GAINING A VOICE:

A STUDY OF THE BREASTFEEDING EXPERIENCES OF A SELECT GROUP OF EDUCATED, LOW-INCOME, MINORITY WOMEN SUPPORTED BY PEER COUNSELORS

by

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"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever does."

– Margaret Mead –

ABSTRACT

Title of Dissertation

Gaining a Voice: A Study of the Breastfeeding Experiences of a Select Group of Educated, Low–Income, Minority Women Supported by Peer Counselors

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This grounded theory study describes the experiences of a small select group of educated, low–income, culturally diverse women who were supported by peer counselors/breastfeeding advocates in their communities as they attempted to breastfeed. The study explores their issues and concerns. In–depth interview data from seventeen women (ten African–American and seven Latina) were analyzed, using constant comparative analysis. Findings

from the study indicated that the perception of successful breastfeeding can have an empowering effect on women when support for their endeavors are gender– and culturally–appropriate. The five themes that emerged as primary descriptors of the experience were *Making the Discovering, Seeking a Connection*, *Comforting Each Other*, *Becoming Empowered*, and *Telling the World*.

The themes build on one another and integrate into the final theme, *Telling the World*. This final theme best illustrates a substantive theory derived from the data.

The knowledge generated by this study will enable health care professionals to be more creative in their approaches to cultural breastfeeding issues and to understand the role that peer counseling plays in providing support to breastfeeding women.

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CHAPTER I

INTRODUCTION

Background to the Problem

The initiation of breastfeeding in the United States has slowly declined from 59.7 percent in 1984 to 52.2 percent in 1989 (Ryan, Rush, Krieger & Lewandowski, 1991). This decline in breastfeeding is also evident among lower socioeconomic groups, particularly among minority women.

Jacobson, Jacobson and Frye (1991) reported that breastfeeding is decreasing among African–American women with only 23 percent initiating breastfeeding at delivery in the 1990s compared to 33 percent in the 1980s. However, a recent Ross Laboratory Survey conducted in 1992 shows a rise among African–American women to 27.2 percent (Healy, 1992). This phenomenon stems from the late 1980s when the Women, Infants and Children (WIC) Program, a federally funded supplemental nutrition program, obtained funds for improved training of WIC nutritionists in the art of breastfeeding and the hiring of breastfeeding peer counselors in WIC facilities. The funds have also been used to promote research on how to encourage low–income women to breastfeed and have enabled demonstration projects to work towards increasing breastfeeding rates among WIC

participants (Riordan & Auerbach, 1993). Each of these endeavors are in the initial stages of implementation; there are no published findings to date.

In studies of Latin women, a large variation in breastfeeding practice between different Latino subgroups has been identified. Bryant (1989) reported low incidences of breastfeeding among Cuban women in Florida, ranging between 10 and 12 percent. Other studies find women of Mexican descent breastfeeding in greater numbers overall, although rates vary anywhere from 30 to 60 percent (Kokinos & Dewey, 1986; Scrimshaw, Engle & Arnold, 1987).

Romero–Gwynn and Carias (1989) demonstrated a large discrepancy between breastfeeding intentions and practices of Latin women. While 67 percent of low–income women interviewed by the researchers intended to breastfeed exclusively, only 17 percent continued upon discharge from the hospital (Romero–Gwynn & Carias, 1989). Early formula supplementation and plans to return to work were cited as the two primary reasons these women chose to combine breast and bottle–feeding immediately following hospital discharge.

In numerous empirical studies, researchers have described the demographic and attitudinal factors that foster a higher incidence of

breastfeeding; the identified characteristics are being white, affluent, high school educated or above, and receiving social support and encouragement (Bevan, Mosley, Lobach & Solimano, 1984; Kurinij, Shiono & Rhoads, 1988; Grossman, Fitzsimmons, Larsen–Alexander, Sachs & Harter, 1990; Ryan, Wysong, Martinez & Simon, 1990; Bee, Baranowski, Rassin, Richardson & Mikrut, 1991).

Until recently, the majority of breastfeeding studies have consisted of samples of women from middle and upper–middle incomes groups. Studies measuring the incidence and duration of breastfeeding among low–income, minority women typically focus on poor outcomes in relation to middle–income women (Magnus & Galindo, 1980; Kurinij *et al.*, 1988; Wright, Holberg & Taussig, 1988; Ryan, Wysong, Martinez & Simon, 1990; Ryan *et al.*, 1991). Few, if any, studies have prompted investigators to focus on successful outcomes.

Because little is known about the low–income, minority woman who elects to breastfeed her infant (Grossman *et al.*, 1990), this study was carried out to identify and describe the experiences of a group of low-income, minority women who nursed their babies. The participants were clients of a community–based breastfeeding promotion program, where peer

counselors (low–income women who have successfully breastfed) are available to support and educate other women.

In this qualitative study, the investigator attempted to gain insight into personal characteristics that may influence breastfeeding success. The role of the peer counselor, based on the personal experiences of the participants, was also examined.

Purpose of the Study

The purpose of this study is to describe the breastfeeding endeavors of a select group of low-income, minority, urban women who received support from trained peer counselors. The generation of a substantive theory regarding the phenomenon of breastfeeding among this select population will be based on the findings from this study.

Problem Statement

According to a report by the Children's Defense Fund (1992), the greater incidence of infant mortality in cities is associated with such factors as low birth weight, teenage pregnancy, lack of prenatal care, and poverty. Infant deaths among poor children are often due to preventable or treatable

illnesses such as diarrhea, pneumonia, influenza, and accidents (Kliegman, 1992).

Infant mortality rates in some major U.S. cities continue to exceed other Western industrialized nations (National Center for Health Statistics, 1990). For example, the infant mortality rate for the city of Chicago is 17 deaths per 1,000 live births (Illinois Department of Public Health Statistics, 1992). Illinois ranks 46 out of 50 states in infant mortality with African–American infants dying at twice the rate of white infants (Stein, 1992). Since infant mortality rates are related to social, cultural and economic conditions, they are particularly resistant to reduction through health care intervention strategies alone.

Sadly, in recent years, there has been an increase, both in the number of children living in cities and in rates of poverty. Twenty percent of American children under age 18 live in poverty. For minority children, the proportion is much larger—46 percent for African–American and 40 percent for Latin children (Children's Defense Fund, 1992). According to Parker, Greer and Zuckerman (1988), poverty is one of the major markers for adverse developmental and behavioral outcomes for children.

Low breastfeeding rates among low–income, minority women contribute to infant morbidity. In studies comparing morbidity among

infants fed human milk or formula, fewer illnesses in breastfed infants have been reported (Auerbach, Renfrew & Minchin, 1991; van den Bogaard, van den Hoogen, Juygen & van Weel, 1991). Human milk is a highly complex fluid with an array of nutrients that is impossible to reproduce. The scientific community is well aware that, at the present time, there is no plausible way to substitute these nutrients in formula.

Despite vast literature on factors affecting feeding decisions and multiple efforts to increase breastfeeding rates, U.S. cities continue to face the problem of low breastfeeding rates among poor and minority women. The rate of breastfeeding initiation in Illinois remains about 22 percent for participants in WIC. Within Chicago, rates hover around 15 percent. Many clinics in the city serving minority populations report breastfeeding rates of only 1 to 3 percent (Illinois Department of Public Health Statistics, 1992). Such low rates are especially troubling since these populations are expected to gain the most from the health benefits associated with breastfeeding.

Research Question

The research question to be answered by this study is: What are the breastfeeding experiences of low-income, minority, urban women who are supported by peer counselors?

Significance of the Study

The need to encourage mothers to breastfeed has been widely recognized. It has been shown that the incidence and success of breast-feeding can be increased by relatively simple measures such as education and support to pregnant and lactating women in and out of hospitals and by slight modifications in hospital routines. Examples of hospital–based initiatives include: ensuring that a knowledgeable, supportive staff is offering bedside assistance to breastfeeding women; rooming–in policies that encourage unrestricted access to breastfeeding; discouraging the liberal use of water, formula and pacifiers; and finally, providing women with access to support, such as telephone consultation and support programs, following hospital discharge (Winikoff, Laukaran, Myers & Stone, 1986; Kistin, Benton, Rao & Sullivan, 1990). There is some evidence, however, that improvement in the initiation of breastfeeding may be followed by rapid decline after leaving the supportive environment of the hospital

(Chapman, Macey, Keegan, Borum & Bennett, 1985; Brogan & Fox, 1984; Romero–Gwynn & Carias, 1989).

Social and cultural support for breastfeeding is perhaps even more important than education by health care professionals. The influence of family and friends in the decision to breastfeed has been documented for middle and higher–income women and appears to be important for low–income women as well. According to Cohen and Syme (1985), women appear to benefit more from the health–promoting behaviors of female relationships and role models than men. Peer support for breastfeeding mothers has been identified as particularly effective in communities where there is little support from family systems, health care providers, or cultural norms (Walker, 1992).

Although low–income, minority women breastfeed in fewer numbers, a population exists nonetheless. It is important to study the breastfeeding experiences perceived by these women and ensure that the data are made available to both health care professionals and to the lay public. According to Walker (1992), education of health care professionals and peer support programs appears to have the greatest impact on raising the breastfeeding rates within low–income populations. From an academic standpoint, studies

that intersect health behaviors, gender, race and class in minority families will enormously enhance nursing scholarship (Watts, 1990).

The type and incidence of infant feeding decisions made by low-income women have been described in empirical studies consisting mainly of prospective surveys or retrospective chart reviews. However, to date, breastfeeding experiences as lived and perceived by the low–income, minority woman have not been described. The similarities (or perhaps unique differences) of women who breastfeed need to be identified.

Implications of the Study

The knowledge generated by this study will enable health care professionals to be more creative in their approaches to culturally related breastfeeding issues. The next step will be to move beyond description toward an explanation of the phenomenon. Health care professionals need a conceptual picture of the perception of successful breastfeeding across ethnic and social classes to better understand the needs of the childbearing woman and the role that peer counseling plays in providing support to breastfeeding women.

Development of the Study from a Feminist Perspective

Proponents of feminist epistemology argue that traditional scientific inquiry is fundamentally biased for one reason. That reason is the belief that everything considered feminine in origin must be rejected in order to maintain a rational world. Yet by rejecting all feminine perspectives (subjective vs. objective, intuitive vs. analytic, value–free vs. value–laden), the scientific community has historically created a limited methodological approach based on a narrow, masculine perspective.

Harding (1986) states that no scientific endeavor undertaken is completely objective and value–free. Each researcher brings to his/her investigation a preconceived set of values based on the social and cultural milieu of the day. But instead of being critical of our present scientific method, those who defend feminist epistemology are seeking to broaden the scope of scientific knowledge by envisioning and working towards a broader definition of science; a science that deals with and acknowledges both the subjective and objective aspects of our world; a science that is critical and self–reflective; a science that has social value; and finally, a science that is unified and in harmony with nature.

Therefore, the underlying conceptual frame of reference for this study evolves from two principles within feminist ideology. The first principle involves the recognition and validation of the *work of women* (Harding & O'Baer, 1987) through scientific research. The second is the acknowledgement of the *voices of women* (Belenky, Clinchy, Goldberger & Tarule, 1986).

Harding the O'Baer (1987) state that there is a critical need in research to focus on the realities that women face, particularly life events that are unique to women, such as pregnancy, childbirth and menopause. Although these experiences are solely that of a woman and can never be experienced by a man, they should be explored with just as much scientific rigor as any other aspect of our modern technological world. Each aspect impacts on the other from an economical, political and social standpoint. For example, the optimal nurturance of an infant requires a stable, loving caretaker for the first year of life (Brazelton, 1992). Yet our society routinely expects a woman to return to work six weeks after childbirth. This illustration points out only one troublesome aspect of our society today. The social ramifications of day care for infants needs to be explored much more thoroughly.

Belenky *et al.* (1986) believe that the care of others is central to the life's work of women. Traditionally, women have always known that

nurturing the development of others can be a deeply satisfying experience. Through listening and responding to others, women come to hear, value and strengthen their own minds and voices. These authors state that social change can occur when women can voice their concerns and work to make changes within a system that values connectedness, cooperation and mutuality.

Both of these principles can be used as guiding frameworks in feminist-based research. Research endeavors based on these principles can help to restore dignity and worth to the fundamental roles of women and their inherent values.

Therefore, the purpose of this qualitative investigation will be to promote an understanding of breastfeeding through the narratives of the women who have agreed to participate in the study. Their endeavor to breastfeed will be explored within the social context of our present-day society and from these feminist perspectives.

CHAPTER II

REVIEW OF RELATED LITERATURE

Peer Counseling

Tindall (1989) defines the concept of *peer counseling* as a variety of interpersonal behaviors assumed by non–professionals who undertake a supporting role with others. Peer counseling includes one–to–one relationships, group leadership, discussion leadership, advisement, tutoring, and all activities of an interpersonal, assisting nature. The role of peer counselors has been used extensively in education for over 30 years (Tindall, 1989). Health professionals also recognize the effectiveness of lay support or support groups as individuals learn to cope with illnesses, such as cancer, diabetes and heart disease.

Fridinger and Vincent (1989) described a peer counselor project to reduce cardiovascular risk factors among male co–workers within a correctional facility. The researchers compared groups with and without peer support, and concluded that lifestyle changes were significant in the peer support population. The presence of peer educators had the greatest effect in reducing systolic and diastolic blood pressure levels and increasing the number of workers who attempted to lose weight. The researchers

recommend further studies to measure the efficacy of peer advocates, particularly among blue–collar occupations. They also concluded that peer advocates not only provide a cost–effective approach to health promotion, but tend to provide greater strength and durability to programs.

The state of Hawaii has responded to the needs of their maternal–child population by focusing on prevention and early intervention, using peer counselors in a comprehensive program called Healthy Start. In 1986, Federal funds were secured to initiate the program. The services provided by paraprofessionals/peer counselors, under the direction of professionals, offer emotional support to families with 24–hour availability. The peer counselors model parent/child interaction activities and facilitate linkages to community services such as WIC, medical needs, housing needs, counseling and food stamps. The goal of the Hawaii program is early identification of children at high risk biologically and/or environmentally. The purpose of the program is to initiate services immediately following birth (Sia, 1992).

Peer counseling programs are being developed nationwide to promote breastfeeding. Peer advocacy programs are currently being implemented throughout WIC facilities in Illinois, Utah and California, with an emphasis on Latino bilingual staff (Morgan & Fields, 1993; Michaels, 1993).

The Chicago Breastfeeding Task Force is one of the first groups in Chicago to focus exclusively on the promotion of breastfeeding among low–income women. The Task Force, established in 1986, emphasizes a community–based model for breastfeeding promotion with peer support as a fundamental component. In 1988, the Task Force established a pilot project at Cook County Hospital in Chicago. To date, 180 peer counselors have been trained at Cook County Hospital and at other sites within the city (Dublin, personal communication, 1994).

Criteria for becoming a peer counselor in the Task Force program includes having breastfed successfully for at least three months, being from the same racial and socioeconomic background as the people served, and having a strong desire to help other women succeed with breastfeeding. Training sessions are ten weeks in length and include instruction in breastfeeding promotion and management, nutrition, basic infant growth and development, counseling techniques, making appropriate referrals to professionals when problems are beyond the scope of peer counselor training (Abramson, Barrera, Condes, Dublin, McKinley & Pitts, 1993).

In a controlled study of low–income women delivering at Cook County Hospital, those with peer counselor support were significantly more likely to initiate breastfeeding, to breastfeed exclusively, and to persist

longer than women without peer counseling (Kistin, Abramson & Dublin, 1994). According to Dublin (Personal communication, 1994), 37 percent of the women delivering at Cook County Hospital are initiating breastfeeding.

Concurrently in 1987, the Illinois Division of La Leche League International (LLL) also launched a peer counselor program to increase breastfeeding rates among low–income, multi-cultural women in the Chicago area. Volunteers for the program attend training sessions to learn basic breastfeeding management techniques and other skills necessary to support mothers who breastfeed. In January 1988, the first LLL peer counselors were deployed in their communities (Lofton, 1988).

Advantages of Breastfeeding

Human milk has been demonstrated as uniquely suited for the feeding of human babies. Biochemical studies have found that the amino acid, taurine, present in human milk but not in formula, is essential for brain growth during early infancy (Lawrence, 1989). In addition, the iron, calcium, and lipase are more easily absorbed from human milk than from cow's milk or formula (Lawrence, 1989; Riordan & Auerbach, 1993).

Numerous other benefits to the infant also have been described. For example, the immunological properties in breast milk provide protection for

infants against infection (Lawrence, 1989; Hanson, Adlerberth & Carlsson, 1988; Lifschitz, Wolin & Reeds, 1990; Pabst & Spady, 1990; Riordan & Auerbach, 1993; Burr, Limb & Maguire, 1993). Breastfeeding for the first four months of life may protect infants against ear infections. In a study published in 1993, the results demonstrate that infants exclusively breastfed for four or more months had half the number of ear infections than those not breastfed at all, and 40 percent less than those whose diets were supplemented with other foods before four months (Duncan, Ey, Holberg, Wright, Martinez & Taussig, 1993).

Allergy occurrence is also less common among breastfed infants (Chandra, Puri & Hamed, 1989). Furthermore, neonatal jaundice among breastfeeding newborns may be deemed less of a medical concern than jaundice in bottle–fed infants and, in fact, may serve as a protective mechanism against infection (Maisels, Gifford & Antle, 1988; Kemper, Forsyth & McCarthy, 1989; Yamauchi & Yamanouchi, 1990; Newman & Maisels, 1992; Martinez, Maisels & Otheguy, 1993).

A recent study using stringent research methodology showed increased intelligence (IQ), psychomotor skills, and school grades among children who were breastfed as infants. Longer durations of breastfeeding were associated with highest scores, especially among those children who

were breastfed for two years or more (Rogan & Gladen, 1993). Karjalainen, Martin and Knip (1992) state that avoidance of early exposure to cow's milk may help to prevent the development of insulin-dependent diabetes in children.

There are benefits to breastfeeding for the mother as well. For example, breastfeeding delays the return of fertility (Thapa, Short & Potts, 1988; Rivera, Kennedy & Ortiz, 1988; Labbock, 1993), and equally important, breastfeeding may provide maternal protection against breast cancer in pre-menopausal women ((McTiernan & Thomas, 1986; Kvale & Heuch, 1988; Ekbom, Hsieh & Trichopoulos, 1993). Breastfeeding also promotes maternal weight loss. Weight loss from one to 12 months postpartum was significantly greater in breastfeeding rather than formula feeding women (Dewey, Heinig & Nommsen, 1993).

In addition, breastfeeding also has been shown to enhance the attachment process between mother and infant (Piaget, 1936; Newton, 1955; Erikson, 1963; Winnicott, 1968; Newton, 1971; Greenspan, 1981; Stern, 1985; Martone & Nash, 1988; Brazelton, 1992).

When special programs to encourage breastfeeding have been measured, breastfeeding incidence and duration are positively affected (Auerbach, 1985; Saunders & Carroll, 1988; Grossman *et al.*, 1990; Kistin,

et al., 1990; Kistin, *et al.*, 1994). The impact of breastfeeding promotion, therefore, can be a critical strategy for lowering infant morbidity and mortality rates in high–risk populations.

Yet, the decision to breastfeed involves more than personal choice for low–income, minority women; social, psychological and cultural barriers may contribute heavily to lower breastfeeding initiation rates among this population.

Gray–Donald, Kramer, Monday and Leduc (1985) suggest that the decision to breastfeed is influenced by two types of factors, non–modifiable and modifiable. Examples of non–modifiable factors would be ethnic background, age, and parity. Potentially modifiable factors include hospital and workplace policies, enrollment in the WIC program and lactation education. Data indicate that women who are better informed regarding the benefits of breastfeeding and the breastfeeding process are more likely to initiate breastfeeding.

Societal Barriers

From an historical perspective, urban migration after World War II and the development of commercial formulas contributed dramatically to the overall decline in breastfeeding nationwide (Carter, 1984). Thus, by the early 1970s, bottle–feeding had emerged as the *normal* method of feeding.

According to Labbok and Simon (1984), the proportion of new mothers initiating breastfeeding reached an all–time low of 22 percent in 1972. This downward trend was reversed by the late 1970s in response to a growing awareness of the benefits of breastfeeding. Hence, educated, middle–income women again steered toward breastfeeding rather than formula feeding their newborns (Becerra & Smith, 1990).

Since 1985, however, more than 65 percent of all women of child-bearing age have been employed, and more than 40 percent of women with infants one year or less have worked full–time or part–time (Ryan *et al.*, 1990). Employment, therefore, may have an impact on both initiation and duration of breastfeeding, contributing to reported downward trends since 1989.

According to Walker (1992), American society has become accustomed to parents holding full–time jobs, creating the perception that this is the expected norm. When careers are viewed as a valued priority or two

working parents essential to survival for poor families, women are seemingly *deprived* of choices, consequently making the commitment to breastfeed a difficult option for some. Thus, low income women, particularly single parents, may view breastfeeding as yet another restriction in their endeavor to seek economic opportunity through work or school following the birth of a baby.

Until recently, the powerful influence of WIC has been a potential force in reducing breastfeeding rates among poor women. By providing commercial formula to qualified low–income women, WIC historically has delivered the not–so–subtle message that bottle–feeding is the preferred method. In fact, the U.S. government is the largest buyer of infant–formula in the world as sponsor of the WIC program. If only half the formula feeding mothers in WIC breastfed for a single month, $30 million could be saved, allowing more families to participate in the supplemental food program (Walker, 1992).

Specifically, as of February 1992, the average yearly WIC cost per bottle–feeding mother in North Carolina was $8,686 compared to $4,484 per year for nutritional support to low–income breastfeeding mothers (Freed, 1993). Therefore, increasing the number of breastfeeding women who

participate in WIC can result in substantial savings in health expenditures for the government as well as for the taxpayer.

The government of Quebec province, Canada, initiated an innovative program on March 1, 1994. They are giving low-income women a cash incentive to breastfeed their newborns. Recognizing the health benefits of breastfeeding, government officials will no longer subsidize formula distribution to low-income families. The Minister of Income Security stated that there will not be any decrease in expenditures at the present time because funds are being transferred from one source to another, however, babies who are healthier because of breastfeeding could ultimately save the publicly financed health-care system millions of dollars a year (*Chicago Tribune*, April 6, 1994, p. 13).

Numerous other barriers to the initiation and continuation of breastfeeding have been identified. Winikoff *et al.* (1987), addressed the problem of inadequate information being accessible to low–income women, as most educational materials about breastfeeding are designed for middle–class women. Access to adequate health care and supportive services also are limited for low–income women (Leeper, Milo & Collins, 1983).

Psychological Barriers

Misinformation and myths may play a role in impeding the acceptance of breastfeeding. Taylor (1985) found that young minority women often perceive breastfeeding as *old–fashioned, embarrassing,* and something that *ties a woman down.*

Many low–income minority women introduce solids to their newborns in the first few days or weeks of life, believing that breast milk or formula is not sufficient food for their babies (Solem, Norr & Gallo, 1992; Winikoff, *et al.*, 1987). The current recommendation of the American Academy of Pediatrics (1985) is that milk feedings alone provide adequate nourishment until about six months of age.

Based on interviews with low–income women through Focus Groups, Bryant (1989) revealed that the major breastfeeding concerns of this population were: modesty, privacy, lack of confidence in the ability to breastfeed, conflicting interests of work or school, and lifestyle constraints such as not drinking enough milk, not eating the right foods or receiving enough sleep. Bryant also found that advertisements portraying well–dressed white women breastfeeding discretely in quiet, private settings may undermine the confidence of low–income women living in overcrowded apartments without access to privacy.

Factors That May Influence Successful Breastfeeding

An attempt has been made to identify factors associated with breastfeeding initiation and duration. Furinij *et al.* (1988) found a strong association between higher educational level and incidence of breastfeeding in a study that examined the influence of sociodemographic factors on the breastfeeding practices of both black and white women. The researchers concluded that educational level is independent of other maternal characteristics such as ethnicity, age, family income and marital status.

Rentschler (1991), in a study of factors predicting successful breastfeeding among upper and middle–income women, found that the need to persevere is cited by breastfeeding mothers as one of the most important motives for success. Personal motivation and perseverance is enhanced when support and accurate information is readily available.

Leff, Gagne and Jefferies (1994) interviewed 26 middle-income women to describe their perceptions of successful breastfeeding. Using constant comparative analysis, five major categories emerged that were associated with successful breastfeeding: good infant health, demonstrated infant satisfaction, maternal enjoyment, achievement of desired maternal role attainment, and compatibility with lifestyle. The authors concluded

that perceived successful breastfeeding can be described as an interactive process resulting in mutual satisfaction of maternal and infant needs.

Several studies have revealed that a woman's perception of family and peer support lengthens the breastfeeding process (Bowering, Lowenberg, Morrison, Parker & Triado, 1978; Brogan & Fox, 1984; Barron, Lane, Hannon, Strumpler & Williams, 1988). For example, friendships, especially the support of a close female friend, play a major role in breastfeeding success and continuance for African–American women. Mexican–American women find support from their mothers to be a major contributing factor, while Anglo–American women view support from a male partner as most important (Baranowski, Rassin, Richardson, Brown & Bee, 1986).

Coreil and Murphy (1988) looked at breastfeeding mothers in a longitudinal study to determine how prenatal intention influenced breastfeeding duration, and whether postpartum events and practices had any additional effects. Although prenatal intent proved to be a strong predictor, lack of social support emerged as the most powerful mediating variable in the decision to begin formula supplementation.

Other studies suggest that future research should investigate the support systems of the breastfeeding mother, including the impact on

low–income women (Hill, 1988). For example, Grossman *et al.* (1990) in a study describing infant feeding decisions by both low– and upper–income women, reported that low–income women who breastfeed resembled low–income bottle feeders in certain medical/social factors, but enjoyed sound support systems similar to middle and upper–income women. When support from family, friends and breastfeeding peers was available, low–income women nursed successfully as described in studies by Sullivan and Jones (1986), Labbok and Simon (1988), and Hill (1988).

Anecdotal reports have begun appearing in the literature on peer counselor programs serving as an important variable in the success of low–income, minority women who desire to breastfeed their babies (Walker, 1992).

Personal Attributes That May Contribute to Successful Breastfeeding

Jacobson *et al.* (1991) recently looked at ego development, depression and verbal competence during the first postpartum year in two groups of low–socioeconomic breastfeeding women. Breastfeeding was found to be unrelated to depression and social support and positively associated with ego maturity and cognitive ability. The relationship of ego maturity to

breastfeeding was generally stronger than that of cognitive ability. The researchers hypothesized that women with more ego maturity breastfeed as a result of increased feelings of empathy or nurturance and/or because they are more attuned to current health advisors. It was suggested that ego strength may enable these women to deviate from community norms and adopt breastfeeding practices more characteristic of white, middle–income women.

Breastfeeding as a Facilitating Mechanism in the Attachment Process

Researchers and clinicians no longer look at maternal/infant attachment as a once-in-a-lifetime opportunity that occurs within a few hours after birth. Attachment theory, as it is described today, focuses on the ongoing infant's relationship with a consistent, loving caretaker over weeks, months and years of life (Eyer, 1993).

The process of attachment is a complex reciprocal set of activities that determine parental nurturing behaviors. These behaviors, in turn, stimulate emotional and physical responses in the infant. Breastfeeding can facilitate the attachment process; both mother and infant are mutually attracted to each other biologically and emotionally. Physiologically,

maternal responsiveness is influenced by the newborn's cry, which triggers production and release of oxytocin. This process, in turn, stimulates nipple erection and encourages the "intimate and mutually satisfying interaction of breastfeeding" (Boulton, 1983, p. 12).

Numerous authors have described the biological activity of breastfeeding with respect to enhancing attachment (Newton, 1955, 1971; Martone & Nash, 1988; Brazelton, 1992). Breastfeeding a newborn is described in these studies as one of the purest examples of the reciprocal nature of a mother–infant relationships.

In the process of breastfeeding, an exchange of energy occurs between the mother and baby, ranging from the concrete exchange of milk to the more abstract provision of mutual comfort, affection, and security. It is the art of breastfeeding, rather than the breast milk itself that triggers the powerful emotional interaction between mother and baby. Initially, suckling at the breast is built on the needs of the mother to relieve engorgement and breast discomfort and the needs of the newborn for food and ultimate survival. Erikson (1963) described breastfeeding as warmth, nourishment, responsiveness and constancy. Winnicott (1968) also referred to breastfeeding as both a method of providing nourishment and a facilitating environment.

Breastfeeding may also be defined as the simultaneous life process between mother and infant whereby nutritive and non–nutritive sucking at the breast provides for nourishment, security, comfort, affection, and intimate interaction to facilitate a reciprocal relationship. Optimally, breastfeeding becomes a mutually satisfying process for both mother and baby, with the baby meeting the needs of its mother and the mother fulfilling the infant's needs in return (Wright, 1987).

Wiesenfeld, Malatesta, Whitman, Granrose and Uili (1985), in a comparison study of breast and bottle–feeding mothers, examined the relationship between infant feeding status and psychophysiologic and behavioral responses of mothers to their infants' emotional signals. The authors found that breastfeeding mothers, overall, seemed to be more personally invested in their feeding choice, describing it as more enjoyable and relaxing both physically and emotionally than bottle–feeding mothers.

In a previous small–scale study conducted by this investigator, a group (N=10) of low–income, minority women training to become peer counselors were asked to describe their babies during their breastfeeding experiences (Locklin & Naber, 1993). Many poignant definitions of the attachment process were expressed. The comments of the women conveyed

a deep personal satisfaction and a strong emotional investment in their infants.

In summary, although low–income, minority women face multiple barriers to breastfeeding that are both institutional and social, approximately 27 percent of them manage to overcome these obstacles and nurse their babies (Healy, 1992). The findings from this study will document how some of these women view and manage their individual breastfeeding situations. The following chapter discusses the research design and focus.

CHAPTER III

RESEARCH DESIGN AND FOCUS

Inductive, qualitative research is indicated in areas of human functioning where little is known about a particular group or social phenomenon (Marshall & Rossman, 1989). Since the phenomenon of successful breastfeeding as experienced by low–income, minority women is largely unidentified in the literature, a qualitative research approach to this issue is appropriate.

The aim of qualitative research is to gain insight and understanding as well as a perspective on the participant's own lived reality. When the information is made public, others then have an opportunity to share in the reality through the narratives.

Naming the experience of breastfeeding and describing the experience of successful breastfeeding among this select group of women makes a once very personal experience become objective and public. The public expression enables others to gain a perspective and an understanding of the phenomenon.

Initially a mute personal experience, breastfeeding becomes a shared social experience defined by specific, objective conditions, identified by the

participant. The vitality of qualitative research, particularly when considered from a feminist, theoretical perspective, provides analytic insights that can touch us in ways that are simultaneously personal, intellectual and social.

Grounded Theory Methodology

The methodology of grounded theory was developed by Glaser and Strauss in 1966, and while derived by sociologists for sociological purposes, many other fields have adopted this approach for research. For example, grounded theory has proved to be a useful tool in nursing research (Stern, 1980, 1981, 1986; Fluery, 1991; Montgomery, 1994).

According to Stern (1986), grounded theory is applicable to cross–cultural research. The qualitative, holistic approach of grounded theory serves as a valuable methodology, enabling the researcher to better understand and explain human experience as lived, especially subjective phenomena that can only be interpreted through the eyes of the beholder. Thus, grounded theory methodology is ideal for defining cultural concepts uncovered by an examination of the data.

Grounded theory methodology is a form of qualitative research which strives to identify concepts and relationships in order to isolate a theory

about the process under study (Glaser & Strauss, 1966). Grounded theory guides the researcher to discover which issues and problems exist in reality and how the individuals involved confront them. Data are collected in natural settings through the use of observation and interviews. This inductive process involves simultaneous collection and analysis of data without a preconceived hypothesis.

The primary aim of grounded theory is theory generation, a precursor to further description of phenomena and quantitative research (Glaser & Strauss, 1966). According to Atwood (1984), grounded theory method typically yields Level I theory with the possibility of progressing to Level II theory. Level I theory is naming, or factor–isolating, theory where the variables present are not known to the researcher. Level II theory is factor–relating, or situation–depicting, theory where a description of relationships among two or more variables is presented (Dickoff, James & Weidenbach, 1968).

The role of the researcher in grounded theory methodology is to purposefully place him or herself inside the object world of the research participants to discover what that world is like, including how it is constructed and experienced (Chenitz & Swanson, 1985). This is done for

the purpose of understanding the phenomena and the object world from the perspective of the participants themselves.

Bowers (1988) suggests that the researcher's goal in this process is to maintain a *marginal status*, thus viewing the participant's world from the inside while maintaining the distance necessary to raise analytic questions. Marginal status allows the researcher to view both the participant's world and the researcher's world simultaneously, making comparisons between them to discover similarities and differences. Juxtaposing the two worlds should heighten the theoretical sensitivity of the researcher.

Strauss and Corbin (1990) identify two sources of theoretical sensitivity. First, it results from being well grounded in the technical literature, as well as from professional and personal experience, and bringing this complex knowledge to the research situation. Secondly, theoretical sensitivity is also acquired during the research process through the collection and analysis of data. This phenomenon is maximized through the process of constant comparative analysis.

According to Bowers (1988), grounded theory methodology differs from other research methods in the sequencing of steps in the research process. The literature review, question/hypothesis generation, data

collection, and analysis occur simultaneously rather than a sequence of distinct phases.

Reliability and Validity

Lincoln and Guba (1985) state that qualitative research results should be evaluated for trustworthiness. Trustworthiness means that the grounded theory accurately reflects the phenomena of interest. The authors identified four characteristics of trustworthiness: (1) Truth value; (2) applicability; (3) consistency; and (4) neutrality.

Truth Value

A theory contains truth value when it is in agreement with the participant's perception of the phenomena. The participants should be able to review the transcripts of their interviews for accuracy. There should be no internal inconsistencies found in the data and the generated theory should follow from a consistent, logical sequence of events (Lincoln & Guba, 1985).

Applicability

The researcher should be able to provide several descriptive illustrations that would allow others to fit the theory within a different context.

Consistency

The theory should follow an organized trail. The rationales for coding decisions are logical and predictable.

Neutrality

The theory must be grounded from the data and should be free of any investigator bias. Biases are made explicit within the text since the objective of being free of any bias is theoretical rather than based on reality.

To summarize, grounded theory methodology can adhere to mechanisms that increase the validity and reliability of the study findings. During both data collection and analysis, these mechanisms can be set into place to facilitate trustworthiness.

Strengths and Limitations

One strength of grounded theory methodology is that the research question and theory are generated directly from the data and from the participant's perspective.

Limitations of grounded theory methodology include the limited generalizability of the emergent theory and the inability to replicate the study exactly due to the unique timing and environment under which the study was undertaken.

Premature closure of data analysis can occur because of time constraints and information overload. Investigator bias may influence data collection and data analysis (Glaser, 1992).

Sample Selection

Theoretical sampling is the process used to select a sample population when conducting a study aimed at deriving grounded theory. The sample is drawn from a population where the phenomenon of interest exists (Stern, 1986).

Women sought for this study were those who consulted or were matched to peer counselors during their postpartum breastfeeding experience and subsequently nursed for an extended length of time (three

months or longer). The peer counselors, with whom this investigator has had a long association, served as key informants. They were asked to select the women to participate in the study. This method ensured that the sample population possessed the characteristics needed for the study.

Eligibility Criteria

Criteria for participant inclusion in the study were:

- Ethnic background other than Caucasian (English–speaking).
- Having breastfed for at least three months and currently breast-feeding.
- Having received or in the process of receiving support from a trained peer counselor.
- Low socioeconomic status as defined by enrollment in WIC.

Sampling Procedure

Potential participants for the study were recruited through peer counselors. The administrative staff of the peer counselor training program provided the names of peer counselors who were working in WIC facilities or clinics throughout the city. The method of contacting participants and

obtaining permission to conduct interviews was carried out in the following manner.

Each peer counselor was personally called by the investigator. After the purpose of the research and methodology was described, the counselor was asked if she would provide the names, telephone numbers, and addresses of women to whom she had provided recent breastfeeding support and who had also continued breastfeeding for three months or longer.

Five peer counselors, two African-American women and three Latina were contacted by the investigator and agreed to participate as informants. Each peer counselor was asked to make an introductory telephone call to the prospective participant eliciting her interest in the study and letting her know the investigator would be telephoning within the week. The peer counselors agreed on a two-week period during which they would gather at least five names of prospective participants and make inquiry calls. The investigator then re-contacted the peer counselors and obtained the names of the women who had agreed to accept the investigator's call.

Each prospective participant then received a telephone call from the investigator to determine if she met the criteria for inclusion in the study. Verbal permission to conduct a face-to-face audiotaped interview was then obtained from seventeen women who were deemed eligible.

The names of twelve African-American women were given to the investigator; ten of the women were eligible for inclusion into the study and all agreed to participate. Two women had returned to work and had subsequently stopped breastfeeding. Seven Latin English-speaking women agreed to participate.

The participants were given the choice of having the investigator travel to their home or meeting at an agreed upon location. The seventeen participants agreed to a home visit interview. The women who agreed to be interviewed were called the evening before to again confirm their addresses and to negotiate a time for the visit. All of the participants were breast-feeding at the time of the interviews.

Theoretical samplings are cumulative. Each counselor and her contacts were contacted in a sequential order. The first interview and each succeeding interview were transcribed and analyzed as quickly as feasible so that identified categories could be compared or contrasted. A theoretical sampling was carried out by interviewing both African-American women and Latina by comparing data from participants of different ages, cultures, parity, marital status, working or staying home with children. The interviews were conducted over a nine-month period from November, 1992 through July, 1993.

Ethical Considerations

The Human Investigations Committee of the researcher's academic setting approved the continuation of the study through October 1993, with the understanding that confidentiality of the participants would be maintained. Each participant was asked to sign a consent form (see Appendix A) before the scheduled interview. She was assured that her identity would remain confidential and no identifying information would be published or released. This investigator conducted all the interviews personally and transcribed the data. Each transcript was coded by number and any information that could identify a participant by her vignette has been altered.

All demographics or identifying information about the participants were kept at the investigator's home. The tapes were erased following transcription and analysis. The typed transcripts have been kept in locked files separate from the demographic data.

Data Collection

A face–to–face interview with each participant served as the method of data collection. The interviews were carried out by the investigator, and responses were audiotaped and transcribed for systematic analysis.

Audiotaping prevented any interference that note–taking may have had in maintaining eye contact with the participants and developing new ideas for questioning during the interview process. Audiotaping also prevented the possibility of missing data that later might be considered significant. The audiotaped interviews varied in length from 45 minutes to two hours. The participants were interviewed once. All the interviews were conducted in the privacy of the participants' homes. When the investigator arrived at the participant's home, the purpose of the study was again explained. Pertinent demographic information was obtained in writing prior to audiotaping (see Appendix B).

The questions were constructed to give the participants permission to define the breastfeeding experience from their own unique perspectives, the goal being that each woman would consider herself the expert in describing the process. To decrease social desirability and increase verifiability, the questions were designed to invite responses that would not be biased toward only the positive aspects of breastfeeding. At the beginning of the interview, the participant was asked to "tell me about your breastfeeding experience." This initial question was designed to make the participant feel comfortable before focusing on more specific questions, if appropriate, such as: "What has your family's reaction been toward your

breastfeeding? Did you have any problems during your breastfeeding? Describe your baby while breastfeeding. What makes you different from others who choose not to breastfeed?" Data collection by theoretical sampling continued until no new variables or relationships were identified in the interview data.

Data Analysis

Throughout the study, data analysis provided direction for additional data collection. Beginning with the first interview, the data were transcribed and coded, allowing further theoretical sampling and more focused questions.

After each audiotape was transcribed verbatim, the content was initially scrutinized line by line to obtain the global meaning of the paragraph and then to look for words or phrases that summarized the meaning of the interview. These words or phrases constituted the substantive codes. Codes were then compared across transcripts to identify phrases related or similar to each other. The codes were clustered together to form categories.

Through constant comparative analysis, the core category and the supporting concepts or properties of the category emerged from the data to

describe the phenomenon of breastfeeding as experienced by this select group of low–income, minority women. Writing memos as well as reviewing the literature as the data were analyzed facilitated abstract thinking and conceptualization in developing the substantive theory.

Various methods were used to ensure credibility and verification of the substantive theory (Lincoln & Guba, 1985; Strauss & Corbin, 1990). The investigator had gained experience with interviewing by conducting an earlier study with breastfeeding peer counselors.

Additional checks were conducted; the transcripts were reviewed by five of the study participants who were asked to comment on the truth of what was written. All five participants agreed that what they read accurately reflected their own breastfeeding experiences.

The derived theory was reviewed by a certified lactation consultant and an obstetrician who served on the investigator's dissertation committee. Three doctorally–prepared nursing faculty were asked to review the theory.

The following chapter describes the characteristics of the participants and the major themes generated from coding and comparing each transcript.

CHAPTER IV

FINDINGS

Characteristics of the Participants

The study findings are based on in-depth interviews with seventeen women who described their breastfeeding experiences and the support they received for their endeavor. These women were matched to a peer counselor, either prenatally or immediately postpartum, because they had expressed a desire to breastfeed when they enrolled in WIC. The respondents represent the predominant ethnic groups in the region of the country where this research took place.

Seventeen women participated in the study. Ten were African-American women and seven were Latina (see Table 1). Table 1 also illustrates the sequential order in which the respondents were interviewed. The women ranged in age from 18 to 37. Six were first-time mothers; eleven were multiparae. Among the African-American women only one had not completed high school; she left school in the 11th grade and is currently seeking GED certification. One African-American woman at the time of the interview was a graduating high school senior. Six were high school graduates, two had earned some college credit, one attended college for one

year, and one had completed two years of college. All of the Latin women had completed high school. One had a college degree and one was a licensed beautician.

Three of the African-American women were married; seven were single. All of the African-American women lived in homes or apartments with extended family. One married African-American woman returned to work six weeks after her baby was born, but quit to stay home when she discovered her infant was having a difficult time bottle-feeding while she was away. Five of the women worked part-time. All of the Latin women were married. None of the Latin women were working outside the home at the time of the study.

Length of breastfeeding ranged from three months to two years. All of the women were eligible for WIC with eligibility in the program, serving as an indication of low income status (Grossman, Harter, Sachs & Amparo, 1990), and in addition, six of the African-American women were receiving Aid for Dependent Children.

All of the participants resided in the inner city of a large Midwestern city. One 18–year–old African–American woman stated that her boyfriend (the baby's father) had been killed when she was just three months pregnant. During the interviews, each of the women made references to the

dangers of their communities (high violent crime, drug and alcohol use, and lack of parenting skills observed among peers). One 20-year–old African-American woman and her husband were living with her grandmother to protect her from gang violence in the immediate area.

TABLE 1

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Ethnicity	Age	Marital Status	Education	Parity	Length of Breastfeeding	Occupation
1. Latina	31	M	High School Grad. Licensed Beautician	2 children	1st baby - 1 yr. 2nd baby - 4 mos. (currently)*	Unemployed (homemaker)
2. African-American	21	M	2 yr. Associate's Degree	1 child	8 mos. (currently)	Part-time cashier
3. African-American	28	S	High School grad.	5 children	1st breastfeeding experience 4 mos. (currently)	Unemployed (homemaker)
4. Latina	20	M	High School grad.	1 child	2 yrs. (currently)	Unemployed (homemaker)
5. African-American	18	S	High School grad.	1 child	3 mos. (currently)	Unemployed
6. Latina	24	M	High School grad.	3 children	1st baby - no 2nd baby - 6 mos.* 3rd baby - 6 mos. (currently)	Unemployed (homemaker)
7. African-American	33	M	1 yr. college	3 children	1st breastfeeding experience 4 mos. (currently)	Unemployed (homemaker)

Ethnicity	Age	Marital Status	Education	Parity	Length of Breastfeeding	Occupation
8. Latina	33	M	4 yrs. college	2 children	1st breastfeeding experience 4 mos. (currently)	Unemployed (homemaker)
9. African-American	20	S	Completed 3 yrs. high school	1 child	5 mos. (currently)	Student (seeking GED certification)
10. African-American	19	S	High School Senior	1 child	7 mos. (currently)	Student part-time (employed)
11. Latina	23	M	High School grad.	1 child	4 mos. (currently)	Unemployed (homemaker)
12. African-American	32	M	GED Certification	3 children	1st breastfeeding experience 1 yr. (currently)	Employed Part-time
13. African-American	37	D	High School grad.	3 children	1st baby - no* 2nd baby - 6 mos. 3rd baby - 4 mos. (currently)	Unemployed (Homemaker)
14. Latina	23	M	High School grad.	2 children	1st baby - no 2nd baby - 3 mos. (currently)	Unemployed (Homemaker)
15. African-American	26	(Sep.)	2 yr. Associate's Degree	3 children	1st baby - 6 mos.* 2nd baby - 1 yr. 3rd baby - 4 mos. (currently)	Employed (Part-time)

Ethnicity	Age	Marital Status	Education	Parity	Length of Breastfeeding	Occupation
16. African-American	18	S	High School grad.	2 children	1st baby - 6 mos.* 2nd baby - 4 mos. (currently)	Employed (Part-time)
17. Latina	22	M	1 yr. college	2 children	1st breastfeeding experience 5 mos. (currently)	Unemployed (Homemaker)

* These participants were supported by a peer counselor with their first breastfeeding experience or sought advice from a peer counselor with a subsequent breastfeeding endeavor.

Themes

During the simultaneous process of data collection and analysis, five themes were identified: (1) *Making the Discovery*; (2) *Seeking a Connection*; (3) *Comforting Each Other*; (4) *Becoming Empowered*; and (5) *Telling the World.*

Making the Discovery

A majority of the multiparous women (N=8) stated that an initial attempt to breastfeed their first babies had been *unsuccessful* because they couldn't seem to understand the process. Nothing appeared to go as expected, and they didn't know where to go for help. Well-meaning but often conflicting advice from friends or family or a lack of advice and support from health care professionals added to their confusion and frustration.

For a majority of the participants (N=14) in this study, the initial few days after the birth of their babies was a time of uncertainty as they began to breastfeed for the first time or after an unsuccessful prior attempt. Initiating breastfeeding can be stressful at first. A few of the women described their feelings the first days after the birth of this current baby.

A multipara Latin mother described her first postpartum day in the hospital: "I was so stressed out the first couple days after she was born, I felt she wasn't getting any nourishment."

A first time Latin mother described her initial attempt to breastfeed: "I was in a lot of pain; I was so uncomfortable. I didn't know how to feel; I never breastfed before."

An African-American woman also described how she felt the first few days: "At first it was like I saw no milk and I was kind of discouraged because I didn't see no milk."

But uncertainty quickly gave way to *discovering*. As each discovery about their own body's capabilities and their newborn's competency was revealed, they became more motivated to keep on breastfeeding. This phase of discovering took many forms and conditions. Each condition was coded by the term *hooking*. The first major theme, *Making the Discovering*, resulted from clustering many *hooks* described by the participants.

The theme of discovering stemmed from the participant's actual experience of breastfeeding. A majority of the women were genuinely surprised at how the baby's competency—the newborn's innate ability to breastfeed—hooked them into the process.

An African–American woman said: "It hurt so much the first time, but it was okay because she did so well." A Latin mother of two discussed her baby's ability to pull out her right inverted nipple and breastfeed easily off both breasts: "She successfully breastfeeds; in fact, the right is her favorite nipple. She's such a good baby and has a strong suck."

Another young woman said: "She knew how to do it!" A Latin mother who had a cesarean section and discovered her baby had been bottle–fed for 24 hours in the nursery stated: "I thought because he got the bottle nipple, he wouldn't breastfeed; but he did real good."

Other illustrations from these women are as follows: "I pick up my baby; I put her in bed with me and she eats!"

"I said I would try it; I would go through the pain, but to my surprise, it worked fine."

"She weighed 5 lbs., 10 ozs. at birth, but in one month, she gained 2 pounds. I couldn't believe it!"

Most of these women were initially ambivalent about breastfeeding. Many had tried in the past and were unable to continue because they were frightened by the initial discomfort and/or engorgement. They only considered breastfeeding this baby because someone, particularly a matched peer counselor, but in some cases a nurse or midwife, suggested it

prenatally or during their postpartum hospitalization. Thus, the actual experience, plus the needed information and support they had received, sparked their enthusiasm so they were willing to try again or for the first time.

Motivation to continue breastfeeding following hospital discharge came from the experiential process itself and the evolving realization that breastfeeding, once learned, is actually *easy*. Every participant stated that once "the hard part was over," initial engorgement/nipple soreness, not getting up in the middle of the night *hooked* them into continuing to nurse. Some women were very specific, saying things such as "the baby doesn't choke or spit up after a night nursing," but easily falls asleep next to the mother. Most of the women reported that their babies slept with them.

An African–American woman described her experience with her fifth baby, but first breastfeeding experience when she said:

> When I got home (from the hospital), I put him on a pillow and I was breastfeeding him and I would feel a little tingle, not a great deal of pain. So if he was nursing off one, I would feel the tingle in the other too. When I got used to not getting up at night, I said, 'Boy, this is great!'

Another motivating factor that *hooked* these mothers was the presence of milk—the realization that, "I can make milk!"

A first–time mother said: "I knew I was making enough milk for him. Once my milk came in, I knew I had a good supply because I could satisfy him."

A Latin teen related: "When I got out of the hospital, I had to go back to school so I could graduate. I was so full of milk, it would leak at school. I knew I had enough."

A 30–year–old African–American mother of three, breastfeeding for the first time stated:

> When I came home from the hospital, I used a breast–pump to see if I had any milk and once I saw the milk, I said: 'I have milk!' It excited me to see the milk.

A 31–year–old Latin mother of two said: "She got so fat so fast, I knew I was giving her enough." An African–American woman breastfed for the first time with her fifth baby. Her older children were so curious about her breast milk and kept asking if they could taste it. One day, she became so exasperated, she said:

> I took out my breast and squirted my milk out to my kids and I said, 'What does it taste like?' The oldest child said, 'It tastes like that sweet milk from the bottom of the cereal bowl."

The mother then commented, "No wonder he be crying for it!"

A final *hook* defined by a majority of the participants was the discovery that their baby disliked the taste of formula. When this group of women discovered the phenomenon, their ideas about discontinuing or weaning evaporated. One woman said "She spits up the formula, so I keep breastfeeding."

A 28–year–old African–American woman described the behavior of her four–month–old infant:

> He only drinks breast milk. I tried ___ (a commercial brand of formula), but he won't take it. I ran out one day to see a cousin that took sick in the hospital and they (her family) tried to give it to him when I was gone, but when he tasted it, no way! I can't sneak it to him. So I gave the formula away.

A 20–year–old African–American woman described her 8 month old son's behavior:

> I want to wean him, but then it's looking at him and how he reacts to the breast, seeing his reaction to the breast. He's known the difference since he was one month old.

To summarize, each phase of *Making the Discovery* increased the participant's knowledge, self-confidence and personal satisfaction with breastfeeding. Their confidence level rose with each pragmatic assessment of the situation. For example, they believed they had milk when they saw

it. They believed they were feeding their babies adequately when they saw their babies grow.

The second emerging theme, *Seeking a Connection*, illustrates the participants' perception of support that they received from peer counselors and/or family members.

Seeking a connection

Support of any kind was a major theme. Lack of support, whether professional, paraprofessional or family, hindered the process. All of the multiparas (N=11) voiced this phenomenon. They were unable to successfully breastfeed a first baby or many babies if there was no one to support their endeavor. The primiparas (N=6) in this study all received support from various individuals and were able to breastfeed for an extended length of time.

Both groups of women acknowledged that they received support from extended family and male partners. All of the Latin women stated that their husbands encouraged them prenatally to breastfeed. However, a partner's support was not enough.

According to the participants, the peer counselors served in the supplemental support role. Prenatally, at the time of WIC registration or during their postpartum period, the participants had been matched to their

peer counselors. The matching took place for two reasons: (1) their common ethnic origin and (2) mutual interest in breastfeeding. None of the participants voiced any expectation or assumption that the relationship would evolve into a long-lasting friendship. But at the time and under the circumstances, this linkage or connection served a very specific purpose.

It appears that the peer counselor's availability and ability to give clearcut instructions and guidance enabled each mother to grasp the mechanics of breastfeeding. Once knowledgeable, they began to trust their own intuitive powers and within a short time took pride of ownership.

Only one Latin woman talked about being isolated from her family when she stated: "My mother and all my aunts breastfed, but they live in Mexico." The other women spoke enthusiastically about family support.

A Latin woman said: "My family believes in breastfeeding."

A 20-year old Latin woman stated: "My husband wanted me to breastfeed; I really never gave it a thought when I was pregnant" (This young woman sought no prenatal care.)

An African-American woman said: "At first it was shaky, but then everyone in the family came to support me."

A 20-year old African-American woman said: "My boyfriend would watch me (breastfeed); he would just stare. He would say, 'It looks neat. What does it feel like?'

A 19-year old African-American woman said: "The first time my own mother saw me breastfeeding, she was shocked! She said, 'My baby is breastfeeding, oh my baby is breastfeeding!'"

An African–American woman talked about her relationship with her peer counselor:

> She called me a lot of times; she was checking up on me. I made an appointment at the WIC office to see her and she said, 'Let me see you breastfeed; come on, show me how you do it.' And I said, 'In here?' And she said, 'Yea, I want to see you do it!' So I went ahead and I breastfed him. You know, maybe if I had that kind of support with the first, I would have done better.

Another woman stated, "The baby makes more milk by nursing and nursing, but that can be very confusing for a woman. All women need is someone to tell them about this."

An African–American woman said:

> Support—that's the biggest issue. Push forward—continue to try—knowing it's going to get better and as you see the baby grow, well that encourages you. That's what kept me going. It's so convenient; when the baby cries, you don't have to warm a bottle.

A Latin mother of three stated:

> I know a woman who had a 10 lb., 14 oz. baby boy. Her doctor said he was so big, he would have a hard time breastfeeding. She tried for three weeks, but no one was there for her; she gave up. She was misinformed by a professional person. And who do people believe? *Doctors!* I got a lot of information through WIC. They gave me a lot of pamphlets and that's how I learned a lot of stuff.

Another woman said, "The WIC counselor was a lifesaver for me."

An 18–year–old African–American woman stated, "At first, I didn't plan on breastfeeding, but after talking to the counselor at the WIC office, she said it would be better for the baby. So that's why I decided to breastfeed."

A 31–year–old African–American woman said, "You know, I wanted to try with my three–year–old, but there was no one to help me."

A 20–year–old African–American woman said, "When I came home from the hospital, B. (the peer counselor) stopped by and she stayed maybe an hour. She was very patient showing me how to do it."

A Latin woman commented, "When I told the breast counselor I wanted to breastfeed, she was more excited than me!"

And another African–American woman said, "I got support in the hospital from the breast counselor, from my aunt and a friend of hers."

A 20-year old African-American woman said:

> When he was five months old, I felt he wasn't getting enough. So I called my peer counselor and she said, 'Do you see the milk come out? What do you see on his mouth? On your breast? He'll get more if you nurse more!' Now I don't want to stop.

An African–American woman said:

> B. (the peer counselor) called me from the county (the city hospital). I was so blessed to have a telephone number to call. I told a woman in my neighborhood how much I liked the peer counselor and my neighbor said, 'We need counselors here. All the women here are drinking and *drugging*; we need her here.'

Finally, one woman described a telephone call from a peer counselor when she stated:

> She told me to get warm towels to put around my breasts and call her back in the morning. She would tell me what was normal, what to expect. If she had said, 'Doll, don't call me. Why are you calling me at this time of the morning?' Or something like that, I would have said, 'Well, forget this. She doesn't care. I don't care.' But she cared enough to get out of her sleep and talk to me, and who am I? I never met this lady before. She cared about me and that made all the difference. When a stranger cares, it's better even than a relative that you've known for years.

In summary, a connection with the peer counselor particularly when reinforced with family and health care professional support, encouraged

these women to breastfeed. The peer counselor connection not only contributed to their understanding of the process of breastfeeding, but just as important, placed a value and credibility on breastfeeding.

The next theme, *Comforting Each Other*, illustrates examples of nurturing behaviors articulated by the participants as they described their babies while breastfeeding.

Comforting Each Other

Because of the supportive interventions that these women received and clearly appreciated, they moved into a phase of reassurance and insight as they continued to breastfeed. The third major common theme, *Comforting Each Other*, illustrated their awareness of a unique shared intimacy beginning to evolve between themselves and their babies. The discovery that their babies were staying healthy for extended periods of time, further heightened their confidence.

When asked to describe their babies during their breastfeeding experience, many women gave poignant definitions of attachment, illustrating their deep satisfaction and emotional investment in their infants. All the participants linked their infant's behavior towards breastfeeding to their commitment to continue.

A 25–year–old Latin mother stated:

> I can't really explain it, but it feels so good knowing the baby depends on you. When they see you, they get all happy. Other babies are happy to see their mothers, but this is different, because you're the sole provider, and that feels so good.

A 30–year–old Latin mother of two discussed her relationship with the four–month–old she is currently breastfeeding as well as her two–year–old son who she breastfed for a year. She stated:

> I've been so happy breastfeeding, and I notice when I feed them, they feel closer to me. Even when I scold him, he comes to me for comfort. He comes to me and hugs me and I feel a need to comfort him. I'm patient with my kids and I truly believe it's because I breastfed them.

A 28–year–old African–American mother said: "Everybody can play with the baby, but I keep him closer to me. And it seems like he's more closer to me than the others, because I'm breastfeeding him."

An African-American woman stated:

> When he cried when he was little, I fed him. I could always grab him, give him the breast and cuddle him. If I fed him, then he would feel better. Now he's trying to walk (8 months) and he gets a little bump; I use the breast for comfort and it calms him down. This is why I stick with it.

A 20-year old African-American woman said:

> When you hold that little life in your hands, and you're breast-feeding and she looks up at you, and you know what she's thinking—it's like—(the mother projects her baby, saying)—'I'm here, and I'm safe.'

A Latin woman commented:

> Breastfeeding is more than an action; it's part of our responsibility as women. I sit down and she looks in my face and she touches me and she stops (breastfeeding) and smiles; it's really wonderful!

An 18–year–old African–American woman discussed her three–month–old daughter: "I get upset when I can't give my baby my milk. I don't want her to miss out on any of my milk."

An African-American woman said:

> I was on the bus. I took a blanket and covered myself, and she nursed; nobody knew. I kept looking out the window; she gripped on so nice and fell asleep.

Another African-American woman said: "You can sit and hold your baby and look at her. When you have eye contact, the baby isn't tense; you're not tense."

A 28-year old African-American woman stated:

> After a while, he started enjoying it more, not so fussy, more laid back—you know, you could actually feel the love between him and me."

Motivation, spurred on by the infant's behavior and competency, strengthened the mother's own commitment to breastfeeding and enhanced her self–esteem and pride in this accomplishment. A recognition that breastfed babies are healthier is evident to these women.

A 20–year–old Latin mother who is still breastfeeding her two–year–old stated:

> I found out that they are healthier. He never got a bottle. I see kids his age and they are always sick and my son is always healthy. I figured out it was because I breastfed and the other mothers didn't.

A 25-year old Latin woman said:

> Why do I keep breastfeeding? First, because I know it's healthy for the baby and second, because it's easy. For now, it seems like the right thing to do. I don't want to take it away from her.

A 24–year–old Latin mother related her experience:

> The nurse who works at the clinic where I take my kids for shots commented on how cute and chubby she is. She asked if she was breastfed and I said, 'Yes.' I knew it; it's their color! 'They have such nice color and tone. They are so firm and healthy.' That was the first time anyone ever said that to me. She is used to seeing babies. It made me realize I'm doing the right thing.

A 19–year–old African–American woman said, "I've never taken my baby to the emergency room like all my friends have to do. She's so healthy." Another African–American woman stated:

> I had decided to breastfeed for four months, then stop. Then as I kept breastfeeding, I said maybe I would go to six months. Now I'm thinking about a year! It's exciting, you know. Since she's been in the world, she only had one cold. She's very strong; she's a fighter!

The theme, *Comforting Each Other*, not only demonstrates the reciprocal nature of breastfeeding, but also provides evidence of a commitment to breastfeeding exhibited when women nurse for an extended length of time. The longer a woman breastfeeds, the more confidence she develops. A personal sense of competency generates behaviors illustrated by the following theme, *Becoming Empowered.*

Becoming Empowered

When confronted with suggestions from others, primarily hospital-based postpartum staff nurses who appeared to be antithetical to the breastfeeding process, they came to rely on their own intuitive and critical judgement rather than the suggestions or mandates of those in perceived authority.

The women supported by peer counselors became *empowered* by their knowledge of breastfeeding, and through their breastfeeding experience and the support they received, they were able to take an assertive stance in relation to breastfeeding when the need to be assertive presented itself. The multiparous women were more assertive than the first–time mothers as would be expected.

A Latin woman described her hospital postpartum experience:

> I lied to the nurse who told me to give the baby formula in the hospital. I said, 'She fell asleep." I wouldn't let the nurses influence me with my second baby.

A 19–year–old African–American woman discussed her postpartum hospitalization and the teaching she received from the nurses. She listened to their advice, but followed her own common sense at home:

> Some of the nurses said to give him the breast for just a few minutes because the baby is just *pacifying* on the breast. But I let him suck until he didn't want to suck any more. I didn't give him a two–hour schedule. Whenever he woke up, I gave it to him. I play with him, but if he's hungry, I give him the breast.

This same woman further stated:

> I don't go back to WIC. I know they say my baby would have to drink ___. He gets only breast milk. That formula looks too heavy for my baby.

A 20–year–old Latin woman talked about her attempts to breastfeed her premature newborn.

> The nurses were tube–feeding him; they said he wasn't eating too good. They told me to give him a bottle. But I told them I wanted to breastfeed and I did.

Another Latin woman stated:

> At night she would nurse every hour and my nipples were so sore. I wanted to stop, but I knew it would pass. I read it in a book and the counselor told me. Eventually, the soreness would go away. It just got easier.

A 33–year–old African–American mother of three, although this was her first breastfeeding experience, described the event:

> A lot of people gave me horror stories about how it hurt, but I was so determined I didn't care, you know. It actually scared me at first, but like I said, I was determined. I'd call my counselor and she would tell me what to do.

A 19–year–old woman stated, "I breastfeed at McDonalds; everywhere I go. If my baby, is hungry, he eats!"

One young African–American mother, completing her senior year of high school and working part–time at a fast–food restaurant, learned how to hand express her milk so her baby could be fed breast milk exclusively. How did she learn to hand–express? She got a pamphlet from the counselor and "figured it out! It's easy and it's quick!"

An African–American woman commented:

> I was sitting at the clinic yesterday and a man said, 'She looks so big and healthy, like a Gerber baby.' And I said, 'This isn't a Gerber baby; this is a breastfed baby!" (she laughs) Gerber had nothing to do with this one!

In summary, the participants were able to internalize their newly gained confidence and make the decision to continue breastfeeding because of a growing reliance on their intuition and experience. Moving along a continuum from discovery to insight, these internal signals manifested externally as they talked about breastfeeding to others. The final theme, *Telling the World*, illustrates this behavior.

Telling the World

Beginning with discovery, moving toward reassurance and insight, these women had finally arrived at a place where the need to pass along this new-found information became paramount. It was surprising but not unexpected to hear comments that reflected a less tolerant attitude towards their formula-feeding peers. The fifth major common theme emerged from the data and was identified as *Telling the World.*

With their sense of competency and accomplishment, these *empowered women* consistently reported a need to share their success with others. These comments were always spontaneously made during the interview.

A Latin mother of two stated:

> I defend breastfeeding to the maximum. Sometimes I'm offended because people say I'm pro–breastfeeding. My outlook is, they should be defending formula!

A young Latin mother of one said, "I tell everyone, 'It's easy! You won't have to get up at night.'"

A 19-year old African-American woman said: "People say, 'Do you do it?' (breastfeed). I always say, 'I did, I did it!'"

An African–American woman said, "When I see someone who is pregnant, I ask if they plan on breastfeeding. If they say no, I ask them why, but I always hear lame excuses."

A Latin woman said, "I went to the education class at WIC. I see women who are pregnant and I really speak out on it."

An African–American woman stated:

> I was at the WIC office picking up coupons and met a pregnant woman and asked her if she was going to breastfeed. She said bottle because she wouldn't have no time to breastfeed, she was going back to work. But I said, 'That's not a problem; all you have to do is pump.' She said she wouldn't pump. I said, 'Take it to work with you.' She said, 'I wouldn't pump at work.' I said, 'Now quit giving me all these excuses! You're not going to breastfeed period!' I think it's exciting to talk to people.

Finally, an African–American women said, "If someone would explain breastfeeding to women, the proper way to breastfeed, then more women would breastfeed!"

This final common theme, *Telling the World*, demonstrated how these women collectively expressed an eagerness and enthusiasm to share with others their knowledge and mastery in the art of breastfeeding. The theme best illustrates a substantive theory taken directly from the data which will be developed more fully in the following chapter.

CHAPTER V

THEORY DEVELOPMENT

According to Glaser (1992), grounded theory must have four basic components: *Fit, Relevance, Workability and Modifiability. Fit* means that the categories of grounded theory are generated directly from the data. The data cannot be preconceived, forced or purposely selected. The categories should easily emerge from the data, creating the emerging theory. *Relevance* means that the data, categories, and theory must be based and firmly grounded in reality. The grounded theorist should not have to convince others of the relevance of the work; it should make sense. By *Working*, the theory should be able to explain, predict and interpret what has happened. And finally, *Modifiability* means that the theory is not absolute, i.e., written in stone. It should be readily modifiable when new data present variations in emergent properties and categories. The theory is neither verified nor thrown out, it is modified to accommodate the integration of new concepts.

This investigator described in the findings section how the participants of this study viewed their breastfeeding endeavors and illustrated what mechanisms were in place to handle the problems they faced through

their personal narratives. In order to develop a hypothesis based on a grounded theory methodological approach, the researcher moves away from the participant's own words and analyzes the data from a more abstract perspective (Glaser, 1992).

Glaser (1992) further states that coding should be done on the participants' behaviors, not on personality traits. For example, the women in this study articulated various ways in which they determined they were producing enough milk for their babies, such as pumping to see the milk, watching their baby's behavior at the breast, feeling the fullness in their breasts. These measures illustrated their behaviors as they confirmed their ability to produce milk.

Examples of the substantive code, *hooking*, that fell under the category of *Making the Discovery* and was gathered from the data on milk-producing behaviors, include *making milk, seeing milk, refusing formula.* After the list of codes was formed, the words or phrases were compared to each other. The investigator then determined which words or phrases fell into similar categories. The categories were clustered together to eventually generate a grounded substantive theory.

According to Glaser (1992), a logical sequential step in the process of theory development involves the ability of the investigator to conceptu-

alize the substantive codes into theoretical language. Conceptualizing substantive data into theoretical language raises the data to a conceptual level and presents a hypothesis that connects and integrates the various categories into a theory. Glaser (1992) states that the methodological principles of grounded theory have been designed for the discovery of concepts and hypothesis only, not for testing or replicating theory.

Five major common themes emerged from the data: (1) *Making the Discovery*; (2) *Seeking a Connection*; (3) *Comforting Each Other*; (4) *Becoming Empowered*; and (5) *Telling the World.* The themes build on one another and integrate into the final theme, *Telling the World.* This final theme best illustrates a substantive theory derived from the data.

The activities of breastfeeding an infant on a day-to-day basis followed by a month-by-month progression developed into a series of self-realizations for the breastfeeding mother. After the initial period of alarming breast changes, i.e., breast engorgement, breast sensitivity and soreness, compounded by the uncertainty about adequate milk production, a mother will come to find both she and her baby are becoming more competent in the process (*Making the Discovery*). Breastfeeding is now referred to as *easy* and *convenient.*

As the women in this study articulated their successful endeavors to breastfeed, they operationalized the phenomenon with expressions such as: "I can do it; this is easy; I have milk; I've breastfed for four months, I'm going to try for six months, I would like to breastfeed for a year!" Their sense of self-realization, competency and perseverance represents the theme of *Making the Discovery*, described by the investigator from a theoretical perspective.

The theme of *Seeking a Connection* described the roles that families, partners, and peer counselors played in the lives of the participants and became the benchmark or critical incident that turned the tide for these women. In other words, her supportive network provided the validation she needed to initiate and then continue to breastfeed. The peer counselor's availability and *expertise* confirmed the mother's own perception that her endeavor to breastfeed was working and she should continue.

Because of these supportive relationships, it became possible for this group of low-income, minority, urban women to achieve a successful breastfeeding outcome. Clearly expressed by the participants, their perceived success manifested itself in a personal sense of mastery and accomplishment.

The psychological and physiologic/hormonal ties (*comforting behaviors*), manifested and reciprocated, are now realized and comments such as "I feel closer to this baby; I can't imagine her not getting my milk," are stated by mothers. Observing over time, that family and friends with formula-fed babies appear to have more common childhood illnesses than their own babies, confirms their growing perception that breastfeeding is a contributing factor in the overall health of their babies.

The participants now articulated *empowering* behaviors based on their newly acquired knowledge in the art and mechanics of breastfeeding. The stories of the women in this investigation move on a continuum from one paragraph to another and from one narrative to another as each set of conditions brings about a renewed self-awareness. Subsequently, the mothers interviewed for this study feel compelled to share this phenomenon with others.

The initial four common themes uncovered from the data became the important structural conditions that contribute to the eventual consequence *Telling the World*.

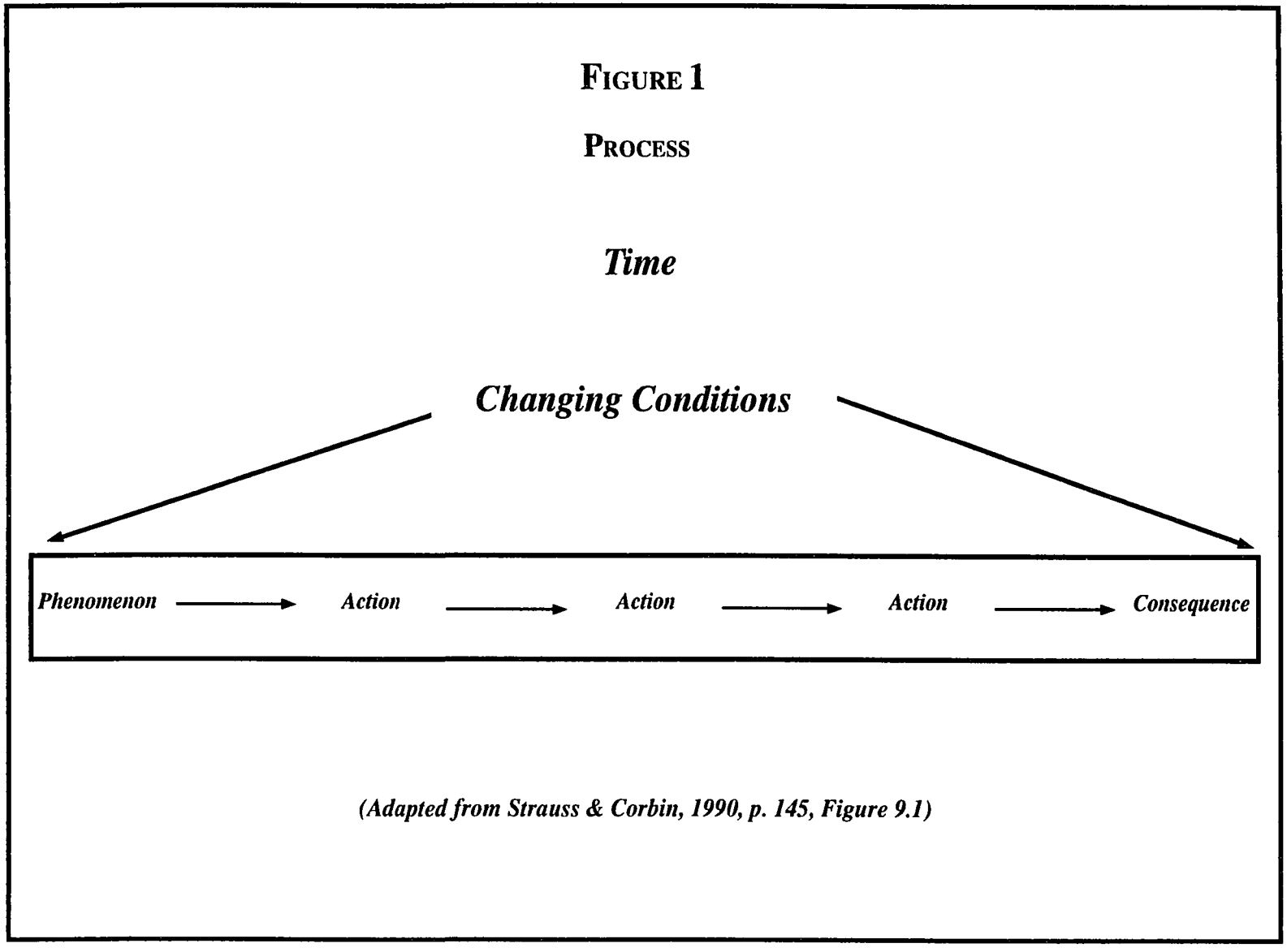
The hypothesis that breastfeeding is empowering for the low-income, minority women came directly from the data. For example, within the first three or four interviews, it became apparent to the investigator that these

women were eager to share their breastfeeding experiences with others. Repeatedly, the phrases, "I talk to anyone who will listen to me about breastfeeding; everyone should breastfeed, they don't know what they are missing; whenever I see a pregnant woman, I ask her if she's going to breastfeed," represent to the investigator that when a low-income, minority woman perceives her breastfeeding experience to be successful, she wants to *tell the world*, thus converting others. The theme of *Telling the World* describes the low-income, minority woman integrating her role as a breastfeeding mother, her gender identity, her relationship with the peer counselor, and her feelings of attachment to her infant into a positive sense of self-affirmation and ego integrity—empowering her to tell the world of her achievement.

Strauss and Corbin (1990) illustrate the process of theory development (see Figure 1). The authors state that grounded theory evolves when the investigator can demonstrate in the data analysis why and how action/interaction occurs in the face of changing conditions. He/she must then describe the consequences of the conditions.

FIGURE 1

PROCESS



(Adapted from Strauss & Corbin, 1990, p. 145, Figure 9.1)

Figure 2 illustrates this investigator's adaptation of the Strauss and Corbin process model to this study.

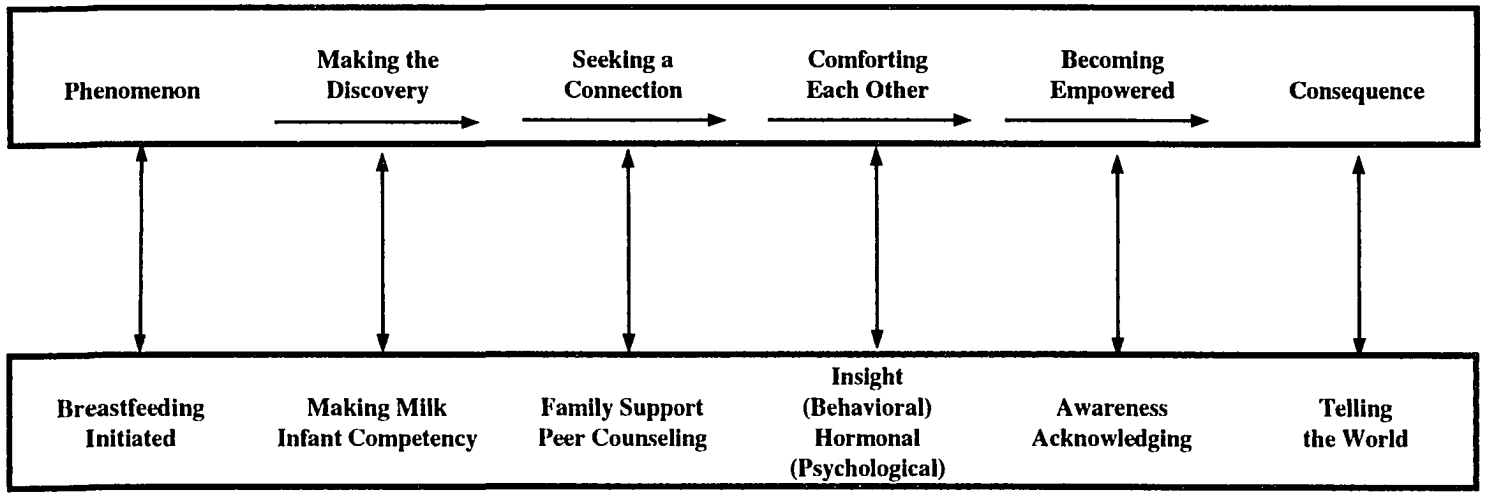
The language within the process model came directly from the data, lending trustworthiness to the developing theory. Each action/interaction moves along in a consistent, logical, sequential way. Each of the conditions occurred over time and eventually led to the final consequence, *Telling the World*. The study remains consistent with Strauss and Corbin's (1990) and Glaser and Strauss' (1967) grounded theory methodological approach. In the following chapter, the findings of this study are discussed.

FIGURE 2

PROCESS

Changing Conditions

Over Time



CHAPTER VI

DISCUSSION

The variables of age, race, and socioeconomic status were not considered indicators for success in these women, yet they are reported to be major contributing factors when measuring successful breastfeeding outcomes in many previous studies (Gray-Donald *et al.*, 1985; Grossman *et al.*, 1990; Ryan *et al.*, 1990). In this study, the participants' educational level supported the findings of others that a strong association exists between higher educational level and increased frequency of breastfeeding (Kurinij *et al.*, 1988). The Kurinij *et al.* study examined the influence of sociodemographic factors on the frequency and duration of breastfeeding in black and white women. The researchers concluded that education level is independent of other maternal characteristics such as ethnicity, age, family income, and marital status. The women in this study were high school graduates, high school equivalency graduates (GED Certification) or attended college.

Parity may also contribute to breastfeeding success, since a woman's confidence in maternal tasks increases with subsequent pregnancies as

demonstrated in the Coreil and Murphy study (1988). A majority of the women in this study were multiparas.

Many of the women viewed their babies as healthier than those of their peers and directly attributed this phenomenon to breastfeeding. Their perceptions are validated by the vast amount of recently published literature on the physiologic benefits of breastfeeding (Burr *et al.*, 1993; Duncan *et al.*, 1993; Karjalainen *et al.*, 1992; Maisels *et al.*, 1993).

The women in this study did not report early termination of breast-feeding because they were returning to work, but actually delayed seeking employment, worked part–time, or according to one participant, quit to stay home when her infant had difficulty bottle–feeding. The two women who were attending school exhibited strong personal motivation to complete high school and go on for further education. The women in this study are a self–selected population: their enthusiasm to breastfeed demonstrates a motivation to provide the best for their babies and illustrates their personal sense of commitment and responsibility to parenting.

Access to this population of women was enhanced because of their availability to the investigator. They were at home to receive the telephone call seeking permission for the interview and being at home during the day helped to facilitate the interview process and length of time that could be

spent in the home. When seeking participants for this study, the investigator discovered that women who had returned to work full–time and were asked to participate in the study, stated they had discontinued breastfeeding. This phenomenon confirms the work of Romero–Gwynn and Caries (1989) who stated that planning to return to work is the primary reason that many low–income, minority women either combine breastfeeding and bottle–feeding or initiate early weaning within the first few weeks.

The women in this small sample population tended to breastfeed for an extended length of time because they were home with their infants. A study that looks at the breastfeeding experiences of low–income, minority women who return to work shortly after the birth of an infant needs to be explored.

Six of the African-American women were receiving Aid for Dependent Children (AFDC) funding. All of the participants in the study were eligible for WIC. Although these supplemental funding sources are allocated for basic maintenance only, they do provide a financial buffer. Women of childbearing age, living in poverty, face limited choices. Full-time employment (often for minimum wage) not only prohibits exclusive breastfeeding, but separates a mother from her infant for several hours during the day. Long separations during the first year of life, when attachment behaviors

are mutually developing and strengthening, can be detrimental for both individuals.

Furthermore, the urban, minority family doesn't have access to a safe, nurturing community environment in which to raise their children (Parker *et al.*, 1988). With so many potential risk factors, it seems reasonable to encourage a supportive, stable, and cohesive family unit, especially for the first year of an infant's life through supplemental funding allocations along with breastfeeding and parenting support systems.

A study examining factors that predict breastfeeding success among upper– and middle–income women revealed that the need to persevere has been identified by mothers as one of the most important motives for success (Rentschler, 1991). Personal motivation and perseverance are enhanced when culturally appropriate support and accurate information are available and accessible. This factor was supported in the study as well.

Grossman *et al.* (1990) state that low–income, minority women who successfully breastfeed may share characteristics with more affluent women who breastfeed. Data from the study demonstrate that this sample population exhibited some of these shared characteristics: (1) seeking support and using it; (2) maintaining personal motivation; and (3) having perseverance.

On the other hand, data from the study also illustrate that these women had no way of predicting success before they began breastfeeding. The perception of success literally unfolded before them. For the participants in this study, the competency of their newborn's ability to breastfeed hooked these mothers into the process.

Babies who have a difficult time latching to the breast-initially would certainly inhibit the process and reinforce a woman's sense of inadequacy. This scenario is played out daily in many hospital postpartum settings.

Professional or paraprofessional hands-on support and reassurance to a mother, informing her that many healthy newborns need time to learn how to latch to the breast is a critical incident that if not handled appropriately, may alter the cause of a woman's decision to breastfeed or not (Riordan & Auerbach, 1993).

Although the women interviewed for this investigation were open to the idea of breastfeeding, none of the women began to breastfeed filled with confidence. A majority of the participants were frightened, wavered and needed clarification about their newborn's behaviors or the function of the breast prior to the establishment of milk. For example, the experience of engorgement is alarming when women do not know it is a common problem that can easily be prevented with instruction and supportive interventions

(Riordan & Auerbach, 1993; Hill & Humenick, 1994). The participants needed someone to be there for them, provide access to information and support, and they received it. They valued the support and knowledge they obtained from the peer counselors.

The women who participated in this study were pragmatists. They believed in breastfeeding when they saw results. They believed they had milk when they saw it. They believed they were feeding their babies adequately when they saw their babies grow. With each discovery and confirmation, "Yes, I can do this; this is easy; my baby is healthy." A woman's confidence in her ability to breastfeed was enhanced and her self-esteem grew. The data confirm that this phenomenon doesn't come to a woman through personal revelation alone. Someone must be available and accessible to confirm her discoveries. Someone must serve as a resource. In these cases, it was the peer counselors.

Numerous authors report that a woman's perception of family and peer support strengthens the breastfeeding process (Leeper *et al.*, 1983; Winikoff *et al.*, 1986; Bee *et al.*, 1991; and Walker, 1992).

In a previous study conducted by this investigator in 1989–1990, a qualitative methodology from which grounded theory was derived, was used to describe the experiences of a small group of African–American (N=8) and

Latin (N=2) women who overcame institutional and personal barriers to successfully breastfeed their infants (Locklin & Naber, 1993). These women initiated breastfeeding at a time when there was very little support or encouragement from health care professionals, families or the community. The women who participated in the 1989 study were recruited while they were volunteering their time to become peer counselors/breastfeeding advocates in their communities. These women articulated pride and enthusiasm in their breastfeeding abilities. Because they had perceived their endeavors to be successful, they were eager to share their experiences with other women. These women appeared energized by their successful breastfeeding experiences, and by volunteering their time to become peer counselors, they were able to mobilize their personal energy in a constructive way, thus contributing to the health–promoting behaviors of others. By reaching out and connecting to other women, functioning as mentors and resources, they appeared to be empowered by the process.

Belenky, Clinchy, Goldberger and Tarule (1986) state that supportive relationships provide women with experiences of mutuality, equality and reciprocity. Women often emerge from supportive relationships with other women with a powerful sense of their own capacity to gain knowledge and

expertise. Truth for women is grounded in the first-hand experiences of others much like themselves.

Finally, when the participants were asked, "Why are you different, why did you breastfeed when so many women in your community don't," the number one answer was, "I wasn't afraid to try." "They [the bottle-feeding mothers] don't realize it's so much easier. They just don't understand."

One young Latin woman spoke more critically: "Women who don't breastfeed are lazy! They don't put the needs of the baby before their own needs." The women enjoyed both the process itself and their relationships with their breastfeeding babies, supporting the work of Wiesenfeld *et al.* (1985) and Leff *et al.* (1994). These authors found that breastfeeding mothers, overall, seemed to be more personally invested in their feeding choice, describing it as more enjoyable and relaxing both physically and emotionally than bottle-feeding mothers.

When the participants spoke of their initial attempts to breastfeed, their dependency on a peer counselor was crucial. Now that they had established their own sense of competency and achievement, their pride in this accomplishment was internalized. And they became critical of others who weren't as motivated to try.

To summarize, incidences that occurred within the narratives as told by the women who participated in this study, support aspects of previous research conducted on breastfeeding women. These confirmations lend credibility to the developing substantive theory. The following chapter discusses the implications for further theory development, practice, research and health care policy.

CHAPTER VII

IMPLICATIONS

The purpose of grounded theory is to generate a substantive theory which will have implications for further theory development, practice, research and health care policy.

Theory

The substantive theory, *Telling the World*, offers validation for the conceptual definitions of empowerment. Rappaport (1981) defined empowerment as not only a process where individuals gain mastery; it also encompasses the growth of personal strength and power. Kopp (1989) states that knowledge is a source of power. The newly acquired knowledge and heightened insight that individuals gain by focusing on a particular problem and achieving a solution is unquestionably empowering.

Gibson (1991) defined empowerment as a social process of recognizing, promoting, and enhancing people's abilities to meet their own needs, solve their own problems, and mobilize the necessary resources to take control of their own lives. From a nursing perspective, Jones and Meleis

(1993) describe empowerment as the process of helping people to assert control over factors that affect their health behaviors.

Rappaport (1981a) further stated that according to the philosophy of empowerment, competency is possible, given the right opportunity and the right circumstances. For the participants of this study, the competency of their newborns to latch to the breast, the realization that they were making enough milk, the support and validation from the peer counselor and health care professionals that they were doing well and that their babies were healthy because of breastfeeding enhanced their self-esteem. Their perceptions became a powerful incentive, not only to keep on breastfeeding, but to tell others of this remarkable achievement.

When the low-income, minority woman recognized her competency in the ability to breastfeed her infant and perceived her endeavor to be successful, particularly when validated by others, she (like her peer counselor), wanted to share her knowledge with others. In other words, she now became a facilitator to others within her family, circle of friends and community. She gained her confidence through the experience of breast-feeding.

Telling the World describes in operational terms the theoretical definition of empowerment. More specifically, this theme illustrates the concept of empowerment from a feminist perspective.

The conceptual definition of empowerment, described in the feminist literature of Belenky, *et al.* (1986), Wheeler and Chin (1989), and Jones (1990), focuses on personal growth and social change through connectedness, cooperation, and mutuality. These attributes serve as the foundation for a feminist philosophy (Hall & Stevens, 1991). Traditionally, women have always known that nurturing the development of others can be a deeply satisfying experience, thus inspiring the belief, "As we empower others, we empower ourselves" (Jones, 1990, p. 12).

Belenky *et al.* (1986) demonstrated in their research that women typically approach adulthood with the understanding that the care and empowerment of others is central to their life's work. Through listening and responding, they draw out the voices and minds of those they are helping. In the process, they often come to hear, value, and strengthen their own voices and minds as well. Thus, *Telling the World* presents a hypothesis that should be explored more fully and under different circumstances and conditions.

Practice

The substantive theory, *Telling the World*, is applicable to nursing practice. Although this substantive theory is grounded in research on one very specific and time-limited event in a woman's life, nonetheless, it may have important general implications and relevance over the life-span of a woman.

For example, the adolescent who has been encouraged and supported in her efforts to prevent an unwanted pregnancy by the successful use of birth control, the pregnant woman who is receiving nurturing and supportive care at a local clinic in her community and delivers a healthy full-term infant, or the menopausal woman who receives support from peers to exercise and sees results from the experience, may well share these achievements with others. Thus, the theory may have direct and practical application in our endeavor to empower women who are living in poverty and currently envision themselves as powerless to change the conditions under which they live.

Innovative approaches to nursing practice are needed as we focus more of our energies towards health promotion activities. Jones and Meleis (1993) state that nurses need to develop new skills and specializations that

will enable and empower individuals to mobilize, both personal and environmental resources in order to achieve their health potential.

Practicing nurses have a dual responsibility today: First, to create interventions that encourage individuals to become active participants in achieving and maintaining their own health. Second, nurses must actively participate in activities that promote health from a social and environmental standpoint. This philosophy was so eloquently stated by Florence Nightingale when she wrote: "The goal of nursing is to put the patient in the best condition for nature to act upon him, primarily by altering the environment" (Nightingale, 1860).

For example, health care professionals must focus breastfeeding education within the context that a woman can have control and decision-making over the nourishment she provides to her infant, and because she is breastfeeding, she may be able to make a significant impact on her infant's overall health and well-being.

Many of the social problems facing the low-income populations within the urban community today are solvable, but the answers will have a paradoxical twist. For example, Rappaport (1981b) stated that experts should be turning to non-experts in order to discover solutions to problems

within communities. Peer support can guide individuals in problem-solving, to gain a sense of control, find meaning to their lives, and empower others.

According to Rappaport (1981b), too often individuals are labeled as unable or unwilling to function successfully in society. But it is often a result of social structure and lack of resources, which make it impossible for existing competencies to operate. For many individuals, their network of friends, neighbors, peers, and church relationships not only provide support, but genuine niches and opportunities for personal development.

Low-income, minority women often perceive themselves as alienated from the health care system. In reality, problems with access, cultural and language barriers, economic barriers make entering the system insurmountable. According to Stevens (1993), nurses are without a doubt, the most appropriate providers to take on a primary health care role in the United States. The nursing profession needs to organize its numbers, expertise, and power to change the dreadful conditions that many individuals face in accessing care. Appropriate education and adequate resources should be provided to communities so that all members are empowered to participate in their own health.

The training of paraprofessionals/peer counselors within an empowerment philosophical perspective, under the guidance and direction of health

care professionals, can provide under-served communities with needed resources and access to care. The World Health Organization (WHO) has mandated that nurses focus their energies on primary health care, forming partnerships with consumers and lay support (Stewart, 1990).

Based on the philosophy of empowerment, the breastfeeding peer counselor could serve as a resource mobilizer. She can facilitate access to resources, foster a sense of control and self-efficacy, and support women in one of the most basic health-promoting behaviors—breastfeeding.

Research

According to Hall, Stevens and Meleis (1994), federal directives have mandated that current and future researchers include women and members of under-represented ethnic and racial groups within the populations being studied. The comments articulated by the women who participated in this study could provide the groundwork for further research, both qualitative and quantitative.

This investigation examined a select group of women whose strengths and personal motivation, coupled with culturally appropriate support, enabled them to breastfeed for an extended length of time. While saturation

was reached in terms of the five major common themes, varying properties of these themes should be further investigated.

Although all the participants appreciated and highly valued the support and encouragement that they received from their peer counselor, two of the women stated they did not want to go back to their WIC centers, perceiving aspects of the program as a threat to their breastfeeding endeavors. Did they envision some WIC personnel as aggressively encouraging the use of formula and downplaying breastfeeding?

The active role that health care professionals play in breastfeeding promotion, support and encouragement for the low-income, minority woman should also be explored more fully. The negative comments made by the participants in this study far outweighed any positive comments concerning the women's interactions with physicians and nurses during their pregnancies or postpartum hospitalizations.

The role of the peer counselor should encourage subsequent studies that address the breastfeeding support needs of women within the health care arena, home and employment. Documentation of a woman's perception that her baby is healthier because of breastfeeding should encourage researchers to further investigate the health effects of breastfeeding.

The attachment behaviors exhibited by the women should be more carefully studied. There is a recognition among researchers and clinicians today that parental/infant attachment behaviors are influenced by an array of factors that can enhance the process or contribute to its breakdown. Some examples include the psychological characteristics of the parents, the environment, and the characteristics and temperament of the infant. Each of these factors could independently or collectively impact on early attachment behaviors. According to Cronenwett, Stukel, Kearney, Barrett, Covington, Del–Monte, Reinhardt and Ripper (1992), the effects of infant characteristics and maternal commitment to breastfeeding have not been controlled or even measured in most studies.

Studies that examine attachment behaviors within the context of breastfeeding may have implications in the prevention of child abuse and neglect. According to the Children's Defense Fund (1992), 2.2 million reports of abused or neglected children occurred nationwide in 1991. Breastfeeding promotion may serve as an important preventive public health service.

The measure of successful breastfeeding involves multiple aspects of a woman's perception of the phenomenon. Narrowly defined *successful* breastfeeding based on duration may inadvertently undermine the self-

confidence of a mother who decides to breastfeed for a short time because she is returning to full-time employment. A broader definition, including a mother's perception of the enjoyment she receives from the process, how she perceives her newborn's reaction, perception of her newborn's health and well-being, is needed to assist in the continuing development and evaluation of breastfeeding promotion and support programs (Leff *et al.*, 1994).

Research could further be done to describe the peer counselor's supportive role more thoroughly and within other aspects of maternal/child health; prenatal care, pre-term labor support, and modeling parenting behaviors.

Finally, Fredrickson (1993) states that given the urgent federal budget deficit, explosive growth in medical expenditure, poor maternal and infant health indices, and poor scholastic performance of U.S. children, it is time to focus attention on all aspects of breastfeeding research.

Health Care Policy

The findings from the study indicate that the perception of successful breastfeeding can have an empowering effect on women when support for their endeavors are gender and culturally appropriate. Hopefully, their experiences can be used to sensitize health care professionals and policy

makers to the importance of providing health care services that are accessible, culturally congruent and empowering.

The problems confronting the inner city are alarming and frightening today. One of the most fundamental answers is the development and nurturance of healthy families. Healthy families convey values, discipline, connection and ultimately self-respect and hope for the future.

Each segment of society will have to assume its share in the responsibility for change. The federal government and industry will have to provide for employment and a decent wage for families to stay intact. State and local governments will have to provide better schools to ensure the future viability of families.

The health care system can provide better access to care that is culturally and linguistically appropriate. Maternal-child health care professionals have enormous capacities to provide for the well-being of families and the health of their children. We can begin with affordable, comprehensive, prenatal care and the promotion of breastfeeding.

The most important strategy to support these endeavors will be the formation of grassroots initiatives. These groups will know the problems of the community in an intimate way and will provide the man (woman) power resources to begin to solve the problems of the inner city.

This study described how the role of peer counselors can help to influence breastfeeding outcomes for the low-income, urban, minority woman who wishes to breastfeed her newborn.

Limitations of the Study

During the research interview, there may have been instances where a lack of shared cultural norms for telling a story, making a point, or giving an explanation may have created barriers to understanding.

There was no attempt, either to define breastfeeding (exclusive or partial), in the study due to the wide variety of women and ages of their infants or breastfeeding toddlers. The women who participated in the study clearly articulated their preference for breastfeeding over formula feedings.

The reliability of the findings is dependent upon the participants' recollections of breastfeeding events. The participants' descriptions of experiences early in breastfeeding may be influenced by later events and can conceivably contribute to bias within the data.

CHAPTER VIII

CONCLUSION

Using grounded theory methodology, the investigator discovered that this particular group of low-income, minority, urban women who received support and encouragement from trained peer counselors demonstrated certain common behaviors that moved along a continuum as they initially began to breastfeed and then continued for an extended length of time.

Beginning with an initial period of uncertainty, then discovery, their behaviors evolved into a phase of awareness and insight that finally developed into a sense of self-confidence and pride.

Five major themes identified the conditions that contributed to these consequences: (1) *Making the Discovery*; (2) *Seeking a Connection*; (3) *Comforting Each Other*; (4) *Becoming Empowered*; and finally (5) *Telling the World.* The final theme best illustrated the substantive theory derived directly from the data. When the low-income, minority woman perceives her breastfeeding endeavor to be successful, she feels a sense of mastery and competency, and wants to *tell the world* of her achievement. This substantive theory has implications for further theory development, nursing practice, research and health care policy decisions.

Health care professionals must pursue intervention strategies that will support the breastfeeding dyad, particularly among low–income, minority women whose infants may benefit the most from the environmental, economical, nutritional, psychological, and immunological advantages of breastfeeding. With accurate information and consistent access, health care professionals can encourage and support a woman's own problem–solving abilities, thus enhancing her competency in breastfeeding.

Breastfeeding promotion through peer counseling encourages community women to provide one–to–one support for the low–income urban mother who makes the decision to breastfeed. When sociocultural support is available, breastfeeding can succeed, particularly in communities where there is little encouragement from the family or institutions.

The success of Chicago's Peer Counselor Program is being measured from both quantitative and qualitative perspectives. Kistin, Abramson and Dublin (1994) have studied the incidence and duration of breastfeeding among women, with and without peer counselor support. The research findings confirm that the concept works. This investigator has provided insight into the program from another perspective, reporting the stories of those who have benefitted personally from the peer counselor program.

Thus, while the quantitative researcher seeks objective, replicable and reliable data, the qualitative researcher strives for data that are rich, real and valid. Qualitative methodology offers the freedom to explain, describe, and even predict on a conceptual level the richness and depth of human experiences and interactions. Realistically, each method has the potential to contribute new knowledge to nursing research and clinical practice.

Romero–Gwynn and Caries (1989) recommend more breastfeeding research concerning multicultural populations in order to guide policy–making and support programs that target women at risk. To prevent under representation of minority women with limited education, the authors recommend avoiding written questionnaires which is the data collection method used in most breastfeeding studies. The goal of this investigator has been to provide a respectful milieu where the participants would feel compelled to share their stories of breastfeeding success.

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APPENDICES

APPENDIX A

RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER
HUMAN INVESTIGATION COMMITTEE

CONSENT FORM

(Please type all information.)

REAPPROVED

NOV 0 2 1992

BY H.I.C.

VOID ONE YEAR FROM ABOVE DATE

(HIC Use only)

I, _____, an adult (or: legal guardian of _____, a minor), have been invited to participate in a study of In-Depth Interviews with Breast-Feeding Women _____ under the direction of Maryanne Locklin, D.N.Sc. _____ *telephone no.* ( ) _____ in which I voluntarily consent to participate.

The implications of my voluntary participation in this medical study, its nature, duration and purpose, the methods and means by which it is to be conducted, and the inconvenience and hazards which may be expected have been thoroughly explained to me by _____.

I have read and understand all written materials which have been provided to me further describing the study and its potential risks and benefits to me.

I have been given an opportunity to ask any questions I wish concerning this study and all such questions have been answered to my complete satisfaction. I understand that I may terminate my participation in this study at any time without affecting the level of my medical care. I also understand that my participation in this study may be terminated at any time if in the opinion of my personal physician or the director of the study this is in my best interest. If I have any further questions, problems or questions about my rights as a research subject, I should contact the above named director of the study.

(If not applicable, check ☐). I certify that, to the best of my knowledge, I am not pregnant at this time. I agree that if I become pregnant during the course of this study I will notify the above named director of the study.

I understand that the information gathered in this study (including medical records) may be reviewed by the sponsor, and appropriate government agencies, including the U.S. Food and Drug Administration (21 CFR Part 50.25 (a) (5)), when authorized by statute and regulation. I further understand that my identity will be kept confidential and no identifying information will be released or published.

I understand that in the event of injury resulting from this study, there is no compensation available from the Medical Center for such injury and that I will obtain any necessary medical care for such injury in the same manner in which I obtain any other medical care. (This notice is printed here pursuant to Federal regulations 21 CFR Part 50.25 (a) (6) and (7) and 45 CFR Part 46.116 (a) (6) and (7)). I understand that in the case of injury resulting from this study, I should contact the Office of Risk Management at (312) 942-7828.

I understand that the director of the study will inform me of significant new findings developed during the course of the study which may affect my willingness to continue to participate in the study.

I understand that any drugs or devices provided to me for use outside of the Medical Center should be safely stored, kept away from children and used only as directed by my physician.

_____
Subject's signature and date

_____
Signature of Parent or Guardian (when applicable)

If subject is a minor:
- ☐ Verbal assent has been obtained.
- ☐ Verbal assent has not been obtained because of a waiver of this requirement (*waiver can only be granted by the Human Investigation Committee).*

I was present during the explanation referred to above, as well as the subject's opportunity for questions, and hereby witness his or her consent to participate in the study.

_____
Witness' signature and date

NOTE: Please type or print name below signature line. *This consent form not valid without the Human Investigation Committee approval stamp.* Signed copies of this form must be: a) retained on file by the Principal Investigator, b) deposited in the subject's medical record, and c) given to the subject.

Attach subject information sheet to this form.

APPENDIX B

APPENDIX B

DEMOGRAPHIC DATA

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

AGE: _____ NUMBER OF CHILDREN: _____

AGES OF CHILDREN: _____

YEARS OF EDUCATION: _____

EMPLOYED: _____

NAME OF BREASTFEEDING COUNSELOR: _____

LENGTH OF TIME BREASTFEEDING: _____

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I hereby guarantee that no part of the dissertation entitled, *Gaining a Voice: A Study of the Breastfeeding Experiences of a Select Group of Educated, Low-Income, Minority Women Supported by Peer Counselors*, which I have submitted for publication, has been copied from a copyrighted work, except in cases of passages properly quoted from a copyrighted work, copied with permission of the author, or copied from a work in which I own the copyright; that I am the sole author and proprietor of the dissertation; that the dissertation in all respects complies with the Copyright Revision Act of 1976; that the dissertation contains no matter which, if published, will be libelous or otherwise injurious to, or infringe in any way the copyright of any other party; and that I will defend, indemnify and hold harmless Rush Presbyterian/St. Luke's Medical Center by reason of the publication of the dissertation.

August 30, 1994
Date

[redacted]
Author's Signature