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The Breastfeeding Experience For Women With Low Incomes: A Phenomenological Exploration

by

V. Jill Aussant

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Science

Centre For Health Promotion Studies

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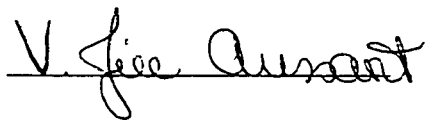

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Abstract

The experience of breastfeeding for women living with low incomes has received little attention despite less than ideal duration rates. To examine the reality of breastfeeding for women living on a low income, a phenomenological research approach was used. Based on interviews with nine mothers, the author explored the phenomena of breastfeeding including experiences that assist women to continue breastfeeding for longer periods, the experiences that lead women to wean early and the degree and nature of social support experienced within the family and broader community. Women spoke poignantly about a desire to breastfeed and a sense of personal motivation. They described unique experiences of breastfeeding that included incongruity between idealized expectations and early breastfeeding problems. Incongruence led mothers to doubt their breastfeeding efforts. Women described how social support was essential and ultimately enhanced their breastfeeding experience. Women who breastfed longer discussed the personal benefits of breastfeeding and perceived that their infants preferred breastfeeding to bottle-feeding.

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Chapter One

Introduction

Breastfeeding and Women with Low Incomes: The Call To The Question

Breastfeeding is the optimal form of nutrition for infants. Despite the documented benefits of breastfeeding, rates of breastfeeding continue to be less than ideal. The rate of breastfeeding initiation among low income women is 61% compared to the national initiation rate of 73% (Heath Canada, 1999). The Canadian Paediatric Society, Dietitians of Canada and Health Canada (1998) encourage mothers to exclusively breastfeed for at least the first four months of life. However, 50% of low income mothers who initiate breastfeeding wean before four months postpartum compared to 30% of the general population.

In Calgary, the percentage of lower income women initiating breastfeeding is comparable to the rate of the general population at 68%. However, despite an increasing initiation trend, many mothers discontinue breastfeeding by 2 months postpartum. In 1997, the rate of exclusive breastfeeding at 2 months postpartum sharply declined to 32% for low income women (Silzer, 1999) compared to 50% for the general population (Silzer, 1999).

Research related to breastfeeding duration has mostly sought to identify determinants of breastfeeding behaviour. Many studies have used quantitative survey methods to identify determinants associated with longer breastfeeding duration. In contrast, there have not been significant research attempts to understand what these determinants and influences mean to mothers in the context of their everyday lives (Maclean, 1989). No Canadian data was found that provides information about the experience of breastfeeding among women living on a low income. Additional qualitative

research is necessary to further understand why women living on a low income are more likely to terminate breastfeeding early.

Significance of Study

Most low income mothers are not breastfeeding for the first four months of life as recommended by the Canadian Paediatric Society, Dietitians of Canada and Health Canada (1998) despite respectable initiation rates. Only half of low income mothers who initiate breastfeeding do so for the recommended first four months of life. Consequently, infants, mothers and families are not receiving the physiological, cognitive, economic and emotional benefits of breastfeeding.

By taking a close look at what the breastfeeding experience is like for women living on a low income it may be possible to begin to identify and understand the context of social, cultural, environmental and individual environments that impact a women's decision to continue breastfeeding. Maclean (1990) explored the need for breastfeeding research within a health promotion framework. She maintains that researchers should be "concerned with meaning of actions and events from participants' frame of reference; as a means of elucidating the interaction of personal and contextual factors that shape [breastfeeding] behaviour" (p.362). From a health promotion program development perspective, Denzin (1989) recommends that the perspectives and experiences of those persons who are served by health programs must be grasped, interpreted, and understood if solid, effective, applied health programs are to be put in place. Research that ultimately aims to create conditions that make breastfeeding more possible, more successful and more valued is the aim (Van Esterik, 1989).

In conclusion, there is a need for research that examines the breastfeeding experience of women living on a low income. In recognition of this need, this study will provide information about the experience of breastfeeding to other mothers who are considering breastfeeding. This study will also be of benefit to health program planners, within a health promotion framework, to guide development of appropriate breastfeeding promotion strategies for women who live on a low income.

Methodological Approach

The research is situated within the methodological approach of phenomenology. This qualitative approach to inquiry is used to guide a research process when the researcher attempts to understand more about the 'lifeworld' of the research participants. The framework of phenomenology was selected because of its potential to be concerned with meanings of actions and events from participants' frame of reference. The phenomenological method focuses on the meaning of an experience to the individual and does not impose a preconceived structure on the organization of the research data (Mozingo, Davis, Droppleman & Merideth, 2000) and therefore was considered the ideal method for obtaining the fullest possible understanding of the meaning of the experience of breastfeeding for low income women.

The phenomenological approach will contribute useful perspectives to the field of health promotion and breastfeeding. It will allow for an enhanced understanding of the experience of breastfeeding among women with low incomes because it provides a means to integrate personal and socio-cultural realities of research participants. This, in turn, will facilitate change by bringing to light the social structures and personal factors that enhance and promote a positive breastfeeding experience.

Public participation in defining the problems and seeking the solutions is a key feature of health promotion (Epp, 1986). This qualitative study will provide a forum for participants to articulate and describe their breastfeeding experience. The qualitative approach will provide a more complete understanding of the breastfeeding experience because it facilitates an examination of the day-by-day life in which breastfeeding occurs. Finally, the findings will contribute to breastfeeding promotion efforts because the data will be rooted in the realities of the people whom the promotion efforts seek to influence (Maclean, 1989).

Purpose of Study

The purpose of this study is to understand the experience of breastfeeding among low income women. More specifically, the researcher will seek to identify the experiences that assist women to continue breastfeeding for longer periods, to understand the experiences that lead women to wean early, and finally to examine the degree and nature of support women experience within the family and broader community.

Research Questions

The research questions are: 1) What is the experience of breastfeeding among lower income women?; 2) What is it about the breastfeeding experience that helps women continue breastfeeding?; 3) What experiences lead women to stop breastfeeding before four months postpartum?; and 4) What is the degree and nature of support experienced by women within the family and the community?

Personal Assumptions Regarding the Research Question

My personal experience, my professional experience and the information that I have gathered from the literature have shaped my assumptions about breastfeeding. These

three areas of influence have helped to focus my research question. I would like to briefly highlight some of my assumptions that have led me to formulate my research question.

My main reason for choosing this research topic is that I strongly support the promotion of breastfeeding. I would like to see every women and child breastfeed and be satisfied with their breastfeeding experience. Before this research, I talked with mothers who had every intention to breastfeed prenatally, initiated breastfeeding but did not continue breastfeeding later in the postpartum period. Consequently, I wanted to understand more fully the experiences that women undergo during this early postpartum time.

As a women, and as a Registered Dietitian, I believe that breastfeeding is a challenging task and women experience many barriers to a successful breastfeeding experience. In addition, low income women seem to face additional barriers to breastfeeding that is reflected by shorter breastfeeding duration rates. Barriers that may exist include increased life stress, competing life priorities, limited transportation and limited childcare. The lives of women living on a low income may include increased stress because of being a single parent, having limited family support and attempting to budget scarce financial resources while providing food and shelter for the family. The stress of these life circumstances may interfere with a mother's intent to breastfeed for a specific period of time. A mother faced with breastfeeding problems may choose to stop breastfeeding as a way of reducing an already 'stressful' life situation.

Low income mothers may juggle competing priorities that include attending school, working and/or caring for other children. These activities may interfere with the time she has available to breastfeed. A mother with other children at home and limited alternate or relief childcare may stop breastfeeding because of the demands that older children place on

her time. In addition, low income women may not have finances available for public transportation to attend breastfeeding classes or breastfeeding clinics and riding the public transportation system with other children may prove to be difficult.

I believe that an important way to enhance the breastfeeding experience for women is to first understand why women choose to breastfeed and what leads them to continue or terminate breastfeeding. I believe that an enhanced understanding of the experience of breastfeeding may ultimately lead to breastfeeding promotion efforts that are more helpful for women.

The existing research about the breastfeeding experience of low income women is scarce. Information about the breastfeeding experience of low income women in Canada is not known to the author. The lack of data combined with the complexity of the breastfeeding phenomena makes the study of the experience of breastfeeding among low income women an important one.

In conclusion, there is a need for research that enhances the understanding of the experience of breastfeeding and how breastfeeding duration can be increased among low income women. In recognition of this need, this study will provide information about these issues to guide development of appropriate breastfeeding promotion strategies for women who live on a low income.

Chapter Two

Contextualizing The Backdrop For Inquiry – Review of the Literature

Benefits of Breastfeeding

There are many documented benefits of breastfeeding. The benefits of breastfeeding extend beyond the fact that breastmilk is the optimal nutrition for infants. "Extensive research, especially in recent years, documents diverse and compelling advantages to infants, mothers, families and society from breastfeeding and the use of human milk for feeding. These include health, nutritional, immunologic, developmental, psychological, social and economic benefits"(American Academy of Pediatrics, 1997, p.1035).

The nutrient composition of breastmilk is ideal for human infants in their various stages of growth and development. The composition of human milk is distinct from the milk of other mammals and from infant formulas. Human milk is unique in its' physical structure and in the types and concentrations of nutrients, enzymes, hormones, growth factors, host resistance factors, inducers/modulators of the immune system and anti-inflammatory agents (American Dietetic Association, 1993; Institute of Medicine, 1991; Janke, 1993).

Breastfeeding is associated with significant reductions in the incidence and duration of both gastrointestinal and non-gastrointestinal infections, including otitis media, pneumonia, bacteremia and meningitis (Institute of Medicine, 1991). Breastfeeding is also associated with a reduced frequency of certain chronic diseases later in life, including insulin-dependent diabetes mellitus, lymphoma and Crohn's disease (Institute of Medicine,

1991). Food allergies also appear to be less frequent in infants who are exclusively breastfed (Institute of Medicine, 1991).

Breastfeeding provides specific benefits to the mother. It has long been acknowledged that breastfeeding increases levels of oxytocin, resulting in less postpartum bleeding and more rapid uterine involution. Enhanced maternal-infant bonding, lengthening of the birth interval and conservation of maternal iron stores because of amenorrhea has also been associated with breastfeeding (American Academy of Pediatrics, 1997; Institute of Medicine, 1991, Janke, 1993).

In addition to individual health benefits to the infant and mother, breastfeeding provides significant social and economic benefits including reduced health care costs and reduced employee absenteeism for care attributable to child illness (American Academy of Pediatrics, 1997; Montgomery & Splett, 1997; Tuttle & Dewey, 1996). The direct economic benefits to the family are also significant. Montgomery and Splett (1997) compared costs associated with formula feeding and breastfeeding and found that breastfeeding saved approximately $500 during the first 6 months of an infant's life when compared to formula feeding.

Women's Reasons for Breastfeeding

When lower income mothers were asked about why they want to breastfeed, health of the infant was the primary reason for choosing the feeding method (Libbus, Bush, & Hockman, 1997; Novotny, Keiffer, Mor, Thiele, & Nikaido, 1994; Trado & Hughes, 1996). In one study (Novotny et al. 1994), health was chosen as a broad term to describe benefits for the infants, while in the qualitative study (Libbus, Bush and Hockman 1997), health was expressed more specifically in terms of "protecting infants" by strengthening immunity

or preventing allergies. Women also felt that breastfeeding would enhance bonding and additional benefits were tied to issues of the women's health, including weight loss and prevention of cancer. (Libbus, Bush, & Hockman, 1997). In a number of studies, mothers described breastfeeding as being convenient (Grossman, Fitzsimmons, Larsen-Alexander, Sachs, & Harter, 1990; Trado & Hughes, 1996).

The benefits of breastfeeding are well documented by the studies mentioned above. Benefits include enhanced health to infant, mother and society as a whole. Lower income mothers recognize the benefits associated with breastfeeding and frequently cite health as a major reason for wanting to breastfeed their infants (Libbus et al., 1997; Novotny et al., 1994; Trado & Hughes, 1996).

Rates of Breastfeeding Among Women Living On a Low Income

Breastfeeding in history.

Maclean (1990) asserts that " women's beliefs, attitudes and experiences do not develop in isolation. They reflect not only a woman's unique personality and preferences but also the social forces and viewpoints that are a part of the world in which she lives" (Maclean, 1990, p. 3). Throughout the last century, women's attitudes about the benefits of breast and bottle-feeding have reflected changing viewpoints in society. The interest in bottle-feeding increased at a time when science and technology promoted infant formula as being a good way to nourish infants. It was believed that scientific technology could improve on nature and mothers wanting to do what was best for their children began using infant formula. By the late 1960s and early 1970s, a skepticism of science had developed. "Women began to question the utility and effectiveness of high technology medical interventions to control their reproductive systems and there was a growing concern about

the medicalization of childbirth"(Maclean, 1990, p. 4). Knowledge about the nutritional, immunologic, developmental and social benefits of breastfeeding was also emerging. The attitudes were beginning to change, and mothers wanting to do the best for their children, were again choosing to breastfeed.

However, this shift, from bottle feeding to breastfeeding, has not taken place completely. I will present information about breastfeeding rates in Canada. Where possible, comparisons will be highlighted between national, provincial and Calgary rates and between general and low-income populations.

Canadian breastfeeding initiation rates.

Throughout the 1970s and early 1980s, a major reversal in the downward trend in breastfeeding initiation rates occurred in Canada. Between 1973 and 1978, initiation of breastfeeding increased by 69% (from 36% to 61%) and between 1982 and 1983 initiation increased by 15% (from 65% to 75%) (McNally, Hendricks, & Horowitz, 1985). Since then, it appears that breastfeeding rates, in Canada, have remained static.

According to the National Population Health Survey (NPHS, 1996) and the National Longitudinal Survey of Children and Youth (NLSCY,1996), the national initiation rate of breastfeeding is 73% (Health Canada, 1999). Both the NPHS and the NLSCY show regional differences in breastfeeding initiation rates with an east to west gradient. The NPHS data range from a low of 53% and 54% initiation rates in Atlantic Canada and Quebec respectively, to a high of 87% in British Columbia. The NLSCY data show a similar pattern but the magnitude of the differences is slightly less, with Quebec having the lowest rate (56%) and British Columbia the highest rate (85%). The rate of breastfeeding

initiation for the Prairie Provinces, including Alberta is 86% in the NPHS and 83% in the NLSCY survey.

Similar to studies in the United States, the NPHS and the NLSCY show that lower rates of breastfeeding are reported among women who are young, single, and who have lower levels of education and income (Grossman, Fitzsimmons, Larsen-Alexander, Sach & Harter, 1990; Health Canada, 1999; Humphreys, Thompson, & Miner, 1998; Schafer, Vogel, Viegas, & Hausafus, 1998). The rate of breastfeeding initiation among low income women is 61% and 68% for the NPHS and NLSCY respectively. Health Canada uses household income and household size to determine income level in the research cited. Household income up to $14 999 and household size of 1 to 2 persons, household income up to $19 999 and household size of 3 to 4 persons or household income up to 29 999 with 5 or more persons is considered low income. A more recent, smaller study in Ontario (n=493) found initiation rates of 77% among low income women (Evers, Doran, & Shellenberg, 1998).

Duration of breastfeeding.

In a recently released publication entitled "Nutrition for Healthy Term Infants", Health Canada (HC), The Canadian Paediatric Society (CPS) and the Dietitians of Canada (DC) encourage mothers to exclusively breastfeed for at least the first four months of life (Canadian Paediatric Society, Dietitians of Canada, & Health Canada, 1998). However, about 40% of mothers who breastfeed report doing so for less than three months according to the NPHS and NLSCY data. In 1982, 17% and 41% of mothers who breastfed stopped at two and four months respectively (McNally, Hendricks, & Horowitz, 1985). Duration appears to decline rapidly in the early postpartum period. In light of the recommendations

by the CPS, DC and HC infants who are breastfed for less than four months can be considered to have been weaned prematurely.

The proportion of low income women who breastfeed for less than three months is 51% in the NPHS and 53% in the NLSCY survey. Women in central and eastern Canada wean their infants at younger ages than women in western Canada. In the Prairie Provinces, the percentage of women who wean early is 30% in the NPHS and 34% in the NLSCY survey. Duration of breastfeeding among immigrant women differs between the NPHS and the NLSCY surveys. NPHS data suggests that immigrant women wean earlier than non-immigrant women while the NLSCY data show no significant differences between these populations. NPHS data indicate that nationally, 31% of women are breastfeeding at six months while NLSCY data indicate a somewhat lower figure of 23% (Health Canada, 1999). These population survey figures indicate that the majority of women who breastfeed do not continue for the recommended four month duration.

Although the NPHS and the NLSCY provide useful national data on breastfeeding, there are limitations to interpreting the data. The surveys do not indicate whether or not breastfeeding is exclusive, as recommended by the CPS/DC/HC. This is due, in part, to a lack of a common, operational definition of breastfeeding. Also, the time periods that information was collected on breastfeeding duration differs between surveys and therefore are not useful to determine the proportion of women who breastfeed for the recommended four months or longer. Data about rates in Alberta are not distinguished in the NPHS or NLSCY reports, rather the Prairie Provinces are placed in one category which limits comparison among each of the western provinces.

In Calgary, breastfeeding data are available for 1997 and 1998 (Silzer, 1999; Silzer, 2000). Data are available for women who breastfeed exclusively and for women who breastfeed with or without supplementation of other milks. Data are collected in the community during routine Public Health Nurse (PHN) visits to mothers during the postpartum period. There are limits to data collection as only women who are contacted by a PHN are included in the data set. Therefore, women in the Calgary Regional Health Authority who do not receive visits, a telephone contact or who do not attend public health clinics are not represented in the sample.

Calgary data compare breastfeeding initiation and duration rates for the general population to initiation and duration rates for a low income population. The low income population consists of participants in the Best Beginning program (BB). Overall, 86% of the BB participants are breastfeeding their infants (with or without supplementation) at one week of age as compared to 90% (Silzer, 2000) of the general population (excluding BB) that receives public health contact. However, despite an initiation rate in Calgary that exceeds the national figures, mothers are discontinuing breastfeeding before four months postpartum. The rate of breastfeeding among the general population (with or without supplementation) at two months declines to 72% and at four months drops to 60%. For BB participants, breastfeeding rates (with or without supplementation) decline more rapidly. The rate of breastfeeding at two months postpartum is reported to be 59% and at four months postpartum is 48% (Silzer, 1999).

In summary, despite the documented benefits of breastfeeding, rates of breastfeeding continue to be less than optimal. Nationally, 73% of women in 1994/1995 reported initiating breastfeeding (Health Canada, 1999). However, 40% who initiate

breastfeeding stop by three months. By six months, only 23-31% of women continue to breastfeed (Health Canada, 1999). This trend of early weaning is also seen in Calgary, and is more pronounced among low income women. These results indicate that although the majority of women in Canada and Calgary initiate breastfeeding, infants are not being breastfed for the recommended period of time.

Determinants Associated with Breastfeeding Duration

Many investigators have studied the factors that are associated with the initiation and duration of breastfeeding. It is useful, for the purpose of this literature review to divide these determinants into demographic, personal and socio-environmental characteristics. Demographic characteristics are maternal age, socioeconomic status, race/ethnicity and marital status. Personal/behavioural characteristics include introduction of infant formula or solid foods, physical discomfort and perceived milk supply while environmental influences include social support networks and types of social support.

Demographic characteristics.

Grossman, Larsen-Alexander, Fitzsimmons, and Cordero (1989) demonstrated a similar trend between low income women and their more affluent counterparts. In a retrospective chart analysis of 2124 women, the low income subjects who were older, better educated, married and demonstrated good health practices were more likely to initiate breastfeeding ($p<0.0001$). Other studies have supported findings that marital status and maternal education are related to breastfeeding (Evers et al., 1998; Grossman, Fitzsimmons, Larsen-Alexander, Sachs, & Harter, 1990; Health Canada, 1999; Serdula, Cairns, Williamson, & Brown, 1991).

The study by Evers et al.(1998), identified factors associated with breastfeeding among low income mothers (n=493) in Ontario. Women with higher education, who were married, who were not experiencing financial stress and who attended prenatal classes were more likely to initiate breastfeeding ($p<0.001$). In addition, women with previous breastfeeding experience or who were breastfed were more likely to breastfeed (Bentley, Caufield, Gross, Bronner, Jensen, Kessler, & Paige, 1999; Humphreys et al., 1998; Perez-Escamilla, Himmelgreen, Segura-Millan, Gonzalez, Ferris, Damio, & Bermudez-Vega, 1998;)

Older and better educated women were more likely to continue breastfeeding (Hill, 1991; Williams & Pan, 1994). Continuation of breastfeeding to three months or beyond was associated with older age, higher education and being a non-smoker ($p<0.01$) (Evers et al., 1998). Being married and having a higher income (Hawkins, Nichols, Tanner, 1987; Health Canada, 1999; Hill, 1991) were also demographic characteristics shown to be associated with a longer duration of breastfeeding among lower income populations.

In a survey of 220 low income women, Grossman, Fitzsimmons, Larsen-Alexander, Sachs, and Harter (1990) identified characteristics associated with the decision to breastfeed and factors associated with the duration of breastfeeding. The decision to breastfeed was significantly associated with older maternal age, being married, higher maternal education, an earlier start to prenatal care, earlier breastfeeding decision, attendance at Lamaze classes and being a non-smoker ($p<0.0001$). A longer duration of breastfeeding was significantly associated with having a vaginal delivery ($p<0.002$).

In another study, smoking was shown to be a predictor of early weaning (Grossman, Larsen-Alexander, Fitzsimmons, & Cordero, 1989). NPHS data corroborated

the findings of Cooper, Murray, and Stein (1993) that women who weaned prematurely indicated that they lived with high chronic stress and had low to very low self-esteem, a low sense of mastery, a recent major life event and high mental health distress.

Personal and behavioural characteristics.

There is a direct relationship between maternal intent to breastfeed and breastfeeding behaviour (Black, Blair, Jones, & DuRant, 1990; Grossman et al.1990). Given the relationship of maternal intention to breastfeed with actual behaviour, it is therefore important to understand how maternal intention is influenced. Bentley et al. (1999) hypothesized that social influence and opinions of individuals within a woman's life are related to infant feeding intention. The authors interviewed 441 African-American, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program participants. Results of the study indicated that a woman's prenatal intention to breastfeed or formula feed was strongly influenced by the attitudes and experiences of friends, relatives, the baby's father and physicians within her social sphere. The most significant influence was the advice to breastfeed provided by the physician as part of prenatal care (Balcazar, Trier, & Cobas, 1995) or provided by the father of the baby (Bentley et al., 1999).

Breastfeeding duration has been shown to be associated with behavioural characteristics of mother and infant. Specifically, duration is associated with the introduction of solid foods, formula and the mother's perceived success of breastfeeding. Hill (1991) found that in addition to perceived success and formula introduction, the frequency of breastfeeding and the time of initiation of breastfeeding accounted for 48% of the variance in the duration of breastfeeding. Hawkins et al., (1987) found that 32% of the

variance in breastfeeding duration was attributed to early introduction of solid foods. This was also supported in the work by Hill (1991), which found that introduction of formula negatively influenced breastfeeding duration and was the best predictor of short duration.

However, supplementation is probably a marker, rather than a cause of breastfeeding difficulty. In a number of studies, perceived inadequate milk supply was the reason most frequently cited for mothers to introduce formula or solid food (Hawkins, Nichols, Tanner, 1987; Hill, 1991). Problems discussed in the literature with regard to the breastfeeding process include fatigue, sore breasts, rejection by the baby and perceived lack of quantity and quality of milk (Grossman, Fitzsimmons, Larsen-Alexander, Sachs & Harter, 1990; Health Canada, 1999; Hill 1991; Kusmurski, 1998). In a number of studies, perceived inadequate milk supply was the reason most frequently cited for mothers to introduce formula or solid food (Hawkins et al., 1987; Hill, 1991). This is a recurring theme among all groups of women (Grossman, Fitzsimmons, Larsen-Alexander, Sachs, & Harter, 1990; Hawkins et al., 1987; Hill, 1991; Maclean, 1990). The term "insufficient milk" may be a proxy for a complex set of interactions (Maclean, 1989) that may not be explained with survey methods.

Environmental Characteristics

Social support.

Breastfeeding is an individual's choice. However, this choice is not made in a vacuum but is directly influenced by economics, culture, hospital policies, available information and social support. Social support has been identified as an important interventing variable that can effect breastfeeding initiation and duration (Baranowski, Bee, Rassin, Richardson, Brown, Guenther, & Nader, 1983; Bentley et al., 1999; Raj & Plichta,

1998). There is little agreement about what type of support or what amount of support best facilitates successful breastfeeding. In this section I will explore the relationship between social support and the initiation and duration of breastfeeding among low income women.

Social support has been defined as "an exchange of resources between at least two individuals perceived by the provider or recipient to be intended to enhance the well-being of the recipient" (Shumaker & Brownell, 1984 in Callaghan & Morrissey, 1993). Cobb (1976) proposed that the function of social support is to give information to an individual that she/he is loved, cared for, esteemed, valued and belongs to a mutually obliging communication network. Social support may be expressed structurally (marital status, size of support network or frequency of social interaction) and/or functionally (offering emotional, instrumental or informational support). It may derive from a variety of sources (spouse, partner, colleague or friend) and its value often lies in the perception of people that it is available, without this actually being the case (Callaghan & Morrissey, 1993, p.203).

Much of the research on social support has been subserved by two major theories (Callaghan & Morrissey, 1993, p.203). The "buffer theory" proposes that social support acts as a buffer to protect people from the stresses in life (Cobb, 1976 in Callaghan & Morrissey, 1993). The "attachment theory" proposes that secure attachments formed in childhood are the basis of an adult's ability to form socially supportive relationships (Bowlby, 1971 in Callaghan & Morrissey, 1993).

The breastfeeding mother's support network - the intention to breastfeed.

"A mother's belief about the advantages and disadvantages of infant feeding methods arise in part from interactions that she may have with various formal and informal social network members" (Raj & Plichta, 1998, p. 42). Sources of support may be from

members of the women's informal social network (such as the infant's father, other family members, friends), or from her formal social network (such as support groups, lactation consultants, physicians, and other medical professionals). These interactions may be either positive or negative toward breastfeeding, and can affect both confidence and persistence in breastfeeding (Black et al., 1990; Grossman et al., 1989; Trado & Hughes, 1996). The particular sources of support for and against breastfeeding may vary according to the women's age, social class and ethnic group (Baranowski et al., 1983).

Among married, Anglo-American women, favourable support for breastfeeding from a male partner was related to a decision by the mother to breastfeed (Baranowski et al.,1983 and Bevan, Mosley, Lobach, and Solimano, 1984) found that. Women who had the father's support for breastfeeding were more likely to breastfeed ($p<.0250$) when compared to mothers who did not know what their partner preferred (Bevan et al., 1984). Among Black American and widowed or divorced mothers, no source of support related to their decision to breastfeed (Baranowski et al, 1983). Among single, Mexican-American mothers, support from the infant's grandmother and mother's best friend were significantly related to their breastfeeding decision (Baranowski et al, 1983). Bryant (1982) found among a low income population in Florida that if the husband did not want his wife to breastfeed or had negative attitudes regarding breastfeeding, she frequently did not initiate breastfeeding. Bryant (1982) also found that health care professionals have less of an influence on a mother's decision to breastfeed than others in their social network such as the male partner, grandmother and friends.

In another study Williams and Pan (1994) looked at breastfeeding initiation influences among American, African American, Asian and Latino women (n=64). The

influence of social support on breastfeeding behaviour was assessed. Breastfeeding initiation rates were highest for Asian women (86%) and lowest for Latino women (46%). All Asian women (n=7) reported receiving encouragement to breastfeed and none of the mothers reported being discouraged by others. African American mothers (n=12) were least likely to be encouraged to breastfeed by someone other than a physician. Forty-two percent of the mothers reported that they neither received active encouragement nor discouragement from any source (Williams & Pan, 1994).

In a study involving Manitoba First Nations women (n=36), Martens (1997) found that women perceived their mother, physician and the community health nurse (CHN) to be most supportive of breastfeeding and most influential in the decision to breastfeed (m = 1.8; Range = -3 'definitely bottle-feed' to + 3 'definitely breastfeed'). Close friends and mothers-in law received mid-range scores of supportiveness (1.2). Women's brothers, people at work/school, women's fathers, sisters and male partners received the lowest supportiveness scores (range 0.1 to 0.6).

Recently, Humphreys et al. (1998) investigated the relationship between social support and the intention to breastfeed among low income pregnant women. Breastfeeding intention was positively correlated with hearing about the benefits of breastfeeding from family members and lactation consultants. No correlation was found between intention to breastfeed and involvement of other health professionals. Results also indicated that social support plays a more important role with a first born than with subsequent pregnancies. The work by Humphreys et al. (1998) shows that women's social support networks are more influential on their infant feeding decisions than the attitudes and beliefs of health professionals. Among women who breastfed previously, breastfeeding experience

predicted intent significantly. Hearing about the benefits of breastfeeding from the father of the infant, family and lay professionals was also positively related to intent to breastfeed.

The breastfeeding mother's support network - duration of breastfeeding

Breastfeeding duration also appears to be directly correlated with a positive support system that includes significant others (Baranowski et al., 1983; Grossman et al., 1989; Hughes, 1984). The commitment to breastfeeding was strongly related to all forms of social support. Through this support, a mother's belief in herself, a belief in her abilities and a feeling of being cared for and esteemed help her to persist in the breastfeeding experience whether or not obstacles are present (Trado & Hughes, 1996, p.38).

Friends have been identified as important sources of support for mothers who breastfeed. In a quantitative study, the influence of friends could have a positive or negative effect on the duration of breastfeeding (Barron, Lane, Hannan, Struempler & Williams, 1988). The sample consisted of 40 low income women who were interviewed. The results indicated that women with friends who breastfed and who had received support from these friends breastfed longer. "On the other hand, women who terminated breastfeeding early, seemed to seek help from friends who were not breastfeeding, perhaps due to a desire for reinforcement of the decision to terminate breastfeeding"(Barron et al., 1988, p.12).

As illustrated by the various studies looking at the influences of support on breastfeeding among low income women; the influence of the social support is complex. For lower income women, the social support network does seem to influence the decision to initiate breastfeeding. It appears that the decision to breastfeed is most influenced by the informal social network such as the infants' fathers, male partners, grandmothers and

friends. In addition, longer breastfeeding duration has been associated with an informal but positive social support system.

Types of social support.

In a study comparing women intending to breastfeed with women intending to bottle feed, Matich and Sims (1992) found that women who intended to breastfeed had greater informational support than those who intended to bottle feed and utilized prenatal care earlier and more often (Grossman et al., 1989). Those intending to breastfeed rated the infants' fathers as providing greater instrumental, emotional and informational support than those intending to bottle feed. Instrumental, emotional and informational support provided to the breastfeeding mothers increased slightly but not significantly between the third trimester of pregnancy and three to four weeks postpartum (Matich & Sims, 1992).

Locklin (1995) described the experiences of 17 educated, low income, culturally diverse women who successfully nursed for three months or longer and who had access to the services of a peer counsellor during their breastfeeding experience. The findings illustrated that low income women recognized their competency in their ability to breastfeed their infant and perceived their endeavour to be successful, only after being validated by others. The women gained confidence through the continued experience of breastfeeding.

Uncertainty about the mother's ability to breastfeed gave way to discovery that she could produce enough milk, that the infant could suckle and that the infant preferred breast milk to other milks. Reinforcement was necessary to validate the mother on her ability to breastfeed. Positive support of any kind was a major theme of this qualitative work and was critical to reinforce the mother (Locklin, 1995). Support provided to the mother was in

the form of informational and emotional support. Lack of support, whether professional, paraprofessional or familial hindered the breastfeeding process. According to the participants, the longer peer counsellors served in a supplemental support role, the more maternal confidence increased and the longer mothers breastfed.

Buckner and Matsubana (1993) investigated the support network utilization by breastfeeding mothers. One of the instruments used in the study was developed to measure perceived emotional, instrumental and informational support in breastfeeding mothers (Hughes, 1984). Subjects came from all socioeconomic groups. Participants obtained a total network mean score of 34 (Range 0 to 203, 0= 'no social network' 203= 'high degree of social network'). The score represented an average total network of three support persons consulted for information, reassurance and problem solving during lactation. Lactation consultants and nurses provided prenatal information, assistance with the first feeding, answered questions, explained principles of supply/demand and helped participants with breast care at home. Professionals provided most of the informational and some instrumental support. Mothers who breastfed at two weeks postpartum reported larger scores for breastfeeding support (148) than did non-breastfeeding mothers (85) ($p<.05$) (Buckner et al., 1993). The authors of this study concluded that effective support utilization appears to contribute to successful breastfeeding.

Trado and Hughes (1996) used a phenomenological study design to describe the phenomenon of breastfeeding among low income women enrolled in a WIC program. In this study, the main goal was to ascertain the participants' lived experiences with breastfeeding and to synthesize and interpret the data to assist with breastfeeding promotion and education. Eleven mothers, from two counties in a southeastern state, who had

breastfed in the past year were asked to participate. All participants were asked to describe their experience with breastfeeding.

"The focal meaning of support as related to breastfeeding emerged during data analysis from the participant's lived experience"(Trado & Hughes, 1996, p.35). The concept of support was found to be integrally related to both the decision to breastfeed and the duration of breastfeeding. Support was categorized into major themes of informational support, emotional support and instrumental support.

Family, friends and/or health professionals provided informational support or knowledge sharing behaviours and actions. This included information about physical factors, health status and/or cost related to breastfeeding. Most mothers reported having some initial physical problems with breastfeeding. "The physical problems and informational support seemed to be correlated with the mother's perception of the severity of the problem"(Trado & Hughes, 1996, p.36).

Emotional support was important to the breastfeeding experience (Trado & Hughes, 1996). Emotional support was expressed in the form of caring, trust and love. The spouse, a significant other and/or other family members provided emotional support. Emotional support influenced the initial decision to breastfeed and the duration of breastfeeding in this sample of breastfeeding women. Maternal confidence was enhanced when emotional support was provided by someone who was perceived as knowledgeable (Trado & Hughes, 1996).

Instrumental support was task-orientated behaviour that occurred primarily at the beginning of the breastfeeding experience. A behaviour, such as meal preparation, was considered instrumental support. Instrumental support was associated with breastfeeding

duration (Trado & Hughes, 1996, p. 38). Both professional and significant others were important instrumental support providers.

The type of support that a mother receives can impact her decision to breastfeed and the length of time that she continues to breastfeed. Spouses, male partners and family members such as grandmothers are important sources of informational and emotional support for low income women. Health professionals are important sources of informational and instrumental support for the continuation of breastfeeding.

Summary

In summary, knowledge of the demographic factors that are associated with breastfeeding is useful to distinguish between women who may or may not breastfeed. Further research is clearly necessary to understand the socio-environmental influences, personal characteristics and behavioural factors that influence low income women's experience with breastfeeding. It is important to explore the complex meaning of events that are subsumed under the categories of "insufficient milk" and to identify experiences that help or hinder breastfeeding. Enhanced understanding of social support is also an important component of understanding the breastfeeding experience.

Chapter Three

Processes of Inquiry

Research Approach

Boyd (1993) suggests qualitative research provides a holistic approach to questions and a recognition that human realities are complex. Further, Boyd (1993) states the qualitative paradigm focuses on human experiences. Corresponding research strategies, such as phenomenology, emphasize the context of human behaviour, often being conducted in places where people normally spend their time. Typically, there is high involvement on the part of the researcher through participant observation or one or more unstructured interviews. Data produced are descriptive in nature; a "story" of how people live through or with their situations. Accordingly, in order to focus on low income women and breastfeeding, qualitative research methods are appropriate to uncover the complexities and realities of the breastfeeding experience.

Phenomenology

Phenomenolgy is an appropriate research methodology when seeking to understand, making sense of and eliciting the meaning of a phenomenon. For that reason, phenomenology is the research method I have chosen to understand womens' lived experience of breastfeeding. "Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences"(van Manen, 1997 ,p.9). The method emphasizes the understanding of the point of view of the person being studied. The aim is to obtain rich and detailed description of participants own concerns, opinions and actions in their own words, rather than eliciting bits of behavioural responses to pre-categorized

stimuli. One is more interested in how matters appear to the participant than in how to fit answers into prefigured categories.

Ray (1987) summarized the main characteristics of the phenomenological method as a) focusing on the nature of the lived experience, b) elucidating one's (researcher) presuppositions about a phenomenon, c) conducting intense dialogues with people about the meaning of an experience, d) developing themes from recorded dialogues, and e) reflecting deeply on the meaning of the whole experience.

Philosophical /Theoretical Premises

It is important to note that not all phenomenologists approach phenomenology the same way. Some make a very clear distinction between description and interpretation. Phenomenologists who take a descriptive stance assume that it is possible to view a phenomena objectively. Husserl is noted as being one of the first phenomenologists to take this stance (Koch, 1995). He believed that through phenomenology, he could know more about something "out there". He believed that there could be a subject-object split and that it was possible for the researcher to distance himself/herself from what was being observed.

This notion of the subject-object split is a point of contention within the phenomenological paradigm. Other phenomenologists such as Heidegger do not believe that suspension of beliefs, assumptions and biases is possible (Koch, 1995); nor is viewing the world objectively. As a result, the researcher cannot observe and describe a phenomenon without some interpretation of meaning happening during the process. Heidegger's philosophy is not concerned with the maintenance of objectivity, in fact, background practices and the natural standpoint of the researcher are integral and therefore inseparable elements of "being" and cannot and should not be bracketed (Walsh, 1996).

With this perspective, the researcher is less concerned with describing the experience than with uncovering meanings about what it is to "be". Van Manen believes in blending both description and interpretations for a deeper meaning. He states, "the meaning of lived experience is usually hidden or veiled" (van Manen, 1997, p. 27) thus interpretation is needed to uncover them.

I believe that it is next to impossible to completely "bracket" preconceived notions because of the intimate relationship that we have with the world. For this research project, I have chosen a philosophical stance proposed by Max van Manen (1997) and Polio, Henley and Thompson (1997) in which "bracketing" is better described as a way of "seeing". The aim of "bracketing" is to make explicit researcher assumptions toward the research topic at hand. This as a way for the researcher and the audience to better understand the assumptions that are brought to the research process. Rather than suspending worldly knowledge, the interpreter applies a worldview so that a phenomenological understanding may emerge (Polio, Henley, & Thompson, 1997). To begin to identify presuppositions it is important for the investigator to consider his or her reasons for conducting research on the topic and document them (Polio, Henley, Thomspson, 1997). I have acknowledged my interest and motives for research in Chapter one. The intention was not to become objective, only to have myself become more attuned to my presuppositions about the nature and meaning of the breastfeeding phenomena and thereby sensitize myself to any potential expectations I may impose on the participants either during the interview or in its subsequent interpretation.

Connecting

Women who were past participants in the Best Beginning (BB) program were the subjects in this study. The BB program is a voluntary Calgary Regional Health Authority (CRHA) prenatal program. It is for women who are economically disadvantaged and for adolescent females who are experiencing difficult life circumstances. This setting was selected as it offers a large sample of pregnant women who live on a low income; as low income is a criterion for enrollment in the BB program. The income scale used to determine low income eligibility is the same scale used by the City of Calgary Family and Social Services and is based on household income versus household size. The program goal is to help women make healthy choices during their pregnancy and in the early postnatal period. Women in the program are encouraged to breastfeed. However women in the program demonstrate breastfeeding duration rates that are suboptimal and lower than the higher income populations in Calgary as discussed in chapter two.

Ethical integrity.

This study received ethical approval from the University of Alberta Health Ethics Research Board and the University of Calgary Conjoint Health Research Ethics Board. Potential participants were asked of their interest in participating in the study by the BB staff or by the principal investigator. The BB staff and/or the principal investigator reviewed the letter of invitation with the potential participants. The letter of invitation (see Appendix A) contained information about the intent of the research and what participation would entail. Participants who expressed an interest to the BB staff were asked if their name could be given to the principal investigator and told that the principal investigator would contact them.

The principal investigator contacted the potential participants by telephone. An explanation of the study was provided to the potential participants. Interviews were scheduled with participants who agreed to participate in the study.

The principal investigator obtained informed consent. At the beginning of each interview, an explanation of the study was given and potential participants were provided with an information sheet/consent form to review (see Appendix B for an example of the consent form). The participants were asked to review the consent form and informed consent was obtained after the participants had an opportunity to ask questions about the research study. The participants were informed that they were not required to participate in the study and that they could stop the interview at any time or refuse to answer any questions. Participants were advised that participation in the study had no bearing on the care they received from the Calgary Regional Health Authority.

The tapes of the recorded interviews were kept in a locked file cabinet at the home of the principal investigator and all identifying information was removed from the tapes during the transcription process. All transcripts were given a code identifier and the informed consent forms were stored separately from the data. Once the research report is finalized, the transcripts and informed consent forms will be stored in a secure area at the University of Alberta for at least five years.

Description of sample.

A purposeful sample of past BB participants was selected to yield a variety of life contexts of low income women. This type of sampling is called phenomenal variation sampling (Sandelowski, 1995). Women who were currently breastfeeding or had breastfed or at least one week were asked to participate. Women who had breastfed for one week or

less were not included in the sample because it was thought that these women did not breastfeed long enough to provide a description of the breastfeeding experience.

The purpose was to seek out informants who had divergent experiences with breastfeeding so that a comprehensive description could be obtained. Breastfeeding duration varied among the participants. Life context such as the presence of older children in the home, the presence or absence of a live-in or live-out partner and age of the mother was considered when recruiting women to participate.

Subject selection was based on the following criteria: a) able to speak English and able to communicate their thoughts and feelings; b) living on a low income; c) 18 years of age or older; d) no previous breastfeeding experience; e) were breastfeeding or had breastfed for longer than one week duration; f) participants had a singleton birth with no major health complications related to birth or with the infant; g) infants were born full term, and weighed 2500 grams or greater at birth.

The principal investigator conducted all interviews. Participants participated in one or two tape-recorded, open-ended interactive interviews. Interviews were scheduled for a time and in a location that was convenient for the participant. All but one interview took place in participants' homes. The other interview took place in a community health center office. This location was more convenient for mothers because they did not have to arrange transportation and/or childcare. Interviews were conducted at one month postpartum or more. Waiting for one month or more postpartum was thought to be necessary to ensure that breastfeeding was well established. In the case of participants who attempted breastfeeding but subsequently terminated breastfeeding, waiting one month

postpartum before interviewing gave participants the opportunity to become somewhat settled into their new maternal routine.

A total of nine women took part in the unstructured conversational interviews. Only one individual who originally consented declined participation when she was contacted to arrange an interview time. She stated she had changed her mind about participating. Sandelowski (1995) suggests that six informants are adequate to obtain comprehensive descriptions about the experience of breastfeeding. However additional informants were added to achieve a variety of breastfeeding experiences and life contexts. The purposeful sampling was terminated after nine participants as the investigator was satisfied that no new themes emerged from the interview data and "saturation" was achieved (Glaser & Strauss, 1967).

Participants provided demographic information including age, school level completed, relationship status, income level, number of people living in household and number and age of children in household (see Appendix C). Demographic information was collected to aid with purposeful sampling of a diverse sample. The information was used to describe the sample and is summarized in the last part of this chapter and in Figure 3.

Generating Text

Interviews are placed in a position of central importance when adopting the phenomenological perspective and are not a mere adjunct to other methods; they are considered a main means of access to the respondent's life world (Hagen, 1986, p. 338). The unstructured interview was used in this research study because the researcher did not want to narrow the scope of the interview by preparing questions based on previous research or knowledge (Morse & Field, 1995). The richer data that one can obtain from

interviewing a person, as opposed to their filling in a questionnaire, is thought to be necessary where one wants to explore the participant's point of view (Hagen, 1986). The intent was to invite women to tell their own stories and for the participants to decide what was important to tell the researcher about their breastfeeding experience.

Participants were asked to share the lived experience of the phenomena of breastfeeding. At the beginning of the interview, the participants were asked an open-ended question on the topic and were encouraged to respond in a narrative form. For example, the opening question most frequently used was, "Tell me about what breastfeeding has been like for you?" Often the participants asked, "Where should I start?" The answer provided was that they should start wherever they wished to start. Subsequent questions were not specified in advance but evolved from the context of the interview and were meant to clarify, validate or summarize the information provided. This approach assured that the content and the participant rather than the interviewer determined direction of the interview. Morse & Field (1995) state, "the participants often know better than the researcher exactly what is and what is not relevant to the topic" (Morse & Field, 1995, p. 91).

Such a strategy of encouraging in-depth descriptions of the experience of breastfeeding also prevented the researcher from prematurely narrowing the informant's description of breastfeeding. Gentle probes were used to enrich the description of the experience and to focus the interview. An interview guide is included (see Appendix D) which was used to demonstrate topics that might be explored during the interview (Rubin & Rubin, 1995).

The initial description of the breastfeeding experience took between one or one and one half hours. After the first interview, the tapes were listened to and notes made about

the interview. Transcription was then carried out. Each interview was completely transcribed and initial analysis started before a subsequent interview was carried out. The principal investigator transcribed all nine initial interviews.

Five of the study participants agreed to take part in a second interview, which lasted about 45 minutes. The researcher attempted to contact all study participants for second interviews but was unable to contact half of the participants because they had moved, were working during the day or failed to return telephone calls. The purpose of the second interview was to confirm individual stories with participants, confirm breastfeeding themes as they emerged from the data and gather additional participant feedback about how themes related to one another. This is described by Miles and Huberman (1994) as "member checking". Member checking serves to verify researcher interpretations of participant responses (Rubin & Rubin, 1995) and as a means of validating phenomenological research (Polio, Henley, & Thompson, 1997).

Researcher as an interview instrument.

In anticipating the interviews with women, I was aware of the contrast between their social position and my different position as a white, middle class professional women with economic and social resources, opportunities and perhaps different values about breastfeeding. I wondered whether the women would think of me as an outsider who might have difficulty understanding their situations and experiences and whether they would perceive what I was trying to achieve as worthwhile. I felt a little twinge of apprehension when I reviewed the informed consent form with the participants and on the form it was clear that they were asked to participate not only because they had experience with breastfeeding, but also because they were living on a low income. My anxieties were

reduced when I considered that the women had been informed of the purpose of the study and had verbally consented to take part. Perhaps for them living on a low income was not the imputative label that I thought it to be. Still, when meeting the women for the first time, I felt nervous about their response to me and about their cooperation in the research process.

I know of the importance of engaging participants from the beginning and developing rapport in the context of neutrality (Morse & Field, 1995; Rubin & Rubin, 1995). This concept was not new to me as I have been working with women who live on a low income for the past four years but somehow it seemed more crucial in this situation. I consciously used a number of strategies to promote the women's acceptance of my efforts. I dressed casually yet neatly for the interview and made sure to wear my plain wedding band rather than my diamond wedding set. I wore minimal cosmetics and perfume. I did this so that I would not make the participants feel inadequate because they didn't have the time to fix themselves up, or perhaps change out of their nightgown due to the demands of being a new mother. I also positioned myself as a learner rather than a health professional. I spoke about being a graduate student and talked about the value of the participant's expert knowledge about breastfeeding. I also stressed that there were no right or wrong answer to the questions discussed; rather what was most meaningful was the conversation about their breastfeeding experience.

I initiated casual conversation with each participant, feeling that I needed to help them relax in this foreign situation; although most were in their own homes. During the interviews, I tried to use language that the participants would understand and relate to and tried not to distance myself from them by using inappropriate words or phrases. I

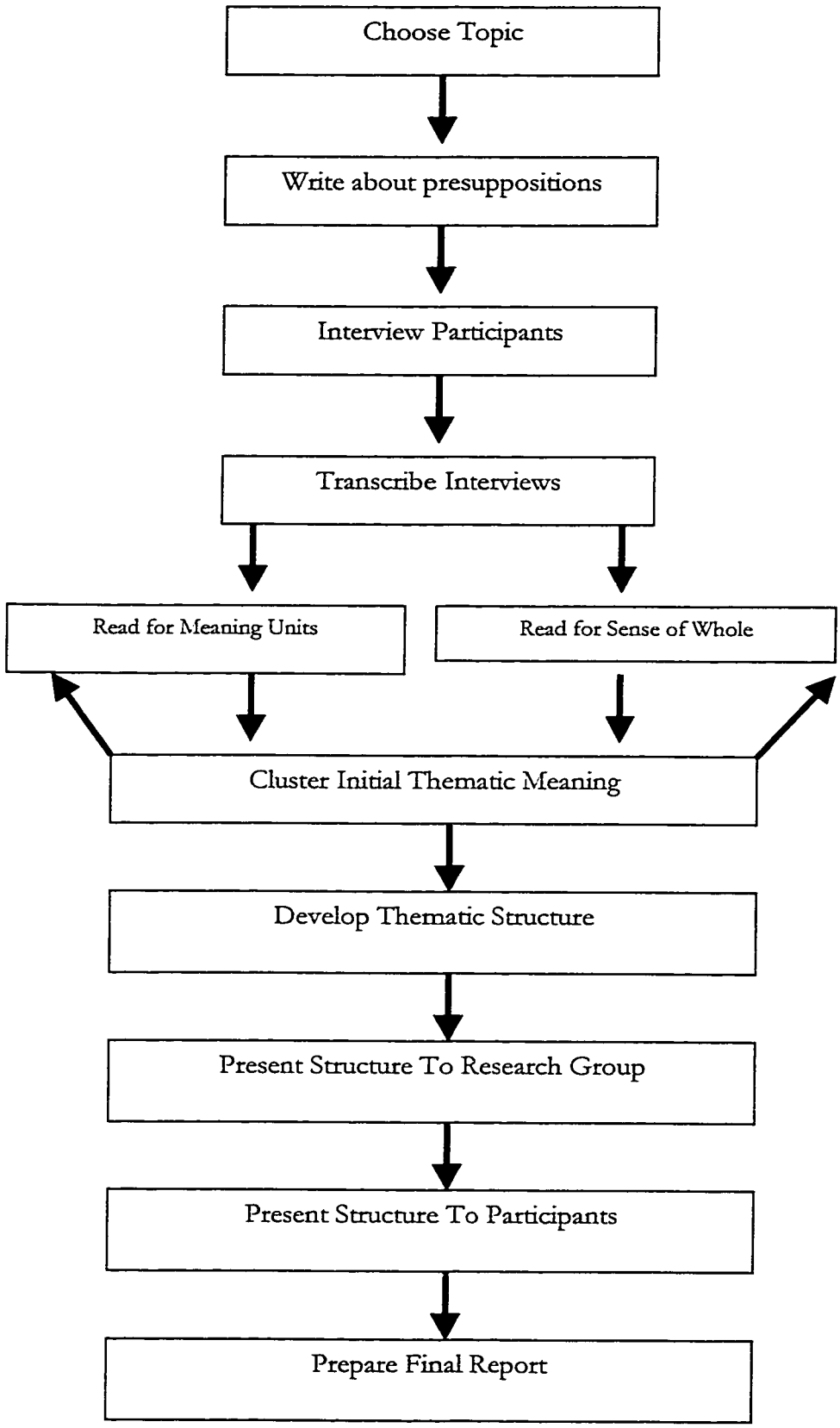
purposefully began each interview by asking about their breastfeeding experience. For the most part, participants readily entered into dialogue with me. Sometimes at the beginning participants needed reassurance and guidance to start the conversational interview. I assured them that there was no right place to start and to begin wherever they thought was most appropriate.

Participants soon demonstrated relaxed postures, and shared personal information about their breastfeeding experience, suggesting that they felt quite comfortable with me. I, too, felt at ease and became fascinated with the women's experiences of breastfeeding, thereby enhancing the quality of the data collected (Patton, 1990). As I sat listening to the women tell their stories I remember feeling overwhelmed by the challenges that these women faced and impressed with the resilience they displayed toward the demands of motherhood. I appreciated their candor and willingness to tell their stories. At times I questioned my own ability to "do justice" with the rich, descriptive stories that they provided for me. However, upon reflection I think their contributions have made me more determined than ever to make this qualitative work informative, meaningful and a basis for action in the area of breastfeeding promotion.

Interpreting Text – The Hermeneutic Circle

The goal of phenomenological data analysis is to interpret the data while remaining faithful to the phenomenon (Colaizzi, 1978). The hermeneutic circle refers to an interpretive procedure in which there is a continuous process of relating a part of the text to the whole of the text (Bleicher, 1980 in Polio, Henley, & Thompson, 1997). Data analysis followed the approach specified by Pollio, Henley and Thompson (1997), depicted in Figure 1, which consisted of a) reading the text of the transcript for meaning units, i.e.,

Figure 1 Schematic Diagram of Interview and Research Process (Adapted from Polio, Henley & Thompson, 1997)



words or phases that seemed to have significance to the interviewee, b) analyzing the text for a sense of the whole, c) aggregating meaning units into themes, d) developing a thematic structure to show the relationships among themes, and e) sharing the derived thematic structure with the research group and some of the participants for validation.

In phenomenology, the first step in data analysis is immersion in the data as a whole (**intraparticipant analysis**) (Morse & Field, 1995). The experience of a particular breastfeeding difficulty or a pleasant breastfeeding experience was not separated but rather kept in context and each interview was summarized in the researcher's journal immediately after completion of the interview and the tape was heard to capture information about the context of the interview and record interview details. In addition, after transcription was complete, the tapes were listened to and extensive reading and rereading of each transcript occurred. The researcher then reflected on each interview in its'entirety and wrote about them. It was important to represent idiographic interpretation of each women's stories and verification of each summary occurred during the second interview with participants.

Then the meaning of the data was considered in light of the complete transcript and statements that appeared particularly revealing were highlighted (van Manen, 1997). Notes were made about each significant statement and recorded in the researcher's journal. A disciplined and systematic search was performed for descriptive expressions that were identified as "at the center" of the experience (Tesch, 1987) and where possible were rendered in terms used by participants. This was completed in an effort to avoid imposing personal researcher meaning onto the interpretation of research dialogue (Polio, Henley, & Thompson, 1997). Initial analysis of the interviews provided direction for additional data

collection. Beginning with the first interview, key phrases were identified, allowing for enhanced exploration of key concepts with subsequent participants.

Interparticipant analysis: In the next stage of analysis, the researcher sought to identify commonalties between participants, gathering statements that were conceptually similar. These interparticipant themes constituted the "essence" of the phenomena and were recorded in the researcher's journal. Some themes were common to all participants while some themes were not. These unique themes provided variation and enriched the data with the range of experiences that are manifest in the phenomena of breastfeeding among different women.

Interrelationships between themes: The third phase of data analysis was to seek interrelationships between the meta-themes and descriptions, using quotes from the interviews as concrete illustrations to provide a realistic and accurate portrayal of the phenomena for the reader. The process of writing and rewriting increased the insights and reflections of the researcher and facilitated interpretation. A visual interpretation or synthesis of the resultant five themes were taken back to the participants for verification and to obtain additional insight about the relationship between each theme. Omissions or any areas of disagreement or inadequate description were further interpreted and revised from participant feedback. The research group (thesis supervisor and thesis committee member) also provided feedback about the themes. In addition, to ensure dependability and confirmability, a journal was kept to record researcher thoughts about interviews, about the raw data and about insights formulated during the transcription and analysis process (Struebert & Carpenter, 1999, p.33).

Full circle.

When I began this research and throughout the "doing" of it, people would sometimes ask me what my topic was. "What are you doing your research on?", they would ask. And I would answer, in the shorthand way I adopted, that this research was about breastfeeding and women living on a low income. Mostly, they would then just nod knowingly, no further explanation required or desired and I was left with the sense that these people somehow felt they already knew, from my brief response, what it was this research was about. That is was easy for them to understand that it was obvious because everyone already "knows" that these women are a problem or have a problem. I don't recall ever being asked about the ways in which these women were the topic of research, or what it was about breastfeeding and women living on a low income I wanted to know more about. It's also true that I didn't often offer this information, neither trusting myself to clearly articulate my grounding nor trusting others to understand. I would say that though I began this research with an intuitive sense that it might be important, I also began with a fear that not only might this work be seen as not worth doing, but that there might not be anything new to say; that what there was to say, everybody already knows.

So I began the listening, the reading, the re-reading and the writing. The more I read and wrote, the more the data began to show me patterns and linkages that helped to uncover insights about the realities of breastfeeding for women living on a low income. I felt surprised by some phrases and stories that leapt out at me and nodded knowingly at others. What emerged were unique stories about the diversity of the breastfeeding experience. These stories complimented the more general tone of the themes that emerged from the stories.

I am now sure that there has been something new to say. Illumination has occurred for me and I hope for others who read this work. Illumination has the dictionary meaning of "to clarify by shedding light upon". This definition fits well when used in the context of phenomenological work. Polio, Henley and Thompson (1997) maintain that any interpretation should allow the reader to see the phenomena in a different light, to allow for a new understanding and I believe that this work has resulted in a new understanding of breastfeeding among women with low incomes.

Limitations of the Study

Limitations of the study related to a) age requirements of the participants; b) the nature of the subject being investigated; and c) methodological considerations in using the researcher as an instrument for interviewing. First, the investigators decided to exclude participants who were less than 18 years of age. This decision was made because it is recognized that adolescence adds a multitude of emotional, behavioural and developmental factors that can impact the experience of breastfeeding. While, it is acknowledged that this sample of mothers would be an important and interesting area of study, they were not included in the sample for this research study for that reason.

Second, the sensitive nature of the breastfeeding may have presented problems if participants felt guilty that they had not breastfed for the length of time that they believed thought was most socially acceptable. These factors may have affected the quality of the responses provided by the participants. However, the researcher is reasonably confident that the methods used to seek informed consent, to establish rapport and to position the participant as the "expert" in the area of breastfeeding and position the researcher as the "student" assisted in minimizing these problems.

The information from an interview depends on the ability of the interviewer to establish rapport and gain the participants' trust. If there is not trust, the setting may change when the researcher is present and participants may decide to withhold information about the topic of interest. In this research study, the researcher was realistic in recognizing that the interview is an interpersonal encounter but efforts were taken to establish trust and rapport with participants as outlined in the 'researcher as an interview instrument' section of this chapter. It is important to realize that all interviews will result in getting 'edited highlights' from respondents. The participants will display what they want to display. This is normal and typical of any interpersonal encounter. What is of central concern is that the descriptions reflect the perceptions of each participant.

The Women

My intent here is to briefly introduce the women who participated in this research. The kind of information offered here is similar to all that we, as health professionals, often know about those for whom we care or counsel. As well as being a kind of "factual" information, representing one way that we can know someone, it can also serve as a point of comparison for stories that follow.

Mary

Mary lives with her husband of one year and her four-month-old daughter. Mary is 28 years old and she has completed grade twelve. She was employed as a courier before giving birth to her daughter. She plans to return to work when her daughter is six months old, as her employment insurance benefits will be finished. Mary and her family live on $1300 - $1600 per month and also pay child support payments for her husband's children from a previous relationship. Mary has been breastfeeding for four months.

Tina

Tina is a full time student enrolled in her second year of a two-year post-secondary program. Her source of income is a student loan and income that her male partner earns working. Together, with their daughter, they rent the main floor of a house close to her school. Tina is 27 years of age and has Type 1 diabetes. She has been breastfeeding for one month.

Sara

Sara is 36, and a first time mother. She lives with her husband in a two-bedroom apartment. Sara and her family live on $600– $1000 per month. Sara completed one year of post-secondary education. She has been breastfeeding her son for seven weeks.

Tracy

Tracy has been breastfeeding for five weeks. Her infant son is her first child. Tracy lives with the father of her baby in a two-bedroom apartment. Their income is about $1600 - $1900 per month. Tracy is 20 years of age and has completed grade ten.

Christine

Christine is 19 years of age and lives with her new husband and their one-month-old daughter. They rent a room from a single mother with one child. Their monthly income is approximately $1300 – $1600 per month. Christine is new to Canada. She moved from the United States less than one year ago to get married. Christine has few friends in Calgary however she is close to her mother and twin sister who still reside in California. Christine's husband is from Calgary. She breastfed for three weeks.

Dawn

Dawn and her partner live together with their four month old son and a roommate in a three-bedroom apartment. She worked before the birth of their son and plans to return to work within the next few months. Her partner is the sole income earner and their monthly income is approximately $600 - $1000. Dawn is 21 years of age and breastfed for 11 days.

Maria

Maria is a young woman; eighteen years old who recently graduated from high school. She is of Spanish descent and lives with her mother, father and two siblings. Maria and the father of her three-month old son continue their relationship, although, they do not live together. Maria plans to return to school or work but is unsure of when she will do that. Maria has been breastfeeding her son for three months.

Jane

Jane is a 24-year-old single mother of two daughters. She rents a room from a family. Her income is between $600 and $1000 per month. Jane does not have custody of her oldest daughter and her youngest daughter is four months old. She did not breastfeed her oldest daughter but did breastfeed her youngest daughter for 12 days. Jane completed grade ten and has been out of school for a number of years. She has plans to begin upgrading her education in February 2001.

Lori

Lori is 23, mother of one daughter aged seven months. She is single; the father of her daughter is not involved with parenting her child. She lives at home with her parents and her younger sister. She works part-time, mostly in the evenings so that her family can

care for her daughter when she is away. Her income varies between $600 and $1000 every month. She pays for clothes, formula, diapers and provisions for herself and her daughter while her parents help with food and housing expenses. Lori completed high school and one university course prior to having her daughter. She breastfed for 1 month.

Chapter Four

Women's Stories of Breastfeeding

This study is about describing the experience of breastfeeding for women living on a low income. A goal of this work is to present themes that describe breastfeeding for the group of women involved in this study. However, when one presents themes some of the individual spirit and uniqueness of each woman's story may be lost. In order to preserve the individuality of each participant and acknowledge the contribution that each woman made to this research, I wanted to present each story in a shortened narrative form. These are the stories of all nine of the women who participated in the study. Five women have read what I have written and confirmed that the stories represent their experience of breastfeeding. Four women did not respond to the researcher's attempts to schedule a second interview and could not confirm or disconfirm the narratives.

Mary

Pain and pure enjoyment is how Mary characterized the first four-months of breastfeeding. Mary commented that the first two to three weeks of breastfeeding were difficult, she said: "when you first start breastfeeding it's extremely painful and it stays painful for about two to three weeks, so if you can get over that then you're okay" (Mary: Transcript 1). Mary elaborated about the feelings she had in the first weeks of breastfeeding and what she did to reduce the pain:

> What I did was that I just paid more attention to her latch and when I knew she was latched properly I just bit my teeth, grinned and beared it, so to speak, and then eventually the pain went away. There were times when I felt like giving up because

it was just too much but I knew it was the best thing for her so I didn't want to give it up. I just grinned and beared it (Mary: Transcript 1).

Mary also described using lanolin cream to help her nipples heal . She mentioned more than once how it was important to take care with latching her daughter on to the breast. She also asked the public health nurse to visit and confirm that she was correctly latching her baby.

Mary experienced doubt about whether breastfeeding was going well. She described doubt in this way:

> As a new mother and for the first time breastfeeding, you 'll always have the question and sometimes I still ask myself, "Is she getting enough, is she getting her proper nutrients and vitamins and it's just one thing that you never know because you don't see how much they're eating, you don't know how much their eating, umm, but often that is a big question (Mary, Transcript 1,).

The pain and the doubt she experienced led Mary to try feeding her daughter formula. However, Mary's daughter did not like the formula. Another important aspect of the early breastfeeding period was the surprise Mary felt when she experienced pain. She described her expectation of breastfeeding in this way:

> I kind of went into it blind. I didn't think it was--going be as much of a big deal as it is. Like I figured it was something that was totally natural, that was just going to come naturally and it would be natural. I didn't realize that there was going to be the pain involved that there was (Mary: Transcript 1,).

As Mary talked about the difficult times and the surprise she encountered while breastfeeding she described her resolve to continue breastfeeding in this way:

> Because I wanted to, umm, I guess I was headstrong going in to it; knowing that I was going to breastfeed my child and I was going to breastfeed for as long as I can. I only have six months off so I want to be able to breastfeed all those six months to make sure that she is a healthier baby for it. I tried to give her supplements. She didn't like the bottle. She didn't like the formula; she would get sick after I fed it to her. That made me want to keep with breastfeeding even more. I just want to do it for her. I hear that breastfed babies are much healthier babies (Mary, Transcript 1).

Mary explained how she began to enjoy breastfeeding after the first two weeks. She stated that it started to get easier, it started to get less painful and that's when she started to feel the closeness between herself and her daughter. She said: "...because your not " Hurry up and eat", you know, gritting your teeth. And you feel a lot closer, she's more at ease, you're more at ease, it's all just totally relaxed and then it's a beautiful feeling that you get between us" (Mary: Transcript 1). Mary described experiencing less doubt about whether her daughter was getting the right amount of milk to satisfy her needs. She stated she learned to "worry less because she grew to know her daughter's cries and cues that would let her know when she needed milk" (Mary: Transcript 1).

From Mary's perspective, the benefits of breastfeeding were numerous. Mary detailed her reasons for continuing to breastfeed:

> Because its so much healthier for the baby. I started to breastfeed because its also an antibiotic and it will help the baby so the baby won't get sick and its easier than mixing formula and buying formula, making the baby scream longer because you got to go and get it ready and warm up the bottle and mix it. I like it for its convenience. You're out somewhere and you can, you know, just duck into a room

and go feed your baby. So I like it for the convenience, I like it for everything else and I like to know that it's actually the healthier choice for her. That's what I like most about it (Mary: Transcript 1).

Mary also talked about her comfort with feeding her baby wherever and whenever her baby needed to eat. Breastfeeding in a public place was not worrisome for her.

For Mary there was one negative aspect of breastfeeding. She stated she wished that she could diet. She wanted to lose some of the weight she had gained during pregnancy by eating less food. However she didn't do this because she would remind herself: "oh yeah, I have to eat this much because the baby needs it"(Mary: Transcript 1).

During our conversation I asked Mary to think about what would help enhance her experience of breastfeeding. She didn't hesitate to say that she wished she had more information about breastfeeding before she began. She admitted that she didn't have much information beforehand because she did not seek it out. She had expected to learn more in prenatal classes. In retrospect, Mary believed that more information about breastfeeding would have helped her to worry less those early days. However, neither the negative aspects of breastfeeding nor the surprises that breastfeeding presented detracted from Mary's feelings about breastfeeding. She declared: "..if I had to sum that up, I guess I would say the closeness, I love how close we are, how precious it is. It's just the most beautiful thing in the world. You know what I mean" (Mary: Transcript 1).

Tina

Tina was unable to breastfeed her son until he was four days old. She began pumping in the hospital immediately after he was born but was not encouraged to put him to the breast until the fourth day. This, she explained, was because her son was in a special

care nursery for ten days after delivery due to complications related to unstable blood sugars due to her Type 1 diabetes. She began pumping her breasts with the assistance of the nurses in the hospital.

"And talk about frustration", said Tina, about pumping her breasts during the first 3 days after delivery (Transcript L). She was able to pump only one milliliter the first day and she called it "liquid gold" (Tina, Transcript 1). The milk she pumped gradually increased to 25 millilitres by the third day. Pumping got easier with practice and by having a picture of her son in front of her. She saw that her milk production increased over the days she was in hospital. By the fourth day, Tina was told that she could put her son to her breast. It was worrisome at first because: "he was latching on and off but still crying a lot and I don't know what was wrong" (Tina: Transcript1). Her son didn't get a lot of milk that first time and he didn't get full. Tina had to supplement with pumped breast milk after breastfeeding.

A turning point came for Tina when she received assistance from a particular nurse in the hospital. She described how the nurse showed her how to position her son "nose to nipple and tummy to tummy with his bottom lip down" (Tina: Transcript 1). She described the difference this made as soon as she latched him on because he took "long draws" (Tina: Transcript 1). Tina expressed gratitude for being shown a way of breastfeeding that worked for her and her son. Her only regret is that she wasn't shown sooner. About this she said: "like I say I had probably done 10 or 12 feeds before anybody actually told me, 'this is the way you are supposed to hold the baby'. If somebody had offered that as soon as I said, 'I want to breastfeed. Can I breastfeed?' That's when it should have been" (Tina: Transcript 1).

Tina left the hospital after five days but returned daily to feed her son. She continued to pump after every feed so that her son could be fed breast milk during the night. She felt "really good" (Tina: Transcript 1,) about the progress they had made and she noticed that her son preferred breast milk to the formula he had received in the first few days of birth. She said: "I saw him eating the formula for so long and forcing it down and then as soon as he got the breast he loved it and he would fight off the formula when we had to give it to him. That made me feel great! Knowing that he'd rather have breast milk"(Tina: Transcript 1).

Finally at home, her ten-day old son was breastfeeding well every three hours. The nighttime feedings were tiring, she said: "I was exhausted" (Tina: Transcript 1). Tina had her sister, niece, nephew and significant other at home with her during this time. It was hectic. She was torn between resting between feedings and completing the projects that her sister wanted her to do. Tina identified her sister as a source of support but also recognized that having too many people around can be overwhelming and may hinder getting the rest that is important for breastfeeding mothers. About this she says:

> It's very important, when the baby is sleeping, you sleep. Well I couldn't cause I got two kids running around the house and it was a lot worse than it could have been. Very, very hectic, which I don't think helped. But I'm just too ... I didn't want to hurt my sister's feelings so I didn't say anything until you finally just snap. I can't handle it anymore! (Tina: Transcript 1).

Returning to school at one month postpartum presented a new challenge for Tina. She started pumping again to have breast milk to feed her son while she was away. She intended to pump every three hours while she was at school. This meant pumping about

midway through the day. One instructor was not supportive of Tina taking an extended break to pump her breasts. Tina was distraught about this; she described her feelings in this way:

> I was stressed, I could not believe it. Cause she is the coordinator of the program. I thought, if I can't make her understand, what am I going to do? So I went down to pump that afternoon and I didn't get one ounce off both breasts together. That's when I realized, 'holy cow, does stress ever make a difference on your production! (Tina: Transcript 1).

Tina later resolved the issue with her instructor and continued to pump milk midday but she stated that if she hadn't been able to pump milk at school, she was prepared to quit school to continue breastfeeding.

Tina talked about support as being critical to her success with breastfeeding. She commented on what had helped her breastfeed for as long as she had:

> The support from my girlfriend and my sister. Definitely. Cause they both have (breastfed). My girlfriend is still breastfeeding right now cause her baby is only three months old and I'm lucky that she had her baby first cause then I can hear everything that I can expect just before it happens and being told by her, 'just try this or try that'. Then it's not like I'm doing it alone. It makes the biggest difference. There is always someone to call, to ask, if you're having problems (Tina: Transcript 1).

Tina also thought her breastfeeding success could be attributed to her son. She talked about how fortunate she was that her baby was able to switch between breast and bottle-feeding, she believed: "that's why I'm so lucky. I think I may not have (breastfed), especially

taking on school and everything at the same time. I may not have continued if he wasn't so good. And I'm lucky that he takes the bottle too" (Tina: Transcript 1).

Sara

When Sara talked about her first attempt at breastfeeding her son in the hospital she said: "I don't know how I managed to get him on!" (Sara: Transcript 1) This she explained was in the middle of a Tuesday night, soon after she had delivered her son. By Thursday morning she developed blisters on her nipples. About the experience of developing blisters Sara said: "you don't know things are not going fine until it's too late" (Sara: Transcript 1). Sara went on to say that she was afraid to put her son on the breast because she didn't want any more blisters. Sara talked about how she felt when she started to develop blisters and she explained how she handled it: " I didn't feel responsible for it. I didn't feel guilty. I didn't feel responsible that I caused the problem or that he (infant son) caused the problem....it's just something that happened that needed to be resolved" (Sara: Transcript 1). Sara sought out the assistance of nurses in the hospital who helped her latch her son on to her breast. She described that she watched very carefully and made sure that she was going to do the exact same thing when she latched him on alone. Sara also talked about attending the breastfeeding class at the hospital where she delivered and about how she was glad she used the service. About going to the class she stated: "it is good for mothers to know what is out there and to utilize those services. Regardless of how they're scared to or not, because it will help" (Sara: Transcript 1, p.2). Sara also explained that when she felt pain with breastfeeding, she took one breastfeeding at a time and that helped her cope with the pain. "And, you know, that one nursing at a time was really good. It really kept things

going. It wasn't pressure like "Oh no, I have to put him back on again. It's just one breastfeeding, at a time" (Sara: Transcript 1).

Sara described how breastfeeding continued to be a learning process once she was at home with her son and her husband. She said: "it's not just a learning process for him, it's a learning process for me. And then we have to balance that together" (Sara: Transcript 1, p.8). She talked about how it takes time to develop breastfeeding, that it isn't a one-day event. "It takes a good three weeks, like even six weeks is still early for breastfeeding" (Sara: Transcript 1). Sara elaborated about her strategy to reduce soreness by taking care to latch her son on properly every time she fed. She said:

> It takes time to develop the pattern to know – to know what to do for preventative measures, in order for you *not* to be sore. At first latching on and that... sometimes they will latch on really well, other times you have to take your time and say, 'Come on, come on... open up.' Especially in the early stages, especially in the early weeks because they are not used to opening their mouth wide to get on and, literally, in order to do that, it's like when you got fish lips around your breast. But, if you don't have that, then they're not latched on properly (Sara: Transcript 1).

About the challenges Sara faced with nipple soreness she said:

> The key is to get the help cause if you don't ..that's the thing. It starts to go downhill. Because once you're in pain, that's it. There's no turning back, you don't want to do it. You don't want to continue once you're in pain. You, literally, at that point, mothers want to stop and you know, it makes sense why they want to stop (Sara: Transcript).

Sara used her support system to help overcome challenges that she encountered with breastfeeding. She stated she tried to find out as much information as possible about things that were happening to her from friends and family. She received advice from nurses and friends about how to deal with blisters and engorgement. She learned from a friend that if she controlled the amount of fluid she drank in a day then her breasts would not get overly full when her milk first came in and during her son's growth spurts. Sara explained that she didn't guzzle fluids but that she probably kept her fluid intake to about seven to eight cups per day. Her sister and friend also offered a willing ear to listen to her concerns and discuss what they had done when they had similar experiences. In addition, Sara identified her husband and her son as important sources of support for breastfeeding:

> I actually had a lot of support. And I would say, most support for breastfeeding besides coming from my son was from my husband. I don't have to do any dishes at all, no housework at all. I have to fend for myself for eating, sometimes. But he makes the dinner. And you know, seven weeks later, all is still the same (Sara: Transcript 1).

While Sara identified support as being a critical reason why she has been successful at breastfeeding she also talked about her own commitment to making breastfeeding work, she said:

> And, you know, I didn't mention it – you work a lot. The commitment is, <u>is</u>, a factor in itself. When you put your mind to it, you should continue. And, I came home from the hospital, thinking, you know, even though I had problems, even though I got the help, I was going so far and there is no reason to even want to stop. You put so much effort into it. Why would you want – why would you want to

stop? All the effort you put in to it, you waste it! Once you stop, you have wasted it. And breast milk, it's *virtually*, penniless ---- to make. It doesn't cost. It doesn't cost anything (Sara: Transcript1).

Her son's behaviour, Sara felt, also influenced her breastfeeding experience. Sara stated: "I would say his behaviour helped. Now how it helped was he just – he wasn't fussy in between feedings, he was sleeping between feedings. When he wanted food, he wanted it and I would put him on and he would just latch on to me" (Sara: Transcript 1).

Sara enjoys breastfeeding and talked in length about the benefits for herself and her family. She liked that breastfeeding provided immunity to protect her son against ear infections and she liked that breastfeeding helped her lose weight. Sara didn't see many barriers to breastfeeding and couldn't think of anything that hinders breastfeeding for her. In fact, she liked that she could breastfeed anywhere. About breastfeeding in public, she said: "there's nothing that really hindered. You just – you just find a spot" (Sara: Transcript 1).

Tracy

Waking her son to feed was the first challenge that Tracy encountered with breastfeeding. She described that breastfeeding went "O.K" (Tracy: Transcript1) in the hospital. However she was only in the hospital for approximately sixteen hours so the more difficult breastfeeding experience began at home. Tracy described her struggles:

> You're supposed to feed him every 3 hours –but that wasn't happening because he wasn't waking up. So whenever he would wake up I would feed him. You know he wouldn't wake up and you couldn't get him, we put cold water on him, we undressed him, we—he would not wake up for the life of us. And we had to get the

> public health nurse, cause she, I'd phone her and she'd be like, 'just do this'. It doesn't work. So she had to come and see it for herself, that he was not waking up, and then we had to try all this other stuff (Tracy: Transcript 1).

Tracy learned that her son had jaundice and she was encouraged to supplement with Enfalac because he wasn't breastfeeding well. By the time her son was about five days old he was finally waking to feed. Tracy explained it in this way: "after he had the formula and had something in him, I think he realized 'this is how I'm supposed to feel'. And then ever since then he's been waking up fine" (Tracy: Transcript 1).

Tracy was frustrated during the first week of breastfeeding. She doubted that she had enough milk for her son and her nipples began to get sore. She felt badly that it seemed like she wasn't producing enough milk. About this she said: "I felt that it was like my fault that he wasn't getting anything" (Tracy: Transcript1). Tracy gave credit to her Mother for helping her through the challenging first week. She also talked about the support she received from the nurse that visited her at home. Tracy stated:

> My Mom used to tell me that 'it would come' and 'not to give up' and would help me and she went out and got me my pump and that stimulated it. And this cream stuff to put on the nipples so that it didn't hurt. It helped harden them up and that was a problem too because it hurt so bad from chomping. And just saying that it's 'O.K.'. The PHN just giving me some tips on how to get him on and keep him awake and just letting me know that it's natural. It takes a while for it to come in (Tracy: Transcript 1).

Tracy's partner added to the stress that she was experiencing that first week, as she described:

> When I was first having problems I think he blamed me too. We were in the hospital and he said, 'We wouldn't be here if your milk would have come in and if you would feed him'. I don't think he understood—what he was saying. And I got mad and I was like, 'why would you say that to me? You don't understand how much', you know, I'm blaming myself as it is saying, Why can't I feed him?'. Now he never says anything [laughs] or talks about it. Now whatever we have to do we do. But he, he's a boy----he doesn't understand (Tracy: Transcript 1).

Tracy also described how she felt about breastfeeding during those first couple of weeks. She said: "I hated it, I don't know why people do it. It's horrible" (Tracy: Transcript 1)

Breastfeeding was easier for Tracy after the first two weeks. She described that she felt more confident and comfortable with breastfeeding because her son was more alert and he could feed faster. She expressed her sense of relief this way:

> He's more alert and he can feed faster. He's not on there for an hour trying to do it. He can suck better now, they get it out, faster and he's done and it doesn't hurt and he's just awake to do it. I don't have to wake him up and I can go until he starts wanting it again (Tracy: Transcript 1).

Tracy and her son had one additional challenge at about three weeks postpartum. A tooth began to grow in the front of her son's mouth. She described how she had to take her son to the hospital and was encouraged to feed her son with a bottle. This was recommended to prevent an infection in her son's mouth or with her nipple. Tracy had to bottle feed for a few days before the tooth was extracted.

About the challenge of breastfeeding the sleepy baby, having the sore nipples and the early tooth, Tracy stated: "it does get better. The first little while sucks but it does get

better and you do have to stick with it and have to have the courage and stuff to stay with it because it is horrible" (Tracy: Transcript1). Tracy affirmed that she doesn't enjoy breastfeeding and she believes that she will never enjoy it, however she exclaimed: "but we're sticking with it" (Tracy: Transcript1). She went on to say that:

> You know, like on T.V. the mothers are so---it's just this bonding moment or something but I don't feel that way. I would much rather play and read with him, do that. I just---I don't—I don't like it. It's not enjoyable for me (Tracy: Transcript 1).

Tracy also talked about not liking the feeling of being a "milk machine" and feeling like "he is always hanging on me". When I asked her why she stuck with breastfeeding for the length of time that she did she said: "I don't know, just –something we stuck with. No idea. He---it just works. But like I won't, I can't do it out in public, I -----. Not for me (Tracy: Transcript 1).

Even though Tracy doesn't enjoy breastfeeding she did acknowledged some benefits of breastfeeding for her and her son. She believed that it is best for her baby. She declared:

> From what everybody says, that it is---the best milk they can get, it doesn't have any of that added stuff that the other, the formula has and for cost wise, we can't really afford to buy formula everyday. And I'm at home anyway so (Tracy: Transcript1).

At five weeks postpartum Tracy continued to breastfeed. She found a system that worked well for her. Tracy breastfed throughout the day and supplemented with formula routinely during the night and when she went out of the home. She liked that her partner

feeds their son during the night to help her sleep a little longer. Tracy wanted other Moms to know that breastfeeding is:

> It's hard at first. It does hurt, it does take a while for your milk to come in and just don't give up. You do whatever you have to do like ---my parents are like, 'you have to breastfeed'. Formula is so expensive, but it is [with emphasis] alright if you have to give him formula and breast milk, like, whatever you have to do to make sure that they get enough, because the first while they don't (Tracy: Transcript 1).

For Tracy, breastfeeding and supplementing was a good solution, she wanted her son to have the benefits of breast milk but at the same time she was able to have a break from exclusive breastfeeding. Her son didn't seem to have a preference for the bottle or the breast. Tracy described:

> I don't think he really minds both of them. He—you know like he—he doesn't do anything. People say that you shouldn't give him a bottle so early because he gets confused but -----I don't think he really knows the difference. [laughs] He'll do either or (Tracy: Transcript1).

As a last thought, at the conclusion of our interview, Tracy summarized her thoughts about her breastfeeding experience in this way: "you just have to trust yourself and experiment. But it does—it does get better if you stick at it" (Tracy: Transcript 1).

Christine

"I was so excited," (Christine: Transcript 1) described Christine about breastfeeding her new daughter. However Christine didn't think that her daughter latched on properly to the breast from the onset. She said, "I didn't really know how to do it" (Christine: Transcript 1). She recalled that it seemed like she had sore nipples "right off the bat"

(Christine: Transcript 1). Christine was surprised and concerned about her sore nipples and she asked for assistance in the hospital. She described that she was shown how to latch her daughter on to the breast so that she was positioned much farther back on the nipple. She explained that by the time she went home she felt like: "I got her on there right, by myself. I felt like I could do it. We could do it" (Christine: Transcript 1).

At home Christine talked about how the pain continued. She explained: "I thought I was doing it good but it just kept hurting. And it didn't seem like it was getting better. You know how they say, the longer she is on the breast, its gonna get better. It didn't feel like it, it felt like it was getting worse" (Christine: Transcript 1). She talked abut how she would 'curl her toes' because of the pain when she breastfed. One night, soon after coming home from the hospital, Christine decided to give her daughter a bottle of formula. About her decision to try the formula she said:

> I think it was just all too much. Like it was hurting --- my breasts weren't my own feeling and like everything put together. And the leaking [laughs] like crazy I couldn't wait until they stopped leaking, you know. And plus, like my Mom you know, she made me feel O.K. 'It's alright to not breastfeed you know' (Christine: Transcript 1).

Christine reported that her daughter took the formula well. She stated she ate it happily and faster than she did from the breast and liked that feeding from the bottle seemed to be less of a "struggle" (Christine: Transcript 1) for her daughter. After that night Christine continued with formula. She tried to put her daughter to the breast three more times over the course of the next two weeks. She reported she attempted to try again because she "wanted to breastfeed" (p.3) and because her husband said: "you have to

breastfeed, you have to try, you have to try, it is best for her" (Christine: Transcript 1). She made the last attempt to breastfeed at three weeks postpartum and about that she said: "it still hurt" (Christine: Transcript 1) and she did not try again.

As Christine recalled the first week of breastfeeding and the pain she experienced she described feeling: "I just figured I did it wrong because it hurt" (Transcript 1). She also elaborated on how she was positive that she was going to breastfeed before she initiated breastfeeding but that as soon as she experienced pain she said: "I guess that's when my self-confidence went away" (Christine: Transcript 1). In retrospect she wished that she would have known to expect sore nipples. About this she said: "if I were expecting it more, I probably would be more ready for it, I think" (Christine: Transcript 1)

Christine also described feeling pressured by her husband and her husband's mother to continue breastfeeding. She knew they wanted her to breastfeed. She described how she experienced guilt because of her desire to stop breastfeeding:

> "When I was feeding her I just wanted to stop because it was hurting. And I felt bad cause I did want to cause they say breastfeeding's the best, you know. And I think it is too ---- but it's sad kind of too. I felt bad --- like guilty kind of" (Christine: Transcript 1).

However Christine described that her mother helped her feel 'less guilty' (Transcript 1) because she also had weaned early due to pain. About her mother's advice, Christine said: "and that kind of made me feel better about going to formula because she did it you know. She told me, "it's O.K, it's not like a bad thing', you know (Christine: Transcript 1). Christine admits that she would have liked to talk to other mom's about breastfeeding and what their experience was like. She thought that this might have helped her to continue

breastfeeding. She identified that she didn't have many people to talk to about what was happening to her other than her mother, her husband and one nurse that visited soon after she got home from the hospital.

At five weeks postpartum, I asked Christine how she and her husband felt about her decision to stop breastfeeding. She described how she felt this way: "I feel, I wish I could have breastfed but now I know it's O.K, you know. It's not like a big deal. I wish I could've breastfed but it's fine with him, he's like, "O.K., she's formula feeding, O.K.", you know (Christine: Transcript 1). Christine revealed that she intended to breastfeed her next child and knowing that she would try again was helpful for her to come to terms with not breastfeeding her firstborn for long.

Dawn

"I was feeling good about it I guess, I was feeling like I was gonna be able to do this and I'm so happy, I'm glad that he was going to be a breastfed baby"(Dawn: Transcript 1) is how Dawn talked about her experience of breastfeeding her son the first week postpartum. She thought that she and her son made a "good team" (Dawn: Transcript1). Things changed for Dawn and her son the second week. She described how she thought it was a combination of multiple factors that led her to the decision to discontinue breastfeeding after eleven days. She explained:

> I started hurting more and so he started not latching on as well. Where he'd start nibbling and chewing and things like that. When I'd try to feed him and just the pain I was in it was just – I couldn't, I guess handle the pain. It was just so painful and I'd say, 'come on (infant son) you have to do it properly, let's try again!' And try again and try again and every time it just more and more and more pain so – just

that last week it got really bad and I got really depressed about having the pain and thinking I wasn't gonna be able to breastfeed him and thinking that I wasn't doing it right and I wasn't making him happy, I wasn't giving him enough food. Like everything was just making me so concerned about him (Dawn: Transcript 1).

In addition to experiencing physical pain when breastfeeding, Dawn also described how she doubted whether she was producing enough milk to satisfy her baby's demanding feeding schedule. Dawn elaborated on her thoughts: "really I think it was that he wasn't getting enough. That I hadn't been producing enough for him" (Dawn: Transcript 1). The sense of doubt that Dawn felt was further exemplified as she talked about her experience of breastfeeding in the hospital:

> I was having a little bit of problems and I'd ask the nurse to come and help me and then it'd be, "oh, you're not doing it right", which makes you doubt – O.K., well I'm not doing it right, so should I just give him bottles or what should I do? If I'm not doing it right then he's not gonna get the nutrition that he needs and he's not going to grow and he's not gonna be healthy. Just especially having the baby blues, that's just even worse on you, cause you're depressed as it is and somebody's telling you that you're not taking care of your baby properly. It's just, "oh my goodness!, I'm a bad Mom!" even though you're not but...(Dawn: Transcript1).

"It was very stressful on me" (Dawn: Transcript 1), said Dawn about breastfeeding. She not only described her stress about the breastfeeding experience but also described the stress of her home life. Dawn, her partner and her infant son moved one month after her son's birth. Dawn explained that she was largely responsible for packing and getting ready

to move as her partner was working twelve and thirteen hour days during that time. Dawn said:

> There was so much going on, it was almost overwhelming for myself because I didn't feel like I was getting the help that I needed from the other people in the household. I just found myself overwhelmed with either cleaning or cooking or moving. Like (infant son) was never really a problem for me, I could always handle him but everybody else on top of that was just too much for me (Dawn: Transcript 1).

Dawn also talked about the multitude of visitors that she had during this time and how this added to her sense of being overwhelmed. She elaborated by saying that having many visitors interfered with her breastfeeding especially because she was just learning and was having problems and didn't feel comfortable breastfeeding in front of others. She stated:

> It's a lot harder with all the people being around all the time. Cause they're like, 'Oh you make me feel uncomfortable cause you're breastfeeding!' And I would think to myself, 'Well leave my house then', because what am I supposed to do, it's my house (Dawn: Transcript1).

Dawn described that she felt she received different messages from different people about whether she should continue or discontinue breastfeeding. She thought it added to her stress during that time. She talked about how her mother in law wanted her to breastfeed while the nurse and her own mother were supportive of any feeding decision that she made:

> With (male partner)'s mother it was, 'well you should be breastfeeding, you should be breastfeeding him. It's not that difficult, breastfeed, breastfeed'. And it was

just, well you don't understand, you didn't have problems with him, I'm having difficulties with this. It's totally different when you had an easy time breastfeeding. You don't know what it's like to have a difficult time. So I felt that I was pressured by her to do it which I think added to my stress and being so upset about thinking about quitting. So --- the nurse made me feel good about it. Which is good. And so did my Mom because my Mom had us both on formula right away at birth so – she was, 'oh you don't need to be breastfed'. And she was telling me that formula fed babies are generally bigger than breastfed babies (Dawn: Transcript 1).

Dawn also received a mixed message from her partner about breastfeeding. She explained that on one hand he wanted her to continue breastfeeding because formula was an added cost they had not planned for. On the other hand she explained: "he said he was jealous that I was being able to feed him and he wasn't" (Dawn: Transcript1).

It had been more than three months since Dawn had weaned her son when we spoke. Dawn talked in length about how she felt bad about weaning before she originally planned. She also elaborated on her decision to make the change to formula. She stated:

I feel regret but I don't. Like I wish I could've still breastfed but I'm also glad that I didn't. It's mixed. When I quit I was so depressed about stopping. I would bawl every single day. 'Oh I should be breastfeeding him, I should be breastfeeding him'. But now I'm glad because (male partner) has gotten to bond with him and you know there are all those factors when you're breastfeeding. You can't eat certain foods and things like that. (Male partner) and I wouldn't be able to go out for dinner or something like that, alone, because we're breastfeeding and things like that. So having him formula fed also gives time for you to keep your relationship

going. I think that is probably a big key in it, after you have a child, is to keep the relationship going cause you're so busy with the baby and things like that that you don't really have time for your partner (Dawn: Transcript 1).

Maria

Maria's experience of breastfeeding was similar to that of other experiences described in this chapter. Maria also had to face obstacles during the first month of breastfeeding but persevered and overcame the breastfeeding obstacles. She described her first breastfeeding experience in the hospital and how she didn't mind the demanding feeding schedule:

> They woke me up at 8:30 and then they brought him in and then the nurse kind of helped to get him on cause he was getting all over the place cause he was really hungry. And I don't know, when he was on I was looking at him cause it was the first day. It was his first day of life and me with him and just being so close to him it was like – you can't really explain it – it's just like I was warm inside kind of thing. At first it's hard because – to get him on cause I had my cut and everything and sitting up. But when he'd get on it's like he depends on me so. I felt like " I'm here for him", kind of thing, like I'm not going to let anything happen to him I mean. So – it was pretty exciting. And then I was at the hospital about 4 days so his eating was all over the place. It's was not like a set thing yet cause he was brand new. So I'd constantly be up to feed him. And --- I didn't mind at all! It's like – amazing. I was going on 2 hours sleep and it felt like 5 to me cause I was so used to it. And when I got up, I wasn't like, "Ohhh", you know. I'd be like, "Hi",

you know, and I'd try to get him on as soon as possible cause he'd be really hungry (Maria: Transcript 1).

Breastfeeding went well at home for the first three days until Maria had to leave her son for a few hours to pick up a family member. She explained what happened while she was away:

> And then I came back and my mom had stayed with him and she was so worried and she didn't know what to do because he was so hungry so she had a bottle and she gave him some water. Just a little bit of water just so he could have something in his mouth before I came back. And after I came back he wouldn't go back breastfeeding. And I was like, "What?" And then, he did a little bit but he fell asleep, so I guess he was more tired then hungry. But he was still hungry so in the middle of the night I was having problems getting him back on – and it's like, "what's wrong?" And I could tell that he was upset because he was hungry. And then on Sunday, we did okay in the morning, he was eating a little bit, not really as much as he usually does. He would usually go on for like half an hour sometimes or even 45 minutes breastfeeding. And then that Sunday afternoon he was crying for an hour. He never cried for that long. I tried to get him on, I did everything. I was like, "What's wrong?" And then, I could tell he was hungry, so I tried to get him on and he would not, he could not get on and by this time I had so much milk. I didn't have a nipple for him to grab on to. And I did not know what to do. (Maria: Transcript 1).

Maria talked about feeding her son Enfalac because she did not know what to do to make breastfeeding better and she know she had to feed him something:

So then that's when I made him a bottle because I had to feed him something, right. And so he just drank that down so fast and he was so calm after that. So then afterwards, after he had the bottle --- everybody says, nipple confusion and it's true! Because he wouldn't go back on to my nipple and as much as I tried. It would hurt me so much cause I had so much milk you know that needed to come out. (Maria: Transcript 1).

The next day the public health nurse came to visit Maria and she talked about how the nurse gave her direction about what she needed to do to try to get breastfeeding established again. Maria explained:

So at first I expressed manually to help get the pain out. And I was taught so I knew how to do it. She helped me do it right so it wouldn't hurt and stuff. And then she helped me try to cup feed him. And she told me to try to breastfeed him before he gets really flustered and super hungry cause then he would not get on at all. That is because he would open his mouth but he wouldn't go down, like he would not go down. He would miss it all the time and he would grab on but he could not suck. Something was wrong! He didn't like it. So I had to give him a bottle. And I was getting so frustrated cause I felt like, "I wanted to breastfeed" and it is just like I wanted to give him the nutrients and everything. And I felt like I was a bad Mom just cause I was not breastfeeding him!--- and I was giving him the bottle. And I was trying (Maria: Transcript 1).

The nurse also suggested that Maria go and purchase a breast pump and she explained how she did that to help maintain her milk supply. She said: "I would pump the milk, when I couldn't get any more milk I had put some powder, some Enfalac milk so at least he was

getting some of the nutrients I thought" (Maria: Transcript 1). However, Maria soon got frustrated with pumping and only getting a small amount of milk. She talked about her extreme frustration with the experience:

> It was just like I did not want to do that (pumping) anymore, at the same time I know I had to for the baby; so he could get the nutrients. So but like I was missing having him close to me and breastfeeding. I just got really sad, like I know I'm not a bad Mom because of that but you just fee....I felt like really down about it. And I was just like, "I am still feeding him (breast milk) with the bottle but it's just not the same!" He's gonna be feeding with the bottle later, like when he's older and I still wanted to do this part, you know (Maria: Transcript 1).

Maria was also frustrated because it took a long time for her son to start to feed from the breast more often. She had to keep trying for the majority of the first month. She elaborated about how she felt about this:

> I just wanted to give up, I was like, "I'm just going to bottle feed him". I was getting so mad, not at him or myself, just at the whole situation, "Why does this have to happen to me?" And my mom was feeling so bad cause she thought it was her fault cause she gave him the water. I'm like, "No, it's O.K., it's not your fault", you know, we will overcome this, It'll get better' (Maria: Transcript 1).

Then, slowly Maria described that her son started to take the breast more often:

> About a month and he was finally back on regularly. So I did not have to do the bottles anymore. And so now I breastfeed all the time when I am home, except when I go out I usually give him a bottle just because I have not gotten used to breastfeeding outside of the house"(Maria: Transcript 1).

About her perseverance to continue trying to breastfeed despite the problems she encountered Maria said: "It was not that I couldn't, I had to keep trying. It was just kind of a bump in the road" (Maria: Transcript1). This was Maria's unique way of dealing with adversity. She simply thought that it was a hurdle that she had to overcome. She attributed her willingness to continue breastfeeding to her own motivation to breastfeed. She exclaimed: "You have to want to, want it that bad inside" (Maria: Transcript 1). She also talked about how it was her own resolve to breastfeed and messages from others that helped her keep trying. She said: "I had people tell me 'it would get better, don't worry' and to 'keep on trying because that's the only thing you'll have and it is greater than you think'. And that is true because I just wanted to give up but for him I kept trying and then after it was like, "Ahh", you feel such relief and satisfaction inside"(Maria: Transcript 1).

Jane

Jane didn't know if she was going to breastfed until she was in her ninth month of pregnancy. Her indecision was tied to her being a smoker and Jane had determined that if she breastfed her baby she would not smoke. She didn't feel right about breastfeeding her baby while continuing to smoke. She mentioned that the cost of formula as a motivating reason to consider breastfeeding her baby. About her decision to breastfeed Jane said:

> Finally I said, "okay, I'm gonna breastfeed". I mean it's good because it's a lot cheaper. Even --- formula, it's so expensive [laughs] you know and you don't have to pay for breast milk. I mean, I don't know (Jane: Transcript 1).

When I asked Jane about what she expected breastfeeding to be like she seemed at a loss for words. Finally she responded by saying: "I didn't expect anything from it, it's just something that you have to learn how to do, right" (Jane: Transcript 1). And she did learn.

Jane talked about how it took about two days to get the hang of breastfeeding. She recognized that: "it was not easy" (Jane: Transcript 1). Jane talked about needing help when she was first learning to breastfeed. She thought that help from the nurses was available in the hospital whenever she needed it. "If I needed help they'd come, they're there to help me which is good" (Jane: Transcript 1). She also went to a breastfeeding course in the hospital, which she described as being: "really good" (Jane: Transcript 1). In fact Jane felt so supported and comfortable in the hospital, she said: "I was upset because I had to leave, cause I felt it was safe" (Jane: Transcript 1).

The first eight days of breastfeeding Jane described in this way: "it went really good" (Jane: Transcript 1). It was about the tenth day of breastfeeding that she said her nipples began to crack and bleed and get really sore. Jane also mentioned feeling confused about how to handle situations that involved feeding her daughter breast milk from a bottle. She had questions about: If I want to go out what am I going to do? How do I do it?, and How much milk do I pump? (Jane: Transcript 1). About her questions she states: "It's just the whole thing was really confusing so I know the bottle (formula) is a lot easier that way" (Jane: Transcript 1). Jane also liked that other people could feed her daughter when she pumped breast milk and put it in a bottle. When she used a bottle Jane also found that she regained some of the personal time that she had lost since she had started breastfeeding.

Jane acknowledged that the first ten days after giving birth to her daughter was a stressful time for her. She described her feelings in this way: "I was very stressed. Every day I cried. Every day. And I --- I'd be sitting at the dinner table and be crying [laughs]. It's sad [laughs]" (Jane: Transcript 1). She acknowledged that she did have some postpartum depression and at the same time she described feeling alone and overwhelmed

and that she did not have much support once she left the hospital: "I had nobody with me and it was --- scary [laughs], you know, really scary" (Jane: Transcript 1).

Jane stopped breastfeeding and pumping breast milk on the tenth day postpartum. When asked about what influenced her decision to stop breastfeeding Jane stated she didn't think it was really a decision: "it was really just about how sore I was" (Jane: Transcript 1). Jane did not take this problem as being one that she was responsible for. Instead Jane regarded her situation this way: "I never felt I was doing anything wrong. I just assumed it was just my body and --- you know – it was too hard on the nipples. So – it didn't make me upset or anything" (Jane, Transcript 1). She said it just hurt her way too much so she just gave up (Jane: Transcript 1, p.18).

Jane's stepmother and her physician encouraged her to give breastfeeding a try for another few days. Jane resisted and talked about sometimes being annoyed when people tried to tell her the right way and the wrong way about how to take care of her child (Jane: Transcript 1). Jane responded to the advice of her physician and stepmother by saying:

> You know, I don't want to do it anymore and I'm gonna give her Similac and <u>that's it!</u> I mean it's my choice, my decision, right. And nobody's gonna tell me [laughs loud] you know, how I was gonna feed her. So umm – I don't regret it" (Jane: Transcript 1).

Jane elaborated more about her feelings related to making the decision to stop breastfeeding and about how she felt now that more than three months had passed since she had been bottle feeding. She stated: -- I feel great [little laugh]. Yeah umm I --- I don't know, I like it. As you can tell she's real healthy, you know, she's enjoying her bottle (Jane: Transcript 1).

Lori

Lori's first experience with breastfeeding was soon after she delivered her daughter. She didn't recall much about breastfeeding that first time only that: "it was 10 minutes after I had her" and that: "the nurse brought her to me and she just put her on for me. So she basically did it for me" (Lori: Transcript 1). Three hours later Lori attempted to feed her daughter again. She had an epidural that hadn't completely worn off and she couldn't get out of bed or move around well. She called for help but had to wait for a long while. In the meantime:

> I didn't know what I was doing – I started trying to feed her myself but I wasn't getting it right cause you have to get them to latch on the whole areola and all that stuff. And I have flat nipples too so I mean I had all these problems [laughs] so umm by the time they got there she was just so hungry you know, it was like she was frustrated and I was frustrated and like I said it's not their fault, they were busy, you know (Lori: Transcript 1).

Lori mentioned feeling like she was on her own in the hospital. She talked about feeling like she had to figure out how to breastfeed herself because: "I wasn't going to really get the help I needed" (Lori: Transcript 1). So she tried to do it. She tried on her own, her daughter would get upset and cry and then she would call the nurses. Lori talked about her daughter and how: "she wasn't patient enough for it" (Lori: Transcript 1). She described how her daughter was losing weight in the hospital and that the hospital staff started supplementing her with formula. Subsequent breastfeeding attempts in the hospital didn't get any more successful. She attributes this to it being easier for her daughter to eat from a bottle then to bother to try to feed from her breast. "And I'd have just a hell of a time

trying to get her to eat, and then I'd give her a supplement and she is like, glug, glug, glug". (Lori: Transcript 1).

Lori talked about how she felt she needed more help during the early days of breastfeeding. "You need the help for those 8 times a day. You need that help. You really do. Umm -- unless the baby is just a phenomenal eater" (Lori: Transcript 1). She recognized that staff were not always available to assist her with latching her daughter on when she required the help:

> For the support I think it's more somebody watching you do it and telling you what you're doing wrong. And encouraging you to do it right. And you need it before they're hungry, before they're really, really hungry" (Lori: Transcript 1).

As well she commented on the lack of experience of one of the staff that was assigned to provide care to her. This person, who she described as a medical student, was not well versed in how to help a new mom start breastfeeding. "But I found that for me it would've been nicer if I had somebody that knew how to teach me how to breastfeed, like help" (Lori: Transcript 1). She had hoped to see the lactation consultant during her early attempts at breastfeeding but ended up seeing her just before she left the hospital. She expressed gratitude and confidence in the advice that the lactation consultant provided but: "I think, like I said by that time I had already been supplementing her so she already knew what the bottle's been like " (Lori: Trancript1).

At home, Lori described the day-to-day support that she received from her mother. She described times when her Mom would come home from work and would care for her daughter so that she could have a bath or have a few minutes to herself. The security of being home and not having to worry about cooking meals or cleaning in the first month of

breastfeeding was also described by Lori as being extremely helpful for her to continue breastfeeding for the first month.

Continuing to breastfeed and supplement didn't get easier over the next month for Lori. She described the way she felt:

> I think it was me getting more and more tired. That was part of it. The other part is that she started to get frustrated too. She described her infant daughter's behaviour in this way: "she was like, 'why are you giving me that thing, just give me the bottle', you know. She'd just say, 'I'm hungry just give me the damned bottle. That's what you're gonna do anyway'. So I think she was getting more frustrated as time was going on and I was getting more tired. It was easier waiting for the bottle than trying from me (Lori: Transcript 1).

Lori tried to pump her breast milk and feed it to her daughter with a bottle. That worked but: "getting the breast pump and doing that you were an hour trying to feed her and then an half hour pumping right and then you have to feed her again in an hour and a half. And then trying to get some sleep in there so it was pretty fun!" (Lori: Transcript 1). Finally, she said she did try for the whole month and it was just like 'fighting' trying to get her to do it so she thought, "okay, this is too much of a headache" (Lori: Transcript 1)

She described the process of trying to make breastfeeding work as being a particularly hard time. This was when she felt the most amount of stress. She also felt frustrated because she said: "even though she vowed to make it so it worked, it wasn't working"(Lori: Transcript 1). This led to feelings of self-doubt and inadequacy when she thought about herself and about what made her different from other mothers who were

successful at breastfeeding. She said this led her to feel like "less of a woman" (Lori: Transcript 1). About feelings of doubt she said

> Yeah, all the time. And that really plays on you. You know, it's like I can't do it, what's wrong. You know, what is wrong with me that I can't breastfeed. It's supposed to be the most natural thing on the planet, you know and I can't do it. I don't understand. So I doubted myself a lot. Sometimes I was like, I'm just gonna give up. But you know then I'd say, No, I'm gonna give it until then" (Lori: Transcript 1).

She also felt guilt because of the feelings of frustration that she had and was worried about the effect that a frustrated and uptight Mother would have on her infant daughter.

The stress of making the decision to continue or terminate breastfeeding was agonizing for Lori. She described a period of six weeks that consisted of wavering back and forth about whether or not she should continue to breastfeed:

> I didn't know whether or not I should. I was like, I don't know, maybe she is gonna take it up. Maybe I should give up now. Maybe – you know – I didn't know what to do. I didn't know whether or not I should continue trying or not. And that really plays on you too cause you don't know (Lori: Transcript).

She wanted it to work and for Lori breastfeeding represented part of being a 'woman' and helped shaped her ideal of motherhood. Not being able to breastfeed made her feel worthless:

> When you're a mother you're supposed to breastfeed – that's what you're breasts are there for is to breastfeed. And I mean - it just made me feel really – like, like – I don't know you just don't feel like a woman – I don't know – or like a mother. I

don't know. Like you're just not doing your job like you're supposed to be doing it. You were put on earth to have babies and you have breasts to breastfeed and you can't do it (Lori: Transcript 1).

Having made a final decision to stop breastfeeding at one month postpartum brought both a sense of guilt and relief. She stated that she felt "kind a bad"(Lori, Transcript 1). She described missing breastfeeding for a couple of weeks after she stopped. She went on to say:

> And once you get past that and you're like, 'O.K. I'm just going to bottle feed her and I'm not going to try anymore' then it just all of a sudden, it's just (like phew) gone, you know. But really, I don't know it just – I don't know how to say it [laughs] --- relief – relieving and then you're not worrying about breastfeeding. You're just worrying about taking care of your baby. Which is what you should be doing, not worrying about breastfeeding. You should be worrying about taking care of the child that's it" (Lori: Transcript 1).

Chapter Five

Enhanced Understanding of the Experience of Breastfeeding

Themes emerged from the data and enhanced the understanding of the experience of breastfeeding among women living with low incomes. Five major themes were identified and a visual interpretation or synthesis of how the themes interconnect to describe the experience of breastfeeding is depicted in chapter 6, Figure 2. The themes presented are expectations of breastfeeding, doubting self-efficacy, perceived social support, making/not making the discovery and personal motivation.

Expectations of Breastfeeding

Expectation That Breastfeeding is Easy and Natural

All women in the study spoke about their expectations of breastfeeding and how expectations were different from the reality of breastfeeding. Likewise, Maclean (1990) found the expectation of breastfeeding to be an important factor in the overall breastfeeding experience of women. Among her participants she found that disappointment was profound when breastfeeding expectations were not met.

All mothers in this study intended to breastfeed and all but one talked about how they thought breastfeeding would be easy. Mary, a 28-year-old mother spoke about her thoughts: "I thought it would work out. I thought it was going to be just fine. I had no ifs, ands or buts about it when I was pregnant. Everybody asked me, "are you breastfeeding?" Oh yeah, yeah, I'm breastfeeding you know, HA, HA, HA, HA---it's painful" (Transcript 1). Christine, a young Mom who weaned her baby after three weeks said this:

> I don't know I just thought it was just going to be super easy, you know. I thought it would come in and I would just put her on there and she was just going to be fine

and keep going and going until the end. And then once I actually did it, it's different, I guess. Not what I expected (Transcript 1).

Tracy recalled receiving idealized messages about breastfeeding from media sources like the television. She explained:

> Yeah, I thought it was easy. You watch the T.V. and the baby comes out and just goes right on and everybody's happy but-----it's not the way that works, it's a lot harder and it's more challenging. After doing it, it's not realistic. It's not what it's cracked up to be. It's ----a lot different than what you see everywhere (Transcript 1).

Dawn's own mother didn't breastfeed so she heard from her boyfriend's mother that breastfeeding was easy:

> I thought it was just gonna be easy. Cause like his mother (male partner) breastfed him and she said she just found it so easy to breastfeed. She didn't have any problem with it, it's a breeze. And – for me, my mother had us on bottles right away. She didn't breastfeed us at all. So expectation was that oh, it's gonna be easy, everybody does it and it's so simple and then it's so difficult! It wasn't at all what I had thought it was going to be! (Transcript 1).

Lori also believed that breastfeeding wouldn't be hard. She stated that she thought it would be natural. For Lori, the naturalness of breastfeeding was tied to having breasts and believing that women were made to breastfeed: "when you're a mother you're supposed to breastfeed, that's what you're breasts are there for is to breastfeed, you know" (Transcript1). Tracy had this to say: "I thought it was just natural and it just happens! (Transcript 1).

Other mothers also believed that breastfeeding needed little preparation and would just happen. Some described how they chose not to learn a lot about breastfeeding beforehand because they believed it would work out instinctively. Mary described her thoughts this way: "I kind of went into it blind. I didn't think it was going to be as much of a big deal as it is. Like I figured it was something that was totally natural that was just going to come naturally and it would be natural" (Mary: Transcript 1). Sara talked about how she believed she couldn't learn about breastfeeding before she actually experienced it. She explained:

> Before he was born I had plenty of opportunity to watch a video on breastfeeding. But I didn't. I figured there's no point because it's hard to know... you can't... you can watch something but until you experience it, it's not going to apply. So, maybe it would help, maybe it would have helped me, I don't know for sure. I just had that mindset that it was not going to work until I had the experience (Transcript 1).

Mozing, Davis, Dropplemen and Merideth (2000) presented results about idealized expectations in a study conducted among women with short-term breastfeeding experiences. In this phenomenological study women expected breastfeeding to be easy, wonderful and natural. The women also spoke about never dreaming that they thought there would be problems related to breastfeeding. In a study conducted for Health Canada (1995) the authors found that women entered into the breastfeeding experience with high expectations believing that breastfeeding would be a natural experience despite what they had heard about breastfeeding from family and friends or had seen for themselves firsthand. Most women expected that when they needed to breastfeed, they and their child would know what to do.

Surprised by Breastfeeding Problems

Over romanticizing breastfeeding and underplaying the difficulties many women face may create distress for first time mothers. Minchin (1985) in the work by Van Esterik (1989) discussed that many women have been disillusioned by their own breastfeeding experience; they expected it to be natural, enjoyable or even sensually pleasurable and were angered when they found that this was not true for them. All nine mothers interviewed expressed surprise and shock when breastfeeding didn't work out the way they had expected. All mothers enrolled in the study encountered challenges during their breastfeeding experience. The most common startling event was nipple soreness. About the nipple pain, Mary said: "I guess you could say I expected it not to hurt. But I was wrong"(Transcript 1). Dawn said she was surprised about: "the soreness. I didn't know it was going to be like that. Nobody ---- told me that it hurt lots so that was kind of a shock to me" (Transcript 1). Christine had a similar experience:

> I thought I was gonna breastfeed, definitely. I wasn't going to formula feed at all and then when I actually did it I didn't really think about having sore nipples and stuff. I just didn't hear people telling me about being engorged but not sore nipples. So I guess I was ready for that but I wasn't ready for the sore nipples, sort of. But I thought it was gonna be different, personally (Transcript 1).

Leakage was also a common discomfort experienced by the mothers. Half of the mothers mentioned this as being a concern. Mary described how she felt about leaking breasts:

> Leakage, that's the worst, when you feed. When your full milk comes in it sort of a hard thing to get a handle on because when you are sleeping at night and the baby

wakes up and you feed out of one side, its like, oh, all of a sudden your shirt and your pants and everything are soaked. I don't like that (Transcript 1).

Mary went on to talk about her surprise about the pain of letdown. She said: "Let down can be painful. Like I really would have liked to have known about that too" (Transcript 1).

Knowing What to Expect

The lack of awareness of potential problems and solutions is a fundamental issue that can affect the duration of breastfeeding (Health Canada, 1995). Mothers talked about how they wished they had been better prepared to know how to deal with potential breastfeeding problems. Mary talked about her surprise about having nipple soreness, leaking breasts and painful letdown. She also mentioned that knowing more about these and other aspects of breastfeeding such as latching the baby on to prevent nipple soreness and about eating the right foods to help maintain milk supply would have been helpful for her during the early postpartum period. Tracy mentioned that "knowing what to expect a little bit more" (Transcript 1) would have reduced her surprise when she encountered nipple pain. Christine said she had known about engorgement and felt somewhat knowledgeable and prepared for that but nipple pain was a shock to her.

Findings in the work by Health Canada (1995) revealed that women reported receiving information about the benefits of breastfeeding and about the naturalness of breastfeeding from health care providers and prenatal classes. However the women reported not receiving information about potential problems they may encounter or the ways in which they might solve these problems. Mothers talked about how they wished they had been better prepared to know how to deal with potential breastfeeding problems.

Similarly, Maclean (1990) reported that women wished they had been better prepared for what to expect and wondered why they had not read or heard about some of the difficulties they encounter with breastfeeding. They described being prepared for only minor difficulties and felt isolated and unique when they ran into problems.

Doubting Self-Efficacy

When mothers in this study found that the reality of breastfeeding was different from their expectation of breastfeeding they became uncertain about their ability to breastfeed. At some point during their breastfeeding experience, eight of the nine mothers talked about having doubt about their ability to breastfeed their infants. Maclean (1990) wrote:

> Many women are disillusioned when their experience of breastfeeding does not measure up to their idealized expectations. The romantic images are frequently divorced from the everyday reality of caring for a baby in much the same way that the romantic image of love excludes the struggles and efforts that are necessary to nurture it (Maclean, 1990, p.4).

The disillusionment that resulted from the contrast between reality and expectation of breastfeeding manifested itself in the form of doubt about breastfeeding self-efficacy. Some mothers were afraid that their infants were not getting enough milk and wondered whether they could produce milk for their infants. Others talked about wondering if their baby was gaining the right amount of weight. Others who were having pain and sore nipples thought that they must have not been doing "something right" (Christine: Transcript 1). Generally, in the literature, reasons for stopping before two to three months revolve around problems with the process of breastfeeding (Health Canada, 1999). Problems discussed in the literature with the process included sore breasts, rejection by the

baby and a perceived lack of quantity or quality of milk (Grossman, Fitzsimmons, Larsen-Alexander, Sachs & Harter, 1990; Health Canada, 1999; Hill 1991; Kusmirski,1999; Tanaka, Yeung, & Anderson,1987; Yeung, Pennell, Leung, & Hall,1981). In a review of breastfeeding conducted by Health Canada (1999) almost every survey examined reported that insufficient milk was the most commonly cited factor for weaning. One exception in this study was Jane. She didn't feel she had doubt about her ability to breastfeed her daughter. She stated she quit breastfeeding because it hurt and because bottle-feeding was a feasible alternative for her. She said she never doubted her ability to breastfeed. About the challenges with breastfeeding that she encountered she said: "No - I never felt I was doing anything wrong. I just assumed it was just my body and --- you know – it was too hard on the nipples. So – it didn't make me upset or anything" (Transcript 1).

In a study conducted by Locklin (1995), the majority of participants (n=14) reported uncertainly in the first few days of breastfeeding. Similarly, Mary talked about the doubt she had as a new, first time mother:

> Is she getting enough, is she getting her proper nutrients and vitamins and it's just one thing that you never know because you don't see how much they're eating, you don't know how much they're eating, but often that is a big question (Mary: (Transcript 1).

She said she learned to relax with time and began to feel confident that her daughter would let her know when she was hungry. Mary regarded breastfeeding as a learning process and thought that with time came confidence in her own ability to breastfeed her daughter. "I learned to relax and not worry about it because if she is hungry she will say something, if she needs milk she will say something" (Mary: Transcript 1). She said about breastfeeding

at three months postpartum versus breastfeeding in the early postpartum period: "the only thing that has changed is that I don't worry about whether or not she's getting enough, cause if she's not, she'll tell me. That's the only thing" (Mary: Transcript 1). Tracy also wondered if her son was getting enough milk and supplemented his intake with formula after she breastfed. "I find that I don't have enough for him" (Tracy: Transcript 1). Dawn's experience with doubt about whether she had enough milk for her son was similar to Tracy's story. About this she said:

> I think it was that he wasn't getting enough. That I hadn't been producing enough for him. Just because, like you see the size of him, he's a lot bigger than most babies at 4 months so he likes to eat and I think that was his main thing, that he wasn't getting so he'd try and try and try and there wasn't anything left and he'd get upset and I'd switch him to the other one and he'd drink all of that and then there wouldn't be anything in the other one !, so I'd be all out and I wouldn't be able to supply him with the food that he needed (Dawn: Transcript 1).

Even after breastfeeding had been going well for more than three months Maria described how she worried about whether she could continue to produce enough milk for her son. "I'm still worried now that maybe the production of milk will go down and not be enough for him. Like sometimes I think, you know, what if I'm not making enough milk to keep him on for too long" (Maria: Transcript 1).

Sara remembered wondering if her son was gaining the right amount of weight. As a result she took him into a local public health clinic before her scheduled physician appointment to weigh her son. She just wanted to make sure that he was getting enough energy from her breast milk to satisfy his caloric needs. She also wondered whether the

pain and soreness she felt in her breasts were because of an infection. She said: "Sometimes when you get sore nipples, or sore breasts, you wonder, Am I getting the mastitis? – An infection of the breasts – sometimes you kind of wonder, is that coming in or is there a problem?" (Sara: Transcript 1).

Researchers have noted the significance of a woman's confidence in her ability to breastfeed. In qualitative inquiries, women have described the 'crisis of confidence' that they experienced with early breastfeeding and subsequent termination of breastfeeding (Maclean, 1990). Lower maternal confidence has been associated with perception of insufficient milk supply (Hill & Humenick,1996; Segura-Millan et al., 1994) and with premature discontinuation of breastfeeding (Buxton et al., 1991; O'Campo, Faden, Gielen, & Wang, 1992).

Self-efficacy theory derived from Bandura's Social Learning Theory has been proposed as a framework to study breastfeeding confidence (Dennis, 1999). Dennis (1999) proposed that self-efficacy theory can influence women's judgments regarding their ability to initiate, persist in and continue breastfeeding. Women develop their self-efficacy expectations based on past experiences and performances, vicarious experience, verbal persuasion and their present physiological and emotional states. Founded on these sources of information, she proposed that healthcare professionals can incorporate self-efficacy enhancing strategies into their general practice (Dennis, 1999). Dennis (2000) has been working on developing an instrument to measure breastfeeding confidence in new mothers. The intent is that this instrument would aid in identifying mothers who would require additional breastfeeding support because of low self-confidence.

Differing Responses to Doubt

The participants in the study seemed to handle self-doubt in two dissimilar ways. One approach was to internalize the breastfeeding problem and feel that breastfeeding difficulty was completely their fault. A reduced sense of self-efficacy appeared to be related to the internalization of breastfeeding problems. Lori described how she doubted her ability to breastfeed all the time and wondered what was wrong with her when breastfeeding wasn't working out. About doubting herself, Lori explained:

> Yeah, all the time and that really plays on you. You know, it's like I can't do it, What's wrong? You know, What is wrong with me that I can't breastfeed? It's supposed to be the most natural thing on the planet, you know and I can't do it. I don't understand. So I doubted myself a lot. Sometimes I was like, 'I'm just gonna give up'. But you know then I'd say 'No, I'm gonna give it until then' (Lori: Transcript 1).

Tracy said that when she had problems feeding her son she immediately:
Felt like she couldn't do it for him" and that she "felt that it was like my fault that he wasn't getting anything. But my Mom was here. If my Mom wasn't here ---I would have just said, 'forget this' and he would be on formula, just formula. But she was here and she helped me (Transcript 1).

In retrospect, Tracy knew that it wasn't her fault that she couldn't feed her son. She said she knows now that: "it happens and he got over it and he's a lot better now and he's – a happy little boy" but initially she blamed herself and without her mother's help she would have given up breastfeeding (Transcript 1). Christine stopped breastfeeding at three weeks postpartum. She said she stopped because she thought the nipple pain she felt during

breastfeeding was a result of her doing something wrong. She stated: "I still don't know if I did it right or wrong you know, but I just figured I did it wrong because it hurt" (Christine: Transcript 1). Dawn talked about insensitive feedback that she received from the nurses in the hospital and how this added to the feeling of failure that she felt:

> The nurses would help me and then it'd be, 'Oh, you're not doing it right', which makes you doubt, okay, well I'm not doing it right, so should I just give him bottles or what should I do?! If I'm not doing it right then he's not gonna get the nutrition that he needs and he's not going to grow and he's not gonna be healthy. Just especially having the baby blues, that's just even worse on you, cause you're depressed as it is and somebody's telling you that you're not taking care of your baby properly. It's just, "oh my goodness! I'm a bad Mom!" even though you're not but.. (Transcript 1).

Dawn weaned her son after one month of breastfeeding. She said she still feels responsible for the problems she encountered with breastfeeding and feels that it was her fault: "it's still depressing to think that you know, you know it's still almost like, 'was I doing something wrong?'-- to make it so that he wasn't getting enough or so it wasn't working? (Dawn: Transcript 1).

The contrasting approach was to regard problems as things that happened as a result of circumstance. Mothers didn't blame themselves or regard problems as a failure but believed obstacles could be overcome. In addition, breastfeeding was regarded as a learning process. In this study, participants who held this belief and took a 'we had to learn' approach seemed to breastfeed longer than mothers who internalized breastfeeding obstacles. In fact, mothers who looked at the diagram of the themes during the second

interview thought that doubt was too strong of a word to describe the concern they felt with the initial breastfeeding process. They agreed that this period of questioning occurred during their experience of breastfeeding but preferred to label the experience as a period of 'concern' or 'uncertainty' about whether breastfeeding was going well. Maria described how she adjusted to an unexpected obstacle:

> I thought (breastfeeding) was really easy but just like, you know, just like everything else you get unexpected things. Like with his birth. I'm like, "oh I'll have a easy delivery" kind a thing and then it was unexpected that his heart rate dropped so long you know, so he had to come out by a cesarean. So with breastfeeding it was like, you know, 'maybe this is just a bump in the road just like that' (Transcript 1).

Similarly, Sara approached problems with the same type of resolve. She had hoped that breastfeeding would go well but when her nipples started to get sore, she took action to help remedy the problem and she explained that she thought she handled it well without getting upset or down about the problem. She described: "I didn't really feel responsible for it. I didn't feel guilty, I didn't feel responsible that I caused the problem or that he caused the problem... It was just something that happened that needed to be resolved" (Transcript 1). She went on to explain:

> When things started to go downhill, and I started to develop the sore nipples, like I explained earlier, that's when I knew, 'Well, it's not working out and you gotta get help'. And don't be afraid to ask. And even though it did not work out to, maybe, what I would have hoped, I was okay with it because it still only... I got the help and you know, there's no turning back (Sara: Transcript 1).

Sara said it was three-and-a half weeks before she began to develop a sense of comfort with breastfeeding. At the time of our interview at six weeks postpartum she said this: "it still takes time to develop breastfeeding, it's not – it's not a one day thing -- it takes a good three weeks. Like even six weeks is still early for breastfeeding" (Transcript 1).

It also took time for Tina and her infant to develop a breastfeeding pattern. She had a frustrating breastfeeding experience, having to pump breast milk for the first 4 days after she gave birth. She often felt like she wouldn't have enough milk for her son and didn't like that pumping took a lot of effort and resulted in little milk. She doubted whether she could feed her son. She explained her frustration with breastfeeding and what she told herself: "You have to make an effort when you know, when you feel ready to have a good cry and you know you have to feed in 15 minutes, get some rest. Because as soon as you start crying, it makes a difference too. So. And it just takes a while to learn" (Tina: Transcript 1).

Doubt about breastfeeding self-efficacy was a common theme among eight of the nine women interviewed. Doubt about the breastfeeding process manifested itself in mothers' concern abut milk supply, adequacy of nutrients in breast milk, worry about breast infection, wonder about adequate infant weight gain and doubt about breastfeeding ability because of breast pain. Doubt was confirmed by participants and was present in varying degrees. Feedback about doubt resulted in two different terms to describe this experience. Some mothers, who weaned early, felt that problems were their fault and certainly doubted their own breastfeeding self-efficacy. They agreed that doubt was a suitable word to describe what they felt and confirmed that doubt was one element of their breastfeeding experience that led to early weaning.

Other mothers regarded obstacles as things that happened and could be overcome. The sense of concern or wonder that they felt about the breastfeeding process didn't lead to early weaning. These mothers may have had a greater sense of confidence in their ability to breastfeed when compared to the mothers who weaned earlier. Further evidence of this may have come when mothers gave feedback about the doubt theme. Mothers who breastfed longer preferred the term 'concern' or 'uncertainty' and thought that doubt was a strong word to describe what they felt. In addition, these mothers may have had supportive persons close by to help with breastfeeding challenges which may have helped to diffuse (Cobb, 1976 in Callaghan & Morrissey, 1993) against increasing doubt. Consequently, mothers who approached breastfeeding as a learning process and who thought that they could overcome breastfeeding problems breastfed longer in this study.

Perceived Social Support

Every mother in this study talked about social support in relation to their breastfeeding experience. Perceived social support from others was an important component of the breastfeeding experience for these women. Tarrado and Hughes (1996) found that the concept of support was integrally related to both the decision to breastfeed and the duration of breastfeeding. Women with support persons whom they could discuss breastfeeding problems and lean on for emotional support breastfed longer in this study. For other mothers who weaned early, emotional, and instrumental support was not as readily available. There is support in the literature that breastfeeding duration appears to be directly correlated with a positive support system that includes significant others (Baranowski et al., 1983; Grossman et al., 1989; Hughes, 1984).

Women who weaned earlier described different experiences of support than mothers who were breastfeeding at the time of the interview. Mothers who weaned early talked about positive and negative experience of support from nurses. Others felt like they had little support once they got home from the hospital. Some mothers who weaned early talked about the support they received from family members when they were making the decision to switch to formula.

On My Own

Christine talked about being on her own once she came home from the hospital. She described that her husband was at work during the day and she was home alone with her infant daughter. She stated: "I was kinda on my own at home, you know. I didn't have a nurse with me 24 hours" (Transcript 1). When her husband was at home in the evenings, Christine felt emotionally supported because: "he cared, you know, I can't explain how he cared but he was like encouraging me" (Transcript 1). However she didn't receive informational support from him with breastfeeding, she said: "he has no idea" (Transcript 1). Tracy had a similar story; her partner was working twelve to thirteen hours per day. She said about being home with the baby: "so it was pretty much just me" (Transcript 1). She wished he had been at home more, maybe a few extra hours per day to help her clean the house or to make something to eat. Tracy did receive help one day from her partner's mother. Her mother-in-law helped her with baby care, cleaning the house and with getting more rest. She said having her visit one day was helpful but that she thought: "I definitely think that you need more than that" (Transcript 1). Lori also felt "on her own" (Transcript 1) because she didn't have a significant other and although she lived with her parents they worked during the day.

Jane didn't say a great volume about support and her breastfeeding experience, because she felt she didn't receive any. She stated: "I don't really know that anybody supported me. Unfortunately, I wish I had support but ---- I didn't" (Transcript 1). She talked about how she didn't know many people in Calgary and didn't have a lot of family that was close by. She said: "I feel bad saying it but it's true" (Transcript 1). Jane also talked about how she felt when she came home from the hospital with her infant daughter: "I had nobody with me and it was --- scary, you know, really scary (Transcript 1). The experience of having very little support was unique to mothers who were not breastfeeding at the time of the interview. These mothers had partners who were away during the day and/or few family members or friends close by to assist with breastfeeding support. As a result these mothers felt like they were basically on their own.

This finding is similar to what was presented in a study of attitudes of breastfeeding conducted by Health Canada (1995) in which the authors found that for women who weaned before four months postpartum, most of the fathers worked outside the home, some on nightshifts, and one was away all week returning home only on the weekends. In these situations, the mother was largely on her own in dealing with the newborn and any problems with nursing (Health Canada, 1995).

Conflicting Messages

Christine's mother lived in California and Christine talked to her on the phone about her sore nipples and pain while breastfeeding. Christine's mother told her about her own experience of pain and sore nipples. She told her that with Christine's youngest sibling she had weaned at three months because of nipple pain. Her mother also told her that the soreness had felt really bad. About learning this, Christine said: "that kind of made

me feel better about going to formula because she did it, you know. She told me, 'it's O.K, you know, it's not like a bad thing' (Transcript 1). Hearing this from her own mother was contrasted by the messages she was hearing from her mother-in-law who was telling her that she should continue to breastfeed.

Both Christine and Dawn were receiving contrasting messages about breastfeeding. On one hand that they should continue breastfeeding and on the other hand that it was all right to stop. Dawn talked about the stress that she felt from her partner's mother. She described what her partner's mother said:

> She was saying that it was really easy and then I think I had a lot of stresses just because she was saying, "Oh, you have to breastfeed, it's bad if you stop breastfeeding". It was a lot of stress on me, you know. 'O.K. I'm gonna do it, I'm gonna do it!' and I tried and it wouldn't work and I tried and it wouldn't work and it almost feels like people were looking down on me because it wasn't working for us (Transcript 1).

Dawn described that she felt pressure to breastfeed rather than supported. She seemed to interpret her partner's mother's advice in a negative way partially because the mother had found breastfeeding easy and Dawn had not. Dawn didn't think that she understood her situation:

> And it was just, well she didn't understand, she didn't have problems with him, I'm having difficulties with this. It's totally different when you had an easy time breastfeeding you don't know what it's like to have a difficult time. So I felt that I was pressured to do it by her, which I think added to my stress and being so upset about thinking about quitting (Transcript 1).

Dawn's own mother told her: "Oh, you don't need to be breastfed" (Transcript 1). Her mother had not attempted breastfeeding but formula fed Dawn and her sibling. Jane also talked about feeling pressure to breastfeed from her stepmother. She said:

> She just told me I should keep on trying, keep on trying to pump and just give it another couple of days and let your nipple heal and it'll be fine. You know, she kept saying that and I just finally said, " You know, I don't want to do it anymore and I'm gonna give her Similac" and that's it (Transcript 1).

Lori tried to breastfeed for one month and her own mother would say to her: "Lori, it's O.K., just feed formula" (Transcript 1). This was hard for Lori because she wanted to breastfeed but was struggling. Lori also spoke about feeling like she had the instrumental support from her parents in the area of meal preparation and house cleaning but felt that she was lacking in the area of emotional support from her parents because they were away at work during the day.

Messages were mixed from family members with regard to breastfeeding. Some women received encouragement from their mothers-in-law. This can be classified as emotional support however mothers in this study did not interpret the messages in a positive way. Instead, some described feeling like they were getting pressured to breastfeed. This seemed to happen when the mothers were experiencing difficulties with breastfeeding. Research has indicated that breastfeeding support is enhanced when women have a close, trusting relationship with the support provider (Humphreys et al., 1998) and if the mother perceives that the provider is knowledgeable (Trado & Hughes, 1996). Perhaps in these instances the women did not have a strong, positive relationship with their mother-in-law therefore the emotional support provided was not regarded as helpful. This is in

contrast to the Health Canada (1995) study that reported women who terminated breastfeeding early were encouraged to switch to formula by their mothers-in-law.

On the other hand the messages that came from their own mothers was received by the participants in a more positive light. This occurred even though the message was not in support of breastfeeding; that it was fine to switch to formula. This may be due to the fact that women in the study trusted their own mothers' advice. This too is in contrast to the finding that women received both emotional and instrumental support to breastfeed from their own mother and also received support from their sister (Health Canada, 1995). The above findings indicate that the relationship the women has with the support provider may be an important factor in how support is perceived and integrated.

Inconsistent Support Experiences

Mothers had different experiences of support from nurses in the hospital. Dawn felt she had poor support from the nurses in both the quality of support and in terms of support available when she needed it. She said the nurses made her feel like she was not breastfeeding her son the "right way" (Transcript 1). Dawn felt that the early experience of inappropriate and inadequate support might have contributed to her breastfeeding termination. About this she said:

> She was always putting me down about my technique of breastfeeding him. Trying to tell me, "well you have to do it my way! You have to do it my way!" But it wasn't working her way with him it was working the way I was doing it with him. So it was, trying to argue with a nurse whether she knows more about breastfeeding or if a first time Mom does (Transcript 1).

Lori was confused by the different messages about the technique of breastfeeding. She asked herself: 'so you're like, what am I supposed to do?' (Transcript 1). She also wasn't happy with the quality of the information she received about breastfeeding technique from her health care worker. She described this person as a medical student. This person, she thought, seemed inexperienced with breastfeeding and she would have liked to have had a nurse that was more experienced with helping new mothers. Lori had requested to see the hospital lactation consultant and was happy with that encounter however; she stated it happened too late because early problems with latch had led to her daughter being supplemented with formula.

For Lori and Dawn the quantity of informational and instrumental support was lacking because they did not get the help she needed to latch their infants on to the breast during the first days after birth. Similarly, inadequate and or inappropriate assistance from nursing care was cited as one theme that characterized the experience of short-term breastfeeding among women in a phenomenological study by Mozingo, et al., (2000).

In contrast, Christine and Jane felt that they received plenty of support from the nurses in the hospital. Jane went to a breastfeeding class and thought it was really good. She said: "I did get lots of help, a lot of nurses came to help me and if I needed help, they'd come, they're there to help me which is good. Cause you need it. You need help" (Transcript 1). In fact she liked the support she received so much she didn't want to leave the hospital: "I was upset when I had to leave. Cause I felt it was safe" (Transcript 1).

Christine felt confident that breastfeeding would go well because of the support she received during those first days of learning to breastfeed. Jane and Dawn also talked about

how they felt supported by the nurse that visited them once they arrived home from the hospital. Dawn said:

> She was really helpful just because she made me feel if I did stuff it wasn't a bad thing. She said I can supplement or I can keep trying or quit entirely and she made it so that it was kind of any thing was an option for me. That I'm not a bad Mom because I'm thinking about stopping breastfeeding (Transcript 1).

Women in the study report different experiences of support from nurses in the hospital. Some positive experiences of informational and emotional support while others experienced negative. The support received by the nurse who visited at home was perceived as positive because the mother was supported emotionally and was provided with information.

Variable Support Experiences

Male partners were mentioned by women who weaned earlier as being involved with the breastfeeding process. Christine described how she felt like she received instrumental supported from her husband because he would bring the baby to her to breastfeed. He would also encourage her to breastfeed. However she felt pressured to continue breastfeeding because of his influence. She said: "I felt like, yeah, he's my husband and I want to do things he wants me to do too, you know" (Transcript 1). He didn't want her to stop breastfeeding. At five weeks postpartum which was two weeks after she had weaned her daughter she stated that her husband had gotten used to her not breastfeeding. In fact, she thought he even liked the idea: "because before it took an hour and I'd feed her so often you know, but now she eats more during the day and less at night

and its shorter so, you know, so he's not kept awake for very long at night anymore" (Transcript 1).

Dawn's partner had contrasting opinions about her continuing to breastfeed. She explained:

> He nagged about the money a little bit. 'Oh well we weren't prepared for spending this money on formula every week' and things like that but you know, it was also at the same time like he said he was jealous that I was being able to feed him (infant son) and he wasn't. I kind of want you to (quit breastfeeding) but the money and – "(Transcript 1).

In two instances, women who were breastfeeding identified their male partner as someone who provided instrumental support for them while breastfeeding. This came in the form of caring for their infant or caring for the women's needs while she was nursing. Sara's husband was a source of instrumental support. Sara said her husband was the most supportive person for breastfeeding excluding her infant son. She was very pleased that her husband not only helped with the household chores but with baby care as well. She described the help she received: "I don't have to do any dishes at all, no housework at all. I have to fend for myself for eating, sometimes. But he makes the dinner. But – and you know, seven weeks later, all is still the same" (Transcript 1). Sara's husband was present for the interview and he spoke about how he regarded "breastfeeding as a big job" and he welcomed the opportunity to help out with household and baby care duties. Likewise Maria spoke about how her male partner visited and took over the care of their infant son or would prepare a home cooked meal for her (Transcript 1).

Women's experience of support from the male partner appears to vary depending on her unique situation. Women who weaned early described varied experiences of support from their male partners. While mothers who were breastfeeding described that male partners were involved with the breastfeeding process. These male partners supported their spouses emotionally and instrumentally.

Heath Canada (1995) found that women reported different experiences of support from their male partner. In a couple of situations, the father of the child was not disappointed when the mother introduced formula because it allowed them to share in the feeding of the child and allowed the father to develop a bond of his own with the newborn. On the other hand a number of the fathers were very much involved and supportive of their spouses' efforts with breastfeeding (Health Canada, 1995).

Mothers who were breastfeeding at the time of our interview typically described more than one person when they spoke about who provided social support during their breastfeeding experience. The most frequently identified sources of support were mothers, sisters and friends. Mothers also discussed nurses in the hospital and to some extent nurses who visited the home when mothers were discharged from the hospital as being sources of support.

Normalizing the Breastfeeding Process

Tracy had a hard time with breastfeeding her son. She had a sleepy baby and had problems latching him on and with her milk supply. Tracy talked about her mother and the emotional encouragement she provided during the early days of breastfeeding. Her mother also helped with instrumental tasks such as obtaining a breast pump. "My Mom used to tell me that it would come and not to give up and would help me. And just saying that it's

O.K. (Transcript 1). Even at five weeks postpartum, Tracy's Mom still called her every other day and encouraged her to keep breastfeeding and continued to normalize the problems she was having with breastfeeding by saying: "well it's natural" (Transcript 1). Maria also had a mother who provided emotional and instrumental support while breastfeeding. She said her mom would always tell her that breastfeeding would get better which helped to reassure her. About the instrumental support she stated: "She helps me with taking care of him (infant son) sometimes or with things I need by bringing them to me. Or like, helping me relax and stuff" (Transcript 1).

Mothers in the study also mentioned that their sisters provided support. Tina said her sister helped to reassure her about the emotions she was feeling while learning to breastfeed:

> When I would go through crying spells or was upset. My sister helped by telling me 'this is normal'. Just hearing that was good enough, you know, even if she was lying to me. It just felt better. 'Cry all you want, let it out. It's not going to get better unless you let it out and this is normal, everybody goes through it'. So hearing that makes a big difference (Transcript 1).

When Tina felt like quitting breastfeeding, she stated her sister helped to get her through the rough time. She stated: "so if I hadn't been told, you know, that it was 'O.K' (Transcript 1) she doesn't think she would have been as successful. She credits her sister with helping her get rest so she could cope better with the demands of breastfeeding. Her sister said:

> "I'll bring the baby in when he's ready to be fed'. Then she would take him away and burp him and change him and do all the rest of it and I could just go back to

sleep. If I didn't have my sister here to do that I wouldn't have done as well (Tina: Transcript 1).

About sticking with breastfeeding and not switching to formula she said: "without that I may have easily gone to formula just so that the dad could feed him. You know, because....it's too bad at that exhaustion state" (Tina: Transcript 1).

Tina, Sara, Tracy and Maria identified their sisters as sources of informational support. Their sisters had breastfed previously and gave them tips and answered their questions about breastfeeding. Sara talked about how her sister told her to rest:

> 'Sara', she said, 'take your time, relax, do as much relaxing as you can after he's born. The more you relax, the better it is – healthier for you – not just breastfeeding but for your recovery. It's healthier for you, it better for the milk supply' (Transcript 1).

Maria's sister told her: 'it's okay, keep on trying to get him back on because that'll be easier, like when he's hungry and stuff, it'll be easier for you later, cause you can just pop him on the nipple and start eating instead of having to do the whole bottle thing in the middle of the night' (Transcript 1).

For the women in the study, their own mothers were sources of emotional and instrumental support during the challenging early period of breastfeeding. Emotional support came in the form of encouragement to keep breastfeeding and in validation that what the mothers were experiencing was normal. Instrumental support was helping with the care of the baby or obtaining necessary equipment to help facilitate breastfeeding. The women also described their sisters as sources of emotional encouragement, said they

provided instrumental help with the care of the baby and were available to provide information about breastfeeding.

Reciprocal Information and Encouragement

Women in the study spoke about friends and how they supported them during the breastfeeding process. Friends provided advice and information. Friends also offered a willing ear to talk about concerns they had as well as encourage them to keep trying when faced with problems. The work by Trado and Hughes (1996) illustrated that friends were important sources of informational and emotional support for mothers. Mary talked about how she would phone her girlfriend in Vancouver when she had questions about anything:

> She has information that I don't know and I have information that she doesn't know so we play off each other, work off each other. And if we don't know it then we find it out. We phone each other and find it out. So it's been really helpful (Transcript 1).

Tina said:

> My girlfriend is still breastfeeding right now cause her baby is only 3 months old and I'm lucky that she had her baby first cause then I can hear everything that I can expect just before it happens and being told by her, "just try this or just try that". Then it's not like I'm doing it alone. It makes the biggest difference. There is always someone to call, to ask, if you're having problems (Transcript 1).

Sara's friend offered advice about feeding often in the evening so that her baby would sleep longer during the night and Sara appreciated the information because it worked well for her and her son (Transcript 1).

For Tracy, her friend in Prince George supported her emotionally and provided advice about breastfeeding because she was always asking her: "'how's it going' and was available to talk about concerns" (Transcript 1). While Maria's friends didn't have children, she described how they encouraged her to keep trying to latch her son on to the breast. They would say to her: "if this is what you really want to do you should keep on trying because if you didn't you would have just given up long ago" (Transcript 1).

Friends have been identified as important sources of support for mothers who breastfeed. In a quantitative study by Barron, Lane, Hannan, Struempler, and Williams (1988), the influence of friends could be positive or negative on the duration of breastfeeding. The results indicated that women with friends who breastfed and who had received support from those friends, breastfed longer.

Breastfeeding Information Encourages Breastfeeding Success

Women in this study identified nurses as sources of informational support. This is consistent with the findings from the work by Trado & Hughes (1996) that health professionals provide knowledge sharing behaviours and actions. On one occasion the participants identified nurses as providers of emotional support.

Sara spoke about the breastfeeding class she attended at the hospital in which she delivered as a source of information and one that she recommended to all new mothers. Tracy described the utility of the breastfeeding information about waking her baby that she received from the nurse that visited her home (Transcript 1). Maria talked about the nurses that came to her home. She said: "I think the nurses did the informational support – a lot 'cause they had tried everything and more". Maria also mentioned that the nurses that

visited during the first two weeks postpartum offered emotional support by telling her "breastfeeding would get better" (Transcript 1).

Mary had mixed feelings about the nurse's visit to her home a few days after she got home from the hospital. She said:

> She caught jaundice, so in a way it was nice that the nurse came over to see the baby to make sure she was O.K. because of the jaundice. On the other hand it was a little bit of an inconvenience for me because your life is in ruins right then and there. You can't tidy your house, you've got a brand new baby, you're up all night, you can't walk, you can't do anything, you know. Ah, you're just settling in to it yourself, so in a way it is nice to have the support but in another way it's kind of, you feel really horrid when they come to the door and you're really unprepared for them to be there" (Transcript 1).

Tina said that while she appreciated the help and support she received with learning to latch her son on to the breast she also mentioned that she found the support confusing because each nurse in the hospital had a different breastfeeding technique to show her.

Nurses were identified as providers of informational support for mothers in the study and on one occasion provided emotional support in the form of encouragement. The informational support provided was with breastfeeding technique such as latching baby to the breast, proper positioning as well as tips to overcome breastfeeding problems. Nurses provided support both in hospital and in the home. Some mothers felt it was confusing if they received different breastfeeding instructions from each nurse they encountered.

Lori weaned her infant daughter at one month after experiencing problems with getting her daughter to breastfeed. However, she attributed her efforts to breastfeed for one

month to the encouragement and information that she received from the heath nurse that visited her at home and to the instrumental support she received from her parents. She described the nurse as being: "encouraging, she was very encouraging" (Transcript 1). The nurse, she said, didn't put pressure on her to breastfeed. She described the support in this way: "she knew that I was really stressed out and she was like, you know, if you don't do you know, it's fine. So she was trying to help" (Transcript 1). Living with her parents was also helpful to Lori as she received help with meal preparation and with housecleaning. She said: "I was sleeping on and off during the day so they'd always have leftovers in the fridge for me to grab. And they told me not to worry about the housework and stuff. That helped a lot too" (Transcript 1).

Tina spoke about what helped to breastfeed for the length of time that she had, she stated: "the support from my girlfriend and my sister, definitely, cause they both have" (Transcript 1). Sara attributed her success with breastfeeding to finding as much information as possible from friends, family and support people. She also said she made sure she got the help she needed: "when she needed it" (Transcript 1). She also spoke about her husband and how he helped her get the proper rest that she needed. In this sample, women who had support from their mother's, sister's, friends and/or nurses breastfed longer than those with inadequate or inappropriate support.

Mothers in this study identified support as a factor that led to longer breastfeeding duration. Likewise, Locklin (1995) illustrated that social support was important for mothers to recognize their competency in their ability to feed their infants. Reinforcement was necessary to validate the mother on her ability to breastfeed. Positive support of any kind was a major theme of this qualitative work and was critical to reinforce the mother.

Lack of support, whether professional, paraprofessional or familial hindered the breastfeeding process (Locklin, 1995).

Summary

As social support was described by women in this study it became evident that it is experienced in a variety of ways. This study suggests that social support is an important component of the experience of breastfeeding for all mothers, whether breastfeeding for long or short periods of time. Mothers, sisters, friends, male partners and nurses were important sources of support for breastfeeding mothers in this study. Data in this study suggest that support received in the early days of breastfeeding may shape the later experience of breastfeeding and have an impact on the duration of breastfeeding. Trado and Hughes (1996) suggests that support and commitment to breastfeeding are related in this way:

> The commitment to breastfeeding was strongly related to the support of others and of society in general. Through this support, a mother's belief in herself, a belief in her abilities and a feeling of being cared for and esteemed help her to persist in the breastfeeding experience whether or not obstacles are present (p.38).

Mothers who weaned early appeared to have inadequate or inappropriate support available to them during the early postpartum period and when at home. Mothers in the study who weaned early described positive and negative support for breastfeeding. Sources of this contrasting support were mothers, mothers in law, male partners and nurses. If support is inappropriate or inadequate, mothers may not be as inclined to continue breastfeeding, especially when faced with doubt about their ability to breastfeed.

Making the Discovery

Mothers in this study made discoveries about breastfeeding as they continued to breastfeed. Social support was an important component of the process of making the discovery about breastfeeding and in becoming confident in their ability to breastfeed. Mothers discovered aspects about their infants' behaviour and about their own personal feelings about breastfeeding. These discoveries represented the positive and the negative aspects of breastfeeding. Some mothers were able to make the discovery that breastfeeding was working for them and that they and their infant enjoyed breastfeeding and subsequently continued to breastfeed. Other mothers in the study did not make the discovery and did not continue breastfeeding.

Mothers Perceive Feeding Feedback

Infant behaviour was part of the 'making the discovery' theme. Mothers discovered and subsequently described how their infants gave them feedback about the process of breastfeeding. Some mothers talked about how they felt their infants preferred to breastfeed rather than bottle-feed and this further helped to reinforce their resolve to continue breastfeeding. These mothers breastfed longer than mothers whose infants didn't seem to prefer breastfeeding. It is interesting to note that mothers who breastfed longer also talked about how they were able to introduce a bottle and feed formula occasionally. This gave them a break from breastfeeding and may have increased overall breastfeeding duration. Another mother talked about how it seemed that her infant was able to breast and bottle feed and how it didn't seem to make a difference to the infant either way. Other mothers, some of whom weaned early, described how their infants were happier and more content being fed formula when they compared it to their breastfeeding experience.

Tina was enthusiastic when she talked about how she thought her son favoured breastfeeding over consuming formula from a bottle. Her enthusiasm was detected when she said:

> I saw him eating the formula for so long and forcing it down and then as soon as he got the breast he loved it and he would fight off the formula when we had to give it to him. That made me feel great; knowing that he would rather have breast milk. One day I had walked in the nursery (in the hospital) and he had the soother in his mouth. He was waiting to be fed, they were just waiting for me to pump off a bit of milk. When I walked back in he heard my voice and spit the soother out. And I thought, "Oh he's ready for me, he's waiting for me! Yeah!" So that felt good (Tina: Transcript 1).

Tina thought she was lucky that she had few problems with breastfeeding once her breast milk was established and she was given permission to breastfeed her son in the hospital. She felt "lucky" that breastfeeding was going well because she had heard horror stories about other mother's experiences of problems latching and sore nipples. She talked about her son's behaviour and how it helped to make breastfeeding possible:

> That's why I'm so lucky. I think I may not have (breastfed), especially taking on school and everything at the same time. I may not have continued if he wasn't so good. And I'm lucky that he takes the bottle too (Tina: Transcript 1).

Sara liked that her son ate well from the breast and after the initial difficulty with sore nipples would latch on and eat. She said this helped make her breastfeeding experience more positive in addition to the enthusiasm that he displayed when it was time to eat. She explained how he reacted: 'Yeah, I do, I want some food!' And he was kicking and

whaling his arms and stuff, just as fast as they can go. Why? He knew that food was coming" (Sara: Transcript 1). Maria also talked about how her son would feed from her breast rather than feed from a bottle. This made her feel special, as she explained:

> It's like he chooses to be with me kind a thing. You know like he wants to be with me. And he knows. It just kind of feels like -- you feel special because somebody wants to be with you. It's just like your boyfriend or your husband that cares about you and stuff and you're like 'Oh, thank you" and it's just like having another person care about you (Maria: Transcript 1).

Like Tina, Sara and Maria also talked about appreciating the fact that their infants had no problems switching between the breast and the bottle and would occasionally give bottles of formula to their infants, especially during growth spurts; when their infants wanted to feed more often. Maria said:

> So at the same time I like breastfeeding cause it gives me the contact with him but then when someone gives him a bottle, usually the dad, I'll get some personal things done. Like some housework done and it feels like --- relief, you know, some time out, kind of a break (Maria: Transcript 1).

Mary also talked about how she thought her infants' behaviour helped to make her breastfeeding experience more positive. She knew that one of the reasons breastfeeding worked for her was because her daughter preferred the breast:

> I tried to give her supplements and she didn't like them. I tried to feed her soymilk. She didn't like it, she didn't like the bottle. She didn't like the formula; she would get sick after I fed it to her. That made me want to keep with it even more. I just

want to do it for her; I hear that breastfed babies are much healthier babies (Mary: Transcript 1).

Mary's success with breastfeeding, along with the success of Tina, Sara and Maria could be, at least partially attributed to the behaviour of their infant. Their infants' behaviour was part of their perceived breastfeeding success. Longer breastfeeding duration has been associated with perceived success by the mother (Hill, 1991; Hawkins et al., 1987). Likewise, in a qualitative study by Locklin (1995) all participants (n=17) linked their infant's behaviour towards breastfeeding to their commitment to continue.

Tracy persisted with breastfeeding her son however she didn't think that her son had shown a preference for breastfeeding. She talked about how he fed using both methods and his behaviour didn't necessarily reinforce either feeding method:

> I don't think he really minds both of them. People say that you shouldn't give him a bottle so early because he gets confused but -----I don't think he really knows the difference. He'll do either or. I don't think he understands or if he does, he doesn't care because he is hungry. He'll do anything (Tracy: Transcript 1).

Christine and Lori noticed positive changes in their infants' behaviour when they fed their infants formula. Christine talked about how her daughter ate fast and good. She said: "It was a good change, she wasn't struggling and taking an hour to feed you know" (Transcript 1). Christine said this had impact on her decision to switch to formula. She said her main concern was that her daughter was fed well and if that meant formula then that was alright because she didn't want her daughter to starve or to suffer: "You don't want to starve her. I didn't want her to ---- you know, be hungry too long" (Transcript 1).

Dawn saw a change in her son when she began feeding formula. Like Christine, she said it was less of a struggle during feeding time:

> He seemed happier right away. Just cause he was getting – what he needed as opposed to having to struggle to get his food. It was just boom, there's your food. Nice and easy for you to eat. He also got to sit with other people and be fed, not just with me and things like that. So he got to bond with other people in the family as opposed to just bonding with me. Which I feel is, is important you know. Cause the mother gets to bond with them for the 10 months that they're in their tummy (Dawn: Transcript 1).

Lori had problems latching her sleepy daughter to the breast and she struggled with this for one month. She, too, found that the change to formula feeding seemed easier for her daughter and resulted in a better feeding experience. She explained:

> I'd have just this hell of a time trying to get her to eat (when breastfeeding) and then I'd give her a supplement and she's like, glug, glug, glug. And it's so much easier and she knows it's so much easier, you know (Lori: Transcript 1).

Weighing the Positive And Negative Aspects of Breastfeeding

All women in the study articulated their thoughts about the positive and negative aspects of breastfeeding. Although there were some similarities discussed, each woman had her own individual thoughts about the positive and negative aspects of breastfeeding. Data from women who were breastfeeding at the initial interview is presented and then thoughts articulated by women who weaned early are discussed.

Mary who breastfed for four months at the time of our interview thought that breastfeeding had way more benefits than negatives. For her it was: "way more beneficial"

to keep breastfeeding (Mary: Transcript 1). She liked the closeness that breastfeeding provided and she thought that it was "the most beautiful thing in the world" (Mary: Transcript 1). She went on to say that she started and continued to breastfeed because of the health benefits:

> Because its so much healthier for the baby. I started to breastfeed because its also an antibiotic and it'll help the baby so the baby won't get sick and its easier than mixing formula and buying formula, making the baby scream longer because you got to go and get it ready and warm up the bottle and mix it. I like it for its convenience. You're out somewhere and you can, you know, just duck into a room and go feed your baby or however. So I like it for the convenience, I like it for everything else and I like to know that it's actually the healthier choice for her. That's what I like most about it (Mary: Transcript 1).

Mary liked that she could feed anywhere and anytime and breastfeeding in public wasn't a barrier for her, she talked about how she fed while she shopped at the mall and while her family went to baseball games. She mentioned only a few negative aspects of breastfeeding. One is that she received a negative comment from her mother about breastfeeding in public. Her mother was concerned that Mary was not discreet about breastfeeding and that people were staring at her. The second aspect of breastfeeding that bothered Mary was that she felt she couldn't diet while breastfeeding.

Tina liked that breastfeeding seemed to get quicker as she and her son gained experience with breastfeeding. She said it used to take her an hour to feed and more recently, at five weeks postpartum, it took her 20 minutes. Tina was motivated to breastfeed because of her own health concerns:

> I know the importance of breast milk. And me being a diabetic, I know that having it makes a difference for him getting diabetes. Now he's got a 20% chance of getting it anyways and there's just so many extra bonuses to breast milk. Lots of bonuses for the baby and for the mom. Cause you lose your weight quicker, which makes me feel more energetic. Not having to carry around extra weight (Tina: Transcript 1).

Tina talked about feeling comfortable to breastfeed among friends and family but not in a crowd. She preferred to go somewhere else to feed if she was faced with having to breastfeed among strangers.

Sara, who had been breastfeeding for six weeks when we first met, discussed the positive aspects of breastfeeding for herself and her son. She liked that she felt she was losing weight 'naturally' because of breastfeeding. She elaborated: I haven't done one form of exercise and I'm losing the weight. Now maybe my waist is like ----- maybe, 32–33 inches – and after I delivered him it was at 38 inches" (Sara: Transcript 1). She also liked that breastfeeding enhanced the bonding with her son and she liked the convenience because breast milk was always "made" and was always available. She talked about how breastfeeding in Wal-Mart and Kentucky Fried Chicken was a bonus for her: "There's nothing that really hinders. You just – you just find a spot " (Transcript 1).

Sara thought that breastfeeding was the healthiest way to feed her son, she said: "there's nothing more healthier than breast milk. And it shows up on them when they start to get fat and tubby a little bit" (Sara: Transcript 1). She had also read that it helped to develop taste buds in her son's mouth and other health benefits included increased immunity to guard against ear infections and allergies later in life. She had seen her nieces

and nephews, who had been breastfed, seldom get sick and wanted the same future benefit for her son.

Like Tina, Maria had breast and bottle-fed her son. The first month of life Maria's son had trouble latching on to her breast and she had to supplement with formula. Maria too, talked about the convenience of breastfeeding and because she had bottle fed as well as breastfed, she felt that breastfeeding was more convenient than "pure" bottle-feeding. The convenience of breastfeeding was a motivation to continue (Maria: Transcript 1). She also talked about the reduced cost of breastfeeding and about the benefits of weight loss. Bonding with her son was also important to her:

> I wanted to do it and I thought it would be awesome because just being with him, the contact and stuff because babies need their mom's love and stuff. And they can tell and like, even from the earliest stage like, there's been stuff that if you spend more time with your children and your babies and they can feel the contact on their face and the body contact and the heartbeat kind of thing. They can hear and it can help them develop better and like, you want to have the smartest baby. And I thought I wanted to do it and I thought it would give him all the stuff and plus me too. It's not like, they grow so fast and I'm not going to be able to spend so much time with them after, like when I go back to work or something or school (Maria: Transcript 1).

Maria was glad that she had continued trying to breastfeed and had succeeded in making it work. She talked about how she would encourage other mothers to keep trying too, because: "the benefits are so much!" (Maria: Transcript 1).

Maria talked about some negative aspects of breastfeeding but it was clear that for her the positive aspects outweighed the negative aspects. She disliked that she had less personal time since the birth of her son and wasn't prepared for the drastic reduction. She also talked about how she didn't feel comfortable breastfeeding in public places and chose to bottle feed when she went outside the house. She explained:

> I usually give him a bottle just cause I haven't gotten used to breastfeeding outside of the house. Inside is like my house and I feel comfortable and stuff you know but outside people are like, 'Oh, you're breastfeeding?' I could just cover up and everything but I feel more self-conscious and stuff (Maria: Transcript 1).

Tracy had contradictory feelings about breastfeeding. She voiced benefits and negative aspects about breastfeeding. She had had a difficult experience with breastfeeding and supplemented with formula however continued to breastfeed at five weeks postpartum. She said she breastfed because:

> It's best for the baby. From what everybody says it is the best milk they can get, it doesn't have any of that added stuff that the formula has and cost wise we can't really afford to buy formula everyday. And I'm at home anyway so. (Tracy: Transcript 1).

Tracy voiced negative aspects of breastfeeding that centered on her personal discomfort with breastfeeding. She didn't "enjoy breastfeeding" (Tracy: Transcript 1) and disliked the pain and leaking she experienced and said she didn't feel the bonding that other mothers talked about. "I hated it. I don't know why people do it. It's horrible", she said (Tracy: Transcript 1). In addition, Tracy didn't feel comfortable breastfeeding in public and preferred to feed her son formula in a public setting. The aspect of breastfeeding that Tracy

said she disliked the most was the fact that she felt tied to her son and didn't like having him suckle at the breast all of the time. About this she said:

> Just how I always have to be around him. I always have to be there and I always have to feed him and I always ---I feel like a milk machine [laughs] that has to feed him all the time and it's just-----it seems when he's awake he's always just on me (Tracy: Transcript 1).

Christine stopped breastfeeding at three weeks postpartum, but talked about enjoying the closeness she shared with her daughter while breastfeeding and liked that only she could nourish her daughter and make her grow. She explained:

> When I hold her and it was like we were hugging each other you know, a good feeling. When I was feeding, I would think, 'Oh, I'm making her grow. I'm making her get bigger and making her gain weight'. That was a nice feeling compared to the bottle. Making her grow (Christine: Transcript1).

However Christine felt she couldn't continue to breastfeed because of her personal discomfort with nipple pain and leaking breasts. She explained:

> I think it was just all too much. Like it was hurting --- my breasts weren't my own feeling and like everything put together. And the leaking [laughs] like crazy I couldn't wait until they stopped leaking, you know. And plus, like my Mom you know, she made me feel O.K. "It's alright to not breastfeed you know"(Christine: Transcript 1).

Dawn breastfed for eleven days. She explained that she heard from others that breastfeeding was good for her son and had a positive effect on her son's immune system. She said she breastfed primarily for the health benefits and because it was less expensive

than formula feeding. Dawn elaborated on the personal factors that contributed to her decision to terminate breastfeeding. First, she didn't feel comfortable breastfeeding in front of people. She talked about initiating breastfeeding in the hospital and said she felt uncomfortable with people around. She found it was easier to breastfed at night when she was alone because she was more relaxed. Dawn also talked about continuing to feel uncomfortable with breastfeeding when she was at home because of the multitude of visitors she received (Dawn: Transcript 1). Her partner also influenced her feelings about breastfeeding. On one hand wanted her to breastfeed and liked that it was less expensive than bottle-feeding but on the other hand he was jealous of the intimacy mom and infant shared. Dawn's partner explained:

> I was extremely jealous. Every time that she'd feed him I just wanted to do it myself. It was -- severe jealousy almost. It was just something that she had with him. You know he's here he's out and every thing but I couldn't do that unless he was bottle feeding (Dawn's partner: Transcript 1).

Jane commented that she liked having larger breasts during the time she breastfed. For her, this was one of the personal benefits for breastfeeding. She also mentioned that she liked feeling close to her daughter while breastfeeding however felt the same measure of closeness with bottle-feeding. The reduced cost of breastfeeding and the incentive to stay quit from smoking was also mentioned by Jane.

On the other hand, Jane found the prospect of pumping milk to use while going out confusing. She wasn't sure about the volume of milk she would pump. The thought of breastfeeding her daughter in a place like a mall washroom didn't appeal to her. For these

reasons she thought formula feeding was easier. Jane also mentioned that formula feeding increased the time she had to herself:

> I liked it that other people can feed her. Even if I was breastfeeding and started to pump it and put it in a bottle and let someone else feed her but then that just takes time [laughs] and I also found that when I breastfed I didn't have time for myself. It was always time for her and I didn't eat and I really tried to eat because you're supposed to eat healthy, right and stuff but it was just – -- really very difficult. You know (Jane: Transcript 1).

Lori perceived the benefits of breastfeeding in a similar way as other mothers. She talked about immunity, the superior nutrition of breast milk, the reduced cost of breast milk and the positive element of bonding with her daughter. What was unique about Lori's perspective is that she talked about how she felt breastfeeding was what a mother was supposed to do. She explained: "the forefront was just the mother issues, kind a thing – that's what a mother's supposed to do" (Lori: Transcript1).

Lori stopped breastfeeding when her daughter was one month old and she worried that if she didn't breastfeed, her daughter wouldn't distinguish her from other women:

> I think that was another thing is that you worry cause I live with my mom so I was worried that if I'm not breastfeeding she's not gonna think that I'm the mom. I know that was partly in my mind too. Is that she was gonna think that I was a big sister or something, you know. But 'No' – that's her word mama so I mean, obviously you know. No – you don't have to worry about that – they know who their mom is. I think that was another thing that nagged at me. I think for me it

was different because I lived with my parents, if you don't live with your parents I don't think you'd have that same thought (Lori: Transcript 1).

Positive (pros) and negative (cons) aspects of a behaviour have been discussed in the psychological literature as being important in the adoption and maintenance of a behaviour (Prochaska, 1997). Decisional balance is the equilibrium that one perceives between the pros of doing the behaviour compared to the cons of doing the behaviour. In order for an individual to adopt a behaviour they must perceive that the pros of doing the behaviour outweigh the cons of doing the behaviour. If the pros outweigh the cons the decisional balance scale is tipped in favour of adopting the behaviour. In the case of breastfeeding, participants voiced their perceived pros and cons of breastfeeding. Mothers who perceived the pros to outweigh the cons continued to breastfeed, while mothers whose cons outweighed the pros terminated breastfeeding.

Summary

It was evident among the participants in the study that making or not making the discovery about breastfeeding was contingent upon the validation a mother gets about her breastfeeding efforts and upon the confidence she builds with continued breastfeeding experience. This was linked to the theme of perceived social support because social support was important to mothers to provide validation about breastfeeding efforts and to help build self-efficacy. In the study by Locklin (1995) uncertainty about the mother's ability to breastfeed gave way to "discovery" that she could produce enough milk, that the infant could suckle and that the infant preferred mother's milk to other milks. However, reinforcement was necessary to validate the mother on her ability to breastfeed. Positive

support of any kind was a major theme of this qualitative work and was critical to reinforce the mother (Locklin,1995).

Behaviour of the infants was another aspect of the experience of breastfeeding for women in this study and was linked to perceived breastfeeding success. Breastfeeding success had been attributed to longer breastfeeding duration. Mother's who noted that their infants demonstrated a preference for breastfeeding, breastfed longer. While mothers who believed that their infants struggled with breastfeeding and subsequently fed faster and easily with formula, terminated breastfeeding earlier.

Mothers in the study talked about the benefits of breastfeeding. Benefits included health benefits for the infant such as superior nutrition, increased immunity and reduced incidence of allergies later in life. Mothers mentioned the benefit of bonding with their infant, the convenience of breastfeeding versus bottle-feeding and the low cost of breastfeeding as personal benefits. The time that breastfeeding consumed and subsequent reduced personal time, feeling like a milk machine, the issue of breastfeeding in public, and the fact that others could not feed the infant were all voiced as negative aspects of breastfeeding. Similarly, Maclean (1990) reported that deciding where to breastfeed and in front of whom are two of the most controversial aspects of breastfeeding. According to Langille (1995), low income study participants did not breastfeed their infants in public even though they thought it was an acceptable behaviour. It appeared that women perceived that breastfeeding in public would be a more negative experience for them than if they organized or scheduled the feeding such that breastfeeding in public could be avoided (Langille, 1995). Findings suggest that there are significant perceived social barriers which prevented these women form breastfeeding in public areas.

Mothers who made the discovery talked about the benefits of breastfeeding outweighing the negative aspects and subsequently continued to breastfeed. The perceived benefits of breastfeeding may help tip the decisional balance in favour of continued breastfeeding. Conversely, mothers who terminated breastfeeding earlier discussed the negative aspects more than the positive aspects of breastfeeding and therefore the decisional balance was in favour of not continuing to breastfeed.

Personal Motivation

The theme personal motivation emerged from the interviews. Personal motivation included motivation to 1) initiate breastfeeding, 2) seek help with initial problems and 3) continue breastfeeding. Persistence appeared to be the major behavioural indicator resulting from personal motivation among participants in this study.

Early Determination

> Mary spoke of her determination to breastfeed before she began, she said:
>
> I wanted to. I guess I was headstrong going in to it, knowing that I was going to breastfeed my child and I was going to breastfeed for as long as I can. I only have six months off so I want to be able to breastfeed all those six months to make sure that she is a healthier baby for it (Mary: Transcript 1).

Similarly, Christine described her determination to breastfeed initially and why she tried off and on for three weeks:

> Cause I wanted to so bad, I think. Cause I kept trying every couple of days. Cause I didn't mean to give her formula, in the hospital I said, ' No, no', I want to try and breastfeed her. But the fact that I wanted to breastfeed so bad, you know (Christine: Transcript 1).

Grinned and Beared It

Persistence was also evident when Mary encountered initial pain with breastfeeding: "it's just painful in the beginning, I just grinned and beared it but I'm one of those people that can do that. I might be lucky that way" (Mary: Transcript 1). Sara talked about how she had to persevere to overcome sore nipples:

> A mother doesn't even know until it's too late. And sometimes blisters just come because ---they come. Which is one of those inevitable things. You just have to bear with it and keep pursuing and working with it, in spite of it. Do whatever you can (Sara: Transcript 1).

Sara talked about taking things one 'nursing' at a time to help her get over the initial problems. She explained: "One nursing at a time is was really good. It really kept things going. It wasn't pressure, to; 'Oh no, I have to put him back on again. It's just one breastfeeding, at a time' (Sara: Transcript 1).

For half of the study participants, their approaches to problem solving often involved trial and error and an ability to persevere. The success of the endeavor astonished the mothers. Confidence, combined with personal motivation, developed when the process worked and subsequently led to a continuation of breastfeeding.

Sara spoke of her persistence to continue breastfeeding despite obstacles. She spoke about her own commitment to breastfeeding:

> You work a lot. The commitment is a factor in itself. When you put your mind to it, you should continue. And, I came home from the hospital, thinking, you know, even though I had problems, even though I got the help, I was going so far and there's no reason to even want to stop. You put so much effort into it. Why would

you want – why would you want to stop? All the effort you put in to it, you waste it! Once you stop, you've wasted it (Sara: Transcript 1).

Tracy was also committed to continuing to breastfeed. While she faced obstacles and didn't enjoy breastfeeding, she spoke about her resolve: "I don't know, just –something we stuck with. It just works (Tracy: Transcript 1). Maria also described her commitment to long-term breastfeeding when she exclaimed: "Yeah, you have to want to, want it that bad inside, kind a thing" (Maria: Transcript 1).

Personal motivation was a component of the breastfeeding experience for women in this study. All but one woman talked about their initial commitment to breastfeeding. Personal motivation was a component of breastfeeding success for mothers who continued to breastfeed and was revealed as persistence. However, personal motivation alone was not enough for mothers to continue breastfeeding. It appears that mothers must have a sense of self-efficacy, adequate and positive social support for breastfeeding and high degree of personal motivation in order to persist with breastfeeding.

Likewise, in current literature regarding breastfeeding, personal motivation and perseverance have been found to be enhanced when support and accurate information are available and accessible (Locklin, & Naber, 1993). Bottorff (1990) completed a phenomenological investigation and found that persistence was a pervasive theme that emerged from the experience of breastfeeding mothers. Persistence was reflected in the mothers' decision to initiate breastfeeding, was present when mothers continued to breastfeed during challenging times, and was reflected when mothers wanted to give their infants that best type of nourishment even when it was not ideal for them. Commitment to

breastfeeding was an important part of their continuing to breastfeed (Bottorff, 1990, p.205)

Emotional Reaction to Termination of Breastfeeding

Mothers who terminated breastfeeding had different emotional reactions. Some women felt relief when they stopped because the pain that they felt while breastfeeding was removed. Jane explained that she didn't want to breastfeed anymore because of the pain and didn't regret her decision:

> You know, I don't want to do it anymore and I'm gonna give her Similac and that's it. I mean, it's my choice, my decision, right. And nobody's gonna tell me you know, how I was gonna feed her. So umm – I don't regret it (Jane: Transcript 1).

Dawn talked about the mixed feelings of guilt and relief that she experienced when she stopped breastfeeding (Dawn: Transcript 1). Maria felt guilty when she stopped breastfeeding temporarily and Lori and Christine experienced guilt when they made the decision to wean their infants permanently. It seemed that women who had a high degree of personal motivation described intense feelings of guilt.

Similarly, comments expressing guilt, disappointment, self-directed anger and a sense of shame were described among participants in a phenomenological study of women's experience of short-term breastfeeding (Mozingo et al., 2000). Data from a survey by Health Canada in 1995 also reported that women who moved away from exclusive breastfeeding expressed guilt. Mothers felt guilt because they thought it was a personal failure on their part or something that they did for their own benefit and not necessarily for the child (Health Canada, 1995, p.36).

Maria talked about feeling like a "bad mom" because she couldn't breastfeed her son for a period of two weeks. She was trying to breastfeed and he later took the breast however she described her feeling when he wasn't taking the breast:

> I was missing having him close to me and breastfeeding because, I don't know, I just got really sad, like I know I'm not a bad Mom because of that but you just feel -- I felt like really down about it ! And I was just like, 'I'm still feeding him (breast milk) with the bottle but it's just not the same!'. Cause I'm like he's gonna be feeding with the bottle later, like when he's older and I still wanted to do this part (breastfeed), you know (Maria: Transcript 1).

Christine talked about how she felt when she stopped breastfeeding at three weeks postpartum:

> When I was feeding her I just wanted to stop because it was hurting. And I felt bad and then cause I do want to, you know, cause they say breastfeeding's the best, you know. And I think it is too ---- but it's sad kind of too. I felt bad ---- like guilty kind of (Christine: Transcript 1).

Like Maria and Christine, Lori felt very badly that breastfeeding wasn't working. She talked a great deal about wanting to breastfeed, wishing it would work and feeling guilty when it wasn't:

> I felt very guilty. Very, very guilty. And I felt guilty too because I was frustrated. Yeah and it's not fair to her to have a frustrated mother. You know, cause she's supposed to have love and support. She just came out into this world and she's like what's going on and we're like, 'ahh'. And you're stressed and babies can sense that. They know, you know. And then it's hard on them (Lori: Transcript 1).

It took Lori about two weeks to not miss breastfeeding. She said after she got over missing breastfeeding she felt a sense of relief about not having to worry about trying to breastfeed her daughter. She described her process:

> And once you get past that and you're like, 'O.K. I'm just going to bottle feed her' and 'I'm not going to try anymore' then it just all of a sudden, it's just 'phew' gone, you know. But really, I don't know it just – I don't know how to say it [laughs] --- relief – relieving and then you're not worrying about breastfeeding. You're just worrying about taking care of your baby. Which is what you should be doing, not worrying about breastfeeding. You should be worrying about taking care of the child that's it (Lori: Transcript 1).

Summary

Mothers described aspects of their breastfeeding experience that represented personal motivation. Personal motivation was expressed as a desire to initiate breastfeeding. For more than half the study participants, personal motivation was also expressed as an ability to persevere with breastfeeding obstacles. Subsequently personal motivation was a component of breastfeeding duration.

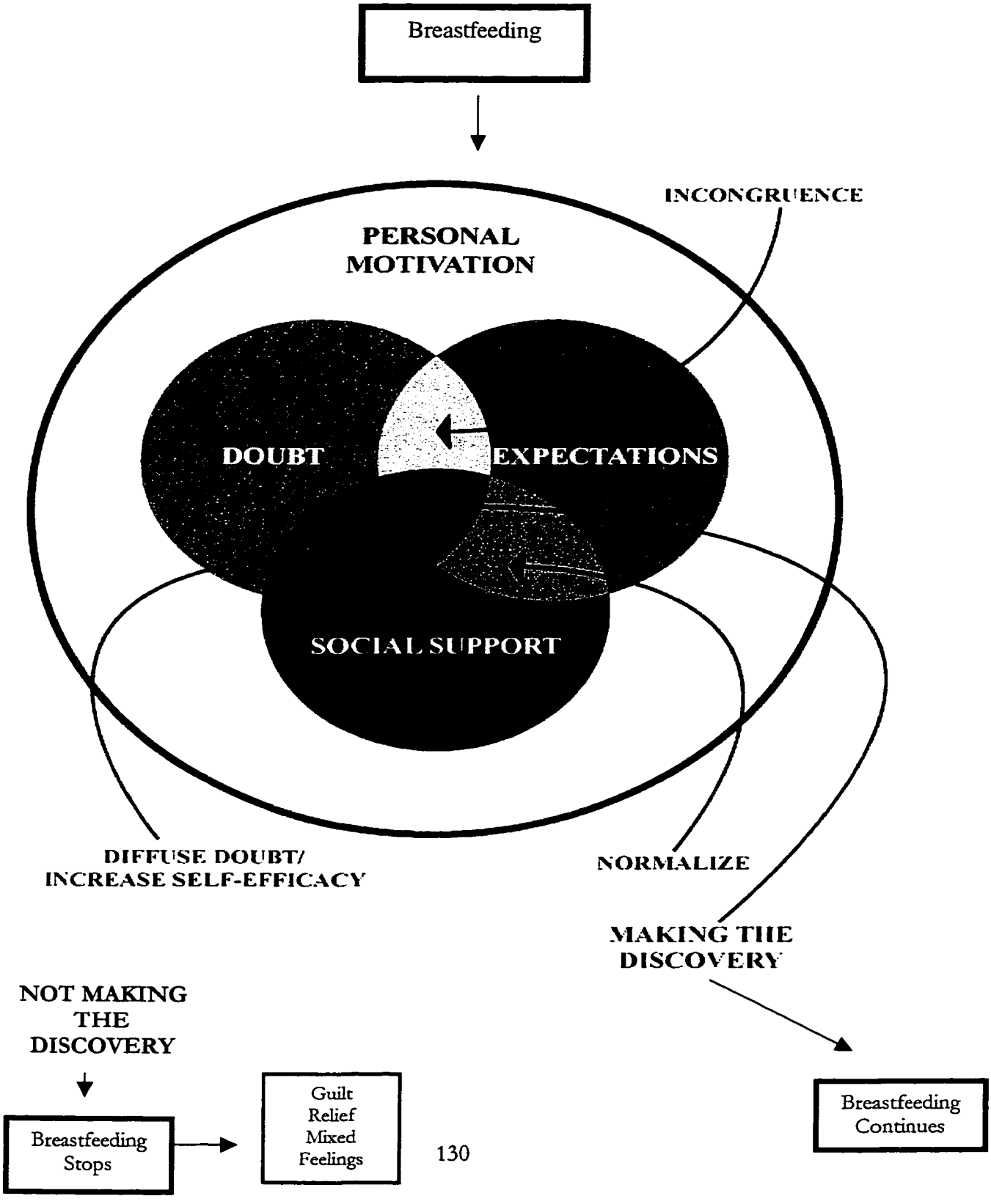
Mothers who terminated breastfeeding, talked about their emotional reactions. One mother felt a sense of relief when she stopped. Another mother felt guilty when she stopped temporarily. A few others talked about feeling both relief and guilt when they made the decision to cease breastfeeding. Among this group of women, feelings of guilt appeared to be related to a mothers' sense of personal motivation to breastfeed their infants.

Chapter Six

Summary of Conceptualizations

What is it about breastfeeding that some women stop breastfeeding, while others, faced with similar situations, continue? The answer to this question is not a simple one and is inherently what was to be understood by undertaking this study. The purpose of this research was to shed light on this question and to understand the experience of breastfeeding among a selected population of low income women. More specifically, the study sought to identify the experiences that assist women to continue breastfeeding for longer periods, to understand the experiences that lead women to wean early, and finally to examine the degree and nature of support women experience within the family and broader community. Interview data have confirmed that breastfeeding is a complex process and a visual interpretation/synthesis of the themes are presented in Figure 2. There is no single experience that can account for early breastfeeding cessation or for continuation of breastfeeding. Rather, it is a complex interaction of experiences that are combined to describe breastfeeding for women living on a low income.

Figure 2: The Experience of Breastfeeding Among Women With Low Incomes



However, women in this study have confirmed that there are key aspects of the breastfeeding experience that influence a mother's decision to continue breastfeeding or to wean early. Themes that emerged from the interview data to describe the experience of breastfeeding among women living on a low income include idealized expectations, doubting self-efficacy, perceived social support, personal motivation and making/not making the "discovery". Mothers in this study made discoveries about breastfeeding as they continued to breastfeed. Social support was an important component of the process of making the discovery and in becoming confident in their ability to breastfeed. Mothers discovered aspects about their infant's behaviour and about their own personal feelings about breastfeeding. These discoveries represented the positive and the negative aspects of breastfeeding. Some mothers were able to make the discovery and subsequently continued to breastfeed. Other mothers in the study did not make the discovery and did not continue breastfeeding.

The data illustrate that women have no way of predicting success before they begin breastfeeding. The perception of success literally unfolds before them. There was a critical time when women had to decide to continue or to abandon breastfeeding. This time was in the initial two to four weeks postpartum when they were faced with early postpartum strains. Mothers in this study faced obstacles during this period and mothers talked about how these early problems caused distress for them and accounted for a large component of their breastfeeding experience. For many study participants it was sore, painful nipples or engorgement while learning to breastfeed. For others it was difficulty latching their infants to the breast because of early supplementation with formula or water or because their infant was excessively sleepy.

Early breastfeeding obstacles caused concern for the mothers in the study. They were shocked by the problems they were experiencing and in retrospect thought that they were unprepared for the difficulties the obstacles presented. Incongruence resulted when mothers compared their 'idealized' expectations of breastfeeding with their actual, more difficult experience.

All nine participants talked about their initial belief that breastfeeding was natural, simple, and easy; that it needed little preparation and was a instinctive process that would evolve between mother and infant. Women were surprised when their experience of breastfeeding was not the same as what they had read about, what they had seen in the media or what others had told them about breastfeeding.

The disparity between idealized expectations and actual experience resulted in self-doubt for breastfeeding mothers. Doubt about individual breastfeeding self-efficacy was a common theme among eight of the nine women interviewed. Women doubted themselves about different aspects of the breastfeeding process; mothers were concerned about their milk supply, with adequacy of nutrients in their breast milk, they worried about breast infection, wondered about adequate infant weight gain and doubted their breastfeeding ability because of their breast pain.

Doubt was confirmed by the women during second interviews and appeared to be present in differing degrees, for each mother. Feedback about doubt resulted in two different terms to describe this experience. Some mothers, who weaned early, felt that problems were their fault and unquestionably doubted their own breastfeeding self-efficacy. The women agreed that doubt was a suitable word to describe what they felt and confirmed that doubt was one element of their breastfeeding experience that led to early

weaning. In essence, a low sense of self-efficacy may have been one factor that precipitated early weaning.

Other mothers regarded obstacles as things that 'just' happened and could be overcome. The sense of concern or uncertainty that they felt, about the breastfeeding process, didn't lead to early weaning. These mothers may have had a greater sense of self-efficacy and confidence in their ability to breastfeed when compared to the mothers who weaned earlier. Further evidence of this may have come when mothers gave feedback about the doubt theme. Mothers who breastfed longer preferred the term 'concern' or 'uncertainty'. They thought that doubt was too strong of a word to describe what they felt.

This study and the existing literature suggest that social support is an important component of the experience of breastfeeding. This study suggests that support received in the early days of breastfeeding may shape the later experience of breastfeeding and have an impact on the duration of breastfeeding. With social support, mothers were able to overcome breastfeeding obstacles because in many cases support from a close person helped to normalize the breastfeeding experience and helped to provide mothers with critical information about the breastfeeding process. Without social support mothers had no way of deciphering whether their expectations were realistic or unrealistic and whether their experience was normal or unusual.

Social support was important during the period of time that mothers doubted their ability to breastfeed because it served to diffuse doubt and to increase self-efficacy by providing positive role modeling, verbal persuasion, anticipatory guidance and social comparison. Mothers who approached breastfeeding as a learning process and who thought that they could overcome breastfeeding problems breastfed longer in this study

possibly because they possessed a higher degree of self-efficacy. This appeared to be enhanced and mediated by the social support mothers perceived. Mothers, sisters, friends, male partners and nurses were important sources of support for breastfeeding mothers in this study and provided the quality of social support that was helpful for mothers. Mothers who breastfed for a longer duration, described consistent and positive examples of breastfeeding support from these sources.

Mothers in the study who weaned early described both positive and negative support for breastfeeding. Sources of this contrasting support were women's own mothers, mothers in law, male partners and nurses. Social support that was perceived as inconsistent or inadequate did not appear to be as helpful to women. This may have occurred because support that was inconsistent or inadequate was not as advantageous in the face of breastfeeding obstacles possibly because it did not help to normalize the breastfeeding process and did not buffer against decreasing self-efficacy.

Mothers described aspects of their breastfeeding experience that illustrated the personal motivation theme. Initially, personal motivation was expressed as a desire to initiate breastfeeding, as all mothers who participated were motivated to begin breastfeeding. For more than half the study participants, personal motivation was also expressed as a desire to persevere with breastfeeding obstacles. Subsequently personal motivation expressed as persistence was an important component of breastfeeding duration because it helped mothers to persist and overcome breastfeeding obstacles.

It was evident among the participants in the study that making or not making the "discovery" about breastfeeding was contingent upon the validation a mother received about breastfeeding efforts and upon the self-efficacy that developed with continued

breastfeeding effort. Social support was consistently described by mothers as being important to validate breastfeeding efforts and integral to the ongoing elevation of breastfeeding self-efficacy.

Behaviour of the infants was another aspect of the experience of breastfeeding for women in the study and was linked to perceived breastfeeding success and to the 'making the discovery theme'. Mothers who noted that their infants demonstrated a preference for breastfeeding; breastfed longer. As well, mothers who perceived that their infants could breastfeed well and feed from the occasional bottle breastfed longer. Mothers who believed that their infants struggled with breastfeeding and subsequently fed faster and easier with formula terminated breastfeeding earlier.

As part of making the discovery, mothers in the study talked about the benefits of breastfeeding. Benefits included health benefits for the infant such as superior nutrition, increased immunity and reduced incidence of allergies later in life. Mothers mentioned the personal benefits of bonding with their infant, the convenience of breastfeeding versus bottle-feeding and the low cost of breastfeeding. The time that breastfeeding consumed and subsequent reduced personal time, feeling like a "milk machine", discomfort with breastfeeding in public, and the fact that others could not feed the infant were all voiced as negative aspects of breastfeeding. For mothers who breastfed, the benefits of breastfeeding tipped the decisional balance in favour of breastfeeding.

On the other hand, mothers who terminated breastfeeding earlier discussed the negative more than the positive aspects of breastfeeding. Mothers who terminated breastfeeding, talked about their emotional reactions. One mother felt a sense of relief when she stopped. Other mothers felt guilty when they stopped. A few others talked about

feeling both relief and guilt when they made the decision to cease breastfeeding. Among this sample of women, feelings of guilt appeared to be related to a mother's sense of personal motivation to breastfeed their infants.

Conclusion

Despite the perception that breastfeeding is natural and instinctive between mother and baby, the experience of study participants provided many examples that illustrated how the experience of breastfeeding is influenced by maternal and infant characteristics, cultural influences, social support networks and the health service environment. Conversational interviews provided a forum for women to articulate their experience of breastfeeding. Phenomenology was an approach to research that facilitated the generation of data based on the 'life world' of low income women who breastfed. Health promotion provided a perspective from which to view the experiences of the women and thus make recommendations to improve breastfeeding duration. A wide range of health promotion strategies form the basis for action (WHO, 1986) including developing personal skills, re-orientating health services, creating supportive environments and strengthening community action.

Chapter Seven

Recommendations for Health Promotion Practice and Future Research

All concerned individuals must work together to press for changes in our individual and socio-cultural environment to facilitate breastfeeding. The breastfeeding mothers or future breastfeeding mothers, caregivers who work with mothers and partners during the early postpartum period and others concerned about the promotion of breastfeeding may be interested in the recommendations that have followed from the findings of this study. Health promotion strategies form the framework for the proposed interventions contained in this chapter. These include suggestions aimed at developing individual skills, creating supportive environments, re-orientating health services and strengthening community action. The ultimate purpose is to help mothers generate realistic expectations about the experience, to become better informed about the breastfeeding process, to help mothers formulate potential solutions and ultimately overcome breastfeeding problems and to increase the probability that women will feel comfortable breastfeeding in public. Efforts to address these identified issues ultimately aim to lengthen breastfeeding duration among women living on a low income.

Issue: Realistic Expectations

Strategies: Developing Personal Skills, Creating Supportive Environments.

Women spoke about the expectations of breastfeeding and how they were very different from the realities that they experienced. This study has shed light on the possibility that women would benefit from being prepared for a realistic breastfeeding experience. One mother talked about the fact that she only heard about positive breastfeeding experiences while she was pregnant: "Of course all I had heard was good

things about breastfeeding. Right. 'I had an easy time with breastfeeding, well I had an easy time with breastfeeding'. You know, no negatives, so when mine was a negative it was like "Oh my gosh, am I the only one?" (Dawn: Transcript 1). This finding informs us that while health professionals and women should be encouraged to share the positive aspects of breastfeeding with future breastfeeding mothers it is important that potential breastfeeding problems also be discussed. Likewise, Dawn thought that she had been prepared only for a positive breastfeeding experience:

> I think they do (help others prepare for breastfeeding) in a positive manner but they don't like to bring the negative in because they want the women to breastfeed. So the women who have the negative end up just quitting whereas if they'd known....O.K. yeah, for the first week it's fine but then the next two weeks say there's pain so you're nipples toughen up and then it's fine again. Because that's what I've heard from other people now but you know it's kind of late now. If I would have known that before then I might have toughed it out for another week and then maybe the pain would have gone away and him and I would have just been smooth sailing from there (Dawn: Transcript 1).

Presenting breastfeeding information in a realistic fashion may help women avoid over-romanticizing the process of breastfeeding. Women in this study also spoke about how they wished they would have had more information about breastfeeding and felt that this would have led to a more relaxed breastfeeding experience . Therefore there is a need to create a more realistic expectation of breastfeeding, by giving factual information about breastfeeding to future parents, particularly mothers. This needs to include reference to the

possibility that they might experience problems initially with breastfeeding and that this is a normal part of the learning curve for a new experience.

In addition, recognition of the effect of the baby's temperament on breastfeeding is an important factor in adjusting to the changes. It is clear from the interviews that infants, like everyone else, display a range of temperaments and mothers who were prepared for that fact were less likely to attribute problems to breastfeeding or to themselves. This should be discussed with first time mothers so they are not alarmed by the display of different feeding behaviours.

Issue: Viewing Breastfeeding As a Learning Process

Strategies: Developing Personal Skills; Re-orientating Health Services; Creating Supportive Environments

When mothers learn that problems can result from breastfeeding, they should also know that most breastfeeding obstacles can be overcome. There needs to be wide recognition among mothers that while breastfeeding is 'natural', success is more a result of learning and support rather than something that is instinctive on the part of the mother and her child. Therefore this would serve to enlighten mothers and validate that they are not 'failures'. Rather they could take comfort in knowing that they were going through normal 'trial and error' which is an integral part of any new learning experience.

Information is critical when learning a new skill. One mother did attend a breastfeeding class in the hospital once she had her son and she found it very helpful and recommended it to all new mothers (Sara: Transcript 1). Others mothers in the study talked about not knowing or finding out late that the hospital offered such a class. Mothers should have access to information while they are breastfeeding and the information should not

only be about the benefits of breastfeeding but should give an accurate, realistic account of the typical breastfeeding experience. Women should be able to read about varied experiences of breastfeeding in pamphlets and books and be able to watch them on television programs and videos.

Mothers involved in a prenatal program like Best Beginning are fortunate that they have access to breastfeeding information while pregnant. However, all mothers should receive information that will present a realistic picture of breastfeeding. Classes in hospital is one route of delivery but these classes should also be offered in the community for mothers who are discharged early and miss the hospital class. In January of 2001, the CRHA initiated drop-in breastfeeding circles at each community health center. Mothers can attend weekly to receive information about breastfeeding from a lactation consultant and from other mothers attending the group. This is an improvement to what was available in the past. Previously few breastfeeding groups existed and a lot of them were in existence because mothers initiated them on their own (e.g. La Leche League). It will be interesting to see the turnout in the CRHA groups and whether they will be accessible and attended by mothers living on a low income. If need be, classes need to be offered in familiar and easily reached locations for mothers of lower income to access.

Issue: Self-Doubt

Strategies: Creating Supportive Environments; Re-orientating Health Services; Strengthening Community Action

Mothers in this study all reported feeling a sense of doubt or concern about whether breastfeeding was going well. Ensuring that mothers have appropriate breastfeeding expectations and are not surprised by breastfeeding obstacles will help to reduce the sense

of doubt that a mother may feel during the early stages of breastfeeding. Christine explained:

Like, if I was expecting sore nipples, I would be more ready for it. When I actually had it, I was so tired, and I wasn't thinking. You know, back before, like before I could have prepared ahead of time, like, 'O.K, I'm gonna have sore nipples, I'm gonna be tired, it's gonna be work'. You know, like getting my mind ready, I guess (Christine: Transcript 1).

Mothers in the study talked about wishing they had been better prepared for breastfeeding obstacles. Christine talked at length about what she would tell a future breastfeeding mother about breastfeeding:

> I would want to tell them you can get sore nipples and it can be sore. Tell them - so they were expecting it. Because if I were expecting it more, I probably would be more ready for it, I think. Cause I heard about it but, about sore nipples, but it wasn't like a big deal you know. And it was (a big deal) for me (Christine: Transcript 1).

Doubt was linked to expectation of breastfeeding and mothers thought that if they had been better prepared for the realities of breastfeeding they would have experienced doubt to a lesser degree. Mothers recognized that validation from others was an important way to diffuse the doubt they had about breastfeeding difficulty and to validate them when breastfeeding was going well. In addition to being well prepared for the realities of breastfeeding, mothers talked about the benefit of having persons close to them that could validate and normalize the process of breastfeeding. Mothers in this study didn't always have access to this and as a result doubt may have been a factor in early weaning.

Enhancement strategies should be directed at maintaining and/or enhancing mothers' self-efficacy. Women develop their self-efficacy expectations based on past experiences and performances, vicarious experience, verbal persuasion and their present physiological and emotional states (Dennis, 1999). Health professionals working individually with breastfeeding women could use a self-efficacy framework when developing breastfeeding assessment, care and evaluation strategies. Dennis (1999) suggests that performance mastery and self-efficacy are enhanced through frequent repetitions and women should be breastfeeding frequently in the hospital and observed by health professionals so that any negatively perceived outcome of their early breastfeeding experience do not undermine their breastfeeding self-efficacy. The Breastfeeding Self-Efficacy Scale (BSES) can be used to identify mothers with low breastfeeding confidence and target mothers who would benefit from self-efficacy enhancing strategies. Health care professionals can reinforce positive breastfeeding experiences and encourage women to employ self-efficacy enhancing strategies such as encouraging mothers to recall the positive aspects of their past breastfeeding performances, envisioning successful performances, thinking analytically to solve problems and managing self-defeating thoughts rather than dwelling on breastfeeding challenges. Observational learning that takes place when mothers watch other mothers breastfeed can provide additional self-efficacy enhancing opportunities. Videos and breastfeeding groups provide positive role modeling, verbal persuasion, anticipatory guidance and social comparison.

Issue: Gaps in Social Support

Strategies: Creating Supportive Environments; Re-orientating Health Services; Strengthening Community Action

Mothers talked about differing perceptions and subsequently experiences of support during their breastfeeding experience. What was apparent is that mothers who perceived that they had positive breastfeeding support and had a greater amount of support people providing support, breastfed for a longer time period. There was clearly a gap in support available to women in this study. Too many women did not feel that they had support when they needed it most.

To enhance the experience of breastfeeding for populations similar to those studied, the data demonstrated that support must be positive, consistent and accessible. As part of this, future parents would benefit from additional information that will help them easily access specific support services and resources (before and after birth of their child), in the event that they anticipate or experience problems.

Support in the hospital was different for every participant in this study. Some talked about receiving appropriate and adequate support to get their infants latched on to the breast while other mothers were very disappointed and frustrated by the lack of or insensitive support they received. What has been learned from this study is that mothers need to have access to appropriate and timely support while in the hospital. Hospital practices and policies need to be improved to support this service. Such strategies and recommendations for breastfeeding promotion in the first postnatal days are discussed in the Family Centred Maternity and Newborn Care National Guidelines produced by Health Canada (2000). Guidelines state that early, frequent, unrestricted, exclusive and effective

breastfeeding is important for the establishment of normal lactation. Skilled, consistent help from a care provider with a positive approach should be available to support this process (Health Canada, 2000). Hospitals in Calgary should strive to incorporate these guidelines into practice.

Mothers in this study shared their thoughts about how their breastfeeding experience might be enhanced. More than half of the mothers mentioned social support as a way to augment their experience of breastfeeding. Jane just wished that her family and friends could have offered more support to her while she breastfed as she recognized that 'being alone' was hard for her (Jane: Transcript 1). Michelle wished for timely help in the hospital from a health care professional who was more experienced with establishing breastfeeding. She identified a lack of support during her first days of breastfeeding in the hospital. She longed for appropriate quantity and quality support as she stated: "if you don't know how to breastfeed it would be better if someone could watch you and encourage you with that" (Michelle: Transcript 1).

Data from this study identifies that there needs to be more attention given to ensuring that mothers have sources of support in their lives once they leave the hospital. Once home a mother should having someone to call who can be a source of emotional, informational and/or instrumental support. Mothers who talked about having supportive male partners and family members breastfed longer while mothers who described being 'on their own' weaned earlier.

Christine talked about having a peer or another mother to talk to about breastfeeding:

> If I actually had talked to a Mom that actually just had a baby and was breastfeeding and she could have told me what happened to her, especially if she had, you know, not a perfect experience or something. If I had talked to a new Mom that had a baby right before me. A person that actually did have the experience (Christine: Transcript 1).

Likewise, Dawn also thought that having someone to talk to about breastfeeding and to learn that she was not alone with the problems she experienced would have been beneficial. She said: "I think so because then I would have known that there was other people going through pain and things like that" (Dawn: Transcript 1). She thought having someone to talk with who could identify with her experience would have helped her to continue breastfeeding. She added that more insight from different mothers with various experiences would have helped to enhance her breastfeeding experience and would have made her feel more comfortable with what she was going through (Dawn: Transcript 1).

Social support interventions have been successful at improving breastfeeding initiation and duration rates among low income mothers. Interventions that have involved professionals or doulas have shown to be positively associated with longer duration if interventions involve home visits (Barron et al., 1988; Sanders & Carol, 1988). Peer support interventions have shown positive associations with initiation of breastfeeding (Schafer et al., 1998; Shaw & Kaczorowski, 1999). Some have shown a positive association between peer support and duration of breastfeeding (Arlotti, Cottrel, Lee & Curtin, 1998; Morrow et al., 1999). Others have shown a positive association between peer support and both initiation and duration of breastfeeding (Kisten, Abramson & Dublin, 1994). This study and existing literature suggest that mothers with an absence of family,

friends or male partner support should be linked with peer support while pregnant. Peer support during the early postpartum period would help to support and encourage mothers during the critical two to four week postpartum.

Health professionals, prenatal organizations and women's groups need to work together to publicize their services and to develop creative ways to fill the gaps in support for breastfeeding mothers. Breastfeeding committees or formalized networks have been successful in developing, coordinating and maintaining consistent breastfeeding promotion, support and protection initiatives at the local, provincial and national levels (Health Canada, 2000)

From the study we know that women living on lower incomes face additional problems. They are more likely to move often and may be less likely to know their neighbours and feel isolated. There is less money for babysitting. They are less likely to have a car and, therefore, have to rely on public transportation to get out with the baby. There is a need for financial support for local community groups and Canada Prenatal Nutrition Programs to develop strategies to support women in these situations. Funding could be used to develop parent/child centers, to organize baby-sitting cooperatives, to develop lending library books and toys or to develop networks of mothers who are willing to lend a hand to one another for peer support of breastfeeding.

Issue: Breastfeeding In Public

Strategies: Developing Personal Skills; Creating Supportive Environments; Strengthening Community Action

Almost all mothers in this study spoke about their discomfort with breastfeeding in public. This is a fundamental concern and one that needs to be addressed. Breastfeeding promotion efforts should be aimed at making the cultural norm in Canada.

Maria spoke of the contrast between the Latin American country she was from and the influence Canadian society has had on her discomfort with breastfeeding in public:

> In my culture mainly everybody just breastfeeds. They usually don't have problems with it or want to bottle feed cause in Spanish culture usually the woman stays home and the husband goes to work. And so she's at home anyways with her child. And it's also more open. It's not seen like, 'Oh, what are you doing breastfeeding in public?' Sometimes they won't even be covered or nothing and it's just like not a big deal to anybody. And here everybody's like 'What are you doing?' you know. They kind of do that when they see women breastfeed. Even if you're covered some people have a problem with that. It's like, 'What are you doing?' It's made me paranoid to even try (Maria: Transcript 1).

Pitman (2000) writes about strategies that have helped mothers feel more comfortable with breastfeeding in public. She proposes practicing how to nurse discreetly and having clothing and accessories like a nursing sling may help make breastfeeding in public a less 'embarrassing' task for breastfeeding mothers. Jones and Green (1996) have proposed ten steps to 'Baby Friendly Communities' contained in the Family Centred Maternal and Newborn Care National Guidelines (Health Canada, 2000). These steps

include addressing attitudes within the community that perceive bottle feeding as the norm and providing education about breastfeeding being the natural and normal way to feed an infant. There are also recommendations to make public facilities, stores, restaurants and work settings mother and baby friendly. Recently in Ontario (Pitman, 2000), breastfeeding coalitions have attempted to educate the public and help change cultural attitudes about breastfeeding in public. Strategies include asking malls to make nursing rooms available to mothers and asking restaurants to post stickers on doors letting mothers know that they were welcome to breastfeed their babies at that location. She states mothers should not be pressured to use separate facilities. The ideal is that a nursing mother can sit down on any bench and feel comfortable feeding her baby. Therefore the continuation of efforts to promote the acceptance of breastfeeding must be on the agenda for those concerned with breastfeeding (Pitman, 2000) and should include changes in public policy to support breastfeeding in public places.

Future Research

Health professionals must understand the life experiences and perspectives of those for whom breastfeeding promotion strategies are intended in order for the strategy to be effective (Denzin, 1989). The need for such understanding is in recognition that a mother bases her decision about how to feed her baby on more than perceived health benefits of the baby. The present study attempted to illuminate information about breastfeeding in the context of women's lives. However, much more research is needed in this area, especially among women of several different ethnic backgrounds.

Although the findings from this study are based on a small sample and cannot be generalized to all low income women, there are issues for consideration. Further research

defining the needs of this population will be necessary to determine the pervasiveness of the themes and to compare the experiences of breastfeeding between low income and higher income mothers. Information on the utilization of support networks, the composition of support networks and about the types of support that would be most beneficial to low income women could be made more available. A participatory action research strategy would be helpful to determine the most important and relevant sources of support for low income women and to evaluate the influence. It would be informative to interview fathers about the support they provide to their female partners during the breastfeeding experience. Participatory action research would also be beneficial to help identify and develop strategies to help make breastfeeding the cultural norm in Canada and help reduce barriers to breastfeeding in public.

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Appendix A: Letter of Invitation

CRHA
Calgary Regional Health Authority

Dear New Mom,

Congratulations on your new baby!

I am a Health Promotion student who is interested in the experience of breast feeding for new mothers. I am inviting you to take part in this project. I am carrying out this project because mothers have unique experiences of breast feeding and it is important to hear about these experiences directly from mothers. Knowing more about breast feeding may help some mother's breast feed longer.

I am asking you to take part in this project because you are 18 or older, you were in the Best Beginning program, and you have never breastfed before but have breastfed this baby for at least one week. I will need to talk with you one or two times in a place that is handy for you. I would like to hear about your thoughts, feelings and behaviours that describe your experience of breast feeding. I will tape record our meetings but all information will be confidential. I will be glad to share my project findings with you if you request.

If you would like to take part in this project, I would like to hear from you. You can contact me directly or let your Best Beginning staff know that you would like to take part and I will contact you.

Yours truly,

Jill Aussant

Ph. 282-1612 or 295-6885

Appendix B: Consent Form

CRHA
Calgary Regional Health Authority

STUDY CONSENT FORM

Project Title: THE BREAST FEEDING EXPERIENCE FOR WOMEN WITH LOW INCOMES: A PHENOMENOLOGICAL EXPLORATION

Investigator: Jill Aussant B.Sc. R.D.
M. Sc. Candidate, Centre for Health Promotion Studies
University of Alberta, Edmonton
Phone No. (403) 295-6885

Supervisor::Dr. Kim Raine-Travers, Ph.D, R.D.
Associate Professor, Centre for Health Promotion Studies
University of Alberta, Edmonton
Phone No. (780) 492-9415

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

I am asking you to take part in a study of breast feeding mothers. This study is part of my Master's project and is taking place because many mothers stop breast feeding soon after having their babies. You are being asked to take part in this study because you were in the Best Beginning program and have breastfed your baby. The information that you give will help other mothers as well as health workers to know more about breast feeding.

I will meet with you and ask you to recall thoughts, feelings and behaviours about your experience of breast feeding. I may also ask you to describe events, places and people that have been positive or negative while breast feeding. I may also ask you what helps you or would have helped you breast feed longer. The meeting will be taped. I will ask you to answer some questions about your age, education level, income and present relationship. You have the right to refuse to answer a question.

The taped meetings, will last about 1 to 2 hours, and take place in a place that is handy for you. After the first meeting, another meeting or phone call will be set to discuss whether I have accurately understood your experience of breastfeeding. This will take 30 minutes to 1 hour of your time.

If you take part, the only risks to you will be that some of your time will be used and you may share some personal information. If you feel uncomfortable as a result of the meeting, I will notify your Public Health Nurse at your request

Any data you share in this study will not be linked with your name. Code names will be used on the survey and the typed interviews. The codes will be destroyed and the tapes erased once the study is finished. Typed interviews and the surveys will be securely stored for five years after the study is complete and only the study team will be able to access them. Direct quotes from meetings may be used in articles, papers and presentations; however you will not be named. All information will be held confidential except when professional codes of ethics and/or legislation require reporting. You may ask for a final copy of the report.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Jill Aussant at 282-1612 or 295-6885.

If you have questions regarding your rights as a possible participant in this research, please contact Pat Evans, Associate Director, Internal Awards, Research Services, University of Calgary at 220-3782.

_____

Participant's Signature Date

_____

Investigator's Signature Date

_____

Witness' Signature Date

A copy of this consent form has been given to you to keep for your records and reference.

Appendix C: Demographic Questionnaire

Demographic Questionnaire

Code Identifier:

Participant's Age:

School Level Completed:

Relationship Status:

Single (No partner)
Live-in partner
Live-out partner

Income Level (per month):

No Income Under $600 $601-$1000 $1001-$1300
$1301-$1600 $1601-$1900
Over $1900

Number of Adults in household:___
Number of Children (under 18) in household:___
Age of Children in Household: ___

Appendix D: Interview Guide
Interview Guide

I) What has breastfeeding been like for you?

A) Probes to find out what the experience has been like in the: first two weeks?
Probes for specific information about how the mother was feeling about breastfeeding, how breastfeeding was different from her expectations, how baby's behaviour impacted her breastfeeding experience, how Mom came to the decision to breastfeed.

B) Probes to find out what the experience has been like in the two to six week period?
Probes for specific information about how the mother is/was feeling about breastfeeding, how breastfeeding is/was different from her expectations, how baby's behaviour impacts/impacted her breastfeeding experience.

C) Probes to find out what the experience has been like beyond six weeks?
Probes for specific information about how the mother is/was feeling about breastfeeding, how breastfeeding is/was different from her expectations, how baby's behaviour impacts/impacted her breastfeeding experience.

D) What has helped you to breastfeed for this length of time?
Probes to find out more about particular factors such as convenience, enjoyment of breastfeeding, reinforcement from family members, significant others, reinforcement from baby's behaviour, peer support etc.

E) What are the positive aspects of breastfeeding? What are the negative aspects of breastfeeding?

F) Tell me about the support you have received while breastfeeding? Tell me about any negative support you have received?

G) Can you tell me about how you came to the decision to stop breastfeeding?
Probes for what factors caused mother to stop such as lack of confidence in ability, insufficient milk (probe for what this means), lack of positive support, dislike of breastfeeding etc.

H) How could your breastfeeding experience be enhanced?
Probes for family supports, community supports, information, or programs that mothers identify as being helpful and may lead to a better breastfeeding experience.

I) Is there anything that I haven't asked you that you would like to tell me about your experience of breastfeeding?

Figure 3 Participant Demographic Information

Participant	Mary	Tina	Sara	Tracy	Christine	Dawn	Maria	Jane	Lori
Age	28.	27	36	20	19	21	18	24	23
Partner	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
# of Children	1	1	1	1	1	1	1	2	1
Ethnicity	Anglo Saxon	Anglo Saxon	Anglo Saxon	Anglo Saxon	Anglo Saxon	Anglo Saxon	Hispanic	Anglo Saxon	Anglo Saxon
Plans to Return To Work/School	Yes Work	Yes School	No	Yes Work	No	Yes Work	Yes School	Yes School	Yes Work
Breastfeeding Experience	Pos.	Pos.	Pos.	Pos. & Neg.	Neg.	Neg.	Pos.	Neg.	Neg.
Breastfeeding at time of interview	Yes	Yes	Yes	Yes	No	No	Yes	No	No
Length of time breastfeeding (at interview)	4 mos.	1 mos.	6 weeks	5 weeks	3 weeks	11 days	3 mos.	12 days	1 month