The Impact of Interpersonal Communication on Breastfeeding

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THE IMPACT OF INTERPERSONAL COMMUNICATION ON BREASTFEEDING

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Dedication

This particular piece of work would not exist if not for my own experiences in motherhood. When I entered graduate school I was the mother of two young daughters, the younger of whom was still breastfeeding. At this writing, I now have three young daughters, the youngest of whom is now breastfeeding in her sister’s stead. It was my own journey into motherhood and beyond, as we welcomed our second and then third daughters into the world, that led me to find this topic intriguing. It was my relentless pursuit to make breastfeeding a priority for my second daughter after my attempts with my first daughter ended up unsuccessful that led me to start asking myself some important questions. The constant feedback I would receive from seemingly well-meaning loved ones made me begin to question what this verbal and non-verbal communication was doing to me and my children and this very intimate breastfeeding relationship. It is because of my desire to be with my daughters more that I decided to pursue a higher degree. For all of these reasons and so many more, I dedicate this thesis, the culmination of all I have worked for these past couple of years, in my education and in my personal life, to my daughters. Isabel, Sophia, & Gabriella, you three are the reasons for so many things in my life, this is simply one more.
THE IMPACT OF INTERPERSONAL COMMUNICATION ON BREASTFEEDING

by

JENNIFER LORIE ALARCON, Bachelors of Art, Communication

THESIS

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Acknowledgements

As my path on the road to my degree comes to a close, I have the opportunity to reflect on the journey that has led me here. It would be unfair to submit this thesis with my name at the top without making it crystal clear that this sacrifice was not mine alone to bear. I will admit that I worked very diligently and stubbornly to do my very best in graduate school and to never turn in anything I didn’t take pride in. But the tireless effort given at seemingly every free moment would not have been possible without many people along the way.

I first and foremost want to thank God for leading me in the many directions down the winding roads of my life. He guided me in every way, He gave my family means where they were needed, He gave me rest when I needed it, He gave me knowledge when I felt confused. He is the reason for all things and I am thankful.

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Abstract

The medical community has offered a lot of evidence in support of breastfeeding which has led to many of the leading medical associations (i.e. the American Academy of Pediatrics, World Health Organization) to recommend breastfeeding infants exclusively for the first six months of life and for at least a full year, up to two years or whatever is mutually desirable to mother and child. However, in the United States, many mothers do not follow this recommendation. Research shows that instances of women being unable to breastfeed exist but are minimal. Many people have attempted to address the problem of low breastfeeding rates because of what the health and cost-saving benefits could mean to the general population. However, approaching the issue of breastfeeding exclusively from a health point of view has not improved breastfeeding rates in the U.S.

This study approached the issue from a communicative standpoint. People, especially new mothers, are in constant communication with the world around them. Perhaps the most influential messages come from those close to us. For this reason, 13 mothers participated in focus groups based on how long they breastfed their youngest child (three years of age or younger). These mothers discussed their breastfeeding behaviors and the communicative factors in their lives that had an impact on them. They shared breastfeeding narratives and talked about those in their lives who helped them continue breastfeeding or encouraged them to quit.

The findings in this study suggest that the communication of those close to a new mother can impact her decision making in regards to breastfeeding. Some of the important findings that emerged were: the willingness of mothers to stop breastfeeding when loved ones expressed acceptance of that desire, the value of peer and expert support in continuing to breastfeed, the importance of mothers setting goals and having high expectations of themselves, the strength of supportive communication especially when compared to non-supportive communication, the helpfulness of a supportive hospital staff, and the importance of a supportive workplace/employer for mothers returning to work and continuing to breastfeed.
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Chapter 1

Introduction: History and Culture

For centuries, mammal mothers in nature have given birth to and nourished their babies with the only resources at their disposal, their own bodies and instincts. But as with most things, new ways of thinking and inventing and, even economic profit often come along and change the balance of nature. The very natural act of breastfeeding is no exception to this. Over time, the act of feeding one’s offspring has changed and evolved. For these reasons, my thesis will examine some of the major changes in breastfeeding behaviors in response to what is being communicated to mothers in North American culture. Throughout this chapter, I will take a look at the history of breastfeeding in the United States and how contemporary U.S. culture has played a part in feeding decisions. I will also explore economic concerns and their impact on breastfeeding as well as marketing and consumer behaviors. Finally, I will examine what the health sciences say in terms of nutrition and what is considered best for most human infants by healthcare professionals.

1.1 History of Breastfeeding

If an infant is not properly nourished he or she would perish; long ago mothers had no choice but to breastfeed their babies. But it was not long before substitutions became available. They initially came in the form of milk from other lactating women. In terms of breastfeeding, as with many other things in the 18th century, the United States often rode on the heels of England. And so the United States’ breastfeeding history is rich with overlaps with Britain’s history as well.

One of the first advances in breastfeeding came in the form of wet nurses, who were often reserved initially for the elite rich. A woman who did not want to bother herself with breastfeeding and what it could do to the female body would hire a woman, usually a peasant, to feed her infant (Cone, 1976), giving the baby what many believed to be best for him or her without the assumed inconvenience of breastfeeding herself. Furthermore, in 17th century America, if a child was orphaned or left in some
similar circumstance, he or she was expected to be given breast milk. According to Cone in *200 Years of Infant Feeding*, “…nursing was thought to be so far superior to dry nursing, or artificial feeding, that in court cases in America involving foundlings, orphans or illegitimate infants, wet nurses were supplied by the county, town or parish” (1976, p. 7). Later, in the 18th and 19th centuries, the fashionable women who used wet nurses had very stringent criteria for whom they would hire, including such things as skin rosiness, hair color, breath, and age.

Early 19th century medical literature was pessimistic about the fate of infants not breastfed. Many authors and founders of pediatric practices wrote that the fate of most children not breastfed would be death. It was around this time that scientists became interested in the components of breast milk. “About the middle of the 19th century there developed a heightened interest in performing chemical analyses of human and animal milks. Infant feeding then began to assume a scientific aspect which it had never had before” (Cone, 1976, p. 18). Although we now have plenty of data on the composition of breast milk and the benefits it provides above and beyond any substitutes, only a century ago this was not the case.

Scientists began experimenting with cow’s milk (and that of other animals) and comparing the components to that in human breast milk. Many were successful at making artificial substitutes, though all were lacking in some respect or another (too much of one protein, not enough sugar, not pasteurized and therefore often not sanitary). All the while, at the end of the 19th century there were very real concerns on the part of physicians that a mother’s state of mind would have an impact on her breast milk, possibly causing harm to her infant. Despite concerns over psychiatric influences on milk quality, most doctors still touted breast milk to be the best for all infants; though the idea of how long an infant should be nourished at the breast was quite different from today’s standards. According to Cone (1976), in the 19th century the standard was for an infant to receive nothing but milk for at least the first ten months of life. As late as the 1920s many were not given solid food until reaching one year of age,
compared to the present day where the first solid foods are generally introduced to infants in the first three months of life. Cone notes that the practice of cutting breastfeeding short and adding artificial alternatives at an earlier age, and consequently, solids as well, became quite popular in the 1900s despite nutrition evidence to the contrary of these practices:

In the early 1900s human milk was thought by some American physicians to have value in increasing the resistance of the infant to infections… favorable results in the treatment of gastrointestinal infections with small amounts of human milk…[it was ]also believed that human milk had therapeutic value in the treatment of bronchopneumonia in infants… striking results were also claimed in the treatment of subacute skin infections like furunculosis. (Cone, 1976, p. 80)

Furthermore, if mothers did not want to breastfeed, most did not have a wet nurse, but rather offered an artificial (usually made up of cow’s milk) substitute. Everything was generally dirty and unsterilized; including the milk, the bottle, and even the nipple that the baby drank from. Around this time some women chose not to breastfeed simply because of body image or societal standing.

In the 1930s and 1940s, many U.S. American women began having a greater sense of independence and their roles were shifting from inside to outside the home as well. During this time, women began seeking an alternative to breastfeeding, something that would be more convenient yet still healthy for their infant. According to Apple,

Women were aware of the higher mortality rates for bottle-fed infants, yet not every mother could or would nurse her child. Allegedly, increasing numbers of women refused to breast feed because nursing “tied them down,” …Though few women voiced this sentiment themselves, no doubt some mothers felt constrained when they had to stay home to nurse an infant. Other
women worried that their milk supplies were inadequate, believing that physical conditions and the effects of modern life could prevent successful lactation…(1987, p. 173)

Indeed, as Americans approached the mid-1900s, more people were turning to science for answers. Prior to the 18th century, physicians were rarely a part of the birthing process at all, but as times changed and thinking evolved, more people turned to science and medicine during maternity and post-partum periods. This change greatly impacted the view of motherhood in U.S. American culture.

As women began to trust physicians more for their parenting decisions, more and more began to turn to formula instead of breastfeeding. It was around the mid-1900s when more women began giving birth in hospitals and with this came more use of formula. In 1920, 20 percent of women gave birth in the hospital, but by 1950, more than 80 percent of women in the U.S. gave birth there (Apple, 1987). With this change came the medicalization of birthing and postpartum care. Mothers and their newborns would have extended hospital stays and the status quo during those stays was not conducive to establishing a good milk supply or encouraging a positive breastfeeding interaction:

Hospital conditions and practices discouraged breast feeding and encouraged the belief that bottle feeding was as good as, if not better than, mother’s milk…hospital routines could inhibit lactation. Mothers and babies were separated for most of the day. Often women saw their children only at fixed feeding intervals, and even then the fear of cross-infection dictated stringent controls over the interaction between mother and child. Women were instructed to use face masks. Nurses would wash the mothers’ nipples before bringing the infants from the nursery. At one Madison, Wisconsin, hospital, the mothers were not even allowed to hold their children after feeding. The nurses would pick up the babies, burp them, and return them to the nursery. Acting on the medical professions’ concern about initial weight loss exhibited by many newborns, hospitals often instituted automatic supplemental feeding programs. Nursing mothers
were often encouraged to sleep through the night; babies received night bottle feedings. (Apple, 1987, p. 160)

Situations like those described above led many women to have a negative experience and made them much less confident as new mothers. Once they left the hospital, they continued to rely on the recommendations of medical professionals in the form of pediatricians and authors of parenting books.

In 1956, the La Leche League was founded in Chicago, Illinois and more support began to form for breastfeeding mothers. Around that same time, several hospitals began allowing parents to “room in” with their newborn. This meant that babies were in the hospital room with the mother and father all or most of the time they had to stay in the hospital. This is, of course, more conducive to establishing a breastfeeding relationship. But these efforts still did not increase breastfeeding rates, there was a decline from the 1950s through the 1960s, until the 1970s when there was a resurgence in breastfeeding in the United States (Apple, 1987; Cadwell, et. al., 2002). Ultimately though, bottle feeding and all that comes with it had a lasting impact on the nature of breastfeeding:

The majority of American infants are still bottle-fed, the overwhelming proportion of which with commercial foods. And whether women decide to breast feed or to bottle feed, they do so under medical supervision. The history of infant feeding from the late nineteenth century to the mid-twentieth century documents the growing commercialization and medicalization of infant care, raising questions about the interaction of science, medicine, and commerce, and illustrating the complexity of cultural change…(Apple, 1987, pp. 182-183)

Motherhood was transformed into something much less natural and much more economic and medical. This change had an impact on how women would mother from that day forward. U.S. American society and its view of mothers would continue to evolve.
1.2 Contemporary & Cultural Impacts on Breastfeeding

Today there are many differing views on breastfeeding in U.S. culture. There are some major cultural differences between Westerners and those in other parts of the world in terms of how we view breasts in general. Additionally, in today’s society, public opinion and media portrayals seem to be playing a part in how people perceive breastfeeding.

Although the United States has become a very diverse country over the years, the norms established here tend to be set by the old majority. According to Jan Riordan:

Although there are approximately 100 ethnic groups in the United States, the dominant cultural group is that of white, middle-class Protestants, descendants of northern Europeans who immigrated to the United States several generations ago. Norms characteristic of this group are a conservative value system, family orientation, commitment to higher education for one’s children, a work ethic, materialism, a personal faith in God, the quest for physical beauty, cleanliness, high technology, punctuality, independence, and free enterprise. (1998, p. 714)

It is this dominant culture that has been and continues to be a guiding force for many in the U.S. This is what people often aspire to be in hopes of living the American Dream. Today, factors such as media and social media have made this an even more significant occurrence. Breastfeeding as a cultural norm has been lost in the United States. In order for breastfeeding to be successful within a society, promotion, protection, and support of the effort must all be present on a large scale. Without one, the others will likely fail (Cadwell, et al., 2002). In the end, the U.S. is behind most other countries in sustained breastfeeding rates and certainly behind goals set forth nationally, most likely because one or more of those three key factors is missing. “Almost two thirds (65.1%) of children had ever been breastfed. At 6 and 12 months, 27.0% and 12.3%, respectively, were receiving some breast milk…Exclusive breastfeeding rates were low in the United States with only 7.9% at 6 months” (Li, et
al., 2003). Often, those who immigrate to North America conform to U.S. cultural norms to try and fit in. This is very much the case with breastfeeding behaviors:

Immigrants tend to adopt the cultural practices of their new country; for newcomers to the United States, adaptation means bottle-feeding instead of breastfeeding…The longer a newly immigrated woman lives in the United States, the more likely she will choose to bottle-feed, even though she may come from a country where the breastfeeding rate is high. (Riordan, 1998, p. 716)

Although many American women see breastfeeding as the best choice and source of nutrition for their infants, Riordan argues, it is also seen as difficult to accomplish and considered a private act. According to Kedrowski & Lipscomb, “One survey found that one-quarter of mothers who decided to bottle feed did so because breastfeeding is ‘embarrassing’…Another study of teenage mothers attributed their low breastfeeding rates to a ‘great concern for body image’ (2008, p. 37). Based on their studies, Kedrowski & Lipscomb ultimately argue that the U.S. public at large is not necessarily against breastfeeding or unsupportive of breastfeeding mothers, and more often than not, breastfeeding is viewed positively in the media. The authors argue, “…incomplete information, which leads to general public and policy makers to have unrealistic or inaccurate expectations of what breastfeeding demands, and what public breastfeeding might entail” (p. 61). Couple this with a need to work and a woman’s level of comfort in that workplace, and many mothers will give up breastfeeding before or shortly after returning to work.

Western women tend to have a different experience and point of view compared to other societies in regard to breastfeeding. The way U.S. culture perceives breastfeeding and how women can be made to feel about lactation have played a major part in how many women proceed to nourish their infants today. In Milk, Money, and Madness: The Culture and Politics of Breastfeeding, Baumslag and Michels discuss the embarrassment women in developed countries experience with breastfeeding, while
their counterparts in developing countries “…don’t think twice about being nursing mothers with bare breasts exposed” (1995, p. 7). In addition to this embarrassment that many western women seem to feel about breastfeeding, especially in public, the authors go a step further and argue that the sexualization of the breast in such areas has made it even more taboo. “As our preoccupation with breasts as tools for sexual stimulation has increased, there has been a corresponding reduction in usage for their primary lactating function… The image of a woman walking around with an exposed breast (no matter that a suckling infant is attached to it) has been wrongly equated with a man walking around with his penis hanging out” (1995, p. 6). Kedrowski and Lipscomb agree with this sentiment and state that our culture is one of only a few that sexualizes the breast. It is no coincidence that those that do not see the breasts as sexual in nature, have a higher breastfeeding rate and more of a normalized attitude toward the practice:

It is not entirely clear that the erotic role that the breast plays in Western cultures necessarily reflects an intrinsic biological norm…only 13 out of 190 cultures report that men view women’s breasts as being related to sexual attractiveness, and only 13 out of 190 cultures report male manipulation of female breasts as a precursors or accompaniment of sexual intercourse. (Kedrowski & Lipscomb, 2008, p. 23)

Thanks, in part, to cultural ideals in the United States, there can sometimes be a stigma attached to breastfeeding and bottle feeding has become the norm in U.S. culture. Because many misconceptions exist about breastfeeding in the public forum, and because sometimes breastfeeding can have a negative impact on the marriage, it is no surprise that there seem to be some issues with policies in terms of maternity leave, breastfeeding allowances, and other such financial matters.
1.3 Economics & Breastfeeding

Many mothers in contemporary U.S. society must work outside of the home. Many families cannot live on just one income and many mothers are single, but because there is a lack of understanding of what it takes to establish a strong breastfeeding relationship (among other important postnatal events), maternity leave policies in the U.S., many say, leave something to be desired:

The lack of governmental policies on maternity leave (and the lack of pay even when such leave is available) means a new mother has to concentrate on preparing to leave the infant at a time when she should be focusing on bonding… Of the ‘traditional’ and ‘modern’ child-rearing situations, it is the modern isolated western mom who is much more likely to find herself experiencing lactation failure. (Baumslag & Michels, 1995, p. 18)

There are many causes for this apparent “lactation failure,” among them not establishing a milk supply before returning to work, not having a comfortable place or enough time to pump while at work, and even not having the desire to breastfeed.

Mothers and scholars alike often note that it is quite difficult to be the best mother and the best employee simultaneously. Certainly breastfeeding is a major part of those early months of motherhood and often overlaps with a return to work. This is not to say that a woman cannot do both quite well, but most women deal with “mommy guilt” or feel like less of an employee after having a child. Payne & Nicholls conducted research on women returning to work and the impact it had on breastfeeding as well as the impact breastfeeding had on their work, and their findings reflect these ideas and also describe some of the behaviors of mothers who felt more successful at being employed:

Combining breastfeeding and paid work required negotiating the positions of good mother and good worker. Being a good mother conferred health benefits on infants. Being a good worker required the mothers to constrain their breastfeeding practices. The practices performed by the mothers involved
stockpiling breast milk, maintaining milk supply, preparing the baby ready for absence, making sacrifices and remaining silent and invisible as a breastfeeding worker. (Payne & Nicholls, 2010, p. 1810)

Not only are women dealing with the expectations of modern U.S. society, but they are also dealing with a new body image and the idea of returning to work and attempting to continue their breastfeeding relationship. Add to that the marketing of baby formula, and the temptation to give up the breast is very strong.

1.4 Marketing and Consumer Behavior

Once scientists began to get the formulations right, it was not very difficult for companies like Nestle to begin marketing baby formulas in big ways (Baumslag & Michels, 1995). Some argue that many of the strategies employed at various points were manipulative to a very vulnerable group: new or soon-to-be mothers looking for what is best for their children and also for them, starting in the early 20th century. And while the initial intention of these companies seemed to be to help, eventually, it appears, greed got in the way:

Whereas infant formula companies in the 1800s worked hard to develop formulations that could be used to save the lives of foundlings and sick babies, by the turn of the century, the lure of the global market had become too much…the goal grew to producing a product that could replace mother’s milk – on every square inch of the globe (Baumslag & Michells, 1995, p. 147).

Many mothers began thinking of formula as a special milk or medicine, one given to premature and sick infants. As they began questioning how good their breast milk was, they also questioned the quantity of milk they were making and many began turning to formula, thinking they were doing what was best for their babies. One marketing ploy that was used around the early twentieth century was
“milk nurses” who were women, often nurses who would visit new mothers (at home or in the hospital) in their uniforms and offer formula to them. Furthermore, according to Baumslag & Michells,

Skillful marketing and promotion efforts, combined with medical complicity, succeeded in artificial feeding gaining an aura of medical legitimacy. Parents grew to believe that a commercial product could be as good as, or better than, the real thing. By the end of World War II, bottle-feeding had become the standard method of infant feeding in the United States, and, to a lesser extent, in Europe as well. (1995, p. 147)

In the 1970s, the emphasis on formula began to change. People began questioning the marketing tactics of formula giants like Nestle (Baumslag & Michels, 1995). Mothers began questioning the use of artificial milk over their own. Health care workers began to take notice of the consequences of formula use both in places like the U.S. as well as (and to a more detrimental degree) in developing nations. Around this same time, several articles and a documentary film, (Bottle Babies, 1975) were coming out against formula manufacturers, trying to prove that they were being unethical and were behind the deaths of many babies, especially those in developing countries. Manufacturers defended themselves, ultimately arguing that people will not buy what they do not want or need.

Eventually, in 1978, there was enough outrage that the U.S. Congress launched its own internal investigation. Senator Edward Kennedy was the chairman of the Subcommittee on Health and Scientific Research. The hearing was regarding the promotion and use of infant formula in developing countries. Senator Kennedy had strong words for the committee and expressed grave concerns:

Senator Kennedy opened the hearing by saying; ‘It is astonishing, and it is an enormous tragedy, that one-fourth of the people on this earth – one billion men, women, and children – have no access to any healthcare whatsoever…and it is always the children who suffer most.’ He went on to ask the witnesses a key question: ‘Can a product which requires clean water, good
sanitation, adequate family income, and a literate parent to follow printed instructions, be properly and safely used in areas where water is contaminated, sewage runs in the streets, poverty is severe, and illiteracy high?’ He also asked, ‘Whose responsibility is it …when economic incentives are in conflict with public health requirements [and] how shall the conflict be resolved?’ (Baumslag & Michels, 1995, p. 159)

There were three panels who spoke at the hearing: the first, a group of missionaries, doctors, and church activists who had worked in developing countries and witnessed the outcomes of formula use there; the second, distinguished physicians and health experts who were concerned with the decline in breastfeeding and felt it had to do with marketing of formula. “It was at these hearings that Dr. Jelliffe stated that even cans of puppy formula contain a warning that it should not be given in the first days of life so that puppies may obtain the anti-infective benefits of colostrum (the initial breast milk). He pointed out this warning was wholly absent on cans of formula for humans” (Baumslag & Michels, 1995, p. 159). The third panel was made up of representatives from formula companies; they insisted that their own Code of Ethics was being followed and would prevent abuse. Although there were more conferences for infant health later sponsored by makers of the formula, the hearing ultimately ended in the WHO/UNICEF Meeting on Infant and Young Child Feeding, which was held in Geneva, Switzerland in October of 1979. Nestle agreed to abide by anything decided at this meeting. One major outcome of this meeting was the WHO/UNICEF Code of Marketing of Breast milk Substitutes (the WHO Code) established as the first international consumer code. Still, it served as a voluntary standard.

On May 21, 1981 an International Code of Marketing of Breast milk Substitutes was adopted by the World Health Assembly. This new code was put into action by an 118-1 vote; the only country to vote against it was the United States (citing a violation of free speech and free trade). Still this code worked to eliminate or at least decrease the advertising of commercially available baby formulas. In the
end, the code has been treated more like a voluntary set of suggestions than a set of standards that are enforceable, especially in the United States (Miller, 1983).

With time, more powerful people and groups took notice of the already scientifically touted benefits of breast milk and the detriments to the child, mother, and economy when formula is consumed too frequently. This change in thinking led to new codes and regulations being put into place on the marketing of baby formula. Further, now there was actually global agreement on formula marketing:

On May 9, 1994, signaling a tremendous policy shift, President Clinton made the World Health Organization’s International Code of Marketing of Breast milk Substitutes worldwide policy by joining the other member nations at the World Health Assembly in Geneva. For the first time, there is worldwide unanimity that, in the infant health arena, profit should not come before public health. (Baumslag & Michels, 1998, p. 169)

Another initiative still in effect today is the BFHI, the Baby Friendly Hospital Initiative, which was launched in 1991 by WHO and UNICEF. A major concern is that formula manufacturers spend hundreds of thousands of dollars to win bidding wars to be the sole provider of discharge packs, which each contain one sample size container of baby formula. The BFHI has breastfeeding friendly criteria and an attempt to end this, but meeting the criteria to be a BFHI, does not mean discharge packs are not distributed. Instead it means that there are certain criteria set to make formula less visible and readily available (Baumslag & Michels, 1998).

Another important program, the WIC (Women, Infants, and Children) program was established in 1974 by the Federal Government as a means to help low-income mothers provide essentials to their children. Initially one of the things qualified mothers would receive was formula. Although this is still the case, as of 1989, breastfeeding was taken into account with WIC (Baumslag & Michels, 1998). Now
a woman will receive a breast pump instead of formula if she is a breastfeeding mother (http://www.fns.usda.gov/wic/).

Although formula companies still make huge profits today, there have been many strides to get back to basics and back to the breast (when possible) in recent decades. Of course, here in the United States, plenty of babies grow up perfectly happy, healthy, and intelligent and have never had a drop of breast milk. But the benefits are still there and they are numerous. Further, the absence of breast milk can be especially devastating in places where living conditions are not as they are in most parts of the U.S. as the next section illustrates.

1.5 Health Sciences

While taking into consideration that a small percentage of mothers are physically or otherwise medically unable to breastfeed, many researchers have determined that breastfeeding produces the most health benefits for babies from infancy and throughout their lives. Baumslag & Michels are among the many researchers whose findings support this:

Breastfeeding has important implications for the survival of our species. Even today, in most of the world, breastfeeding is the single largest determinant of whether an infant lives or dies… If every newborn in the United States were breastfed for just twelve weeks, the health care savings from avoiding non-chronic diseases in babies’ first year of life would amount to $2-4 billion annually. And the actual savings would be much greater, as breastfeeding confers a host of long-term health advantages (e.g., reduced incidence of allergies, asthma, heart disease, juvenile diabetes, obesity, etc.). (Baumslag & Michels, 1995, p.70)

Breast milk has many components that cannot possibly be replicated in an artificial form. And although breastfeeding exclusively and for longer confers the most benefits, it is well understood that
from the colostrum, which arrives right after birth and immediately before the milk to the mature milk at two years of age, nothing else compares.

[B]reast milk is alive. Every drop contains living cells that are constantly altering to accommodate to the infant’s changing needs…The milk produces antibodies against whatever organisms the mother is exposed to, helping to protect the child from local pathological invaders. The ability of milk to change both in response to the environment and to the child is part of the miracle of breastmilk. (Baumslag & Michels, 1995, pp. 77-79)

Baumslag & Michels continue their argument on the wonders of breast milk stating that human breast milk has living cells that can actually “eat” germs. It can attack viruses, pathogens, and organisms, and the antibodies that double as food supplements. Cadwell et. al. agree in listing the numerous health benefits to mother and baby, even in industrialized nations like the United States. Among these are fewer instances of: gastrointestinal illness, respiratory illness, otitis media, bacteremia and meningitis, juvenile diabetes, malignant lymphomas, breast cancer, multiple sclerosis, allergies and other health problems such as obesity and high cholesterol in children and adults who were breastfed. Additionally, the breastfeeding mother benefits with better health as well, with a reduced risk of ovarian and breast cancer as well as improved bone remineralization.

The World Health Organization, in a statement issued in January of 2011, recommended that infants worldwide be breastfed exclusively for the first six months of life (exclusive means no supplementation with anything other than liquid vitamins, minerals, or medications) with an addition of age appropriate and healthy food at the age of six months and the continuation of breastfeeding for up to two years of age or beyond (http://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115). One of the reasons such recommendations exist may be explained by Baumslag & Michels: “Breastfeeding is
the crucial bridge between being in utero and being able to explore the world on one’s own” (1995, p. 68) Human infants begin to eat solid table foods and explore their surroundings as they become toddlers, around the ages mentioned in the WHO’s recommendation.

In reviewing the history of breastfeeding to the current day, cultural impacts on the practice of breastfeeding, the economics of breastfeeding, the effects of marketing and consumer behaviors, and the documented health benefits of breastfeeding, it is clear that breastfeeding is a health issue for babies and their mothers. Additionally, cultural factors have played a part in how breastfeeding is perceived and how women who do or do not breastfeed are viewed and treated in U.S. society.

Interpersonal communication is such a prevalent part of everyday human interactions. However, the implications of these interactions on a woman’s sense of self in motherhood, specifically with breastfeeding, has rarely been addressed in communication research. After a woman has experienced pregnancy, delivery, and the first days of motherhood, she often feels the need to share her experience with others. These stories are of value, when shared candidly and with the passion of a mother, they tell a valuable history of a person’s beginnings (the woman as mother and her child, entering the world). These can also serve as cautionary tales or as a means to connect with someone else who has experienced the same things. With this in mind, my research questions are as follows:

RQ1: How do interpersonal messages influence the breastfeeding behaviors of women with at least one child three years of age or younger?

RQ2: What stories do mothers with at least one child who is three years of age or younger share of their breastfeeding experiences and what insights do they produce?

In the next chapter, I will review of some of the prevailing theories that exist that can help explain the phenomena I will study: the impact of interpersonal communication on breastfeeding. In chapter three, I will explain the methods and data collection procedures used to carry out this study, and
in chapter four I discuss the results of the present study. The final chapter offers conclusions and possibilities for further research in this field.
Chapter 2

Literature Review: Interpersonal Communication Theories

This study seeks to understand the connection between the communication of family and friends and a woman’s success with breastfeeding. Because interpersonal communication with those close to us is almost innate in daily interactions, it serves to reason that it is very impactful in the decisions we make. Several researchers did a study on the reasons for communication in the late 1980’s:

… investigated why people communicate with others and identified six interpersonal communication motives: pleasure, affection, inclusion, escape, relaxation, and control…[I]nterpersonal motives clearly impact a diverse set of interpersonal behaviors that are practiced in a relationship…[others] argued that both support receivers and providers enter interactions with needs and goals. (Frisby & Martin, 2010, p.321)

Thus, this study seeks to examine how those needs and goals of interpersonal interactions will impact behaviors on the part of those involved, specifically, how a mother seeking support from family and friends in the context of interpersonal interactions will shape her decisions regarding breastfeeding her child. In order to examine these relationships, in this chapter I outline some key interpersonal communication theories, such as relational communication, identity issues, social support and persuasion.

Another important theory to be explored is the social coercion for weaning theory. This theory specifically relates to breastfeeding and how the surveillance and opinions of others can persuade a mother to make decisions about breastfeeding to which she may have previously been opposed. By examining these various interpersonal communication theories, the relationship between the communication of family and friends and a breastfeeding mother’s choices can more easily be
understood. This is of value because, while most mothers know that breast milk is considered the best form of nutrition for their baby, many still do not breastfeed for the recommended amount of time. Examining the communicative aspects of breastfeeding success may lead to further studies that could increase breastfeeding rates in the U.S.

2.1 Interpersonal Communication Theory

Interpersonal communication is so ingrained in our everyday lives and, has been essentially since birth, that there is a lot to study and understand about the complexities of these seemingly simple interactions. Virtanen & Isotalus explain, “[C]ommunication in the interpersonal context is a complex, situated social process in which people who have created a communicative relationship exchange messages in an effort to generate shared meaning and accomplish social goals” (2011, p. 26). The dynamics of interpersonal communication are multifaceted, which can lead to confusion and frustration at times, as well as a greater satisfaction in everyday interactions.

Furthermore, many scholars theorize that we gain much of our identity based on what those around us think of us and communicate to us interpersonally. Because people can communicate interpersonally with or without words, there is much to be examined as people need communicative interactions for nearly everything. It is the communication in these interactions that form us and our viewpoints, as Matsumoto contends:

Relational processing is at the root of most of our daily encounters whether with a long-term relational partner, a stranger with whom we share a brief encounter, or the cashier you greet everyday purchasing your morning coffee. The complexities of interpersonal connections are situated in an array of dynamic human features and personal attributes such as experience, developmental process, and social and personal identity orientations. (Matsumoto, 2010, p.3)
**Interactional and Relational Communication**

One important component of interpersonal communication theory has to do with how we directly interact and relate to others and how we communicate these relations. In turn, these concepts are also studied in terms of how the communication in certain relationships impacts us. Smith and Wilson argued that certain relationships have the tendency to have a greater impact on the feelings of those involved. In other words, interpretations and responses to behaviors are altered based on the relationship of people in the given interaction. As such, their studies found that when family members are hurtful to one another it tends to cause more emotional pain than if someone else acts in a hurtful way. They hypothesize that this may be due in part to the fact that family members have more knowledge of one another and what makes each other tick. Additionally, one’s own perception about a comment has a great impact on how they feel about it: “Research suggests that comments or behaviors that are perceived as intentionally hurtful are considered to be more intense and to cause more damage to relationships that are those seen as unintentionally hurtful” (Smith & Wilson, 2012, p.226).

Another important aspect of our interactions and how we relate to one another is what these interactions do for our own definition of self. In these relations much is already interpreted and people define their relationships by the other. Smith & Wilson explain,

…transitions create change that involves the reorganization and reintegration of identities, roles, relationships, or behaviors, which may require people to alter their current conduct or the way in which they define themselves or their relationships. In other words, when people move from the known to the unknown, the social context within which they live also changes (2012, p. 117).

Furthermore, a new mother whose identity has already been influenced by the birth of her child, may be in a fragile state. Because we already understand that the communication of those closest to us can
impact us the most, it makes sense that a breastfeeding mother could be swayed to think a certain way about breastfeeding based on her interactions with her loved ones.

**Interaction and Identity**

As it turns out, there is more to one’s definition of self and identity. As already discussed briefly above, much of this has to do with interactions with others. More importantly, are the way those interactions are interpreted: “In every communicative situation there are at least two versions of the interactional meaning: (1) the meaning intended by the first person speaking, and (2) the meaning assigned by the conversational partner” (Tracy, 2002, p.11). Tracy explains that in every interaction there is the chance of miscommunication since each person has their own view of the interaction and its verbal and nonverbal components. These differences in meanings can often lead to an awkward moment or even major conflicts.

Many times a message is miscommunicated due to a number of noise factors, other times the speaker meant exactly what they said, it is always up to the receiver to notice these accurately. “Talk sounds differently when it is spoken by a man, a woman, or a child…But not only does talk reflect a speaker’s geographic, social class, and gender origins, it is also used strategically to display affiliation or hostility” (Tracy, 2002, p.99). Tracy argues that senders need to choose their words (and actions) wisely in order for their message to be received accurately. “Besides the basic form of a speech act, communicators need to select the act’s linguistic clothing: Should the act be carried out in a barebones, minimalist manner? Or should words be added to soften any negative or face-attacking implications?” (p. 138).

Tracy also speaks to the concept of identity and notes that identity has to do with aspects of character as well as some background characteristics that tend to remain unchanged (gender, ethnicity, etc.). Finally, identity is also wrapped up in the roles people take on with others (such as mother-child,
boss-employee, and so on). These identities are wrapped up in those interactions and what those interpersonal interactions mean to the people involved in them. In other words, a great deal of how people see themselves has to do with how others see them and, more importantly, how others tell them to see themselves. In this way, when loved ones interact with a new mother, it is often not in the context that it likely should be. They are dealing with a woman in a context which she has always been in relation to them; a child, friend, spouse, co-worker. But in doing so, the woman’s role as mother is often minimalized and the sender often does not take her new role into consideration when communicating with her. Heisler and Ellis also discuss the formation of a mother’s identity:

A woman with children will have a unique experience from women without children, and thus a differently constructed identity as a result of those cumulative experiences with her children…One’s self-identity is partially constructed through interactions with others. This further suggests that identity is not stagnant or permanently described but rather a continuous, yet flexible, belief about oneself that is trimmed or shaped (Heisler & Ellis, 2008, pp 447-448).

Even well-meaning messages can be sent in a way that could cause a negative outcome for the mother and the decisions she makes for herself and her child.

Social Support

It is perhaps because of the reliance on others for much of the identity one will take, that another important aspect of interpersonal communication is social support. According to Virtanen & Isotalus:

The experience of social support is familiar to most people. We can fairly easily recall an interaction in which we received comfort or assistance from another –or when we did not and how it made us feel. Research on social support has focused on capturing such experiences and
instances between people. Studies have traditionally viewed acts of social support as seeking, providing or enacting, receiving and perceiving support. (2011, p. 27)

These authors further discuss the different functions of social support, such as emotional, esteem development, comfort and so on. The most common purposes are for emotional support. Further, Virtanen & Isotalus posit that supportive behaviors can be found in many different relationships and interactions, both formal and informal. They have found data to show that certain relationships are better for certain types of support than others and that certain people may be better equipped to help one deal with certain issues than others. Finally, there can be many outcomes to the different kinds of support and these outcomes rely heavily on the situation, the message content, the features of the relationship, and context, to name a few. The evidence suggests that social support and how one experiences it is a good indication of one’s sense of connectedness to others and often reflects the relational ties they share with others.

The impact of having social support (or a lack thereof) can be far reaching, especially for the emotional wellbeing of an individual. According to Vangelisti & Perlman, “Emotions are resources used to define and enact social norms and roles. In fact, it is hard to imagine a domain of close relationships that can do without emotion” (2006, p. 369). Furthermore, when emotion is studied it is usually in the realm of everyday people as opposed to experts. It is believed that people learn about emotion over time as they experience life events, and these memories play a crucial role in how they experience future relations:

Humans play a variety of relationship roles over the course of their lives, and every role comes with its own set of norms, rules, and expectations. Implicit within all such role identities are feelings and emotions… Brody (1999) documented the differences between men’s and women’s emotion roles in the family, with wives and mothers expected to carry the bulk of the so-called
emotion work involved in nurturing and soothing others’ feelings. (Vangelisti & Perlman, 2006, p. 378)

Because of the work of emotions and the roles that people take accordingly, there tends to be, at some point, a power struggle in these relationships. In fact, the basis of all power is dependency. Vangelisti & Perlman claim that power and status are ever present in all human interactions and the shifts in these will leave a person feeling a particular emotion: “Thus, a perceived loss of power triggers anxiety; a perceived gain in power triggers pleasure. A perceived loss of status triggers hurt, depression, shame; a perceived gain in status, or esteem, elicits the happiness that comes from the feeling that one is a valued relationship partner” (2006, p. 379). And, they posit, in every relationship this power struggle exists (whether implicit or explicit).

Finally, Vangelisti & Perlman discuss the overwhelming presence of emotion in the many theories:

Emotion can be seen as a prime mover in evolutionary and attachment theories, as a hidden dimension of social exchange theory, as kind of kinesthetic sense in dialectical theories, as a mysterious travel companion in stage theories, as a friendly collaborator in social cognitive theories, and as an instrument of negotiation in theories of social roles and power. (2006, p. 369)

Emotion evokes emotional responses. Human emotions are ever present in day to day interactions, much like the communicative acts that accompany them. It is inescapable and can impact an interaction greatly. People, especially those emotionally close to someone, can have a major impact on the decisions a person makes. And of course, it is not only the message sent but how that message is perceived by the receiver that is important. When emotions become involved, such as a tired and frustrated mother seeking support from a loved one, decisions are often made based solely on trying to make the mother feel better as quickly as possible, as opposed to doing what may be in her best interest.
over the long term. Because of the emotional attachment, feelings and ideas are often manipulated by loved ones. Whether done maliciously or not, when strong emotions are involved, persuasion in interpersonal contexts can have influential effects on a new mother.

**Persuasion**

Persuasion is an important instrument in communication. People who use the power of persuasion can make things happen for themselves and others. It can also be seen as something of a tool of manipulation and can sometimes lead to regret (in instances where a person was convinced to do something they preferred not to, for example). According to Perloff, “[P]ersuasion represents a conscious attempt to influence the other party, along with an accompanying awareness that the persuadee has a mental state that is susceptible to change. It is a type of social influence. Social influence is the broad process in which the behavior of one person alters the thoughts or actions of another” (2010, p. 13).

Persuasion, in some ways, is like no other form of communication. It relies on many facets of day to day communication to be in line, in order for it to successfully occur; things such as the mood of the receiver as well as multiple criteria having to do with the sender’s delivery and the message itself.

The message may be verbal or nonverbal. It can be relayed interpersonally, through mass media, or via the Internet. It may be reasonable or unreasonable, factual or emotional. The message can consist of arguments or simple cues…Persuasion is a communicative activity; thus there must be a message for persuasion, as opposed to other forms of social influence, to occur. (Perloff, 2010, p. 14)

In the case of mothers and their breastfeeding behaviors, the message of persuasion is clear; either breastfeed or don’t. But this is one of those decisions that must be made by the mother at some point.
By not making the decision (i.e. not breastfeeding), a decision is automatically made. In other words, the woman must choose what to do consciously and at many points during maternity or post-partum periods, the mother may be swayed on her decision. In these crucial times, it is up to those close to her to support and remind her of what she has previously expressed she really wants to do. However, in those moments of weakness, loved ones will often (purposely and not) persuade the mother to take action a particular way that they believe is best.

**Disclosure**

Often in a power struggle, there are elements of emotion as well as persuasion at play. Additionally, when the relationship has been defined in some way, and a level of comfort is achieved there is often a time of disclosure where the parties involved begin to share more intimate details of themselves with the other. The reasons to share are numerous:

The self-focused reasons for self-disclosure deal with the psychological and tangible benefits to the discloser and include catharsis, self-clarification, and seeking support. Other-focused reasons for self-disclosure include duty to inform and a desire to educate. Relationship-focused reasons include having a close and trusting relationship with one’s partner, similarity or having something in common, and a desire to increase intimacy or closeness. Situational-environmental reasons include availability of the target person, the other person asked or ‘demanded’ disclosure, and the other’s involvement in the subject matter of disclosure. (Vangelisti & Perlman, 2006, pp 415-416)

Furthermore, these authors argue that the communicative cues being given by the person who will receive the information is vital. These signals will help the other decide whether to share private information and how much to share.
In some cases, people express themselves and communicate in the form of a narrative or story. It is of value in many situations. According to Tracy, some of the functions of narratives include: to make an argument for or against something (persuasion), to indirectly communicate something (such as a warning), to present oneself or introduce oneself (as the main character in the narrative), to set the stage for what role the other will play or plays in their own narratives (how one sees them in relation to self). People can also tell narratives about others to express disapproval or to question the behaviors of others.

A story may often serve more than one purpose: Above its very referential and informative functioning it may entertain, be a piece of moral advice, extend an offer to become more intimate, seek audience alignment for the purpose of joint revenge, and serve as a claim as to ‘who I really am’ – and all that at the same time. (Tracy, 2002, p. 157)

When one sets out to share a narrative, it becomes a product of the interaction at hand. Not only do these stories serve to give information or to entertain but they also have very personal purposes and help to enhance the relationship or at least set the stage for what the people involved hope to achieve in their interaction. In the case of motherhood, women share a new kind of bond when they become mothers, especially biologically through the physical processes of pregnancy, childbirth, and breastfeeding. Once these moments have been experienced, women often want to share their stories with those close to them. They are especially likely to self-disclose to other mothers, often in hopes of being validated and sharing a commonality. There is a therapeutic benefit in narrative telling and disclosure and no matter what the outcome was, women will often explain their story of breastfeeding. Rarely will a mother simply tell how long she breastfed and walk away; the story exists to help the mother work through the situation herself and oftentimes to excuse her behaviors, show pride at her achievements, or give advice in disguise to someone else.
2.2 Social Coercion for Weaning Theory

Another theory that falls under the umbrella of interpersonal communication, is directly related to breastfeeding: social coercion for weaning theory. This theory posits that mothers are being watched, and communicated with on some levels, for their breastfeeding behaviors (Morse & Harrison, 1987). Cindy Stearns described this phenomenon, “breastfeeding is a behavior under surveillance by friends, family, and others and that mothers are socially accountable for their breastfeeding behaviors” (2011, p. 541). Morse and Harrison (1987) describe the endless and often unsolicited advice that mothers receive about baby care, including comments from strangers about the need to wean. In particular, they note that mothers are discouraged from breastfeeding “too long” and that in order to avoid negative comments, some of the mothers chose to keep the breastfeeding a secret as the child neared the one-year mark.

There is very little research on the social coercion for weaning theory at this point in time. However, it is relevant to this research because it could help explain the relationship between communication of others (verbal and nonverbal) and a mother’s breastfeeding decisions. In fact, examining this surveillance and unsolicited advice is exactly what this study aims to do. Perhaps, the findings here can contribute to more knowledge on this theory.

The connection between several forms of interpersonal communication and breastfeeding behaviors is becoming more apparent. The everyday interactions of humans, both verbal and nonverbal, and especially with those close to them have a major impact on things such as self-perception, decisions made, relationships formed and broken and so on. This is even more the case in the construction of a woman’s new identity as mother. “Research on family influence has suggested that new parents often rely upon their families of origin as references for their new roles as parents (Massey, 1986)…these extended networks often provide social support and serve to alleviate stress and encourage well-being during life transitions (i.e., births)” (Heisler & Ellis, 2008, p. 446). Heisler and Ellis also suggest that
in U.S. American culture there is a clash of desiring autonomy while still desiring connections. They contend that a person’s self-concept relies heavily on the “self-other perceptions” leaving new mothers in a very vulnerable state (Heisler & Ellis, 2008). All of these communicative dynamics are what will be examined in the women who were interviewed for this project.
Chapter 3

Methodology: Focus Group Interviews

This chapter discusses the methods and data-collection procedures used to conduct this study. Before data collection began, I completed IRB training, filed an IRB application, made necessary changes, and received IRB approval. Before interactions began with interview subjects, they received and signed informed consent forms.

For this study, I conducted interviews of which I recorded and transcribed the responses I received. I used these transcriptions to code and categorize common themes among participants’ responses. My methodological approach was qualitative research in the field of communication (Lindlof & Taylor, 2010). I conducted an ethnographic study including focus group interviews and narrative interviews (thus allowing participants to tell their own stories in depth). According to Lindlof & Taylor, what occurs in a focus group is “[A] kind of ‘chaining’ or ‘cascading’ effect in which each person’s turn of the conversation links to, or tumbles out of, the topics and expressions that came before it” (2010, p.183). This building of stories and information was very valuable to the research as themes and emotions will be more easily identified when they have been expressed by a group as a whole.

Additionally, where warranted I have included autoethnography to enhance the narratives of my participants. According to Ellis, Adams, and Bochner:

Autoethnography is an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience…usually, the author does not live through these experiences solely to make them part of a published document, rather, these experiences are assembled using hindsight…the author may also interview others…to help with recall. (Ellis, Adams, & Bochner, 2011, pp1-2)
The advantage of hindsight sparked by the answers of my participants gave me the opportunity to more fully tease out the important themes and findings of this project.

### 3.1 Site of Research

The only initial criterion to be a participant in this study was to be a mother with at least one child three years of age or younger. Once mothers were recruited online (for example through Facebook) and through word of mouth and snowball method, they were placed into categories based on their answers to a simple questionnaire, indicating the length of time they breastfed their child(ren). Three to five women were then selected for each focus group (three groups in total) and met at a location and time that was convenient for them (this included private residences, offices, and cafes).

### 3.2 Selection of Respondents

The women chosen for participation in this study had at least one child who was three years of age or younger at the time of the interview, thus limiting the amount of time between breastfeeding and these interviews. “Because inaccurate reporting can arise from poor recall, the desire to give ‘socially acceptable’ responses, or both, there is a concern about the accuracy of breastfeeding data collected retrospectively, particularly when it is obtained after a considerable period of time” (Li et. al, 2005, p. 103). Participants fell into one of three focus group categories: breastfed exclusively for four months or fewer, breastfed for 6 – 12 months, and the long-term breastfeeders (women who breastfed past 18 months and while pregnant).

Women from all walks of life were considered for the questionnaire portion of this study, which ultimately led to the focus group participants being chosen. I worked with a diverse population of women as far as ethnic background goes and of all levels of health, as health was not a determining factor in who I studied. Women from all educational backgrounds and career fields, as well as single, married, or widowed were considered.
In the 0-4 month breastfeeding group, the mothers were both white and Latina. They had varying education levels, though all had at least some college education up to post-graduate and law degrees. Of the five participants in this particular group, four worked outside of the home and one was a stay-at-home mother who attended college full-time. Three of the mothers in this group were married, one was in a relationship, and one was single.

The six mothers in 0-6 month breastfeeding group had some cultural diversity (white and Latina) as well. They had attained varying levels of education from high school diplomas to college degrees (two with graduate degrees). Of the six, half worked outside of the home and half were stay-at-home mothers (one of whom worked at home part-time as a hairdresser). One of the stay-at-home mothers was attending college full-time (but stated that her schedule was such that it did not impact her breastfeeding at all). All six mothers in this group were married.

In the long-term breastfeeding group, both mothers worked outside of the home, one full-time and one part-time. Both possessed a bachelor’s degree, were of different cultural backgrounds (white and Latina), and both were married.

Overall, of the 13 women interviewed for this study, eight were Latina (two of which were of mixed ethnicities) and five were white. Two participants fell in the 20-25 age range, five each were in the 26-30 range and the 31-35 ranges, and one participant was older than 40 years of age.

3.3 Focus Group Interviews

Although each of the three focus groups was guided by basic questions I formulated in advance, the participants essentially ran the focus groups with their interactions among themselves. Interviews lasted anywhere from 20 minutes to one and a half hours, depending on how many people were involved, where it took place, what kind of distractions were present, and how in-depth the interviewee
was willing to go with her answers. The data collected determined the themes discussed in the next chapter.

For the purpose of this study, respondents were recruited via Facebook, email, and snowball sampling methods. Of those who volunteered via these various methods, 13 women participated in the final interviews (based primarily on availability and willingness to participate in face to face focus group interviews). Once gathered and informed consent was attained, the respondents were invited to respond to my questions and prompts as well as to the responses of their peers in the focus group. They were encouraged to converse with one another and offer stories of their experiences. They were asked to specifically focus on communicative behaviors and, if they had more than one child, to reflect on all, but focus on their child who is currently 3 years of age or younger.

The focus groups were conducted at a location where the participants felt comfortable being candid and sharing their experiences such as at private residences or offices. I was the only party with access to the interview data and once collected, each person was assigned a pseudonym. All interview data was collected and stored on my personal laptop computer that was not utilized by anybody else for the duration of the study. Interviews were recorded (audio recording) and the label was that of the subject’s assigned code. The codes were stored in a secure file on the laptop. These files remained on the computer until the information had been transcribed and saved with only the codes to identify participants.
Chapter 4

Results: Communication Matters

This chapter explores the outcomes of focus group interviews and how respondents’ answers gave insight into the research questions initially posed. Through the interactions of the women as well as the opportunity to offer a narrative on their breastfeeding experience, the following were the major themes and findings. Two themes were found in response to RQ1, which asked: How do interpersonal messages influence the breastfeeding behaviors of women with at least one child three years of age or younger? First, mothers who felt discouraged with breastfeeding were more likely to stop when given permission by those close to them. The next theme was that those who were determined and sought support from peers or experts were successful at breastfeeding (in terms of their goal and those set forth by experts). Lastly, women who lacked intrinsic motivation and set low goals for themselves were more likely to breastfeed for a shorter length of time.

In response to RQ 2, which asked, what stories do mothers with at least one child that is three years of age or younger share of their breastfeeding experiences and what insights do they produce, three themes were found. First, women who received supportive communication were more likely to overcome the non-supportive communication they received and continue breastfeeding. The post-partum experience at the hospital sometimes set the women up for success or failure and often determined their feelings about breastfeeding once home. Additionally, those who had to return to work outside of the home found that a supportive workplace helped them to continue providing breast milk to their children. And the post-partum experience at the hospital sometimes set the women up for success or failure and often determined their feelings about breastfeeding once home.

4.1 Acceptance by Others

It is not uncommon, as a new mother searches for identity, for her to lean on those close to her for advice and acceptance. Heisler and Ellis explain, “As a new mother, a woman may struggle to
balance her constructed, mother image and acknowledge her insecurities, need of connection, support, and advice from others” (2008, p. 446). When mothers in this study started out with more loosely based criteria on breastfeeding and somewhat low levels of intrinsic motivation, this often led to the mothers stopping short of the goals they had set for themselves (earlier than they had hoped and/or earlier than is recommended by experts) once someone close to them communicated their support or acceptance of that decision. This was the case for a 24 year old mother of one child, who stopped breastfeeding her son when he was two weeks old. She expressed her frustration with the process and her emotional vulnerability. Before giving birth, she had hoped to breastfeed her son for three to six months. When asked if anybody helped or hindered her efforts with breastfeeding, Charlotte responded: “…I didn’t want to stop doing it because I felt like he would not, that I would be hurting him in some way by stopping and my mom was really there for me in telling me, ‘he’s going to be fine, you need to do what’s best for you’, so my mom really helped me and was really supportive” (February 27, 2013). She went on to share that she had several friends having trouble with breastfeeding and that it was nice to have support from them as well; “…it didn’t make me feel as bad that I was stopping” (Charlotte, February 27, 2013).

This was a common finding, especially among the mothers who breastfed for 0-3 months. Many of these mothers experienced physical or emotional difficulty with breastfeeding and really wanted to stop. Additionally, many had set more lax standards for themselves in terms of length of breastfeeding than the other two groups. Once somebody close to them, either a friend or family member expressed that it was okay to stop and that it would not impact their abilities as a mother, they were willing to stop breastfeeding. In talking with the mothers, it was as if this approval from a loved one took a weight off and they finally felt that any pressure they had been putting on themselves in terms of breastfeeding had been relieved. They quit soon after receiving such feedback.
Family members’ support is very important to breastfeeding success, especially that of the new mother’s own mother. Research has shown that another major player in whether a woman will continue breastfeeding is her spouse. The support of a spouse during the early days of motherhood is pivotal, especially to breastfeeding success (Ekstrom, Widstrom, & Nissen, 2003; Hoot, 1993). In this way, a spouse can help the mother (knowingly or not) to make decisions regarding breastfeeding. This was so with another mother in this study who is 29 years old and pregnant with her second child; she expressed this sentiment from her husband:

… {my son} was just crying and crying and crying at some points and he {my husband} was like, ‘maybe we should just give him a bottle, maybe we should because he’s hungry you know so instead of trying to overly exert yourself breastfeeding and he’s not getting enough and he just starts crying maybe we should just try this other option.’ So he definitely left it up to me but he was kind of telling me at the same time maybe we need to do this…and I would start to transition at that point about 3 weeks after he was born... (Lisa, December 29, 2012)

This theme is seen throughout responses from the mothers, primarily in the group who breastfed for four months or less, and even more significantly in those mothers who breastfeed for less than three weeks. A major theme at work in these scenarios is identity in how women define themselves as mothers. These identities are further complicated by the interactions the new mother has with others, particularly those close to her. According to Smith & Wilson, “…transitions create change that involves the reorganization and reintegration of identities, roles, relationships, or behaviors, which may require people to alter their current conduct or the way in which they define themselves or their relationships. In other words, when people move from the known to the unknown, the social context within which they live also changes” (p. 117). Because people rely so heavily on the communication of others to help form their changing identities, this approval expressed by the mothers in these scenarios, explains how they came to accept that failure at breastfeeding did not mean failure as a mother.
The respondents viewed this communication from family and friends as supportive and helpful. However, in some ways, based on the outcome, it could be viewed as a hindrance to breastfeeding success. Due to the approval of others, the women were actually convinced to stop doing something that they at one point viewed as important. According to Perloff, “…persuasion represents a conscious attempt to influence the other party, along with an accompanying awareness that the persuadee has a mental state that is susceptible to change. It is a type of social influence…” (p. 13). It becomes clear, that although the family and friends were likely well-meaning, they knew the new mother was susceptible to changing her mind. In these cases, instead of watching a loved one endure a hardship, loved ones worked to convince the person to rid themselves of the stressor regardless of the long term impact and often without weighing the pros and cons of the situation as a whole.

4.2 Peer and Expert Support

On the opposite end of the spectrum, those mothers in this study who were determined to continue breastfeeding but had perhaps hit a roadblock were helped immensely by the support of others. Communication with a support system (usually experts or peers, but sometimes a “role model” figure) appears to be of great value in the successful continuation of breastfeeding (and a major pitfall when one is lacking). In the group of mothers who breastfed for 6 – 12 months, some spoke of their sisters-in-law who were also breastfeeding when they were and how that source of peer support was invaluable. For them, it was even more powerful when the support came from the entire family unit, as Belinda explains:

Both sides of my family were encouraging and supportive. My mother breastfed us until we were twoish or at least one and a half. My mother in law had seven kids and breastfed them all at least for a little while if not for a long while because they were poor too, so they were both encouraging and supportive. My sister in laws [sic] had babies at the same time and we would
breastfeed at the same time too…same thing she [Valerie, another mother in the group] was saying. You know, ‘hey are you having trouble with this?’ ‘yeah,’ or ‘try this’ (Belinda, December 29, 2012)

When mothers in this group found a safe place and a comrade of sorts they often felt more confidence from this source of support. Virtanen & Isotalus argue that social support is even more valuable when the person offering it has some sort of personal experience. “The definitions so far have given us evidence that the experience of social support includes the sense of being connected to others. Social support is a core element of close relationships and often, but not always, support is received due to strong network ties” (2011, p. 30). This is possibly the reason mothers feel inclined and welcome to offer advice to pregnant women; this common bond of motherhood leads them to feel trust and to open up to one another. When it comes to breastfeeding, it is an even more exclusive group so the women feel they can relate and are able to share with one another. “The self-focused reasons for self-disclosure deal with the psychological and tangible benefits to the discloser and include catharsis, self-clarification, and seeking support…Relationship-focused reasons include having a close and trusting relationship with one’s partner, similarity or having something in common, and a desire to increase intimacy or closeness…” (Vangelisti & Perlman, 2006, pp 415-416). For the mothers in this study, the give and take communication shared with sisters-in-law and other women in the family helped build a bond among them.

While many mothers in this study benefitted from the support and fellowship of a woman who was nursing alongside her (or had done so before), some mothers in the study also say they benefitted greatly from having an expert in lactation to turn to. Both mothers in the long-term breastfeeding group went to the El Paso Baby Café, not only for the expert help but for the support and empowerment they felt from other nursing mothers. One of the participants who is 41 years old and breastfeeding her only child says the support of an expert drove her to visit the baby café. Laura stated that her family support
system was long distance, for this reason, she turned to the El Paso Baby Café and received support from the lactation consultant:

…The support that was most valuable to me was what I received at the baby café …because I even had friends that they tell you about how it can be hard, I had a friend that even got me the gel pads so I could have some relief. But Libby was the person who sat with me and then she placed the baby in the right position and she put the pillow and she said, ‘you have to do this and this and he’s going to try to do this, but you have to change and do this.’ So it was, I guess, direct teaching and that was best. (Laura, March 15, 2013)

In these situations mothers who felt supported were able to continue breastfeeding through the length of time they had set their initial goal and in some cases, beyond. These mothers credit their success to many things, one of which being the support of others who understood what they were going through, whether as a comrade of sorts or as an expert in the field through social support. Virtanen & Isotalus explain that “…studies have shown that some relationships are more supportive than others, and certain people may be better sources of support for particular problems than others”(2011, p. 27). In the case of the mothers who visit the Baby Café, they benefit from receiving support from other mothers (if this is what they seek) and from a certified lactation consultant who can speak to them as an expert on the subject of breastfeeding.

4.3 Mother’s Goal-Setting

Another important finding was that of the role of intrapersonal communication on a mother’s breastfeeding decisions. Those who breastfed longer and with more success (high level of satisfaction) were those who had set higher goals for themselves from the beginning (mostly prenatally) and were unwavering in their decision. Those who had lower goals for long-term breastfeeding or no goal at all often had much less satisfaction and earlier cessation of breastfeeding (even earlier than the goals set).
But these intrapersonal goals are often influenced by interpersonal communication of those close to the mother. Because of this communication and perceived support, the mother often set herself up for success or failure long before the baby even arrived.

In the 6-12 month breastfeeding group and the long-term breastfeeding group all eight of the mothers set goals in the one year range, while the five mothers in the 0-4 month breastfeeding group either had no goals, didn’t want to breastfeed at all, planned to stop breastfeeding upon returning to work, or said they would breastfeed “as long as they could.” Take for example, Lisa, who said she initially would have liked to breastfeed for six months, but ended up nursing her son for three weeks:

…but my biggest goal was to get him past the first three days because I think that’s the most important because of the colostrum so I was happy to get that…I was just gonna quit after I went back to work. I already knew with my work schedule and everything it would have been really, really difficult, probably more frustrating than anything because I knew if I made my mind up to do it and I couldn’t I think it would be really hard on me so I think I made my mind up before I went back to work. (Lisa, December 29, 2012)

Most of the mothers in the 0-4 month breastfeeding group had already decided that even if successfully breastfeeding once it was time to return to work, they would still likely stop due to the perceived inconvenience of pumping at work. Of the five mothers in this group, four had already stopped breastfeeding before returning to work and one did not work outside of the home (she did attend school), but stopped at two weeks anyway. Ultimately, the low goals set, combined with other factors (most of which are discussed later) led to short-term breastfeeding outcomes in the same way that long-term goals led to breastfeeding for more time. Hoot found this to be true in her quantitative study on breastfeeding. One of the four factors of importance in her findings was “anticipated length of breastfeeding” (1993, p.59). In this way, a woman’s support system must start from the beginning of
her pregnancy. If she knows she has a network of support for after the birth of her baby, she is more likely to set higher goals and start and continue breastfeeding for a longer length of time.

4.4 Supportive Communication versus Non-Supportive Communication

Another important finding for the mothers in the current study was that supportive communication with the mothers improved breastfeeding outcomes (duration, satisfaction) as compared to those who had more non-supportive/negative communication experiences. In fact, when faced with both supportive and non-supportive communication, many mothers would embrace the support and dismiss the negative. Valerie, a 29 year old participant in the 6-12 month breastfeeding focus group, expressed how negative comments didn’t have the same impact on her with her third child, partly due to her previous experience (with her first two children) but also because the positive interactions with her sisters-in-law overshadowed the well-meaning but negative comments of her own mother. Another young mother in the 6-12 month breastfeeding group, 23 year old Sophie, expressed similar sentiments in that she was very determined to breastfeed (she is currently breastfeeding her one year old son) and even though she received negative feedback from family, especially her own mother, with her own determination and the support of others, she was able to continue. When asked what helped contribute to her success with breastfeeding, she said:

Knowledge, that anytime anybody had anything negative to say, especially now I’m getting it more. A lot of people, it’s more on my side of the family, like my mom she only fed each of us, me and my brothers for three months and then she was done. She would always tell me there’s no need, they don’t need it that long and you’re tied down, this and that, this and that. And then when I told her I was trying to go further into it, she told me it was going to be awkward that my son was going to have issues, that it was going to be gross, if I do it in public. This and that. But I didn’t really care and I have all the support I need, anytime she would really tell me anything
negative I would really read up on it because it would kind of get me down, because I don’t really have like a support group from breastfeeding mothers. All of my friends who had babies didn’t breastfeed. I think the main person that really helped me was my mother in law, my husband’s mother. We don’t live with her or anything like that but she would just keep me going. She doesn’t remember because her youngest is 17 years old, she remembers it’s painful but, [interviewer: but she supports you] yeah [interviewer: so even when someone can’t completely relate, them saying, “you can do it, keep going,” helps?] yeah, most definitely. (Sophie, March 1, 2013)

Even though Sophie experienced very negative communication from her mother regarding breastfeeding and even lacked a peer support group, the support of a “role model,” one person cheering her on and encouraging her made a lot of difference in helping her to keep going. Sophie credits the support she received and the research she did on the reasons to continue breastfeeding, with her continued success. She recently met her goal of one year of breastfeeding and has changed her own criteria to let her son continue to breastfeed until he shows signs that he is ready to stop. There could be many reasons for Sophie’s mother’s negative reaction to her decision to breastfeed and I would argue that a woman with less intrinsic motivation and no source of outside support would have likely stopped breastfeeding because of such negative verbal communication she is receiving. This is further evidence of the multitude of factors that contribute to success or failure with breastfeeding. It also raises questions about cultural and generational ideas about breastfeeding behaviors (including negative/sexualized stigmas associated with breasts) as well as a possible lack of knowledge about the benefits of breastfeeding on the part of certain people.

There are several theories that are relevant in this situation, the first being the concept of social coercion for weaning. This theory relates specifically to breastfeeding behaviors and how mothers and their behaviors (specifically related to feeding) are under surveillance by those around them. Cindy
Stearns discusses the advice mothers receive: “…In particular, they note that mothers are discouraged from breastfeeding “too long” and that in order to avoid negative comments, some of the mothers chose to keep the breastfeeding a secret as the child neared the 1-year mark” (2011, p. 541). Later in her interview, Sophie mentioned that she would not breastfeed in front of her family members and that if she tried, her mother would “send her to a room.” She is dealing with a lot of negative pressure and social coercion for weaning is most likely at play here.

Daily interactions are an integral part of relationships. For a mother, her breastfeeding status becomes very much a reflection of who she is as a mother. According to Matsumoto:

Relational processing is at the root of most of our daily encounters whether with a long-term relational partner, a stranger with whom we share a brief encounter, or the cashier you greet everyday purchasing your morning coffee. The complexities of interpersonal connections are situated in an array of dynamic human features and personal attributes such as experience, developmental process, and social and personal identity orientations. (2010, p. 3)

We often take these interactions very much to heart because they are involved in our most dynamic encounters. In this way, the mothers who received negative feedback but persevered regardless, dismissed the negative interactions and instead relied on the positive relationships in their lives. Most likely they were able to do this because of their own understanding of the benefits of breastfeeding, their own goal-setting, and a strong source of support elsewhere that they chose to focus on.

Finally, there is the theory of social support and how very crucial this communicative element is for mothers. When a mother has set a goal and is trying to breastfeed her child for a particular length of time, social support, despite negative communication, will often help her to achieve this goal. Positive communication can often trump such negative communication. Virtanen & Isotalus offer this insight:
The experience of social support is familiar to most people. We can fairly easily recall an interaction in which we received comfort or assistance from another – or when we did not and how it made us feel…Indeed, communication research has shown that social support has various functions. Such functions may be informational support, emotional support, esteem support, tangible support and social network support, among others (Cutrona and Suhr 1994). Emotional support and comforting appear to be most frequent of those purposes and are the expressions of care, concern, empathy and reassurance (Burleson 2003). Recently esteem support, a particular form of emotional support, which is provided to others in an attempt to enhance how they feel about themselves (Holmstrom and Burleson 2011), has gained leverage. (2011, p. 27)

This idea of emotional support and more specifically, esteem support, are important interactional concepts in this study. These forms of communication help a mother find comfort and success in this new endeavor as a parent and in achieving particular goals she had set for herself and her child.

4.5 Support of Hospital Staff

Another interesting finding was that the respondents were also heavily impacted by the communication of hospital staff during their postpartum hospital stay. Some of the mothers who stopped breastfeeding early on described the hospital stay and/or staff to have made them feel uncomfortable and even to have turned them off to breastfeeding altogether. These were likely well-meaning, under-educated (on breastfeeding) employees (usually nurses) of the hospital. While other factors, such as low goal setting may have influenced these mothers to stop breastfeeding early, the first breastfeeding experience(s) in the hospital and how the mother was helped or not helped and made to feel played a major role in whether she successfully continued breastfeeding when she got home from the hospital. According to a study on helping to increase the exclusive breastfeeding rate in the well-baby population:
While the rate of “any breastfeeding” (partial breastfeeding and partial bottle-feeding) during the early postpartum period is important, numerous studies indicate that exclusive breastfeeding during the postpartum hospital stay is one of the most important influences on the duration of exclusive breastfeeding after discharge (California Women’s, Infant’s and Children’s Association & University of California Davis Human Lactation Center, 2008). Therefore, support for exclusive breastfeeding during the early postpartum period is essential for achieving the long-term outcomes for mother, baby and society as well as the Healthy People 2010 and 2020 goals. (Davis, Stichler, & Poeltler, 2013, p. 462)

Several respondents in the 6-12 month breastfeeding group stated that the staff was helpful in some ways but should have known certain things or communicated differently to be more effective. Among the mothers in the 0-4 month breastfeeding group, the interaction was often negative and contradictory and lead many of the mothers to only breastfeed for a couple weeks or less. One 33-year-old mother with a 9-month old son and 5 year-old-daughter told her story:

Ally: … But I will say that I felt that my experience with [my son] in the hospital really turned me off to wanting to breastfeed and I don’t think they meant to but...so the lactation nurse said he’s fine for about 12 hours, you don’t need to bother him, just let him sleep. But then the nurse came in and said he needed to eat and kept putting him on me and neither of us had slept [Anna, another mother in the group: that’s what I experienced]. Yeah, she was very rough with me, she was pinching my nipples in a way that was uncomfortable [Anna: see that’s what I experienced] and this is just the nurse, not the lactation consultation and she kept going and telling the lactation consultant that I was concerned because he wasn’t eating and so the lactation consultant would come tell me, ‘it’s okay he doesn’t need to eat now,’ and I go, ‘it’s her not me, she keeps waking him up and trying to make him eat and he’s gagging, he doesn’t want to do it.’ And so by the time that crucial point has come, the 12 hours or whatever has passed. Then he needed to
eat and I almost felt like he didn’t even want to be on me because it had been a constant. And so that same nurse was on me, so by the time I left and I did give him a bottle. [Lisa, another mother in the group: it’s a big turn off] And when we got home [my husband] asked me if I wanted to try and I just said no, I was so turned off to it by now, I’m able to hold him and feed him and look at him, I’m good [Lisa: yeah]…And I felt like the communication was lacking. I had been told not to wake him but this nurse it was like, this isn’t something I made up. But 2 separate lactation consultants told me something else and this nurse for some reason it wasn’t registering. And so …and I felt like it was so forced he wasn’t interested and that bond, I mean we did the golden hour and skin to skin but the actual nursing I didn’t feel like was a bonding experience, it felt like more of a fight [Lisa: yeah, like do I really want this?! Anna: they were so forceful]. (Ally, December 29, 2012)

Although it was my respondents who brought this theme to light, in hindsight I should have thought of this as a major possibility in terms of breastfeeding success in correlation to the initial hospital birthing and post-partum experience. It was my own experience with my first daughter that led to a very short and traumatic breastfeeding relationship and the initiative on my part to change everything I could for the birth of my second child. It was my own knowledge of one of the root causes of my poor outcome with breastfeeding the first time around (she breastfed, became dehydrated at four days old, and I pumped and gave breast milk and formula for three months before I quit completely) that allowed me to accommodate for those things and have a successful breastfeeding relationship with my second daughter (she nursed for 2 years, until I was 6 months pregnant with her baby sister) and with the youngest child as well (currently breastfeeding and almost 7 months old). As these mothers spoke of their negative hospital experiences, I was reminded of the negative interactions I endured as a new mother and how those shaped my perception of myself as a mother and what my body could and could not do and how as determined as I was to breastfeed my oldest daughter, I eventually stopped very short of my goal. In
hindsight, a major force in this failure was my treatment at the hospital; likewise, it was the changes I made to that for my second and third births that likely contributed to my success with breastfeeding.

4.6 Workplace Support

A final theme that became evident in the responses of the mothers was that a mother who had been successful at breastfeeding at home, but had to return to work, would be more likely to continue breastfeeding after returning to work if she had support there. Based on the small sample size in the current study, there is reason to believe that a breastfeeding mother will be more likely to continue breastfeeding after returning to work, if the workplace environment was supportive. One of the mothers in the 6-12 month breastfeeding group expressed that having a longer maternity leave helped her to establish a solid breast milk supply and relationship with her baby and that her employer set up a room for her at work to continue pumping. Additionally, both mothers in the long-term breastfeeding group told stories of how supportive their workplaces were in allowing them the time and space to pump breast milk once they returned to work. They felt that this support, along with other forms of encouragement in their lives, was instrumental in their continued success. Darla, an elementary school teacher shared that her boss found her a private location and other teachers to cover her classes so that she could pump twice daily. She credits this as one of the main factors for her to be able to maintain her milk supply and continue breastfeeding her son. This sentiment was echoed by Nancy, the other long-term breastfeeding mother, who is currently pregnant and still breastfeeding her 2 year old daughter:

In terms of support, I have got to agree with Darla [other mother in the group] that I also felt very supported by my boss because I was also pumping at work even though it was only part time but I still had to pump in the morning and I mean considering I was only there 4 hours, I still had the time allotted and it was actually really nice because when I went back to my office, I
had a window on my door and he bought a blind so that I would have the privacy to pump in my office. [Darla: that’s really nice]. (Nancy, February 28, 2012)

Here again, the theory of social support is a very important one. The employers found ways to help the mothers continue to provide for their family in more ways than one. These women were able to continue doing such a primal thing for their offspring while still being very active in a contemporary world where many mothers must work outside of the home to provide income for their families. “The definitions so far have given us evidence that the experience of social support includes the sense of being connected to others. Social support is a core element of close relationships …” (Virtanen & Isotalus, 2011, p. 30). In this way, employers allowed these mothers to maintain their connections with their child as well as to connect and function successfully in the workplace. According to a study done by Beverley Zinn on supporting the working breastfeeding mother, these employers are doing just the right thing based on the American Academy of Pediatrics’ guidelines, “… particularly those related to creating a place of comfort and privacy for the employee for nursing or for pumping and those related to break-time and flexibility” (2007, p. 224).

4.7 Summary

The 13 respondents in this study were broken into three separate groups. Five were part of the 0-4 month breastfeeding group, six were part of the 6-12 month breastfeeding group, and two were part of the long-term breastfeeding group (both breastfed their children at least two years and both breastfed while pregnant). Among these respondents, many commonalities existed, especially within each of the three groups specifically. The communicative themes in this chapter show that, in the case of the 13 respondents, the communication of those close to a mother can influence her breastfeeding behaviors greatly.
The mothers in the 0 - 4 month breastfeeding group tended to have set lower goals from the beginning. This was evidence that they perhaps were not as determined to breastfeed as the mothers who indeed did breastfeed longer (and tended to have set higher goals for themselves). Once these mothers became discouraged, for various reasons, the affirmation of others that it was okay to stop, gave them the permission they felt they needed to stop. Furthermore, mothers in this breastfeeding group, expressed that having a negative post-partum experience at the hospital negatively impacted their breastfeeding behaviors.

The mothers in the 6-12 month breastfeeding group, as well as the long-term breastfeeding group, found that the support of other breastfeeding mothers (their peers) and experts was invaluable to their success at breastfeeding. They were able to overcome obstacles and difficulties by being able to communicate with other women who were experiencing the same thing they were or had previous experience and/or extensive education on the topic.

Additionally, primarily in the 6 – 12 month breastfeeding group, the mothers shared experiences that indicate that positive communication about breastfeeding can overcome any negative communication of others. Without the positive to overshadow the negative, many of the participants in this study stopped breastfeeding.

Finally, the mothers in the long-term breastfeeding group as well as the 6-12 month breastfeeding group found that once they had gotten to a comfortable place in breastfeeding, they were able to continue successfully with the help of a supportive employer and workplace. The mothers felt valued as employees and it made the transition back to work as a mother much easier. The respondents were able to remain successful in two important realms of their lives thanks mostly to the nonverbal communicative actions of one or more people (especially in an authoritative position).
Overall, of the 13 women interviewed for this study, eight were Latina (two of which were of mixed ethnicities) and five were white. Although the sample size was small, ethnicity did not appear to be a factor in duration of breastfeeding. This is likely due in part to the scope of the study and the focus being on interpersonal communication as opposed to demographics. Two participants fell in the 20-25 age range, five each were in the 26-30 range and the 31-35 ranges, and one participant was older than 40 years of age. Here again, there was no relationship between age and breastfeeding duration. Similarly, education level or employment or marital status of the mother did not seem to impact her breastfeeding decision either. Respondents were not asked about socioeconomic status, but research has shown that this can be a factor in breastfeeding rates (Anchondo, Salinas, & Akins, 2008). Further research may be warranted in all of these areas as possible relationships may exist between various demographics groups, breastfeeding rates, and interpersonal communication.
Chapter 5

Conclusion: Implications and Further Research

Experts in the fields of health and nutrition, and specifically infant and child nutrition agree that (the majority of the time) the best way to feed an infant is with breast milk. In fact, according to the American Academy of Pediatrics in their most recent statement on breastfeeding:

Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice. The American Academy of Pediatrics reaffirms its recommendation of exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant. Medical contraindications to breastfeeding are rare. (2012, p. 827)

In some rare circumstances a mother will be physically unable to breastfeed her child and turning to formula is her only option. However, in most cases, with the help of others for both physical and emotional support, a mother can successfully breastfeed her child for the recommended one year’s time. The study at hand examined how communication of those close to the mother might increase or decrease her chances of successful breastfeeding. There have many studies done that examine factors that increase a woman’s success at breastfeeding for varying lengths of time and varying demographic groups but few have examined the impact of communication on breastfeeding longevity. This study went a step further and looked at communication practices in relationship to the length of time a woman breastfed and what role that communication had on this length of time.

Not only did the communication of significant others, parents, siblings, and in-laws play a role in the respondents’ breastfeeding decisions, but they also received meaningful communication from support groups (peers, sometimes strangers), experts (lactation consultations), and employers. The
respondents who were successful usually had somebody to credit and often they had more than one person or group to credit along the way. This may be because the nature of breastfeeding is ever evolving, as the child grows and the breastfeeding as a practice changes, the mother often needs new and different types of support. At first, experts can help a new mom to overcome the common physical troubles, as time goes by and a mother is set to return to work, the employer can ease the burden by offering support. As the mother nears the one year mark and people may be offering negative feedback, the mother can again turn to her support system of loved ones or peers to reinforce her desire to continue the breastfeeding relationship.

5.1 Implications

There are some basic actions that should be considered to help increase breastfeeding rates in the United States. These ideas come from basic research and my previous knowledge as well as the confirmation provided by this study, that support and knowledge are very important to breastfeeding success. Some suggestions for taking action include:

1. Expectant mothers should receive breastfeeding education beginning at the first prenatal appointment

2. Expectant mothers should be given resources during their pregnancy (support groups, lactation consultants, informational brochures, etc)

3. Expectant mothers should continue to be educated and encouraged to set high goals for themselves and their babies (in terms of breastfeeding).

4. Family members and close friends should be invited to attend informational sessions on breastfeeding and the importance of support should be stressed.

5. Breastfeeding sessions should focus on the “things nobody tells you” about breastfeeding as well as the practicalities of breastfeeding.
6. Expectant mothers should be encouraged to connect with other mothers in breastfeeding sessions to have a built in support group from day one.

7. Expectant mothers should receive informational brochures that they can offer to their employer regarding breastfeeding and returning to work.

At the present time there are only a handful of official Baby Cafés in the United States. One way I would like to take action is to take my research and help open more of these operations in different parts of the United States. For example, my hometown is Riverside, California, however if a mother there wanted to go to a Baby Café, her nearest option is where I currently reside, in El Paso, Texas. This sort of support should be offered closely enough for any new mother to receive it. There are other sources of lactation support throughout the United States (including in the Riverside area), such as La Leche League and independent lactation consultants/doulas, as well as those affiliated with hospitals, and support groups run by breastfeeding mothers. However, the Baby Café is a dynamic arrangement that brings fellow breastfeeding mothers together with the assistance of a certified lactation consultant at a comfortable and convenient location (not a hospital). This outreach was found to be invaluable to many of my study participants, and I believe it could help in other areas of the country.

5.2 Limitations, Lessons, and Next Steps

This project was limited in scope due to the sample size and research questions at hand. Much more research can be done on the topic of interpersonal communication and breastfeeding. I think this project could serve as a springboard to more in-depth studies on more focused topics. More research could be done on the relationship between breastfeeding rates and socioeconomic status, marital status, ethnicity, education, or age. All of these can then be connected back to interpersonal communication and the differences in communication styles between people of different backgrounds. Furthermore, the social coercion for weaning theory could be reexamined with the outcomes at hand. Communication
literature has taken on the topic of mothering, however it is lacking in research on breastfeeding. While this study is a step in the right direction, more could be done along these same lines to possibly improve breastfeeding outcomes.

When I set out on this thesis journey, I had decided to research this topic because of my own personal experiences with breastfeeding in a family community where it was not the norm. But as I began the process, I had to frequently ask myself how this is relevant to others. Nearly everybody has somebody in their life who is pregnant or will be, and understanding the value of support is priceless. On an even larger scale, research shows that breastfeeding a child can cut costs in many ways. The benefits of breastfeeding are extensive for both the mother and child. The mother is likely to miss fewer days of work caring for a sick child (increased productivity) and therefore also visit the doctor much less and avoid any other healthcare related costs (Cadwell, 2002 also see National Women’s Health Information Center website). Furthermore, with obesity and diabetes (even among children) reaching epidemic levels, breastfeeding has actually been linked to decreased levels of both (See AAP guidelines). Mothers are not the only ones responsible for making breastfeeding successful. The saying that it takes a village to raise a child is very true in the case of breastfeeding. Anybody who is a part of the mother’s life has the opportunity to offer positive or negative communicative feedback to help or hinder the possibility of the mother breastfeeding her child. The implications here are far reaching. It is my hope that this study will shed some light on that.

The six important things learned in this study were that if a mother started out with low expectations and became frustrated, she sought permission from others to stop. A second theme was that of the value of support from peers or experts in lactation. Additionally, if a woman started out with low expectations or goals, she often stopped breastfeeding earlier than those with higher goals. It also became apparent that supportive communication practices are extremely important in regard to breastfeeding and can sometimes help to overcome negativity. Another important theme was that of the
importance of the communication of the hospital staff with the mother during her post-partum stay. And a supportive workplace helped mothers who overcame the early obstacles of breastfeeding and helped them continue providing breast milk for their child even when they were away. Based on these findings I offer the following suggestions to improve breastfeeding practices:

1. At least one certified lactation consultant should be on the post-partum unit at all times.
2. All labor and delivery and post-partum nurses should be trained as lactation consultants and have a set amount of time to become certified (this should be paid for by the hospital).
3. The entire staff should have a few common rules and teachings established so that the communication is consistent and effective.
4. New mothers should be encouraged to breastfeed but not feel as if they are being forced or bullied. Communication training would be important for all staff as well.
5. Resources should be made available to the mother upon discharge so that she would be able to get breastfeeding help once home with her baby.

All of these suggestions, coupled with those mentioned earlier in this chapter, help set a mother up for success with breastfeeding from the beginning of the pregnancy, to the immediate postpartum period and beyond, once she is home and does not have the professional assistance anymore. If everything ran as it should and all of the suggestions were implemented the new mother should feel confident, prepared, and supported; all important elements for breastfeeding success.

The experience of becoming a mother is not something for which anybody can fully prepare. The adjustment time that it takes to become acquainted with a new baby and the bodily changes are things that women should be given. It is in this time that what seems nearly as essential as offering a warm meal and quiet, is support. Family, friends, co-workers, bosses, and even the medical team can help a new mother with their words or without saying anything at all, with supportive actions. As a whole, if the mother is surrounded by love and support, she is left only to love and support her baby and the bond
that is forming. A mother that is nurtured can then nurture her baby. The effects of simple helpful communication are boundless.
References


Appendix A

Informed Consent

University of Texas at El Paso (UTEP) Institutional Review Board

Informed Consent Form for Research Involving Human Subjects

Protocol Title: The impact of interpersonal communication on breastfeeding

Principal Investigator: Jennifer L. Alarcon

UTEP Department: Communication

1. Introduction

You are being asked to take part voluntarily in the research project described below. Please take your time making a decision and feel free to discuss it with your friends and family. Before agreeing to take part in this research study, it is important that you read the consent form that describes the study. Please ask the study researcher or the study staff to explain any words or information that you do not clearly understand.

2. Why is this study being done?

You have been asked to take part in a research study of breastfeeding in American culture, a study of what is being said (and not said) to breastfeeding mothers.

Approximately, 15 mothers will be enrolling in this study in El Paso, TX and Riverside, CA.

You are being asked to be in the study because you do or have breastfed at least one of your children.
If you decide to enroll in this study, your involvement will last less than a week.

3. What is involved in the study?

If you agree to take part in this study, I will interview you about your experiences with breastfeeding.

4. What are the risks and discomforts of the study?

There are no known risks associated with this research.

5. What will happen if I am injured in this study?

The University of Texas at El Paso and its affiliates do not offer to pay for or cover the cost of medical treatment for research related illness or injury. No funds have been set aside to pay or reimburse you in the event of such injury or illness. You will not give up any of your legal rights by signing this consent form. You should report any such injury to Jennifer Alarcon, jilmapstead@miners.utep.edu, (951) 217-9088 and to the UTEP Institutional Review Board (IRB) at (915-747-8841) or irb.orsp@utep.edu.

6. Are there benefits to taking part in this study?

There will be no direct benefits to you for taking part in this study. Although there may be a publication about the topic with content from your interview put out at a later date. This research may help us to better understand the reasons women are successful or have difficulties with breastfeeding and possibly address the communication dynamics that can improve breastfeeding success.

7. What other options are there?
You have the option not to take part in this study. There will be no penalties involved if you choose not to take part in this study.

8. Who is paying for this study?

Funding for this study is provided by UTEP Department of Communication, although the expenses for this study are very low.

9. What are my costs?

There are no direct costs. You will be responsible for travel to and from the research site and any other incidental expenses.

10. Will I be paid to participate in this study?

You will not be paid for taking part in this research study.

11. What if I want to withdraw, or am asked to withdraw from this study?

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you do not take part in the study, there will be no penalty.
If you choose to take part, you have the right to stop at any time. However, we encourage you to talk to a member of the research group so that they know why you are leaving the study. If there are any new findings during the study that may affect whether you want to continue to take part, you will be told about them.

The researcher may decide to stop your participation without your permission, if he or she thinks that being in the study may cause you harm.

12. Who do I call if I have questions or problems?

You may ask any questions you have now. If you have questions later, you may call insert Jennifer Alarcon at (951) 217-9088, jlmastead@miners.utep.edu.

If you have questions or concerns about your participation as a research subject, please contact the UTEP Institutional Review Board (IRB) at (915-747-8841) or irb.orsp@utep.edu.

13. What about confidentiality?

Your part in this study is confidential. None of the information will identify you by name. All records will be kept in files on a personal computer used only by the researcher. Any audio or video recordings will also be kept on the personal computer. Everything will be accessed by the researcher for purposes of maintaining accurate records. After the final project is submitted and the interviews are transcribed, the recordings will be deleted.
Every effort will be made to keep your information confidential. Your personal information may be disclosed if required by law. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include, but are not necessarily limited to:

- The sponsor or an agent for the sponsor
- Department of Health and Human Services
- UTEP Institutional Review Board

Because of the need to release information to these parties, absolute confidentiality cannot be guaranteed. The results of this research study may be presented at meetings or in publications; however, your identity will not be disclosed in those presentations.

14. Mandatory reporting

If information is revealed about child abuse or neglect, or potentially dangerous future behavior to others, the law requires that this information be reported to the proper authorities.

15. Authorization Statement

I have read each page of this paper about the study (or it was read to me). I know that being in this study is voluntary and I choose to be in this study. I know I can stop being in this study without penalty. I will get a copy of this consent form now and can get information on results of the study later if I wish.
Appendix B
Interview Questions

1. What is your age, race or ethnicity, education level, income level, job/career, how many children
do you have, what ages are they?

2. Are you currently breastfeeding? If so, how long have you been breastfeeding?

3. How many children have you breastfed (and for how long each)?

4. Did you set a goal for yourself in terms of breastfeeding? (If so) How were those goals set? Or
what criteria did you use to decide on those goals?

5. Did you have any obstacles or difficulties when it came to breastfeeding success? (If so) What
were they?

6. What has helped contribute to your success with breastfeeding?

7. Have any of the people in your life helped or hindered your breastfeeding experience? If so,
how?

8. How do you feel about breastfeeding in public? Do you do it? What experiences have you had
with it (if any)?

9. How have your family and friends reacted to you choosing to breastfeed?
10. Do you have any significant stories or moments having to do with breastfeeding, that stick out in your mind?
Vita

I am seeking a highly communicative and creative position where I can put my education and experience to work. I am earning a Master’s Degree from the University of Texas at El Paso in May of 2013 and have been named the Department of Communication Outstanding Graduate. I am graduating with a 4.0 GPA. My undergraduate degree is in Communication with an emphasis on broadcast journalism and a minor in political science. I received my Bachelor’s Degree in December 2004 from California State University, Fullerton. During my time working toward my Bachelor’s degree I also attended Riverside Community College where I earned an Associates of Arts degree. I spent many semesters on the Dean’s list as well as taking part in the Associated Student Body. During my time as a graduate student I worked as both a graduate research assistant, as well as a graduate teaching assistant in the Department of Communication.

Before pursuing my Master’s degree, I spent five years teaching a high school communications course. I worked closely with students, parents, administrators, and community members to help my students achieve success in high school. I taught many important skills both academically and for the real world. My experience in the classroom was invaluable and helped prepare me for many different endeavors. I was also reminded of the value of communication in everyday interactions. This proved helpful for me in connecting with my students, having relevance and rigor in my instruction, and developing rapport in the classroom. Furthermore, I worked with students on a club that was new to our campus, called Destination Imagination. In this capacity I was able to help students achieve new goals and envision new concepts. Our teams advanced to state competition both years we competed.

Previous to my time in the classroom, I spent two years working as a news producer at an El Paso news affiliate. I planned what elements would appear in two newscasts every weekday and wrote many of the stories. During the newscast, I made decisions pertaining to the newscast, as situations occurred. I adapted to a fast paced, deadline oriented environment successfully due in part to an emphasis on interpersonal communication with my colleagues.

In my employment history, I have been quickly promoted to high positions with more responsibility and more opportunities to train others. I have strong leadership skills, a high level of
intrinsic motivation, and excellent interpersonal communication skills. I am proficient in conversational Spanish and adapt well to different cultural climates.

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This thesis/dissertation was typed by Jennifer Lorie Alarcon