding (the white way) because it would align her with the action of other African American mothers, thereby providing with safety (and potential anonymity) among her “own.”

The participants in the study waded through the noise. For the eleven mothers who had either been nursed or had witnessed a sibling being breastfed, making the decision to breastfeed was relatively easy. All of these mothers, except one, knew that they

\textsuperscript{16} The knowledge set that only mothers have. They attain this specialized knowledge through their experiences as mothers.
wanted to (and received support to) follow the “mother” script outlined by their mothers. Lydia was the sole exception. She was not breastfed, but she saw her mother breastfeed her siblings. Unlike the other women in the study whose mothers had breastfed, she planned to use infant formula during both of her pregnancies because she disliked the act of breastfeeding. She watched her mother breastfeed a younger sibling. Lydia believed that it was easier to mix formula and use a bottle than negotiate the corporeal sensations of breastfeeding. Also, she was repulsed by the idea of leaking breasts and breastfeeding in public. By the end of their pregnancies, the nineteen mothers, whose mothers never breastfed, made the decision to become breastfeeders.

**Birth (Interrupted)**

“It’s time.” This phrase has been uttered in movies and television alike to mark the moment when a pregnant woman recognizes (or medical professionals identify) that it is time for her baby to be born. While the woman is pregnant, there is space for speculation about everything from what she will call the baby to what she will feed the baby. Once the baby is born, fantasy becomes tangible reality. The preliminary “maybes” morph into actualities which have to be addressed. Feeding is one such actuality. The decisions that the respondents made about infant feeding were shaped by how and where they gave birth to their babies. Also, their experience(s) of birth informed how they felt (physically, and emotionally) about what they chose to feed them, as well.

All of the participants in this study had health insurance coverage (private and government sponsored) when they gave birth. Six
of the participants used Medicaid to pay for the cost of their prenatal care, the birth of their babies, and the extended stay of the mother and/or child (when necessary). Twenty-four of the mothers in the study relied on private health insurance to cover those medical expenses. As a result of having health insurance to pay for their birth related medical expenses, mothers who had C-Sections were able to benefit from extra recovery days in the hospital. The extra time in the hospital became a double edged sword for the participants in the study. On one hand, extra recovery days meant that the mother could rest, and have others take care of her while she was in the hospital. Also, she had easier access to her and her baby’s healthcare provider(s). Another benefit of being in the hospital, specifically if her child had to stay in the hospital for an extended time because of prematurity or a birth-related complication to the child’s health, was that the mother was in the same facility as her child(ren). When mothers were in close proximity to their new babies, they were able to have more frequent with the child. Also, when mothers were mobility-challenged after birth, the babies could easily be brought to them. As a result, mothers could have skin-to-skin contact with their babies, even if they were not able to physically feed them at the breast\textsuperscript{17}. Also, mothers in the study who birthed at hospitals which had lactation centers were more likely than other respondents to have facilities where they could pump and store their breastmilk. Also, hospitals which invested in on-site lactation centers, had a greater likelihood of having full-time lactation consultants on staff than did

\textsuperscript{17} Kangaroo skin-to-skin refers to the practice of having mother and baby have direct physical contact. Preference is placed on having the baby on her/his mother’s chest. This practice has been shown to help the child regulate her/his breathing and body temperature. Also, it has been suggested that this type of contact positively affects the mother’s milk supply, as well as, her mood.
hospitals which did not invest in those facilities. The downside of being in the hospital was that mothers in the study felt that because of the rules and practices within the hospital, they had lost control of their bodies and their babies. In the hospital, their movements were monitored, and nurses controlled when (and how) they had access to their children.

The feelings that the participants had about “losing control” of their children were exacerbated when they were discharged from the hospital, but their children had to remain there. Nzingha, a 34-year-old billing clerk, reflected on her experiences with breastfeeding after her first child was born,

they kept him, he was there, I want to say for probably five days, it could be from 3-5 days they kept him, and I said I was going to breast-feed, but they sent me home and they kept him, so I had to keep coming back and forth, and I did it for probably about one or two days, going back and forth to the hospital to feed him, and I just said no I can’t do this, so I waited for them to release him. Then when I brought him home, he had already been having all these bottles, so it was hard for me. I think that’s what caused the problem.

Nzingha’s plan to breastfeed her child was disrupted by the hospital’s policy of keeping newborns in the hospital beyond birth, even when there were no complications (to mother or child) during birth and the child. According to Nzingha, her child was full term and her attending doctor told her that her child did not have any medical problems. Nzingha attempted to work within the system so that she would be able to follow through with her feeding plan and remain compliant to the rules and regulations established by the medical authorities who were

\[18\] Lactation consultants are healthcare providers who are recognized as experts in the fields of human lactation and breastfeeding. They do everything from watching a mother latch her baby onto her breast to providing hands-on assistance with breastfeeding and providing pro-breastfeeding external resources to mothers.
responsible for her child. Once her son was released to her, she had to reconcile the postnatal infant feeding plans that she had oriented herself toward during her pregnancy with the reality that her child had grown accustomed to being bottle-fed infant formula while he was in the hospital. As a result of her compromise, Nzingha’s feeding experience was greatly compromised. She struggled with maintaining her breastmilk supply and getting her son to latch on to her breast for feedings. Nzingha wasn’t opposed to her child being fed infant formula as an alternative to breastmilk, but she wanted to choose when (and how much) it was used. Once Nzingha’s milk supply started to decrease, her son weaned himself. Ultimately, her “one to two years” breastfeeding plan with the possibility of occasional infant formula use was replaced with the reality of three months of breastfeeding and a primary reliance on infant formula. At the time of the interview, Nzingha remained angry about what had transpired after the birth of her first child. The experience reinforced her distrust of the medical establishment. She blamed the problems that she had with breastfeeding on the doctors keeping her son and feeding him bottles. Once she was able to reflect upon her first infant feeding experience, Nzingha resolved that when it came to her future child(ren) she would not just go along with what she was told by doctors. The unexpected interruption in her feeding plans intensified her desire to breastfeed her child(ren) past six months. At the time of the interview, she had breastfed her third (and youngest child) until she was 11 months old.

When mothers in the study experienced complications with their birth or the baby developed health challenges, they were more likely to feel gratitude towards and surrender their decision-making power to
medical authorities. In Amy’s case, she had a c-section with her first (and only) child. She said:

So yeah, I couldn’t feed her because I had too much medicine in my system after I had it. So they started giving her Good Start from the day she was born, but then I switched over to breast milk.

Amy, who was an 18-year-old data entry clerk at the time of the interview, talked about the events in a matter-of-fact way. Even though she had planned to breastfeed her daughter from birth, she accepted the decision that her doctors made to initially feed the child infant formula. Although it wasn’t what she had planned, she trusted that the doctors would do what was best for her baby. Amy adapted to her new circumstances by adjusting her feeding plan. She chose to (and was comfortable with) temporarily relinquish her control over her daughter’s daily care because she believed that she would be able to regain it and that choosing to let medical authorities take over the care of her daughter was in the child’s best interests. Once she was cleared to breastfeed her daughter, mother and child did not experience any challenges with latching and Amy had an ample milk supply. She judged herself to be a “good” mother and her child to be a “good” girl because even though they took a detour from her initial plan, they were able to get back on course without any problems.

Mothers in the study, who opted for pharmaceutical intervention(s) in their birth experiences, faced the effects of the drugs on their new babies with aplomb. Yvette, a 35 year-old mother of two, knew that she wanted to breastfeed. She did not experience any complications during (or after) her vaginal birth, but:
Yvette: She was kind of sleepy, so we had to give her a little bit of formula there just to make sure that she wouldn’t dehydrate.

Interviewer: Why was she sleepy?

Yvette: I think it was from the epidural, but I’m not sure, I didn’t think to ask, but they think it might have been, they think that it might have been.

Yvette planned to breastfeed her child exclusively for her first six months. Because of her daughter’s sluggishness—a common response that babies exhibit when their birth mothers receive epidurals during the birth process—she did not immediately respond to being breastfed. After this was explained to Yvette, she adapted to the new situation, which nurses caring for her daughter told her necessitated her daughter being fed infant formula. She kept her general plan, and took her daughter to the hospital’s lactation consultant before she was discharged from the hospital. While she did not experience any challenges with breastfeeding, once her daughter’s groginess subsided, she “wanted to make sure that the latch was okay.” Yvette was determined to have a positive breastfeeding experience, both for herself and her child, so she made use of all of the resources that were available to her.

When participants in the study experienced complications with their birth and/or complications to their child’s health, and breastfeeding, they blamed themselves (faulty bodies) and absolved medical professionals of any culpability if they experienced problems with breastfeeding. According to Kendra, a 29 year-old homemaker, with two children,

My thoughts on formula, frankly, I thought it was an easy way out. I didn’t think that it was the best option for babies. Honestly, when I had to use formula with him, I was disappointed. When I wasn’t able to breast feed, I took that as a failure on my part that I wasn’t able to take care
of my son on a bare and basic level.... Since my son has had to take it, he’s fine. If people want to use formula, fine. If they want to use breast feeding, I’m open to anything. I’m not quite as judgmental.

Like other mothers in the study, who were opposed to using infant formula, Kendra’s unexpected birth outcome and her child’s health shaped the way that she thought about her feeding experience. She developed an apologetic narrative which supported her decision to use infant formula as the primary food for her baby. The apologia provided her with a comfortable counterbalance to the guilt and disappointment she felt about not breastfeeding. Once she became a regular infant formula feeder, Kendra changed the way that she judged people who fed their babies infant formula. This concession was common among the participants who did not initially plan to privilege infant formula use over breastfeeding in theory or practice, but wound up having to primarily feed their children infant formula and maintain breastfeeding as supplementary or discontinue it altogether.

When mothers in the study had a vaginal birth with little or no complications and proceeded to breastfeed without any challenges, they focused on the process of birth and breastfeeding as “natural.” They believed that their experiences reinforced the actuality that women’s bodies were made to do both (grow people and breastfeed). In regards to the mothers in this study, belief in the “naturalness” of breastfeeding, after experiencing an “uneventful” vaginal birth was not a reliable indicator for initiation and/or duration of exclusive breastfeeding. These mothers were equally likely to exclusively breastfeed for six months or more as they were to initiate breastfeeding and begin supplementing with infant formula shortly after their babies was born. (Chapter two provides a detailed
discussion of why the mothers in the study chose the feeding option(s) that they did).

The participants in the study who had c-sections discussed feeling a greater obligation than the women who had vaginal births to breastfeed their babies. According to Amy,

I wanted to get up and do things on my own, because I didn’t just want to be sitting there. If my baby started crying, I would go pick her up. I knew I wasn’t supposed to be doing that stuff, but I had to get up and start moving and start interacting with my baby, because I felt like if all those people are around my baby, she is not really going to get to know me. . . . if she needed to be fed I would be like, don’t, leave her alone, I’ll come get her, I’d pick her up, put her on, do what she needs to do.

Despite the fact that she was in the process of recovering from major surgery and had been advised to avoid lifting, going to the bathroom without assistance, and to reduce her movements, Amy believed that she had to go to her baby and breastfeed her so that her daughter would “know her.” She believed that simply being around her child was not enough because she had to create a physical bond. Although her child had already been fed formula, she insisted on breastfeeding her. Like other mothers in the study, Amy held firm to her beliefs about what was “natural” for herself and her baby. While her birth and initial feeding was interrupted by an unnatural act, she would make sure that her child would experience natural feeding from the body of her mother. While she could (and would) adapt to less than ideal circumstances, like the need for surgical intervention in her birth experience, she would do her best to expose her daughter to the natural things that she “needs to do.”
**Tech Support**

In today’s society, the process of birth is predominantly managed by healthcare professionals and technological intervention. Mothers have access to different technologies that shape the way that they experience infant feeding. In order to understand this phenomenon, I will explore the relationship between those who provide technical support to pregnant girls and women and mothers (obstetricians, midwives, lactation consultants, and nurses), technology (breast pumps and infant formula), and their intersectional impact on the infant feeding experiences of the mothers in this study.

**The Machine**

I swear there should be a book in the Bible called “breast pumps” [Laughter] because it was one thing after the other (Shaniqua)

Shaniqua, a first time mother, wanted to do everything “naturally.” She wanted to have her birth with a midwife at a birth center. She didn’t want any drugs during her labor. She wanted to breastfeed her baby as soon as he was born. She stuck to her plan and had a drug-free labor at a birth center with her midwife. According to Shaniqua,

He knew what to do. I didn’t. That’s why I was like, okay, everything is going to go easy. He came out, and he was like [Slurp] [Laughter]. He latched right on. . . . I was like, okay, no problem, no conflict; he knows what to do. I just let him do it.

Everything seemed all right. One week passed without incident then:

I started to feel pain in my right breast. I would nurse him. I tried nursing him on my side, and he wouldn’t nurse. I’m thinking he’s full, but he would still be upset. It didn’t take long for me to realize something was wrong. I’m like go ahead and eat, and he would try, and then he would stop and be upset. Something is wrong. There was pain. I thought it was because I was engorged, but it was clogged.
He wouldn’t nurse on this side. We were like, okay, it’s time to get a pump.

Shaniqua found out that she had a clogged milk duct and thrush. She found relief (and a means of continuing to breastfeed) by pumping her breastmilk and feeding it her son in a bottle. Initially, she bought the most cost effective breast pump that she could find at a local store. She quickly discovered that, “all pumps are not created equal.” Shaniqua talked to her midwife. Her midwife referred her to a lactation consultant who recommended a specific brand of breast pump. The cost of the pump was prohibitive, but Shaniqua got one as a belated shower gift. After she began using it, she saw an immediate difference in the amount of milk that was able to extract from her breast. She summed up her feeling about breast pumps when she said, “You get what you pay for.” Shaniqua was able to build supply of breastmilk that could be stored and fed to her son while she was healing from her infection. Without the proper pump, she would have been forced to use infant formula which she did not want to do.

Elaine, a 32-year-old mental health technician, was happy when her first child began breastfeeding without any challenges. Her mother was not able to breastfeed her and she was afraid that she would experience problems with breastfeeding, as well. Her child latched on to her breast and suckled happily. For good measure, she agreed to try using a breast pump at the hospital. She wanted to make sure that she was prepared with expressed milk, “just in case.” Speaking about her first experience with a breast pump, she said,

I didn’t like being milked. I had no problem with the birth thing, but I didn’t get nauseated until they milked me.

19 Thrush is a fungal infection which is characterized by white spots inside the baby’s cheek or on the gums. It can be caused by taking antibiotics or oral contraceptives (La Leche League International, 1995).
They put the little milk suction thing on me, and literally I got nauseous. I’m like I’m being milked, and I didn’t like it [Laughter]. I was like get this off of me, so they brought the baby, and then we more worked with him getting the milk from me as opposed to the entire suction machine thing. I felt better.

The breast pump did not suit Elaine, but her child nursing from her breast did. Elaine decided that she did not want to use a breast pump. Also, she was not comfortable with expressing milk from her breasts with her hands. She turned to infant formula as her “just in case” food.

Edibles

Fledgling doctors, who would cement themselves as specialists in children’s medicine, promoted the scientific food which could replace the need for a woman to breastfeed a baby (Blum 1999). According to the Centers for Disease Control, Touted as the “formula” for babies, artificial breastmilk substitutes have replaced human breastmilk as the primary food that is fed to infants in the US. At the time of their interviews, eleven of the mothers in the study had not fed their infants infant formula. The rest had either consciously chosen to feed their babies infant formula, or had the choice made for them by their doctors and/or nurses. Among the participants in the study who chose to exclusively breastfeed, one mother began to supplement her child with rice milk when he was nine months old. Three of those mothers had babies who were younger than six months old, at the time of the interview. Three others weaned their babies between the ages of nine and ten months old. Subsequently, each mother transitioned her child either to cow’s milk or soy milk.

Eighteen out the thirty mothers in this study used formula to feed their babies. Two of the participants in the study chose to
introduce infant formula as their baby’s first food. Eight of the respondents, all of whom had a c-sections, found out that their babies received formula after they were delivered. Each of these mothers had a variety of drugs in their system as a result of the sedation and added medication to stabilize their vital signs. As a result, they were instructed to wait to breastfeed their babies. After the complication of their interrupted birth, each mother was happy that she and her child was alive and healthy. She expressed disappointment that her birth deviated from her plan, but she did not display distress that her baby had been fed infant formula. According to the respondents, the nurses explained that their babies would be fed formula to keep them healthy. After the mothers indicated that they wished to breastfeed, they were told that once they bodies were clear of the medicines, they could breastfeed. The mothers in this group accepted this information and waited until they were cleared to breastfeed. In their collective opinion, technology was keeping their babies alive and healthy, so that they could get better and take over the job of caring for their babies.

The mothers in the study had mixed feelings about the policy that their hospitals had of feeding newborns infant formula shortly after birth. At the time of her interview, Brihanna was a 32-year-old mother of two. She had formula fed her first child, who was born 1997. Brihanna said that formula was all that she knew about at that time. Her son had ear infections and other health problems when he was younger. Over the years, she learned more about breastfeeding. When she found out that she was pregnant again, she decided that she wanted
to breastfeeding this child. Reflecting on her experience in the hospital with her second child she said,

Well, when I had her I nursed and I told them definitely do not give her a bottle, not matter what the circumstances was, don’t give her a bottle; if she needs to be fed bring her to me. And I kept her in the room for that simple fact. I kept her in the room with me the whole time was in the hospital.

Brihanna knew that using infant formula was fast and easy for the hospital staff. In order to prevent her daughter from being fed formula, she adamantly sought to keep her child near her. As a result of her objection to using infant formula, Brihanna positioned herself as able to breastfeeding her daughter on demand.

Outside of the hospital, eighteen of the respondents in the study actively combined breastfeeding and infant formula use. Participants in the study, like Evelyn, a 21-year-old first time mother, began supplementing with infant formula when she return to her job as a medical assistant. For Evelyn, infant formula was a stand-in for her breastmilk. She experienced less stress about having food for her daughter on the days that she could not express the quantity of milk that she desired. Also, she could take formula along on trips and anyone could easily mix it without in her absence and feed the baby.

Leila, a 38 year-old mother of two, happily breastfed her daughter, but when her daughter wasn’t producing dirty diapers, she thought that something was wrong. According to Leila, her pediatrician told her to stop breastfeeding and feed her daughter infant formula. Leila, a nurse, complied. She pumped her milk in the mean time. Her daughter began urinating and defecating so Leila continued feeding infant formula and expressed her breastmilk. She never put her to the breast again.
Elaine completely transitioned each of her three children to infant formula. She said that initially she felt guilty about not breastfeeding them and then she “got over herself.” Elaine evaluated what was important to her. After she observed that her children were not getting sick, as she feared that they might without her breastmilk, she relaxed into the ease that came with using infant formula. Despite whether or not each of the mothers in the study liked (or used) infant formula, they all agreed that its lure was that it was technology that made their (and other people’s) lives easier. They believed that using infant formula meant that they didn’t have to worry about their milk supply, the quantity or quality. Also, the cultural norm for the women in the study is that others (othermothers, their partners, childcare workers, etc.) would be actively engaged in the care of their babies. So, they knew that having bottles that could be handed to anyone would facilitate this practice.

Human Resources

According to the participants in the study, obstetricians and midwives had opportunities to play significant roles in their infant feeding decision-making. The role of the healthcare provider was expanded when the respondents had challenges with their births and/or breastfeeding. When Lydia found out that her daughter had GERD20, she relied heavily on the advice of her doctor when she determined how she would proceed with feeding her child. While she was committed to using infant formula, her daughter’s pediatrician encouraged her to breastfeed the baby. Following his advice, Lydia breastfed her daughter for a few days and her child’s health improved. Despite this

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20 Gastroesophageal Reflux Disease (GERD) is a condition in which the esophagus becomes irritated or inflamed because of acid backing up from the stomach.
positive turn of events, Lydia decided that breastfeeding was not something that she wanted to continue. She said,

I tried pumps, I tried everything. I had like three or four pumps trying to get something out to give her. I wasn’t comfortable with her latch\textsuperscript{21}. I didn’t like breastfeeding at all, it was just ugh. It hurt.

Lydia’s negative experience with breastfeeding trumped the advice that she received from her daughter’s pediatrician, as well as, the evidence that her daughter’s health improved once she stopped receiving infant formula and started getting breastmilk. Lydia embraced infant formula. Although she did not choose to follow his initial recommendation to breastfeed, she sought him out to find a technologically enhanced formula that would easier for her daughter to digest. At the time of the interview, Lydia’s daughter was three years old. She still suffered from the symptoms of GERD. Lydia believed that despite the episodic vomiting that her daughter experienced, the prescription infant formula that she used was the right choice because her child would be fed food that she would not make her sick all of the time without Lydia having to breastfeed her.

Esther, a 37-year-old, a full-time mother of two, found out that she had Hepatitis B before she got pregnant. She believed that she contracted it from her mother while she was breastfeeding. Esther’s mother did not find out that she had contracted the disease until after she received a blood transfusion many years later. After Esther found out about her infection, she spoke with her obstetrician about the utility of discussing breastfeeding with a lactation consultant. According to Esther her obstetrician said that,

\textsuperscript{21} The term “latch” refers to when a baby takes her/his mother’s nipple into her/his mother while breastfeeding.
He didn’t think it [breastfeeding] was a good idea, but . . . he wasn’t a pediatrician and he didn’t want to influence my decision, but this was his opinion as my doctor. He didn’t think that it would be a good idea. And he told me this earlier on.

Esther’s obstetrician’s response was that she would not need one because he believed that she should not take the chance of passing the disease on to her child through breastmilk. He acknowledged that his expertise didn’t lie in children’s health, but he asserted his authority and his vested interest in her, as “her” doctor. The implicit message was that a pediatrician, her child’s doctor would not be focused on “her” best interests, but on that of the child. So, what he said should hold more sway. Also, based on Esther’s recollection, he clearly asserted his stance on her proposed feeding practices “early on,” thereby reiterating his status as “expert” during the time that she was beginning to gather information about her options. Esther went on to interview pediatricians, so that she could choose one before her baby was born, and asked them what they thought about her breastfeeding even though she had Hepatitis B. According to Esther, all of the doctors believed that she should breastfeed. Each doctor based his decision about breastfeeding on the recommendation that was issued by the Centers for Disease Control and Prevention (CDC) for Hepatitis B infected mothers and breastfeeding\textsuperscript{22}. Despite their advice, Esther chose to use infant formula, although she had previously committed herself to breastfeeding. She “didn’t want to take a chance.” The fear of her child contracting the disease, which was reinforced by the OB she trusted, superseded everything else.

\textsuperscript{22} According the CDC, Hepatitis B is not spread through breastfeeding.
Throughout the interview, she lamented the flaws of infant formula. She said,

It was awful and I felt terrible because I’m like if I was breastfeeding this wasn’t happen... I was so upset about it. I took him to specialists because it continued. He would have really, really hard bowel movements. And I switched his formula a couple of times and the same thing. He didn’t have a problem with his intestines or his colon or anything they checked. His stomach was fine...it was just the formula.

Although she firmly believed that the food that she was feeding her son was keeping him sick, she did not attempt to breastfeed him. Esther exhausted every other possibility, even switching formula brands, but never modified her fear.

After giving birth to their babies, 28 out 30 mothers in the study initiated breastfeeding. Of those, 22 mothers delivered their babies in hospitals and six of the mothers delivered at birthing centers. Many of them, particularly first time breastfeeding, stated that they were plagued with the fear that they would not be able to get their babies to latch correctly. All of the mothers in the study who delivered at birthing centers received help from their midwives with latching their babies to their breasts after the baby was born. The form of help that was offered was either “supportive talk” or direct hands-on instruction. Supportive talk consisted of verbal encouragement and/or loose verbal instructions which guided the mother through taking the baby to her breast and positioning her/his head. Direct hands-on instruction involved the midwife touching the mother and baby. She physically showed the mother how to get her child to latch on to her breast. Also, she showed the mother how the child’s head should be positioned against her breast. According to the mothers in the study, this help was invaluable.
Participants in the study who birthed with obstetricians said that they did not receive advice about the mechanics of breastfeeding or any hands-on instruction from them. According to the mothers in the study who birthed at hospitals, when they received help with the mechanics of breastfeeding, nurses were the healthcare providers who helped them after they indicated that they wanted to breastfeed. According to Amy,

"Yea, a lady came in and sat with me the day after I had my daughter...she asked me what my decision was to breast-feed or formula feed, so I let her know I was going to be breast-feeding and she brought a pamphlet in there and let me, they had pictures of how to hold the breast and how to hold the baby and she showed me, she had this doll in there and she showed me how to hold the doll so that the doll would be like the baby, the baby would get a good amount of milk and it wouldn’t hurt and everything. So I think that’s why I had a good experience breastfeeding. Oh, it was really easy for me in the beginning. Because she showed me the steps and everything so I wouldn’t hurt and (so) that my baby would get enough milk and be full.

Like other mothers in the study who said that they received help with breastfeeding while in the hospital, she credited her success with breastfeeding to the help that she received from a nurse. Amy had not experienced breastfeeding, nor did she know anyone who was doing it. The nurse provided her with a live person, not a book, a video or a disembodied voice on the phone, who could answer her questions about breastfeeding while physically guiding her when she had any problems. Also, the prop that the nurse brought eased some of Amy’s tension and made it possible for the nurse to guide Amy through the physical aspects of breastfeeding without having to handle Amy’s breasts. Having a medical professional there, who was eager to talk with her while she was breastfeeding, provided Amy with external validation about her mothering."
All of the mothers who birthed at hospitals did not have positive experiences with their healthcare providers. Chelsea wanted to breastfeed her daughter. She initiated breastfeeding, but began having problems. As we sat in her living talking about her early experiences with breastfeeding she recalled:

"I breast fed, and she was very hungry... I don’t know if I was doing it wrong... it was making my nipples really sore... They were teaching me how to do it. They were trying to show me the finger removal like when to stop and how to alternate breasts. The nurse showed me that, but it wasn’t nothing really in details. To be honest with you, I don’t really think that they were very helpful. I think if they may have been a little more helpful and a little bit more understanding as opposed to just saying it will be okay eventually, you’ll get used to it, maybe I would have breast fed longer."

Chelsea received some assistance, but not the type of detailed, hands-on help that she felt that she needed to continue breastfeeding. When she spoke with her obstetrician about the scabs that she was developing on her nipples because she believed that may have been breastfeeding her daughter incorrectly, he told her to “just keep trying” and that her feeding experiences would improve. He said that if they didn’t she could just go to formula. According to Chelsea that advice did not reinforce her desire to breastfeed. Nor did it validate her breastfeeding experience. Instead, it provided her with a justification for quitting. She believed that her doctor’s attitude supported the interchangeability of infant formula and breastmilk. Chelsea’s breastfeeding experience did not improve so shortly after her visit to the doctor, she weaned her daughter and switched to infant formula. In sum, Chelsea breastfed her daughter for approximately five weeks. At the time of the interview, she said that if she had any other children, she would not initiate breastfeeding.
Mothers in the study, who were breastfeeding for the first time, were most likely to desire the presence of a healthcare provider when they initiated breastfeeding. Participants in the study, who birthed in hospitals, which had lactation consultants, were most likely to have one visit them before they went home with their babies. According to the respondents, their presence and accessibility was both a blessing and an annoyance. According to Monica, a thirty-three-year-old, housewife, the white lactation consultant at the hospital where she delivered her baby was too enthusiastic with her “help”:

> It probably is similar to what happened to me at [the hospital] when everyone was forcing me to do something and they're whipping my breast out and giving it to the baby and they were always just pushing, pushing, pushing. Then I got kind of well, you know, no. I'm not going to do that. So now I'm going to formula-feed and there you go. . . . You can't make me do this with my body. I can do whatever I want to do with it.

Monica felt as though she was being pushed beyond her level of comfort because of the uninvited way in which the lactation consultant touched her body. Rather than feeling empowered to breastfeed her child, the lactation consultant’s unsolicited manipulation of her breasts left Monica feeling violated, and her response was to reject breastfeeding. By rebuffing the act, she believed that she would be taking charge of how she would feed her baby and by extension, regain control of her body. The participants in the study gained the most knowledge, experience, and comfort with breastfeeding when their healthcare and social service providers understood the boundaries of their roles and provided them with information and access to resources while remaining within those boundaries.
CHAPTER 4

ON DOING MOTHER

When Carla, a 36-year-old mother full-time mother, found out that she was pregnant with her first child, she told herself that she would not fall into the rut that she saw some of her girlfriends occupying after they started having children. According to Carla, her past self was clear that she would “have a life” and that life would involve sex with her husband. In Carla’s recollection, she says that her friends would throw her looks that said, “Ha, we’ll see what happens when you have your kid.” Carla believed that she was older and wiser than they were when they first had their children. At the time, she believed that she knew more about how her sex life, motherhood, and everyday living would come together. She says that she had read the parenting books, taken care of not only numerous nieces and nephews, but also the children of the women sitting before her. Carla told herself that she knew what to expect and what she had to offer during that first pregnancy. She told herself over and over again that she knew, and then she had her first baby. She said, “It [was] different. You know it change[d].” After she had her baby, Carla realized that her parenting books and experiences babysitting children did not prepare her for actually being a mother.

In this chapter, I examine how the participants in this study do motherhood and how that performance is impacted by and shapes their infant feeding choices. Also, I explore how the way(s) that they perform motherhood affects their sexual activity and sexual availability. Finally, I analyze how the perceptions that the mothers
in the study have about their bodies and physical boundaries inform their self concepts and infant feeding practices.

I’m A Mom Now...

Throughout the course of my interviews with the respondents, the mothers reflected on the difference between their ideas of mother and the reality of “being somebody’s mother.” As the earlier quote from Carla shows, the transition from childless to “children on board” brought unforeseen changes to the mothers’ lives. According to the participants in the study, they were not prepared for the degree to which motherhood would affect their time alone and with their partners. Carla knew that things would change but in what she calls her “naivete,” she didn’t know how things would change. She said, “We don’t even know what’s it’s like to be alone anymore...and that’s sad.” Similar to other mothers in the study, Carla was prepared for sleepless nights and busy days, but she did not realize how intensely the near constant presence of her children would disrupt the private time that she had with her partner, thereby changing how she and he interacted with each other. She goes on to say:

We have gotten into brother and sister mode. . . . But yeah, we'll think of it as something we have to do. We have to get up and feed the children. We have to get up in the middle of the night and put Chioke back to sleep. But we don't think about we have to get up and tend to each other, we had to get up and be in the intimate space. So we are hoping that once we get them back moved out of this room in here, we can go back to our college days and what have you. So we'll see what happens.

In her moment of reflection, Carla echoed what mothers said about their experiences with juggling motherhood, breastfeeding, and having a partner. They discussed time that had once been theirs which became divided between taking care of children, being in the paid labor
market, work in the home, and finally they spoke about their personal wants and needs. Yolonda, a stay-at-home mother said:

I just remember, you know Yolonda, he’s a baby. He needs you. He needs you. He needs you...Alex is hungry right now and he needs. So I just look at that little face and I say okay.

Similar to other respondents, Yolonda focused on the specialized labor of breastfeeding that only she can provide for her son. She reminds herself that the work (and by extension the sacrifice) is finite. Yolonda looks at her son’s face to remind herself of her “duty” as his mother. In the end, she reminds herself, “It’s like, okay, Yolonda, you got to do it.” The mother labor that she believes (and society is telling her) she must do for the care and well being of her child is constructed as gendered work. We, members of society, are socialized to believe that it is work that good mothers do whatever their circumstances might be. In her book, *At The Breast*, Blum (1998) likens the rhetoric of “good mother” to that of the sacred mother. The sacred mother follows the ideology of intensive mothering that states:

1. It is critical that the mother is the central caregiver—men, apparently, can not be relied upon to provide the same level of care, there is an assumption that the child requires consistent nurturing...and the mother is the best person for the job, when the mother is unavailable, it is other women who should serve as temporary substitutes; 2. Appropriate child rearing requires that copious amounts of attention, time, energy, and material resources be lavished upon the child—the mother must put the needs of the child above her own...child-centered, expert-guided, emotionally absorbing, labor intensive, and financially expensive; 3. A comparison between paid work and child rearing activities is ludicrous. The child is more important than paid work, and a completely different logic applies to child rearing than paid work.

African American mothers have adapted their construct of the good mother to be one who centralizes the needs of her family rather than
focusing only on her children (Collins 2000). To that end, she is valorized because she sacrifices herself.

All of the mothers in this study ascribed to this logic in one way or another. While mothers routinely returned to the paid labor market, they made sure that they transitioned their child to a bottle or worked out a schedule whereby they could visit their child and nurse him/her during the workday. Such concessions were rare because few mothers had jobs that allowed them to leave frequently to nurse their children. Also only a few of the mothers in study were able to find childcare that was close enough to their place of employment to allow for such an arrangement to be successful. Also, some mothers left the paid labor market specifically so that they could be full-time mothers. The majority of mothers in this study viewed formula as “fine.” They believed that while breast was best, formula was still good. As a result of this, a mother who chose to formula feed or feed from a bottle was not immediately a bad mother.

Historically, the good mother has been constructed as White and middle or upper class (Carby 1983, Davis 1987, Hays 1998, Litt 2000). Lower class, White women could achieve the status of good mother, if they followed a narrowly defined script of motherhood performance. However, this avenue was never made available to Black women in the larger American imagination. By virtue of their blackness and constructed inferiority, they could not care for their children in the way that White women would care for theirs. The pervasive narrative of Black motherhood was benched in the belief that Black women engaged in wanton coupling which lead to irresponsible pregnancies as a result of their animalistic fertility. Routinely characterized as “bad mothers,”
Black mothers sought to create their own definition of good and bad mother. Part of this self definition required a constant policing of other mothers, to insure that the stereotypes of deviant Black motherhood would not be applied to them. The implicit challenge in this policing was the reality that Black women were navigating competing narratives of the “good” and “bad” mother. While they were denied good mother status within White America, Black mothers sought and managed it within their own communities. Invariably, the ideology of good and bad mother was influenced by the largely Christian rhetoric that permeated the African-American community. Here, the good mother was expected to be chaste, private, decent, and respectable (God-fearing). Among African Americans the meanings attached to and opportunity to embody the good mother were mediated by class. The black middle class maintained a within-group hierarchy which reinforced the idea that there were good black mothers who upheld the virtues of True Womanhood.

Today, dominant discourses about the intensive (good) mother dictate that she should be breastfeeding, as well. Shaniqua discussed the challenges that some of the mothers in the study faced when they sought to be “good mothers” who organized their time around breastfeeding their babies, managing paid labor work scheduling, and maintaining a relationship with a partner:

I got off at 5:00. My husband gets off at 5:00. There was a conflict when I was working from 10:00 to 7:00 for so many reasons that you can imagine. My husband gets off at 5:00. He comes home at 5:00. I would not get home ’til 7:00. I had to nurse the baby. . . . I was feeding the baby from 7:30 to 8:00. I was pumping from 8:00 to 8:30, and the baby was in bath and then bed at 9:00. It was really stressful. But, I got a promotion shortly after that, so I worked 8:00 to 5:00. Me and my husband were working the same hours, and then I would come home . . . . I needed to get home in
enough time to pump before I fed the baby and the baby not be screaming, “Why ain’t I eating and what are you doing?” If I do that and we eat and the baby is in bed by 8:00, our relationship wasn’t affected by the nursing. I guess it was affected by the postpartum and the hormonal changes and the stress I was feeling because I was so tied to pumping and nursing. Because no matter what happened, I had to come home to pump; I had to. It just made things really complicated in the evenings...I was unhappy, and that affected our relationship. The nursing and the pumping itself wasn’t a cause of strain for him. It was a strain for me, and then I would get on his nerves, and he would retaliate. It was just really complicated.

Shaniqua attempted to convince herself that breastfeeding was not a problem for her to do. Her job as a good mother was to balance everything. She placed the blame on herself, specifically her hormonal body, for the problems that she was having before she finally admitted that her stress and the discord that she and her husband were experiencing were tied to difficulties of negotiating her first (paid work outside the home) and second (unpaid labor in the home) shift that included breastfeeding and expressing her breastmilk. Similar to Yolonda, she “had to” pump so that she could perform her role as the good mother.

In contrast to Yolonda and Shaniqua, Amy chose to switch to formula. She said:

Oh, that was tiring, because it was like she is taking all my energy the night before and then I have to get up and go to work or she’ll wake up in the middle of the night and want to be breastfed. So it was like, it was kind of exhausting, because I was trying to make sure she was still being fed properly and trying to go to work. So I didn’t want my stress to try and dry out my milk or whatever, I didn’t know what could happen. So I had to try and quickly get her on the bottle.

Amy sacrificed her time and energy to breastfeed her daughter and provide for her economically. Despite her exhaustion, Amy planned to continue to breastfeed her daughter. She transitioned her to formula
because she was afraid that her heightened level of stress might affect her health and negatively affect the quality of her breastmilk. She could not chance becoming a bad mother due to her failure to feed her child “properly.” She could not control the quality of her breastmilk and she had to work. Amy was able to maintain her standing as a good mother because she centralized her daughter’s needs.

The participants in the study started talking about their needs and comparing their lives before and after having children. Sex became an issue. The mothers in the study had different experiences and ideas about sexual activity and parenting, in general (breastfeeding, in particular). According to the participants in the study, fatigue was a big factor in their sex lives, particularly during their early stages of motherhood. The participants talked about sex as a low priority. Leila exemplified this when she said:

Being sexual, I didn’t really think about it, because we were just so busy, because my husband was working, I had a new born, we had no one to help, so we were just exhausted, so I don’t think it really came into our mind about being sexual around that time...Our relationship was, we were both exhausted, we were both, the whole conversation, everything we talked about was the baby.

Leila’s reality of mothering in isolation significantly impacted the opportunities that she and her husband had for spending time together without their child. Also, since both were in the paid labor market (Leila took maternity leave), their free time was even more limited. Their lives revolved around parenting. The participants, who were partnered, saw their lowered libido as a phase. Many of the mothers in the study who were breastfeeding and had multiple children expressed contentment with the lessened sexual contact. Yvette, a mother of two, said:
[With my first daughter] I don’t remember feeling, I hear it called touched out... Now with her [my second daughter], because she is nursing and then she needs her mommy time too, then daddy wants to touch me too, I’m like, will y’all leave me alone ... . I’ll be back in about 15 minutes.

Kendra adds another dimension when she says:

Just the fact that he, right now, feeds every one and a half, every two hours and since it is just me, and he doesn’t really take the bottle that well, that means every hour and a half or two hours, we’re together. . . . I want a little bit more freedom, a little bit more time to me, kind of reclaim my body back.

Both Kendra and Yvette are bothered by the hyperavailability of their bodies. Similar to other mothers in the study, both women view time away from the physical demands of their children and partners positively. Each of the mothers viewed that period along as time for them to reclaim their identities and control access to their bodies.

The participants in the study who exclusive nursed had the greatest challenges with balancing their being tethered to their babies and having time for themselves. Over time many of the mothers in the study came to view being their child’s sole food source with some ambivalence. Often in negotiating their discontent with the realities of having their the mobility restricted, as well as dealing with the caregiver restrictions that arose with their exclusive mothering, mothers developed “empowerment” narratives which doubly acknowledged the root of their discontent and explained it away with language which elevated their specialized labor as breastfeeding mothers to a deified function. Briahanna said:

It's beautiful. I do. I feel like a woman, truly. That I'm able to do this, it's amazing that your body makes nourishment for your own child. It's amazing. I feel like a woman doing that and giving -- the whole giving birth and everything.
Similar to other mothers in the study, Brihanna highlights the wonder of her body being able to provide food for her baby. Being a breastfeeder validated her womanhood. So when she found herself struggling with the challenges of breastfeeding, work, and other caregiving responsibilities to her two children, she could reflect on this narrative which elevated the motherwork that she did.

**Romancing the Breasts: Maternal vs. Sexual**

My body was so unfamiliar to me anyway, that the idea of what sexual relations and sexual connotation of my breasts afterwards was like – for me, it was more like whatever happens, it’s going to be weird. It’s weird now; it’s going to be weird later. I didn’t try to analyze it, and I didn’t try to predict because I couldn’t relate. I didn’t know anybody. I didn’t ask anybody. It was more like we’ll see.

-Shaniqua

The mothers in the study stated that prior to being interviewed, they had not spent so much time talking about the ideas that they had about their breasts before and after they began breastfeeding. Repeatedly, the participants created a binary wherein their breasts existed as either sexual or maternal. For the mothers in this study, sexual breasts were available for erotic stimulation and viewing. They were active participants in sexual activities and were to be consumed for their beauty. Also, attractive breasts were perky and came in various sizes. Maternal breasts were mothering breasts. They either served as the source of feedings, either directly or indirectly, or they were attached to a woman who, by virtue of her position as a woman who birthed one or more babies, earned the moniker of mother. The respondents believed that how their breasts looked and felt wasn’t stereotypically sexual. While they came in various sizes, they differed in shape. One breast might be bigger or sag more than the
other. They weren't for visual consumption and/or random sexual play.

According to Sholanda,

I think you're using what you got to meet a need for your [baby], you know what I mean? It's like I'm using...they have a purpose, it's not just to look good or for someone else to think they look good. They really serve a purpose, sexy is not the word. But I feel like they're utilized for a better purpose than just wow, you're heavy-chested.

Lactating breasts have a job. She equated working breasts with meaningful existence, "they have a purpose." Hence their appearance if immaterial and they have to be judged by a different standard that non-lactating breast. While Sholanda does not clearly state that one is better than the other, she clearly differentiates between the passive breasts—available for consumption and random (possibly irresponsible) play and the active (purposeful) breasts.

For the mothers in this study, with the exception of Ebony, maternal (breastfeeding) breasts were asexual. According to Carla,

As young children, we're socialized to think the breast[s] are sexual part of us. And it's really not. Absolutely not. First it's your breasts, and that it's a means to feed your baby.

In her quote, Karen Peters touches on her experience, that while she was being taught breasts had a decidedly sexual designation, their characterization as sexual objects changed once they were able to make food for a baby. In her assertion that breasts are for feeding babies, she negates her prior socialization and takes the position that her lactating breasts were not for sex. Likewise, sexualized breasts should not be breastfeeding. Hadiatu adds another dimension to this perspective when she says:

Prior to having my children, I wasn't all prudish - like don't touch me. Now, I'm like, don't touch me. I don't
like that . . . . I can’t pretend like I’m cool with just letting him have free reign over my breasts.

As Hadiatu reminisces on her orientation ante- and postpartum, she, like many mothers, reflects on what she discusses as a period of free incorporation of breast play and stimulation into sexual activity. Breast play was an integral part of sexual intercourse and sex play. Breast play is defined as any licking, sucking, caressing, biting, etc. of the breasts, specifically the nipples. During the period of breastfeeding, mothers either reduced the amount of breast play during sex or eliminated it altogether. When explaining this decision, mothers who had a steady, consistent partner expressed discomfort with including breast play with sexual activity. The participants in the study explained that timing was the key factor shaping their decision-making. Specifically, the respondents were concerned that their child might want to breastfeed directly after or before they had sex. That possibility created two challenges for the mothers in the study. The first was that the mothers in the study (and in some cases their partners) were concerned that the inclusion of breast play during sex meant that their breasts would cease to be sterile, asexual objects akin to the artificial nipples that one could purchase. In order to create/maintain the illusion of these sanitary nipples mothers would be mindful of extra cleaning of their nipples after sexual activity or as mentioned earlier forgo the inclusion of breast play. The second challenge was that the participants found it jarring to transition from non-sexual sucking to sexual stimulation (which could include sucking), particularly if it happened within a short period of time.
The mothers in the study who breastfed multiple children or who breastfed beyond six weeks were more likely than their counterparts to release their inhibitions about breast play and breastfeeding. Some of the mothers decided that sexual play with their nursing breasts should be avoided because of the leakage or full out flow of breastmilk that came with stimulation. While Yvonne was concerned about when she’d get to have sex again after she had her first child, she was not prepared for the performance of her lactating breasts during sex.

After um, I had Jasmine and what I did not know is, when you get excited, milk comes out and actually shoots across the room. So, that sort of freaked me out a little bit. I didn’t know that that was going to happen. Of course, by the time I had Dereka, I was a little more experienced and took steps to make sure it didn’t happen.

While Yvonne didn’t elaborate on what she meant by the statement, “took steps to make sure,” she makes clear that she believed that leakage/projection of breastmilk while being sexually active with her husband was something that required remedying. Yvonne was freaked out and other mothers in the study expressed being “grossed” out or thinking that their partner would be by the visible presence of their breastmilk. It was one thing for the breastmilk to be present coming from the breast or in a bottle for the baby. Something changed when the breastmilk was present and dripping from her breast(s) during sex. Mothers indicated that their partners (all men) were either amused by the presence of the breastmilk, neutral (because of this wasn’t the first time that the mother was lactating or due to familiarity because of a prior relationship with a breastfeeding woman) or turned off. The majority of the mothers in the study said that they experienced some apprehension the first time that they had sexual intercourse with
their partner after the baby was born. In part, this alludes to the ways in which bodily fluids are treated in popular American culture. Bodily functions, and by extension, bodily fluids, especially among women, are hidden unless they part of a comedy routine.

Yvonne’s description of her experience was shared by other mothers in the study who nursed beyond six weeks. Four mothers nursed their children for six weeks or less. One mother did not breastfeed. These women did not discuss any issues with leaking breastmilk during sexual intercourse. One possible explanation for this was that they, following the advice of their healthcare providers or due to the fatigue of the early transition phase after the birth of a child, they did not engage in sexual activity until on or after their sixth week postpartum check-up. By this time, their breastmilk could have dried up. Another possibility is that they did not engage in breast stimulation during the time that the baby was breastfeeding.

**Size Matters (The Look and the Feel)**

This is a society which is heavily focused on appearance. It is commonly taken as fact that people who are considered attractive are treated better in regards to everything from jobs to speeding tickets. Those who are deemed unattractive are often given the short end of the stick. Because of the patriarchal nature of this society, men carry a cache of acceptability regardless of their appearance, especially as they age. In other words, because men hold and utilize the majority of power/access to resources in this nation, albeit differently when variables like race, class, and sexuality are included in the equation, they are able to enjoy a constructed desirability based on stability, economic acumen, virility, strength, etc. that detracts
from their physical appearance. This holds true as men age. Differently than men, women are largely judged by their appearance. Their worth, as women, is shaped by the culmination of their hips, thighs, breasts, and all of the rest. African American women have fared no better than their European American counterparts. While some studies show that African American girls maintain positive self esteem longer than European American girls, some scholars argue that the apparent difference appears because of the types of questions being asked. Lack of cultural sensitivity/awareness is presented as an explanation for this assertion. Sensitivity to the cultural morals, values, and beliefs of the African American community highlights the varied ways in which beauty is shaped that are centered around body parts and shades of color that do not function the same way (if at all) in the larger European American community. A case in point would be hair. While value is placed on different characteristics of hair in the larger European American community, they differ from how the politics of hair are treated in the African American community. This political negotiation arises from the legacy of enslavement and dehumanization which has shaped the African American community. Texture (from coarse to straight), length, and the amount of hair one has have served as markers of beauty, tangible evidence that a person is something “other than Black.” This “otherness” has been rewarded in European American as well as African American communities through allocation of privilege and power. An example of this is the practice of hiring a light skinned African American person instead of medium or dark skinned African American person. The absence of the “otherness” has served to reinforce the racist rhetoric of inferior difference
which lies in the Blackness. As African Americans have survived and fought to thrive, many of these ideologies have been internalized and imprinted on the bodies of African American girls and women. The hypersexualization of the bodies of Black girls and women has only served to complicate this situation. Historically, Black women’s and girls’ bodies have been placed on open display. This happened routinely happened on the auction block, as girls and women were bought and sold as slaves. Because of the overwhelming power placed in the hands of Whites over Blacks, it could happen anywhere. Through stories and licentious images, the message of Black girls’ and women’s excessive sexuality was passed on through the public imagination.

Views of the body are intimately tied to desire. The views can be internally generated and/or externally imposed. Pregnancy, birth, and breastfeeding will change a woman’s body significantly. As the mothers in this study discussed their views about their bodies, it became clear that the perceptions that they had about their individual bodies was intimately affected by the changes that they experienced through their birthing and breastfeeding experiences. Some mothers, like Destanni, had a very challenging time with the changes that she experienced. Their feelings were amplified because they were breastfeeding women. As such, they could garner more attention in public and private spaces. Also, this position necessitated them having share and expose parts of their bodies when their children fed. According to Destanni,

Yvonne: Because of my weight. Maybe if I was thinner. After having kids, it’s just that I am – how can I say it. I’m just more shy because of my weight. I think people have this thing with – oh my goodness, look how big she is, and she’s exposing herself. I’m just very conscious about that.
Interviewer: How do you think you would feel if you were skinny and you were breast feeding?

Yvonne: I think I’d feel different because I see these thin people. They’re like walking through the mall, their belly button is pierced, and their short shirts and stuff. I think maybe I wouldn’t be...I wouldn’t be as shy or as - I don’t know. I think my personality has changed since I’ve put on weight - the way I dress. I don’t even wear sleeveless clothing.

Yvonne talks about the significance placed on thinness in the contemporary constructs of beauty put forth in the popular media. The models are generally young, semi-androgynous, tenable women (and girls) who have little, if any curves. When curves are present, there is an emphasis on breasts. According to Faluke, they are, “nice perky breasts that sat where they’re supposed to sit and that are not gravitating to the south.” Hadiatu furthers these views and ties them to her conceptualizations of her sexual self when she says:

Saggy breasts and saggy stomach is not attractive, so it has affected my idea of my sexuality, and I don’t feel as sexual. I don’t feel like a sexual being when I look in the mirror. If I got a dress and I got to put the bra on, I got to suck in the stomach and wear something, then I feel it. As long as this is exposed, I don’t feel it. But, I still feel that my face is still up to par. Still feel like everything else is up to par. It’s just the stomach and the breasts. As long as I got a bra on and I can cover this up, I’m a ten. Take that off, I’m a negative two [Laughter]. No, not that bad - probably like a five when I’m all butt naked. I feel bad. I want my surgery [Laughter]. I’m plotting on it now. I’m going to get this fixed, this fixed.

Hadiatu, like other mothers in the study, allude to a sense of body parts that are broken (and can be fixed with surgery or a bra/girdle) or somehow impaired because of their altered appearance. Other mothers like Chelsea said,

I told everybody, look, I just had a baby, this is the shape that you get afterwards. I’ll be okay, eventually. It will go away, and I’ll be me again.
She likened the pre-pregnant or pre-lactating body to normalcy and being “ok,” thereby rendering their present experience as post-pregnant, and lactating (or post-lactation) abnormal and like Hadiatu’s description something that requires fixing.

A significant number of mothers in this study viewed the changes that they experienced in positive terms. They spoke happily about their breasts increasing in size once they started breastfeeding. For example Yvonne said that she thought that her breasts were small prior to her initiation of breastfeeding. She believed that smallness was somehow less appealing than larger sized breasts. Diana thought that her change is breast size was a “positive turn of events.” According to Juanita, her change in size caused her to develop a different relationship with her breasts. She says:

Oh! You were asking me about how my relationship with the breasts once I started nursing? Um. Hm-hmm. I-I’m not sure I actually had a relationship with my breasts because they were small. I think I resented them because they were small. So, I actually, kinda tried to avoid them. Or just do something else with them… that… you know… Padded bras… and whatever, tissues, stockings, whatever you call it! You know, you know. To make it. I always connected it with some form of sexuality or attractiveness or that kind of thing. Um, but I do know that once I became a mom, which is great! Because all of a sudden, you’re like filled up with these new boobies. . . . Now you have these boobies. But, now you also have this stomach. And when the stomach gets gone, you have this baby and now you’re a mom. And you start to put things into perspective. You know, like, like what really matters. And the most important thing is that I am able to breastfeed and this is exactly what my breasts are really for. So I think that, you know, that it’s probably what I’ve gotten as far as a relationship with my breasts. I’m-I’m still struggling with the small breast thing. You know, who doesn’t.

Initially, Juanita had misgivings about her small breasts. She viewed them as sexual objects that should have a certain size and shape to be
appealing. She went used all types of materials to achieve that look because she did not want to be undesirable. Once she became a mother, she shifted her focus from negatively judging her body based on perceived desirability to praising her positively appraising her body because not only did its appearance change, but her breasts were finally doing “what they were supposed to do.” Similarly, the mothers in study judged their bodies more positively when they were able to breastfeed without challenges. Once the participants in the study developed a comfortable relationship with their breasts, they were more likely to breastfeed in public.

**The Politics of Exposure**

According the Webster’s dictionary, the word expose has multiple meanings.

1. to lay open to danger, attack, harm, etc., 2. to lay open to something specified, 3. to present to view; exhibit; display, 4. to make known, disclose, or reveal (intentions, secrets, etc.), 5. to reveal or unmask, 6. to hold up to public scrutiny, 6. to subject, as to the action of something

When discussing the body, particularly women’s breasts being exposed, availability takes on a distinctive meaning. When breasts are exposed, they become subject to an action. The action in question could be sucking, licking, caressing, staring. Women’s breasts are sexualized by the larger American society. This can be seen in everything from billboards to movies to print ads selling watches. Within the context of this patriarchal society, women’s sexualized breasts are presented as consumable objects with a specific availability for the male gaze. According to Roberts (1998), Black women, and by extension their bodies, have been experienced a matchless subjectivity because of their history as enslaved persons in the United States. Black women’s
bodies were constructed as commodities that were to be owned, bought, sold, and in any way “used” by her enslaver(s), but not by the women themselves. Black women were constructed as thoughtless beings, ever available for sexual exploitation and reproductive labor. According to Blum (1998), lactating Black breasts were sometimes charged with sustaining the children of enslavers to the detriment of Black babies. In her article titled, “Selling Hot Pussy: Representations of Black Female Sexuality in the Cultural Marketplace,” Hooks (1998) discusses some ways in which Black women’s bodies are still dissected and exposed as having an innately deviant sexuality. According to Collins (2005), this constructed sexuality is then paraded throughout the media, particularly in music videos. Through video culture, anyone, who is anywhere on the planet, can bring a specific representation of sexual, Black female bodies directly into her/his living room and revel in whatever she exposes.

The mothers in this study had differing views about a breastfeeding mother’s rights to expose her breasts while nursing. According to them, “exposure/exposing herself” refers to when a mother makes it possible for her breasts to be seen while she is nursing. This can be done purposefully, as in the case wherein a mother does not use a blanket or other material to cover herself and her nursing child during a feeding or inadvertently, when a breastfeeding mother attempts to “cover,” but has the cover removed by the nursing child or some other person. According to Denitra:

I see some of them breastfeeding in public, which I didn’t have a problem with it, you know, as long as they not exposing themselves, all out, it's fine. They cover up with the blanket or whatever. It was fine for other people to breastfeed out in public. I don’t have a problem with it.
Mothers in the study who shared Denitra’s viewpoint expected breastfeeding mothers to choose to either utilize a form of covering so that they were not “all out” and/or go to a private, female-specific place, like a restroom, or designated nursing area when nursing their respective babies. If a breastfeeding mother took another route, she was not acting in a way that was “fine.” According to Lydia, there is “right way and a wrong way” to breastfeed a child in public spaces. She said:

I have different views as far as breastfeeding in a public place. It is a natural thing, but throughout the years they have constructed different spaces for you to go and be private, you don’t really want to expose yourself. I mean, if you’re doing it and you’re covered and breastfeeding that’s one thing, but some people they just, okay here I am, this is what I gotta do, my child has to eat. Everybody is not gonna, they don’t want to just walk by and see breasts hanging out everywhere, you know? So I think, especially in the malls, they have designed special rooms, so I think people should take advantage of the room and space that has been provided for them for that.

Lydia believed that mothers should be able to do what was “natural,” but she held firm to her beliefs about respectability. Like some mothers in the study, Lydia believed that breastfeeding should be a private act. She believes that since accommodations have been made in some places for breastfeeding mothers, that they are obligated to use them. Lydia’s imagery of “breasts hanging out everywhere,” is an exaggeration of breastfeeding which is painted with uncontrolled availability.

The mothers in this study did not have a single shared vision about what was and was not acceptable in regard to the choice of exposure. All of the mothers believed that they should be able to nurse their children in public however they chose without being
bothered. They argued that feeding their children was part of their responsibilities as mothers. Also, they held the belief that they should be able to feed their babies by whatever method best suited them when they chose. While all agreed with the right to choose a method. The participants in the study had different perspectives about how a mother should breastfeed her child when they were in a public space. Amy chose to attach a moral judgment to how a mother chose to feed her child in public. She said;

Amy: Because, I mean, I understand that the baby has to eat, the baby is hungry, whatever, but that is not for everybody around you to see, just cover it up, you know what I’m saying, just be decent. As long as you be decent and keep yourself intact, let the baby eat, but still don’t show everybody everything, it is fine to breastfeed in public.

Interviewer: So what about formula use?

Amy: Formula use is better, because you can use it anywhere, all you have to do is take out a bottle already made and give it to the baby. Breastfeeding you have to go through more details and trying keeping everything covered up while trying to get the baby ready to eat. Instead of formula, you just pull out the bottle, mix it together and give the baby a bottle.

Interviewer: You mentioned you were talking about being decent. Can you elaborate a little bit more about, because you’re using the word decent.

Amy: I mean decent as in just being respectful to the people around you. I mean, I know the baby has to eat, but don’t show everybody everything. Everybody is not eating from there, just the baby, just be respectful.

For Amy, covering up meant providing a visible barrier between the partially exposed breast and the gaze of the “people around you.” Amy intimates that nursing without covering would not be acceptable. Amy focuses on decency and “keeping yourself intact,” as though the exposure would lead to one becoming undone and loose due to exposure and the availability that it insinuates. The state of being “intact”
is a virginal space to which purity and goodness are assigned. The ultimate of “good” mother, Madonna/Mary is both virginal and a mother. Ironically, the most famous, classic representations of her depict her exposed breast. Further, as she reflects upon her experience of feeding her daughter at a park, Amy says,

I mean, it’s just like, once you go out to the park...it is so many people out there and you’re sitting there trying to feed the baby and people will walk by and they’ll be looking at you. People don’t care how bad they stare at you or what they say about you, they’ll just walk past and be looking at you, get down in the way and say something, “oh did you see her out there, she is trying to cover up, she’s feeding the baby.” I’m like okay, “but my baby needs to be fed, so therefore you shouldn’t have anything to say.”

This quote exemplifies the feeling that feeding at the breast is not safe in an open, public space. Amy’s concern is that her moral position as a good mother is threatened. She believes that onlookers see her and her nursing baby as vulnerable. For Amy, breastfeeding her daughter in the park when she is hungry is her responsibility, as a good mother. She must provide for the needs of her child. Specifically, her daughter must eat and she won’t take a bottle. In her performance of the “good mother,” she is both fulfilling her role as caregiver and covering up to fulfill her role as protector. Also, she upholds the decency that she believes should serve as a shield against hostile encroachment. Ultimately, for Amy and other mothers in the study who share her mindset, being able to use formula eliminates the need for her to place herself and her child this type of position. While Amy would nurse in public if she didn’t have any other options, she preferred being able to avoid the public gaze.

The participants in the study treated people differently based on their gender and race, who violated their breastfeeding space. Juanita
discussed how race and gender played a role in how she classified people as violators or simply curious observers when people breached her breastfeeding Mommy/baby border. Juanita said,

It's primarily white women who came up to me, it was like, they had this open right to just do it and I was just like, “hello, excuse me.” And it wasn't about them seeing my breast or anything like that. It was just about the -- about the whole, “I'm just going to go and pull your blanket over and see your baby because I want to see it and I'm not going to ask.” I thought that was a little crazy. I did have one Black guy, one time . . . he came from behind me. He said, “Oh let me see the baby.” He gasps. I think I might have actually went like this. [She throws her arms up in the air] He said, “Let me see the baby” and I went like this [She shows the baby feeding at her breast in a sling], and he gasped, and I kind of laughed. I kind of knew it was going to startle him. So, it was cute.

Here, Juanita clearly views the curiosity of the White woman in hostile terms. On the other hand, she responds to the curiosity of the Black man playfully and describes the exchange in positive terms. The White women with whom she interacted with made her angry when they touched her or entered her personal space without permission.

Juanita’s specific recollection of “one Black guy” (as opposed to “white women”) suggests that Black men did not routinely interact with her while she was covered breastfeeding her baby. She believed that as a group, white women believed that they were entitled to touch black and brown people without their permission. Other mothers in the study, tied this grievance to their experiences with white lactation consultants and nurses. According to Juanita, there was proper protocol that had to be followed. Proper protocol entailed asking the mother for permission to touch her body and/or baby or enter her protective space that she placed around herself and her child.

The participants in the study who covered created secluded havens with towels and blankets for their breastfeeding babies. Restricting
exposure by covering served as means of protecting peaceful mommy-baby
time for some mothers. In Sholanda’s experience, the option of
covering while nursing offered a door into a world of comfort and
protection that had previously been closed to her. She said,

Sholanda: I was a little uncomfortable nursing in church
and one of the lady ushers the other day, she's like, girl,
get this towel and put it over you and feed that baby.

Interviewer: Why did she say that?
Sholanda: Because I was like oh my God I need to feed my
baby, I need to leave. She was like leave? Put this
towel over you and feed your baby. You don’t need to
leave out of church to feed your baby. He has to eat
doesn’t he? I was like, wow, yeah, thanks. And at
my own church the first time I took him I did go out
to feed him. The second time I went the usher
stopped and she was like sit down. And I fed him. I
put on my apron and it was fine.

The advice that she received from the elder woman gave her a sense of
comfort and connection. Sholanda regularly attended church, but she
felt uncomfortable with breastfeeding there. Once the female usher
talked her into covering and breastfeeding where she sat instead of
leaving the sanctuary, Sholanda felt like a door had been opened for
her. Prior to that day, she was anxious about feeding her child in the
church. She was unsure what other members in the congregation would
think of her. She had not noticed other mothers nursing within the
congregation. Now she could enjoy church while her son discretely ate
his mid-morning snack.
CHAPTER 5
THINKING BACK, LOOKING FORWARD

When I began working on this project, I was surprised to find out that African American women were not overwhelmingly breastfeeding their babies. I decided that I should review the literature that I could find on breastfeeding and African American women’s experiences. Ultimately, I found myself disturbed that the literature that was available on the experiences of Black women breastfeeding was overwhelmingly written centered on examining their experiences in relation to white women’s. Also, when African American women were included in studies, the studies tended to focus on poor and working class black women, with little formal education beyond high school. I believed that the studies that I read did not reflect the great diversity within among African American women. I was most disturbed by the fact that the studies did not reflect me or the black mothers who I know.

Throughout this project, I sought to examine the politics of infant feeding among African-American mothers using Black Feminist and Symbolic Interactionist paradigms. Black Feminism addresses the need to centralize black women’s experiences in pursuit of understanding the meanings that black women use for themselves. Symbolic Interactionsism provides a microlevel analytical lens through which we can identify and explore the meanings that the women in the study attach to their beliefs about their intersecting identities as mothers and black women. Further, SI is useful for understanding how those interlocking identities shape the decisions that they make about infant feeding, as well as, how they experience their infant feeding
practice(s). While the findings from this research project are suggestive and not generalizeable to all black mothers, they are nevertheless quite useful in understanding how and why African American mothers choose to (and not to) breastfeed their babies, as well as, how their lives and identities are affected by those decisions.

**Connecting the Dots: A Discussion**

**The Politics of Choice**

When this project was in its nascent stage, I focused on understanding why women chose to either breastfeed or use infant formula. Through my hours of conversations with the mothers in the study, I came to understand that the breast-versus-bottle debate that kept rearing its head in maternal health circles is based on a superficial binary. The presumption of the breast-versus-bottle argument is that women are either breastfeeders or they are infant formula users. The reality of infant feeding is not so clearly black and white. For example, while the most recent data from the Centers for Disease Control and Prevention indicates that 61% of black mothers have ever breastfed their babies, only 19% of those mothers report exclusively breastfeeding when their child was three months old. Further, 25% of mothers who initiated breastfeeding reported supplementing within two days after their babies were born. Similarly, the majority of the mothers in this study (28 out of 30) initiated breastfeeding after birth, and 18 of those respondents fed their babies infant formula before their children turned 6 months old. In the case of some mothers, like Hadiatu, Amy, Nzingha, and Kendra, the choice was not completely theirs. For example, Nzingha was forced to
leaving her son in the hospital which disrupted her breastfeeding practice. The healthcare workers there initiated infant formula use. After her milk supply dwindled and she decided that she would not continue to travel back and forth to the hospital to give her child pumped breastmilk, Nzingha decided to transition her son to infant formula. She continued giving her son her breastmilk with the formula until she stopped lactating. While Hadiatu was committed to breastfeeding, her daughter’s pediatrician told her to switch from breastfeeding alone to using infant formula because her child was losing weight and “failing to thrive.” According to Hadiatu, the doctor did not overtly threaten to contact social services if she did not agree to feed the baby infant formula, but she believed that the implication was there when she spoke with him during her daughter’s physical examination. She chose to feed her daughter a mixture of her expressed breastmilk and infant formula so that she would be able to track exactly how much food her daughter was consuming daily. Mothers like Deidre, Elaine, and Dejonnae chose to include formula of their own free accord. Elaine did not like to pump her breastmilk, so she chose to supplement with infant formula. Once she reached her breastfeeding goal (six weeks), she transitioned her children to infant formula. Similarly, Deidre and Dejonnae supplemented their babies and transitioned them completely to infant formula based on their timetables. Although they agreed that breastmilk was the best for their babies, the majority of mothers in the study remained opened to the possibility of using infant formula. In chapter 2, “Why We Choose”, I focus on understanding why the mothers in this study chose their respective infant feeding practice(s) and explore what their
choice(s) mean to them. The prominent themes which emerged in regards to “choice” were the following: exposure to breastfeeding and infant formula use, autonomy and agency, social support, embodied experience, convenience, and infant feeding ideology.

The participants feeding philosophy was impacted by their exposure to breastfeeding and infant formula. The mothers in the study who saw black women breastfeeding were more likely to be open to trying it themselves. Participants who knew someone who was breastfeeding were more likely to commit to breastfeeding, set feeding duration goals, and believe (or become convinced) that they could do it. On the other hand, respondents who had no personal experience with breastfeeding were more likely to desire to try it, and view formula as a backup in case their breastfeeding experience wasn’t what they wanted it to be.

The decision whether or not to breastfeed and/or use infant formula was tempered by each participant’s mothering style, particularly the way that she utilized social support 23. The mothers in study indicated that they used the following forms of social support: family, friends, daycare centers, and paid babysitters. Scholarship on the parenting styles of African American mothers has shown that they mothered collectively (Collins, 2000; Blum, 1998; Roberts, 1997; Davis 1981). In this mothering paradigm, which Blum (1998) identifies as community mothering, African American mothers share mothering responsibilities with other female relatives and female friends, othermothers. The specific source of support and the

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23 Social support is defined as any formal or informal network of assistance. This network can be comprised of familial members, friends, coworkers, religious affiliates, as well as, childcare workers, and babysitters.
degree to which the participants used the support impacted whether or not they believed that exclusively breastfeeding was a viable option. Amy and Chelsea are examples of two mothers who specifically articulated the challenge that solely breastfeeding presented when Chelsea said, “She has to go to daycare and my breasts can’t accompany her.” While influenced by other factors, like her embodied experience with breastfeeding, Chelsea looked pragmatically at the feeding options available to her and her plans for childcare. She did not choose to express breastmilk and send it with her daughter because she did not like to pump milk from her breasts. She chose infant formula. Amy had similar reservations about exclusive nursing and she believed that her heightened state of stress might somehow negatively affect her daughter, so she chose to transition to formula as well. Mothers in the study who were either able to provide full-time care for their babies or remain in close proximity to them breastfed for longer periods of time. But participants in the study who mothered full-time did not necessarily breastfeed exclusively. At the time of the interview, 19 out of 30 mothers in the study included formula in their feeding rotation.

Autonomy and agency were recurrent themes. The participants’ feelings about infant feeding were tied to the degree of control that they believed they had over the choice to use both or choose between the two methods. Also, the respondents’ judgment about their nursing experiences was tied to the initial expectations they had about breastfeeding and/or infant formula use. The mothers in the study were most positive about their experiences with their chosen method(s) when they were able to actively determine how to feed their
child(ren). Also, the feelings that the mothers in the study had about themselves as women and as mothers such as contentment, guilt, resentment, etc., were influenced by the degree to which they could actively control the revised outcomes of their feeding experiences.

The participants’ infant feeding choices were shaped by what practices worked best for their families and themselves. Infant formula use remained a viable choice for the majority of participants because they viewed formula as an acceptable food for their babies which, unlike breastmilk, could be fed to their child at any time by anyone. The respondents had to negotiate jobs that took them away from home, as well as school, having multiple children, and other responsibilities. As a result, their feeding practices had to work conveniently with their lifestyle choices.

Mothers in the study developed their infant feeding ideology based on the vicarious experiences that they had with breastfeeding and/or formula use. The respondents who were not breastfed as children talked about the assumptions that they had from childhood that they would feed their babies infant formula. These participants believed that they would feed their babies “milk” out of a bottle. They did not articulate a clear distinction between breastmilk and formula. They simply stated that they knew it was milk.

In contrast, with exception of Lydia, the respondents who had been breastfed as children indicated that they assumed that they would breastfeed. Prior to giving birth, all of the respondents believed that they would replicate the normative activity that had been established and modeled by their mothers and other female relatives.
Their beliefs about infant feeding coalesced during pregnancy, but remained dynamic after the birth of their child.

**Negotiated Birth Effects**

The birth experiences of the participants in the study influenced whether or not they breastfed exclusively or combined breastfeeding and infant formula use. The ability to invoke agency continued to be a recurrent theme throughout chapter three, “The Birth Connection.” Also, interaction with resources, human and material played a significant role in the initiation, duration, and attitude towards nursing and infant formula use. In chapter three, I explore the interplay of these factors.

During their pregnancies, the respondents were exposed to “noise” in the form of advice from family, friends, medical professionals, and strangers (particularly when they were visibly pregnant), as well as, information from the parenting books, and advertising aimed at pregnant women and (new) parents. In general, obstetricians asked mothers about their feeding preferences and gave them “goodie bags” which contained formula samples, coupons, and other paraphernalia. According to the participants who used them, midwives provided the same “goodie bags,” but encouraged them to breastfeed and offered information to promote their success.

According to the participants in the study, advice about breastfeeding was mixed. Respondents with mothers who had formula fed them were most likely to say that their mothers encouraged them to formula feed throughout their pregnancy. Mothers in the study said that often they were told that breastfeeding was painful. Also, among family and friends who did not breastfeed (or were not breastfed) the
decision to nurse was racialized and contextualized as an “us” (African Americans) versus “them” (white Americans) discourse. Specifically, respondents spoke about family and friends asking them why they would choose do breastfeed because it was “something that white people did.” Because of the complex race politics in this country that are borne out of the legacy of slavery and the persistence of racial discrimination by the white establishment against the black community, blacks connect “acting white” to being counter-black.24

The mothers in the study who had been breastfed (or whose partners had been breastfed) talked about receiving a lot of positive support for them to breastfeed. Within their familial circles, breastfeeding was constructed as something that was not simply “best” but also normal. In the end, participants weighed the advice that they received and balanced it with the preexisting knowledge that they had about breastfeeding and infant formula to make a wide variety of decisions.

While the chatter surrounding infant feeding did not disappear once their babies were born, the mothers in the study shifted their focus from the noise of others to the embodied experience (and consequences) of their birth. Mothers who had “normal” births were more likely to focus on feeding on their own terms. They sought out human (like lactation consultants and childcare workers) and technological (breast pumps, nipples, etc) resources which would

24 The expression “acting white” refers to the normative behaviors and attitudes that are ascribed to the white majority, particularly middle class, in this society. These things, e.g. dress, speech patterns, preferences, etc., are not solely done by white people, but they are portrayed in the media, hence stereotyped, as modus operandi of the white population in this society.
improve their breastfeeding outcomes. While having a healthy birth was the first step in having success with breastfeeding, it did not ensure it. Despite having healthy vaginal births, some mothers found themselves dealing with challenges like access to resources, and healthcare providers who did not respect the wishes and/or parameters of care established by the respondents. These elements negatively impacted the participants’ duration of breastfeeding, especially when the mothers did not have access to family and friends who supported their breastfeeding efforts.

Mothers in the study who had premature babies and/or c-sections found themselves caring for healing bodies and dependent on the medical system. These participants were most likely to blame their bodies when their infant feeding plans were disrupted. Also, these mothers were most likely to view medical intervention positively. They adapted to the changing landscape of their personal care, as well as, that of their babies. While their breastfeeding outcomes differed, these respondents were most likely to use innovative ways, such as expressing breastmilk for three months without feeding from the breast or mixing breastmilk with infant formula because they were determined to feed breastmilk to their babies despite being instructed by their baby’s doctors to formula feed. Regardless of her birth experience, each mother did what she believed a good mother should do.

Perform-ing Mother-hood and Sex

The participants in the study wanted to be good mothers. They read the books, they listened to advice, and they did their own research. They entered the arena of mothering with their own ideas about what they should (and should not do) to avoid being a bad
mother. In chapter four, “On Doing Mother,” I discussed how the
participants in the study negotiated their internalized identities and
performances as mothers and as sexual beings.

In the black community, mothers are empowered to “mother”
everywhere. It is not uncommon to have a mother discipline a child out
in public. Likewise, it is common to see a group of black mothers,
aunties, friends and neighbors passing around and taking care of
children who are not biologically tied to them. Within the black
community, mothering breaches the bubble of the nuclear family. In
this context, the good mother mothers many.

Similar to the black mothers who were interviewed by Blum (2000),
the mothers in this study desired community mothering. Some of the
mothers were unable to avoid independent mothering because they lived
far away from their relatives and had not established a group of
friends. Due to their economic status, some mothers were able to be
full-time mothers. This position reduced the likelihood that they
would acquire paid childcare which coupled with separation from her
female relatives and a lack of a nearby circle of friends served to
isolate the mother. When this happened, mothers found themselves
mothering in isolation. When I spoke with isolated mothers, they spoke
about ways to change their social situation. They gave preference to

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25 Community mothering refers to the practice of collective mothering which incorporates social
other mothers (unpaid and paid) in the task of raising and caring for children. It has a historic
legacy within West African societies. Also, enslaved African American mothers extended this
practice to cope with the children who were orphaned because of sale to or from a plantation or
the death of their mothers. Because the common practice of raping girls and women on plantations
as well as during the imprisonment prior to the voyage away from Africa or during the voyage, the
paternity of children was not always known. Children would be adopted by both the women and men
with an enslaved or free community of African Americans.

26 Blum (1998) and Collins (2000) identify this mothering style as the prominent practice of
mothering among whites. Within this model, women are expected to mother their children in
isolation. According to Collins (2000) this model of parenting is borne out of the ideology that
children are property of the father. As a result, it is the mother’s responsibility, as his
subordinate helpmate, to maintain his goods.
the model of having, at least, their mothers available to share parenting of their children. Some of the mothers in the study focused on how they would get through this phase of mothering with limited assistance. Others speculated about the future when their children would be older. They believed that they would be able to find new friends, travel more to see family, or possibly join organizations which would connect them with (black) mothers whose children were comparable in age to their own. The participants in the study viewed independent mothering as undesirable because they believed that it made mothering more difficult. For instance, according to Carla, a mother of two at the time of the interview, mothering in isolation is “not the way it was supposed to be.”

The normalized incorporation of the othermothers within African American culture differs from the model of independent mothering which is portrayed as a standard in this society. My findings suggest that while community mothering was the desired mothering model that African American mothers wished to follow, increased mobility, e.g. moving for work or school, made it a difficult practice to maintain. While the mothers in the study indicated that they were most influenced in their decision-making about infant feeding by female relatives--primarily mothers and sisters, and female friends--the participants who reported mid-upper middle class status were more likely to find themselves living far away from their family of origin. Also, the time that it took to maintain their jobs, families, and take care of themselves greatly reduced the participants’ opportunities for finding new female friends who could act as othermothers. As a result, they were more
likely to independently mother\textsuperscript{27}. Independent mothering was most likely to be practiced by participants who were full-time mothers. African American mothers who mothered independently were more likely than mothers who utilized the community model to express guilt and/or a sense of failure when their breastfeeding outcomes weren’t what they originally planned. Also, these participants were more likely to find themselves “mothering in isolation.” While all of the mothers in the study, discussed the benefits of breastfeeding for their babies, full-time mothers were most likely to articulate a sense of obligation to breastfeed their babies. These mothers were more likely than other respondents to align their constructs of “best practices” for feeding and care of their baby with the dominant (white) discourses of the “good” mother. A key departure from that discourse among the respondents is the privileging of community mothering over independent mother even when the participants were not in a position to do it themselves.

Similar to the findings Weisskopf (1980), mothers in this study had challenges with reconciling the notion of the eroticized breast with what they viewed as their asexual working breasts. This conflict was most keen for women who were in partnered relationships. While there were different degrees of desire for sex, the mothers in the study discussed being conflicted with the role that breast play should factor into their sexual activities\textsuperscript{28}. The cognitive dissonance they experienced arose out of their desire to keep their breasts as feeding...
vessels for their baby, while also believing they had an obligation to make their breasts sexually available to their partners. Some fathers consciously avoided breast play because they felt that his wives’ breasts were for their children. Another area of conflict arose when mothers had to navigate nursing away from home. Some mothers viewed breastfeeding as something that should happen in a private and protected place. For example, Evelyn believed that mothers who breastfed in public needed to cover up themselves and their breastfeeding child. The participants (those who covered and those who did not) in the study believed that covering would block the male gaze and protect the virtue (and innocence) of their child and the act of breastfeeding. Lydia went so far as to say that, “covering kept them [the mothers] right.” These mothers’ ambivalence about nursing in public places was tied to notions of the “good” and the “bad” mother. Historically, African American women, in general, and mothers, in particular, have been demonized and blamed for the ills of the black community (Moynihan 1967, Davis, 1983, Carby 1987, Blum 1998, Roberts 1998). Despite their accomplishments, they have been shut out of collective construct of respectability of the idealized white women (Carby 1987, Roberts 1998). According to Collins (2000), motherhood itself positioned diasporic African women as valuable and sacred within their own communities. Mothers are central agents in maintaining the integrity of community because they take care of families and pass on cultural traditions (Collins 2000, Carby 1987, Davis 1983). With the end of slavery and the intensification of internal stratification, African American women developed their own within-group standards for respectability which allowed then to define
and judge themselves using their own criteria. In opposition to the Jezebel, hypersexual seductress that white America promulgated, Black mothers created and maintained a construct of respectable motherhood— the God-fearing Club woman— that was tied to her control of her display of her sexuality, via dress, and social interactions (Davis, 1981). Unlike Mammy, the Club woman took care of her own family and represented the “higher qualities” of the race (Carby 1987).

The mothers in the study stood firmly on middle ground which was neither solely maternal nor solely sexual. Further, notions of bodily integrity and control necessitated a decoupling of the maternal self and the sexual self. Also, participants found themselves fighting to maintain their bodies as their own, not their children’s or their partner’s. According to the respondents, juggling access to their bodies, especially when they were partnered, left mothers feeling “touched out.” Rather than allowing themselves to be overwhelmed, mothers sought/created moments of refuge when they would be able to control access to their bodies. The participants created routines that would allow them time by themselves. Some examples of the activities that they performed were as follows: grooming, going for a walk, or going to the gym. According to the participants, the brief respites that they received from their mothering duties helped to rejuvenate them. Also, breastfeeding mothers created narratives which situated their feeding practices as both finite and uniquely crucial to the health and well-being on their children. They positioned themselves as “good” mothers because they were dutifully sacrificing for the long term benefits of their children. In their framework of mothering, that was all that mattered.
The participants in the study who breastfed for six months or more eventually adjusted the preconceived notions that they had about their sexuality and breastfeeding over time. As time progressed, they became more comfortable and less embarrassed with their lactating breasts. Mothers in the study found ways to minimize when their breasts leaked milk or grew to see dripping breasts as a regular (albeit finite) part of sex while they were lactating. Mothers in the study who used infant formula did not discuss any problems with breast play. In the case of some mothers, transitioning to formula improved her sex life. For example, Cassie believed that her husband was pleased with her cessation of breastfeeding because her breasts would be fully available to him again. Participants in the study who transitioned to formula did talk about fatigue and time, though. Also, mothers who were using infant formula did not focus on feeling “touched out” in the way that breastfeeding mother did. They reported having more freedom to spend time away from their child.

Closing Remarks

Reflections

When I started this project, I believed that I had a strong sense of what I would find. After all, I am an African American woman who had to examine these options and make my own choices. Once I began talking to the mothers in this study, I had to let go of my preconceived notions about where our interviews would take us. I videotaped each interview to help me hear each mother individually, as well as to facilitate viewing the group collectively. I found viewing these tapes along with reading the transcriptions of the interviews
central to my understanding of and connection to the women in the study.

Once the mothers in the study began to forget the camera, our interviews became fluid conversations. All of the mothers expressed gratitude that a black woman was talking to them about their feeding and birth experiences. Most of them said that they hadn’t spoken about their birth experiences and the beginning of their infant feeding odyssey until our interview. Many of the women had cathartic moments when they connected a past experience with their feelings about infant feeding. Also, others were able to talk about feelings of resentment that they harbored about their feeding options, as well as their partners and family members who did not support their infant feeding choices. These displays are most visible on film when the mothers’ expressions and body language communicated many things that their words masked. I left each interview with renewed conviction that this research is valuable not only because it can inform public policy, but because it validates the experiences of the women being studied. Also, while the women in this study would probably have granted an interview to a non-black research, I argue that the free use (and understanding) of Black vernacular language and laughter (feeling) within the exchange would have differed. Hence the richness of the data would have been affected.

While this study is not intended to serve the purpose of intervention, I hope that my findings will inform policy and campaigns aimed at increasing breastfeeding among African-American women. Currently, programs are focused on providing information about the many health benefits for the child. My findings suggest that providing
mothers with more relevant (beyond the superficial), and detailed information about the plethora of benefits for them would enhance the appeal of breastfeeding. For example, all of the mothers in the study knew that breastfeeding positively affects weight loss, which they understood. Some of the mothers knew that breastfeeding increases the speed of the uterus returning to its pre-pregnancy size, but the only person who understood why that process was significant was Leila, the nurse. If the mothers in the study understood that breastfeeding immediately after birth significantly reduced their chances of dying because of a hemorrhage, it is likely that they would prioritize breastfeeding differently. According to my findings, while public health campaigns like “Breast is Best” have been successful in getting the message out that breastfeeding is best for infants, they have not provided adequate information to mothers about how to integrate breastfeeding into their lives. Also, while mothers understand the message that breastfeeding is best, the practice is not normalized in the larger society. As a nation, we have not universally addressed the structural issues that impede the breastfeeding choice, e.g. flex schedules for working, extended paid leave for all mothers, on-site daycare facilities, on-site lactation centers, laws (indecent exposure), etc. Studying sites where these options are made available to African American mothers would aid in understanding how structural policies impact breastfeeding rates among African American women. Finally, my findings suggest that women are significantly receptive (on a conscious level) to information about infant feeding during pregnancy. During that time, healthcare providers are empowered to

\textsuperscript{29} It is important to get the uterus back to its pre-pregnant size quickly because that reduces the likelihood of a postpartum hemorrhage. Postpartum hemorrhaging is a leading cause of maternal mortality around the world.
present soon-to-be mothers with materials (goodie bags, etc) and information (pamphlets, support group contacts, etc.) that normalize breastfeeding instead of infant formula. Also, mother who have had challenges with their births and/or new mothers are particularly vulnerable to hospital practices regarding infant feeding. According to the mothers in this study, nurses and lactation consultants were both helpful and harmful to the participants’ feeding plan. My findings suggest that the respondents, particularly those who had little or no experience with breastfeeding, were pleased to be able to talk/work with a healthcare professional who could assist them with the mechanics of breastfeeding. But, the respondents were displeased when the nurse(s) and/or lactation consultant did not respect their physical and emotional boundaries. I argue that both nurses and lactation consultants, particularly those who are not women of color, should receive cultural sensitivity training which would provide them with information about guidelines for touching black women’s lactating breasts, as well as parameters for “encouraging” black women to breastfeed. Also, hospitals policies which routinely either remove the baby from the mother immediately after birth and/or feed the infant formula before (s)he can attempt to nurse are detrimental to the mother’s breastfeeding effort because babies who have full bellies from eating formula out of a bottle are not very likely to want to breastfeed shortly after being fed. So, when the mother attempts to breastfeed her child, there is a significant likelihood that only (s)he will not latch. In many cases, the child and mother will become frustrated with attempting to breastfeed. There is a significant chance that shortly thereafter the mother will stop attempting to
breastfeed the child. Hospital policies should reflect the normalization of breastfeeding. So, rather than assuming that babies will be formula fed and/or fostering an environment which perpetuates infant formula use, hospital should encourage policies like having babies breastfeed soon after birth and keeping the mother and baby together throughout the stay of mother and child in the hospital. It is important to note that the abovementioned suggestions are routinely practices at birth centers and at home births.

Thoughts on Future Research

In an extension of the present project, I plan to delve more deeply into how external and internalized constructs of the black mother (self, biological/adopted, mother-in-law) impact what mothers in the study think about their infant feeding experiences. For example, I would like to understand how and why a mother of three would come to decide to breastfeed one child while using infant formula to the other two or vice versa. I would like to further examine how black mothers are impacted by their mothers and in-laws. Also, I would like to explore how their relationships are affected when the mothers in the study transition from one feeding method to another. I am particularly interested in how the mothers’ experiences with breastfeeding are shaped by the politics of negotiating between the beliefs of their mothers and their partners’ mothers when the two have different proscriptions for infant feeding. Finally, I would like to understand how that dynamic shapes how mothers in the study construct “good” and “bad” mother(ing).

Because breastfeeding is both physical and psychological, I would like to examine how constructs, internalized and external, of pain
associated with breastfeeding shape the respondents’ preconceived notions about the practice. I would like to examine how it compared to their lived experiences, as well as how their ideology of pain shaped their evaluation of their breastfeeding experience. Particularly, I am interested in understanding how they felt while they breastfed. For example, I would ask the following questions: Does breastfeeding hurt?; Are you aroused when you breastfeed?; How do you feel in general, once you start to nurse? I would like to know how those sensations affect how they feel (and talk) about breastfeeding.

As a feminist researcher, I lament the loss of information that comes with reading what participants have to say about their experiences. I find it more rewarding to read their words than to have their ideas presented solely as an interpretation of their responses to close ended surveys or other statistics. But the women remain two dimensional. As a means of creating a more accessible (and truer) representation of the mothers in my study, I have begun making a documentary from their interviews. Documentary films provide a window into other people’s lives. In the case of my project, it provides the viewer with an opportunity to go beyond reading what the mothers in the study have to say. For example, while it is touching to read that Esther felt guilty about not breastfeeding her child, it touches the spirit on a different level to see the look in her eyes as her baby nuzzles her neck. Documentary filmmaking takes feminist research to the “next level” by providing the moving stories of the lives of research participants. Also, I plan to use video clips and sound bytes from the interviews in this project to augment my presentation of this study.
Finally, I am interested in understanding what black fathers think about infant feeding in general and breastfeeding in particular. The mothers in the study spoke about what they thought they thought. In some cases, the participants reflected on the fact that they had no idea what the fathers thought. So, they said that they would talk to them and find out. Based on the findings from this study, fathers (married and unmarried) play a role in the politics of breastfeeding. For the final piece of this project, I would interview (and film) the fathers.
REFERENCES


Appendix A:

Consent Form
Title: Infant Feeding Choices Among African-American Women.

Principal Investigator: Wendy Simonds, PI; Nicole Banton, Student PI
Sponsor: N/A

I. Purpose:
The purpose of this study is to learn about decisions that African-American women make when it comes to feeding their infants and toddlers. This research study involves interviewing approximately thirty (30) African-American women for approximately one and half hours each. The questions that each woman is asked revolve around understanding why she chose to breast or bottle feed her infant(s) and/or toddler(s).

II. Procedures:
You will be interviewed for approximately 1 ½ hours in a place of your choosing. During the interview you will be asked a series of open-ended questions. You are expected to answer them to the best of your ability. All of the interviews will be taped and later transcribed. If you are willing, the interview will be filmed as well. If you choose to be filmed, an all female crew (two camerawomen and one assistant) will be present to film the interview. All questions will come from the student PI. You will only be expected to interact with the student PI during the interview. You will only be interviewed once.

III. Risks:
There is a possible risk of embarrassment to participants in this study because of the subject matter. There are no foreseeable physical risks to the participants in the study. While some emotional response to the subject matter is anticipated, nothing beyond a minimal experience is expected.

IV. Benefits:
The information that we gain from this study helps to build researchers’ understanding of the attitudes and behaviors African American women have about themselves and how that impacts some of the decisions that they make as mothers. What we learn can be used to shape policies and programs geared towards bettering maternal and infant health among African-Americans.

V. Voluntary Participation and Withdrawal:
Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to stop the interview at any time. No negative action will be taken against you.

VI. Confidentiality:
We will keep your records private to the extent allowed by law. We will use a fake name rather than your name on study records where we can. The findings will be summarized and reported in group form. Your name and other facts that might point to you will not appear when we present this study or publish its results unless you agree to be filmed. If you agree to be filmed, your likeness may be used during public presentations. You will not be identified personally unless you agree to be filmed. If you agree to be filmed personal identifying information may be used.

Please feel free to call Nicole Banton at (407)325-8204 or Dr. Wendy Simonds at (404)651-1841 if you have questions about this study. Nicole Banton may be contacted at diansakhu@yahoo.com, as well.

If you have questions or concerns about your rights as a participant in this research study, you may contact Susan Vogtner in the Office of Research Integrity at 404-463-0674 or svogtner1@gsu.edu.
We will give you a copy of this consent form to keep. If you are willing to volunteer for this research, please sign below.

______________________________________                        _________________  
Participant                                      Date

_____________________________________                        _________________  
Student Principal Investigator                   Date

**Videotape Participants ONLY:**

If you agree to have your interview videotaped, please sign below. Your confidentiality cannot be guaranteed if you are videotaped. Your likeness may be used in the form of a documentary and/or other public and/or private presentations of the interviews. You will not receive any compensation for your participation in this project. You agree that you will not pursue any legal action against any of parties involved in any aspect in the production of this film because of any materials that you consider unsuitable or objectionable. If you have any questions or wish to have any parts of your videotaped interview removed, please contact the student PI at the phone number or email address above. You have the right to stop the interview of the filming at any time. Videotaping your interview is entirely voluntary.

______________________________________                        _________________  
Participant                                      Date

Last revised 10/25/2006
APPENDIX B;

Schedule of Questions
1. Tell me about the ideas that you had about breastfeeding and formula use while you were growing up?
Probes- How were you fed? If breastfed, for how long? What types of feedings did you witness? Tell me about your reaction(s) to seeing women breastfeeding/bottlefeeding (in public and private).

2. Tell me about the ideas that you had about breastfeeding and formula use while you were pregnant.
Probes- Influence of family, friends, father of the child? What types of feedings did you witness? Tell me about your reaction(s) to seeing women breastfeeding and bottlefeeding (in public and private); the things that influenced your ideas about breastfeeding and using formula, e.g. books, television, doctors, etc. Have you ever heard of wet nursing? What do you think about it?

3. Where did you have your birth experience? Why?

4. Tell me about the infant feeding method that you ultimately used when your [insert gender of child] was born.
Probes- Why did you choose this method? Tell me about: the first few weeks that you used this method, any challenges; how did you feel physically, emotionally; how did you handle the accessories that you used, e.g. bottles, breast pump, formula, nursing pads, etc.; duration, if breast-feeding; what was the experience of weaning? What do you think makes a "good" mother? Does how she feeds her infant have anything to do with it?
4. What role did your family, friends, and child's father play in your experience?

5. Tell me about the role that healthcare providers played with helping you to succeed with [insert method].
Probes- Did they offer advice, physical assistance, information about support groups, positive or negative support, supplies? Discuss.

6. Tell me about your experiences combining your lifestyle with [insert method].
Probes-Issues with work/school, social life, sexuality, e.g. body image, sex life, etc.; if partnered- relationship

7. Tell me what you think about society's views on formula use and breastfeeding.
Probes-Why? How do you think these views are furthered? What do you think about differences in race and class?
APPENDIX C:

Recruitment Flyer
...to be a participant in a study which explores the social factors that impact African American women's infant feeding choices. If you are an African American mother in the Orlando area who has at least one child who is three years old or younger, you can participate in the creation of this groundbreaking project. Please join us.

Contact Nicole Banton at diansakhu@yahoo.com or 407-325-8204 for more information.
APPENDIX D:

Bennetton Advertisement