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COMMUNICATING SOCIAL SUPPORT:
UNDERSTANDING COMPLEXITIES OF
BREASTFEEDING COMMUNICATION
AMONG AFRICAN AMERICAN MOTHERS

DISSERTATION

A dissertation submitted in partial fulfillment of the
Requirements for the degree of Doctor of Philosophy in the
College of Communication and Information
at the University of Kentucky

By

Nicole Rachael Peritore

Lexington, Kentucky

Director: Dr. Elisia Cohen, Professor of Communication

Lexington, Kentucky

2016

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ABSTRACT OF DISSERTATION

COMMUNICATING SOCIAL SUPPORT: UNDERSTANDING COMPLEXITIES OF BREASTFEEDING COMMUNICATION AMONG AFRICAN AMERICAN MOTHERS

Breast milk is the best choice for meeting the nutritional needs for an infant whenever possible. Despite the knowledge that this nutritional choice is the best choice for an infant, data demonstrates that there is a sharp decline in the rates of breastfeeding mothers. Among African Americans, breastfeeding rates are significantly lower than the national averages. Despite many of the applications of social support in communication research, there is a gap in knowledge on the social support systems in the context of breastfeeding, especially for African Americans. With the social ecological model as a framework, social support theory provides understanding of the exchange between the mothers and their interpersonal relationships and community resources in the provision of emotional, tangible, and informational support. Study 1 consisted of focus group interviews with mothers and grandmothers. Mothers (n=16) discussed their experiences in receiving social support and grandmothers (n=12) discussed their experience giving social support to the mothers. The findings revealed the different communication and actions that mothers received from healthcare providers, peers, loved ones, strangers, and the grandmother of the child. Healthcare providers and peers seemed to have the largest positive communication in regards to a mother's initiation and sustainment of breastfeeding; strangers had both positive and negative supportive interactions, and family members and grandmothers were reported to provide negative support. Further exploration into the mother/ grandmother communication detailed the dissonance between the giver of support (the grandmother) and the receiver (the mother). Study 2 explored how breastfeeding champions (community level support) reported providing social support to breastfeeding mothers. Breastfeeding champions (n= 13) provided positive emotional, tangible, and informational support to mothers. The findings from these studies are discussed in terms of family relationship dynamics, the types of community level support, and future directions for communication research.

KEYWORDS: Breastfeeding, African Americans, Social Support, Qualitative, Communication

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11-29-2016
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COMMUNICATING SOCIAL SUPPORT:
UNDERSTANDING COMPLEXITIES OF
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AMONG AFRICAN AMERICAN MOTHERS

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*This dissertation is dedicated to my husband,
who never failed to know which kind of support was needed.*

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CHAPTER ONE: INTRODUCTION

Six months of mothers' exclusive breastfeeding has been associated with the reduction of allergies, colic, and other infant illnesses. The American Academy of Pediatrics recommends that an infant breastfeed exclusively, meaning no other liquids or solids, for the first six months of the infant's life. Yet, in the United States, the percentage of mothers who reach six months of exclusive breastfeeding is low. *The Breastfeeding Report Card* (CDC, 2014), reported that 18.8 percent of mothers exclusively breastfeed until the sixth month. Among African American mothers the percentage of mothers exclusively breastfeeding at sixth months is lower than that of all mothers. Some data suggest that only 8% of African American women exclusively breastfeed at six months (Health and Human services (HHS), 2011). Even when controlling for factors associated with longer breastfeeding rates, such as income and education, the racial disparity in breastfeeding is evident (HHS, 2011; CDC, 2007).

There have been numerous studies examining the health benefits of breastfeeding for both mother and child (American Academy of Pediatrics (AAP), 2012; HHS, 2011; Ip, Chung, Raman, Chew, Magula, DeVine, et al., 2007), the psychosocial benefits that occur with breastfeeding such as the bonding and the lowering of post-partum depression for mothers (Bai, Middlestat, Peng & Fly, 2009; Guttman & Zimmerman, 2000), and the economic benefits for families, employers, and insurance companies (Ball & Wright, 1999; CDC, 2013; HHS, 2011). There also have been attempts to explore the reasons why African American infants are less likely to be breastfeed when compared to other racial populations. Employment practices (Ip, et al. 2007), media (Bentley, Dee, & Jensen, 2003; Brown & Pecuchand, 2008), hospital policy (CDC, 2008), social and

cultural norms (Thulier, 2009) and advice from friends and family (Ingram, Cann, Peacock & Potter, 2008; Lewallen & Street, 2010) all may play a role in this disparity. However, according to the *Surgeon General's Call to Action for Breastfeeding* the “persistently lower rates of breastfeeding among African American women are not well understood” (HHS, 2011, p. 8).

The *Surgeon General's Call to Action for Breastfeeding Support* calls for further research focused on the disparities of breastfeeding rates that are found along racial lines (HHS, 2011). New research is needed to identify barriers to and supports for breastfeeding among African American mothers. A communication perspective offers a unique lens into the social-cultural communication patterns that may be influencing breastfeeding outcomes among this population given that communication regarding breastfeeding is multi-sources and not all sources are providing communication with positive outcomes for breastfeeding (Goldsmith, 2004; Hirsch, 1979; Pierce, et al, 1991). The examination of how social support is enacted in interpersonal conversations may help identify social-cultural antecedents to breastfeeding or barriers which inhibit the practice. This approach can offer foundational understanding of the messages received by an African American mother and provide a social-cultural communication framework useful for improving breastfeeding outcomes.

There are various macro-and micro levels of influences on the initiation and sustainment of breastfeeding for all mothers, including African American mothers (Lincoln & Chae, 2011; Hurley, et al., 2008; Bentley et al., 2003; Brownell, Hutton, Hartman, & Dabrow, 2002). However, there is currently is a gap in research which demonstrates what the different mechanisms of social support for African American

mothers from a communication lens. Additionally, the social ecological model offers a framework for understanding the various levels of social support that may affect an African American breastfeeding mother. The choice to breastfeed and sustaining breastfeeding is clearly more than just a decision made by the mother alone. Indeed, her interpersonal communication and communication with community entities can influence breastfeeding outcomes.

Social Ecological Model

The social ecological model (SEM) provides a framework for understanding the various strata that impact an individual and demonstrates the dynamic complexity of health behaviors (Bronfenbrenner, 2009; Lounsbury & Mitchell, 2009; Bronfenbrenner, 1977). The model itself can assist understanding the dynamic relationships between people and their environments (Owen & Fisher, 2008; Stokols, 1996, Stokols, 1992). Central to the social ecological model is the establishment of the individual as the centerpiece with dynamic interactions at the interpersonal level as well as through the social and environmental levels that encase the exchanges that an individual experiences (Bronfenbrenner, 2009; Lounsbury & Mitchell, 2008, Owen & Fisher, 2008; Tiedje, et al., 2002; Stokols, 1996; Stokols, 1992; Bronfenbrenner, 1977).

The key components that are situated within the individual context include the personality traits of the individual and the attitudes and beliefs that the individual holds. Additionally, the individual level contains any biological and physiological responses, emotional responses and self-efficacy (Bronfenbrenner, 2009; Lounsbury & Mitchell, 2008; Moran, Frank, Zhao, Gonzalez, Thainiyom, Murphy & Ball-Rokeach, 2016; Owen & Fisher, 2008; Stokols, 1996; Stokols, 1992). The interpersonal level is constructed

through interpersonal discussion of the central individual with others around him or her, social networks, and group and social norms (Bronfenbrenner, 2009; Owen & Fisher, 2008; Stokols, 1996; Stokols, 1992). The community level encompasses community health and community norms, collective community efficacy, as well as institutions within the community (Bronfenbrenner, 2009; Lounsbury & Mitchell, 2008; Moran, Frank, Zhao, Gonzalez, Thainiyom, Murphy & Ball-Rokeach, 2016; Owen & Fisher, 2008; Stokols, 1996; Stokols, 1992). Last, the environmental level's key components include the societal norms which can be identified through mass media, the healthcare system, political systems, and societal values (Moran, et al. 2016; Golden & Earp, 2012; Bronfenbrenner, 2009; Lounsbury & Mitchell, 2008, Sallis, Owen & Fisher, 2008; Stokols, 1996; Stokols, 1992; Bronfenbrenner, 1977). A critical assumption about the social ecological model is that factors across and within each level are interrelated and all are equally significant on the outcome (Sallis, Owen, & Fisher, 2008).



Figure 1.1 The Social Ecological Model

Figure 1.1 clearly demonstrates how different levels in the Social Ecological Model encase the individual and offer insight into an individual's health behavior. Studies have shown that population-level behavior change is maximized at the

community and society levels; however, one cannot ignore the social norms and motivation that occurs at the individual and interpersonal levels that have implications for sustained change (Owen and Fisher, 2008; Stokols, 1996; Stokols, 1992). An individual is less likely to be able to sustain long-term change if there is a lack of infrastructure to support such a change (Owen & Fisher, 2008, Tiedje, et al., 2002).

Moran, Frank, Zhao, Gonzalez, Thainiyom, Murphy, and Ball-Rokeach (2016) emphasize that utilization of an ecological model to understand a health behavior offers a more all-inclusive examination of the various factors that influence a health outcome. Communication is a central occurrence throughout multiple levels of the model and could be determined as a foundational component that is interwoven throughout the model (Moran, et al., 2016). Through the understanding of the communication both within and across all levels of the model, there is an opportunity to more fully understand influences of health outcomes (Moran, et al., 2016). Research reveals that there are a number of factors situated within the social ecological model that could help explain why there is such a dramatic drop in breastfeeding from initiation to the recommended six month mark.

Barriers to Breastfeeding

Through the lens of the social ecological model, one can view the multifaceted nature of social influences on breastfeeding. The interactive nature of the individual within the interpersonal, community, and environmental conditions influences the outcomes, whether positive or negative (Moran, et al., 2016; Bentley, Dee, & Jensen, 2003; Tiede, et al., 2002; Stokols, 1996). Utilizing the model as a guide for which to examine the various barriers to breastfeeding allows for careful consideration for the

ways in which communication directly influences the choice of a mother to not only initiate breastfeeding, but sustain the practice. Although not all the research presented is directly examining African American women, the context of the research provides a foundation for understanding some of the social support that has been shown to work and some the challenges that have been examined.

At the level of the individual, the key components are the mothers include the personality traits of the mother, her attitudes and beliefs, as well as any biological or physiological responses and self-efficacy. Maternal extraversion has been demonstrated to be a significant personality factor for breastfeeding mothers (Bick & Chang, 2015; Brown, 2014; Wagner, Wagner, Ebeling, Chatman, Cohen, & Hulsey, 2006). A mother is more likely to breastfeed if she has positive attitudes towards breastfeeding and sees breastfeeding in a positive manner (Bose, Bauer, Bernhard, Baumgardner, 2014; Dunn, Kalich, Fedrizzi, & Phillips, 2015). There are cases where a mother cannot breastfeed for biological or physiological reasons and she may want to, thus causing internal conflict about breastfeeding (Hoddinott, Craig, Britten, McInnes, 2012; Heinig, 2009).

Additionally, an already tired mother may give up breastfeeding due to the feeling of frustration that she is unable to breastfeed when, in fact, the issue may be corrected easily and / or quickly with assistance (Mozingo, Davis, Droppleman, & Meredith, 2000). Last, there is evidence that mothers who have strong self-efficacy are able to initiate and sustain breastfeeding longer than mothers who lack self-efficacy (Brown, 2014; Fahey & Shenessa, 2013; Dennis, 2003; Creedy, Dennis, Blyth, Moyle, Pratt, & De Vries, 2003; Arlotti et al., 1998).

At the individual level, from a health behavior theory perspective, the Theory of Planned Behavior has been applied to breastfeeding research demonstrating the significance of its key components: attitudes, beliefs and self-efficacy (Giles, Connor, McClenahan, Mallet, Stewart-Knox & Wright, 2007; Swanson & Powers, 2005; Duckett, et al., 1998). Breastfeeding has also been investigated through the lens of the theory of reasoned action to predict the initiation and sustainment (DiGirolamo, Thompson, Martorell, Fein & Grummer-Strawn, 2005; Humphreys, Thompson & Miner, 1998). These are common ways in which research has examined breastfeeding at the individual level but do not offer a clear picture of other influences on the choice of breastfeeding initiation and sustainment.

The next level of the model is the interpersonal level, which includes individuals that are within the mother's social network, which could be spouse/partners, family, friends or co-workers. Research has demonstrated that fathers and grandmothers have an influence on a mother's decision to breastfeed (Mikuka & Rizzi, 2014; Mannion et al., 2013; HHS, 2011; Bently, et al., 2003; Arora et al., 2000). Although positive support from the interpersonal network is significant (CDC, 2014, HHS, 2013; Bentley et al., 2012; Shahla, Fahy & Kable, 2010; Meek, 2002; Tiedje, Schiffman, Omar, Wright, Buzzitta, McCann, & Metzger, 2002) the mere presence of a network does not guarantee positive support. Research suggests some relational influences can actually have a negative influence on an outcome (Goldsmith & Albrecht, 2011; HHS, 2011; Grassley & Eschiti, 2008; Goldsmith, 2004; Scott & Binns, 1999; Quick, Nelson, Matuszek, Wittington, & Quick, 1996; Pierce, Sarason, Sarason, Joseph, & Henderson, 1991). Pierce and colleagues (1991) also acknowledge that the presence of a social network does

not offer certainty that the support will be available and offered when is support is needed.

There has been research concentrated on interpersonal relationships and their influence of those relationships on breastfeeding outcomes (CDC, 2014, HHS, 2013; HHS, 2011; Rempel & Rempel, 2011; Shahla, Fahy & Kable, 2010; Grassley & Eschiti, 2008; Hurley, Black, Papas & Quigg, 2008; Rempel & Rempel, 2004; Match & Sims, 1992). However, despite the valuable contributions this work provides to the understanding interpersonal relationships and its effect to the initiation and continuation of breastfeeding, there is a lack of research examining specific communication between a mother and peers, partners, healthcare providers, strangers, and the grandmother. Research into communication phenomemena may offer insight into the positive or negative influences that may affect a mothers' choice to breastfeed.

An addition to the interpersonal level of influence, the community level of the SEM also offers insight to potential for breastfeeding initiation and sustainment (CDC, 2014; CDC, 2011; HHS, 2013; Feldman-Winter, 2013; Goodman, Majee, Olsberg & Jefferson, 2016). When a mother chooses to breastfed, the local organizations and support groups such as Le Leche League International, the Health Access Nurturing Development Services (HANDS) program, and other community based assistants can provide emotional support and information that may not be found anywhere else (CDC, 2014; Jacobson & Wetta-Hall, 2014; Ferguson & Vanderpool, 2013; HHS, 2011; Shala, Fahy & Kable, 2010; Bentley et al., 2003; Meeks, 2002; Tiedje, et al., 2002; United States Department of Agriculture, n.d.). The lack of these organizations could be a detriment to a mother's desire and/or ability to reach the AAP's recommendations for

breastfeeding (CDC, 2014; Furman & Dickinson, 2013; HHS, 2011; Zimmerman, & Guttman, 2001). Communication offered through these groups could be the critical component for breastfeeding to a mother who has no other support system in place. There is a lack of research that demonstrates what these critical connections to breastfeeding are telling mothers and how they are working to support breastfeeding in the communities in which they work.

The outer most level of the social ecological model, the environment, is mostly understood through the application of breastfeeding policies that effect the environment surrounding a breastfeeding mother. At a local level of understanding, hospital policies towards breastfeeding and “Baby-Friendly Hospitals” offer improvements in breastfeeding initiation rates (Perrine, et al., 2015; Hawkins, Stern, Baum & Gillman, 2015; Philipp, et al., 2001). Additionally, the level would include larger, national policy such as the influence of legislation on breastfeeding efforts such as the “Right to Breastfeed Act” and the “Affordable Care Act” (Garvin, Sriraman, Paulson, Wallace, Martin, & Marshall, 2013; Drago, Hayes & Yi, 2010; Bentley, et al., 2003; Arlotti, et al., 1998). The environment in which the mother lives in can have either a positive or negative influence on breastfeeding initiation and/or sustainment and although not being specifically studied, this level is an important part of the model.

SEM research exhibits that within all levels of the social ecological model, there are several factors that affect the final outcome of a health behavior (Moran et al., 2016, Bronfenbrenner, 2011; Sallis, et al., 2008; Stokols, 1996). For a mother, these factors can have implications on breastfeeding initiation and sustainment (Hawkins, et al., 2015;

Fahey & Shenessa, 2103; Furman & Dickenson, 2013; DiGirolamo, et al., 2005; Bentley et al., 2003; Arora, McJunkin, Weher & Kuhn, 2000; Arlotti, et al., 1998).

Often research does not account for the context in which people live which may limit researcher's ability to account for the health choices made by those individuals (Moran, et al., 2016). To account for this gap, this research seeks to provide foundational information regarding the African American mother's experiences to breastfeeding through the framework of the social ecological model with the assumption that communication is a central aspect that occurs throughout all levels. Moran and colleagues (2016) suggest that it is time to "capture communicative phenomena beyond simple individual-level exposure" (p. 137) and that "in particular, ecological health communication research must use a more grounded approach that captures the ways in which people experience everyday life and, in the process, captures the dynamics that may affect their health" (p. 137).

As such, this study sought to understand the communication of social support between mothers and their social network, with deeper exploration of the communication between mother and grandmother regarding breastfeeding. Additionally, there was a consideration for breastfeeding champions who assist these mothers. These breastfeeding champions could be an additional source of breastfeeding support, or they could be viewed from the mother's perspective as the only support for her feeding choice. Examining social support from these numerous levels of influence may offer the researcher a deeper understanding of why African American mothers make the choice of whether or not to breastfeed and if breastfeeding, sustaining or not sustaining that feeding choice.

Project Overview

Through the employment of the social ecological model as a framework to which better understand an African American mother's ability to initiate and sustain breastfeeding, this study seeks to understand the communication that occurs within interpersonal relationships that may affect breastfeeding. Further, this project seeks to understand the enacted community level support for breastfeeding women from breastfeeding champions.

Chapter two presents social support theory within communication (Gottlieb, 1981; Goldsmith, 2004) and dimensions that compose the overarching term of support (Price et al, 2009; Goldsmith, 2004; Match & Sims, 1992). Additionally, a review of the roles that individuals play in providing support is provided (Pierce, et al., 1996). Next, there is a review of the social ecological model and brief review of the ecological approach to examining ways to reduce health disparities, of which breastfeeding is identified as one. Additionally, there is a review of the literature regarding breastfeeding in each of the social ecological model levels. The chapter concludes with the research questions that guide the work of this dissertation.

Chapter 3 details the research methodologies that were utilized for Study 1 of this project, which includes focus groups with African American mothers and grandmothers. This study sought to understand the communication and actions that mothers received from her social network about breastfeeding. Additionally, this chapter delves into the grandmother's perception of her provision of social support about breastfeeding. The use of a qualitative, interpretative approach is justified. This first study utilizes focus groups

to answer the first two research questions. Last, this chapter provides the findings from the focus groups with mothers and grandmothers.

Chapter 4 reports the methodologies and findings from Study 2. Study 2 sought to understand the ways that breastfeeding champions provide social support for their clients through the use of one-on-one interviews. This chapter structures the findings in terms of how breastfeeding champions provide mothers with emotional, tangible, and informational support as well as how the mothers react to this support. Additionally, this chapter examines how breastfeeding champions react to their experiences with mothers and their perceived limitations in how they provide support.

Chapter 6 includes a discussion of the overall findings from the research project, the implications of the findings for future work, and the limitations of the study. First, consideration for how the findings provide foundational information about the communication and experiences that African American mothers have with their breastfeeding choice. Specifically, addressing the main findings of the support coming from individuals other than the grandmother and the differences between the grandmothers and mothers account of social support. Last, the breastfeeding champions account of how they support breastfeeding mothers in their challenges to breastfeed. Second, there is discussion the need for continued use of the social ecological model to assist in understanding the various communication resources than individual encounter. Finally, the limitations are discussed, which include participant factors (e.g., location of participants) and method factors (e.g., focus group and in-depth interview limitations).

CHAPTER TWO: LITERATURE REVIEW

This dissertation examines social support through the understanding of infant feeding experiences for African Americans situated within the social ecological model. The overarching objective is to better understand the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed and how is that support communicated through interpersonal relationships with grandmothers and breastfeeding champions. The study aims to determine how African American mothers reported receiving social support about their choice to breastfeed from their health care providers, peers, loved ones and strangers. Furthermore, the study examines how African American mothers report receiving social support about their choice to breastfeed from the grandmother and how do grandmothers' report providing social support for their daughter's choice to breastfeed. Last, this study identifies how breastfeeding champions reported providing social support about the choice to breastfeed for their clients (mothers).

This chapter will present a literature review that considers social support theory within the field of communication research and reviews the roles that individuals play in providing support. Next, there is a review of the social ecological model. The chapter continues with a review of the literature regarding breastfeeding within each of the social ecological model's levels and concludes with the research questions that guide the work of this dissertation.

Literature Review

There are many factors that influence a mother's decision to breastfeed or bottle feed her child. Various macro and micro levels of influences are impactful for the

initiation and sustainment of breastfeeding, especially for African American mothers (Lincoln & Chae, 2011; Hurley, et al., 2008; Bentley et al., 2003; Brownell, Hutton, Hartman, & Dabrow, 2002). In an attempt to gather support for their breastfeeding decision, a mother may rely on a partner, parents, partner's parents, other family members (Mannion, et al., 2013; Rempel & Rempel, 2011; Grassley & Eschiti, 2008; Rempel & Rempel, 2004). However, due to the complex nature of the relationships within a family, breastfeeding mothers may not receive the support desired. With the absence of support from breastfeeding, or negative support, a mother may be inclined to either never attempt breastfeeding or cease breastfeeding short of the recommendation by AAP (Rozga, Kerver, & Olson, 2015; Odom, Ruowei, Scanlon, Perrine, Grummer-Strawn, 2014; Odom, Ruowei, Scanlon, Perrine, Grummer-Strawn, 2013).

This dissertation is centered on the mechanisms of social support for an African American breastfeeding mother. Specifically, how do these mothers experience supportive communication for their breastfeeding choice? Further, what support do breastfeeding champions (individuals within the community that work to provide breastfeeding women support) provide for these mothers? The examination of these various levels of influence can shed light on why a mother may choose to bottle feed rather than breastfeed despite the positive health outcomes and economic savings that accompany breastfeeding (HHS, 2013; Bartlick & Reinhold, 2010; Meek, 2002).

Social Support Theory

Social support has been studied through various disciplines which contributes to the “messiness” of application in understanding the various constructs and contexts of social support. Cassel (1976) defined social support as being feedback given to an

individual that is health protective during a time of stress. Shumaker and Brownell (1984) offered another definition, “the exchange of resources between two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient” (p. 11). Gottlieb (1985) explained “social support is a feedback provided via contact with similar and valued peers” (p. 353). Gardner and Cutrona (2004) define social support as “verbal communication or behavior that is responsive to another’s needs and serves the functions of comfort, encouragement, reassurance of caring, and/or the promotion of effective problem solving through information or tangible assistance” (p. 495) and Goldsmith (2004) simply defined social support as the “ways in which social relationships moderated the influence of stress on health and well-being” (p. 12). As such, Price, Price and McHenry (2009) state that in general, social support acts a protector and stimulates recovery from the stress. In essence, social support has been used as a term referring to the social relations that individuals have and how they affect the stresses that an individual has throughout his or her lifetime.

Individuals who identify the term social support may feel as though they have an intuitive understanding of what social support actually is; however, there are many descriptions and definitions. Three main dimensions can conceptualize social support: emotional support, informational support and tangible support. Emotional support is the most common form of social support and includes such actions as empathy, concern for another, caring, love and trust. This type of support is commonly received from family and close friends (Price et al, 2009, Quick et al., 1996; House, Umberson, & Landis, 1988; Match & Sims, 1992).

Informational support could be described as advice, suggestions, and directives that can offer assistance to an individual in response to his or her needs. This type of support could be given from a wide range of individuals such as family, friends, healthcare professionals, social media connections, and /or co-workers (Quick et al., 1996; House et al., 1988; Match & Sims, 1992). Furthermore, this type of support seeks to provide answers to problems that an individual may be encountering (Price, et al., 2009). Tangible support, also referred to as instrumental support, may be considered the most concrete form of support and can be demonstrated in the actions of providing money, time, and assistance of other explicit actions as directed to the recipient of the support. (Quick et al., 1996; House, et al. 1988; Price. et al., 2009; Match & Sims, 1992).

In Pierce, Sarason, Sarason, Joseph and Henderson's (1996) model of social support, they argue that the model is made up of three components: support schemata, supportive relationships and support transactions. A support schema is the perception an individual has on the availability of others that they can rely on for support. This is also called perceived social support (Pierce et al., 1996; Goldsmith, 2004). The understanding of this component has been shown to be a reliable and strong predictor of personal adjustment to situations encountered. Further, there is a general agreement that perceived social support is stable across time and situations (Pierce, et al. 1996; Goldsmith, 2004).

Pierce and colleagues (1996) further explain that in supportive relationships, people have expectations about how other individuals will respond should assistance be needed. Although this is different from the support schemata above, supportive relationships are likely directly influencing support schemata development. The designations of one person as the provider of the support and the other as the receiver of

support are roles that allow for dyad interaction to be studied (Bodie, Burleson, & Jones, 2012). However, this relation is complicated by the fact that there is an assumption that the stressor event only impacts one individual of the dyad and that once a role is established the role could not change during the transaction of support (Pierce, et al., 1996).

These three components do not stand in isolation, rather they influence one another in dynamic and profound ways as seen when an individual's support schemata are influenced by the experiences of supportive (or unsupportive) transactions. Likewise, when supportive transactions occur within a supportive relationship, that transaction is more likely to have beneficial outcomes (Goldsmith & Albertson, 2011; Goldsmith, 2004; Pierce et al., 1996). The utilization of the concept "supportive communication" is a critical component for living a healthful life and has cross-disciplinary strength that allows for its application in many different areas of research (Goldsmith & Albrecht, 2011).

Before an individual seeks support, he or she must recognize that support is needed (Goldsmith, 2004; Pierce, et al., 1996). There are times when an individual may actually begin thinking about the need of support before a stressful event has even occurred which then allows an individual some control over the stressful event. However, there may not be recognition that support will be needed resulting in a missed opportunity for support. Just as the receiver of support must discern the need in order to elicit support from others; the provider of support must be able to perceive that support is warranted. However, the relationship between the two can be complex and may not be the only

influence on an individual's health behavior choice (Goldsmith, 2004; Pierce, et al., 1996).

Negative Social Support

Quick et al. (1996) states that there is often the assumption that if an individual has a social network, there will be positive social support. However, there is evidence that many interactions actually have a negative influence on the outcome of the situation. Part of the assumption is based on the lack of understanding that a present social network does not guarantee a social support system is available. A provider of support may believe that he or she is acting in ways that are supportive, but are in fact, unsupportive (Hirsch, 1979; Pierce, et al, 1991). When an individual is being unsupportive, it does not simply mean that he or she is not contributing supportive behaviors; their behaviors could have severe negative consequences on the receiver's efforts towards their anticipated outcome (Hirsch, 1979; Pierce, et al, 1991).

Goldsmith (2004) offers several examples of ways that support is unhelpful and does not produce the intended results for the receiver. Such examples include: social support that minimizes the issue for the receiver, when support is given without emotion behind it, when rude or insensitive remarks are made by the provider of support, criticism of the receiver, the statement "I know how you feel," when the provider of support is overbearing and overly concerned, the support provider is trying to manipulate the receiver, there is patronization or the feeling of pity, and when there are negative attitudes towards the beliefs about the issue (Goldsmith, 2004).

Further, Goldsmith (2004) argues that the act of providing information is not enough to assist someone in a stressful situation. The information that is being provided

should be relevant to the issue and it should be accurate if the support is to make a positive difference for the receiver. As Bentley et al. (2011) explained, a grandmother often provides informational support for a mother who lacks infant feeding experience and knowledge. Although support is needed to address these challenges, a grandmother who provides information solely based on her experiences or wrong information may actually move a mother away from attempting breastfeeding, thus leading to negative health outcomes for mother and child. The negatively imbalanced information that is offered as social support often comes from family members (Goldsmith & Albrecht, 2011) and should be considered when assisting new mothers in their infant feeding choices. The interpersonal influence and the community resources and environment all could play a role in a mother initiation and sustainment of breastfeeding.

Breastfeeding Rates

A quick glance at the percentage of mothers who initiate breastfeeding at the time of their child's birth demonstrates a façade of achievement. The CDC *Breastfeeding Report Card* provides information on breastfeeding practices and accompanying supports throughout the United States. The report also provides state-by-state data that can be used to help public health practitioners, health professionals, community members, child care providers, and family members work together to protect, promote and support breastfeeding (CDC, 2014). The 2014 report card determined that 79.2% of mothers in the United States had breastfed at least one time. At six months, 49.4% of mothers were breastfeeding yet only 18.8% were breastfeeding exclusively at six months (CDC, 2014), which is the recommendation by the AAP (2012). Furthermore, only 26.7% of the

population was meeting the AAP recommendations of continued breastfeeding for the first full year of the infant's life (CDC, 2014).

In addition to the breastfeeding rates, the 2014 Breastfeeding Report Card also recorded information about community-based assistance that mothers may utilize. The report included the number of International Board Certified Lactation Consultants (IBCLCs) per 1,000 live births, the number of available Certified Lactation Counselors (CLCs) per 1,000 live births, and the number of Le Leche League Leaders. This type of assistance can be invaluable to a breastfeeding mother who needs assistance with initiating or sustaining breastfeeding. Nationally, the 2014 Breastfeeding report card determines there to be 3.5 IBCLCs per one thousand live births and 3.8 CLCs per one thousand live births. The national average is 0.90 Le Leche League Leaders per one thousand births.

In the state of Kentucky, the rates are lower than the national percentages in all areas. Only 61.3% of mothers reported ever breastfeeding. The *2014 Breastfeeding Report Card* states that only 31.5% were breastfeeding at six months and 14.2% were exclusively breastfeeding. Further, at the twelve-month mark, 22.8% of mothers who reported to still be breastfeeding (CDC, 2014). The availability of IBCLCs and CLCs may be of surprise in the state of Kentucky. The CDC reports there are 3 IBCLCs and 6 CLCs per one thousand live births, which is higher than the national rate of CLCs. The available of Le Leche League Leaders however is only 0.36 per one thousand live births (CDC, 2014).

Although these numbers do not illustrate successful patterns of breastfeeding, among African American infants breastfeeding rates are significantly lower than the U.S.

averages. Nationally, only 59% of African American women initiate breastfeeding at least one time. Furthermore, the statistics show a significant drop to a rate of 28% breastfed African American infants at six months, with only 8% exclusively breastfed at six months (HHS, 2011). There is no state level data available that shows the rates of breastfeeding for African American mothers specifically. Even when controlling for factors such as income and education that are correlated with breastfeeding outcomes, the gap is evident (CDC, 2007).

There are still opportunities to gain understanding why African American mothers have these lower breastfeeding rates. The U.S. Department of Health and Human Services recognizes that there are gaps in understanding the reasons for the drops in breastfeeding rate (HHS, 2012). The *Call to Action for Breastfeeding Support* requests that further research focused on the disparities in breastfeeding rates that are found along racial lines. Additionally, new research is needed to identify barriers to and supports for breastfeeding among populations with low rates of breastfeeding. An expansion of social support theory in this context could allow for a foundational understanding of communication interactions about breastfeeding for African American mothers and provide information about social support systems for starting and sustaining breastfeeding, as well as training and programs for the interpersonal network to offer support more effectively.

Social Ecological Model

There is a dynamic relationship between people and their environments (Moran, et al., 2016; Bronfenbrenner, 2009; Lounsbury & Mitchell, 2009; Bronfenbrenner, 1977). The SEM offers structure for understanding the dynamic complexity in health behavior

(Moran, et al., 2016; Lounsbury & Mitchell, 2009) with the assumption that there are various personal and environmental factors that influence that choice based on the interplay between individuals, groups and the environment (Stokols, 1996). The model offers the ability for researchers to examine those complexities comprehensively with the recognition that an analysis at a singular level may be limiting (Moran, et al., 2016; Lounsbury & Mitchell, 2009; Stokols, 1996).

The model itself can assist understanding the dynamic relationships between individuals and their environments (Owen & Fisher, 2008; Stokols, 1996) through the depiction of the individual as the centerpiece, followed by an interpersonal level, community level and environmental level encasing that individual (Bronfenbrenner, 2009; Lounsbury & Mitchell, 2008, Owen & Fisher, 2008; Tiedje, et al., 2002; Stokols, 1992; Bronfenbrenner, 1977). An individual is less likely to be able to sustain long-term change if there is a lack of infrastructure to support such a change as seen throughout the various levels (Owen & Fisher, 2008, Tiedje, et al., 2002). When the social ecological model is applied as a framework for understanding the various levels of social support that may affect a health behavior, one can see that the various levels of influence can have both positive and negative influences of behavior decisions.

Breastfeeding Through the Lens of the Social Ecological Model

The SEM provides a framework for which to better understand the literature around breastfeeding social support. The examination of breastfeeding starting from the individual level and progressing through interpersonal, community and environmental layers allows for an understanding in gaps in research. Additionally, Moran et al. (2016) assert that the employment of an ecological model in the examination of a health

behavior allows for a more comprehensive view of the multiple factors that influence the behavior.

Individual Level.

The individual level of the SEM centers on the attitudes and beliefs, personality traits, biological responses of a person, and self-efficacy. This is the center of the SEM and all of the other levels have a bi-directional effect and as such the individual influences the outer levels and the outer levels influence the individual (Bronfenbrenner, 2009; Stokols, 1992; Bronfenbrenner, 1977).

Attitudes and beliefs. Libbus, Bush, and Hockman (1997) sought to understand beliefs of low-income mothers who are pregnant for the first time. Their work found that these participants felt that breastfeeding was for health benefits for the infant and provided bonding opportunity. Further that when they breastfed there were some disadvantages that included interference with the schedule of the mother and that others would not be able to feed the child. Additionally, mothers were afraid of discomfort. This population was mostly white however (Libbus et al., 1997). Similarly, Spencer, Wambach, and Domain (2015) found that African American mothers felt that bonding was a positive outcome of breastfeeding and that the infant would receive health benefits from breastfeeding. Also similarly, there was a concern for pain, being uncomfortable during breastfeeding and possible interference with things that have to be done on a regular schedule. This is not an uncommon reason for the early cessation of breastfeeding (Bose, Bauer, Bernhard & Baumgardner, 2014; Brown, 2014; DeClercq, Sakala, Corry, Applebaum & Herrlich, 2013; HHS, 2013; Brownell et al., 2002).

Personality traits. Brown (2014) examined the maternal personalities affect duration and attitudes towards breastfeeding. The results found that mothers who breastfed were found to have higher levels of extroversion (defined as sociability, assertiveness, and talkativeness), emotional stability, (defined as anxiety and impulse control), and a higher level of conscientiousness (defined as discipline, organization, and achievement orientation). Additionally, this research found that extroversion was inverse related to the belief that breastfeeding was difficult and conscientiousness was significantly positively related to the belief that breastfeeding was a healthier choice than formula feeding. Last, extroversion, emotional stability and conscientiousness were significantly associated with longer breastfeeding duration. In the reporting of demographic characteristics for this study, ethnicity/race was not included (Brown, 2014).

Biology. Although rare, biology can also impact the ability of a mother to breastfeed (Huggins, Petok, & Mireles, 2000). Despite the research that demonstrates that the majority of mothers can breastfeed, research has shown that fear of not being able to breastfeed and overall stress level of a mother can lead to a decrease in the production of breastmilk and eventually the inability to further produce breastmilk (Hoddinott, Craig, Britten, McInnes, 2012; Heinig, 2009). The need for recognition that not all mothers are able to physical produce enough milk to fed the infant, and as such a baby that is getting the caloric intake needed is more important than exclusive breastfeeding has not always been apparent for mothers (HHS, 2014; AAP, 2012). It is the hope that this type of message would reduce the stress that a mother feels (Eldelman, 2012).

Self-Efficacy. To understand the role of self-efficacy in breastfeeding initiation and sustainment Dennis and Faux (1999) developed a Breastfeeding Self-Efficacy Scale (BSES) to allow for continued research and identification of mothers with low confidence who were at high risk of not breastfeeding. The scale was tested on African American women in the United States (Spaulding & Dennis, 2010) and results continued to show consistent results that women with higher levels of self-efficacy had higher levels of breastfeeding initiation and duration. However, this work was contradicted through research by Bose, Bauer, Kiley, Bernhard and Baumgardner (2014) which found that for the lower socioeconomic populations studied while there was a relatively high self-efficacy rates, the breastfeeding initiation rate was lower than expected. Additionally, the study determined that low breastfeeding initiation rates were associated with lack of exposure to breastfeeding, not breastfeeding immediately after delivery, being of the African American race, and having a lower socioeconomic status (Bose, et al., 2014). The discrepancies in the research may indicate that having self-efficacy and supportive attitudes and beliefs alone may not be enough to support women during the initiation and sustainment of breastfeeding.

The aforementioned research has provided evidence of the attitudes, beliefs, personality traits, biology and self-efficacy's influence on a breastfeeding mother and as researchers continue to collect data and examine breastfeeding mothers, they would be remiss to overlook the different social support systems and their impact on breastfeeding. The current study provides information on how individuals in the interpersonal level affect those constructs.

Interpersonal Level

The interpersonal level of the SEM situates the interactions that a mother has with her social network, co-workers, healthcare care providers and others. The argument has been made that the interpersonal level could have the greatest influence on an individual and their decisions (Dunn, Kalich, Fedrizzi & Philips, 2015; Golden & Earp, 2012; Bronfenbrenner, 2009; Stokols, 1996).

Partner social support. Scholars have examined the connection between the father's attitudes, knowledge, and/or support of the mother and duration of lactation (Arora, McJunkin, Wehrer, & Kuhn, 2000; Hurley, Black, Papas, & Quigg, 2008; Mannion, Hobbs, McDonald, & Tough, 2013). Fathers have been found to be a strong support system for breastfeeding mothers (Arora et al., 2000; Ingram, Johnson, & Greenwood, 2002; Mannion et al., 2013). Programs that work with fathers in supporting their partner have seen success in breastfeeding initiation rates and maintenance (HHS, 2011). Unfortunately, partners do not always have the ability to give the support that is needed, if they are even available to do so. Banks, Killpack, and Furman (2013) found that the fathers whom they interviewed showed low self-efficacy with respect to supporting a mother in her ability to breastfeed; they knew that they had an important role in the emotional and tangible support that they gave to the mother, however they felt that they did not have the ability to provide that support.

Grandmother social support. Grassley and Eschiti (2008) found that grandmothers are a significant support for mothers, especially first time mothers who may lack infant feeding experience and knowledge. Bentley et al. (2011) found that the grandmother provided role in a woman's decision to breastfeed, insofar as the provision

of information about when and what to feed the infant. Previous research by Bentley and colleagues (2003) found that grandmothers influenced a mother on her decision of when to introduce solid foods and other liquids. Further, this work noted that several of the younger population in the study actually lived with their own mothers which could also shift the decision making about feeding the baby from the mother to the grandmother, who exerts authority and experience.

Pikuskas (2014) also examined households where there was a child, a mother, and a grandmother living under the same roof. Through this exploratory work, decreased breastfeeding odds were found among the sample that was considered to be economically “less advantaged” (p. 1955) but no difference was found in the national sample as a whole. This research had less than a 14% African American population included, which is worth noting. Research by Emmott and Mace (2015) and Susin, Giugliani and Kummer (2005) also found that frequent contact by the grandmother was associated with lower levels of breastfeeding and short duration of breastfeeding in their mixed-race studies. As Pierce et al. (1991) explains that while familial relationships could certainly provide its members ample social support, there is no certainty that support would be available. Additionally, research has shown negatively imbalanced information that is presented as social support often comes from family members (Goldsmith & Albrecht, 2011).

Although the significance of a grandmother’s supportive communication has been identified in some research, there is also concern regarding the negative impact that a grandmother’s communication could have for a breastfeeding mother. Further, there is a lack of evidence about what is actually being communicated to a mother from the

grandmother and an opportunity to explore breastfeeding within this frame of social support.

Friend social support. Peers that have experienced similar difficulties can be a great resource for social support (Gottlieb, 1981). These individuals can be people already in their social network or can be inserted into the network. Further, Gottlieb (1981) references the application of reference group theory to demonstrate that when there are uncertainties in an individual's life he or she has a need to share and compare the reactions and experiences with others, and preferably others that have presently or recently experienced comparable events. This makes friends of a breastfeeding mother who have recently had the same experiences important providers of social support.

Mothers who are able to initiate and sustain breastfeeding commonly have a friend as a support. Powell, Davis, and Anderson (2014) found that the mothers that were successful in breastfeeding had friends who were able to share their experiences and offer support. Additionally, many researchers have determined that when a friend was available to assist a mother, she breastfed longer than when no friend was available (Bunik et al., 2010; Kaufman, Deenadaylan, & Karpati, 2009; Meier et al., 2007; Wambach & Koehn, 2004). However, the literature is lacking in providing information about exactly what was said by the friend to a mother that may affect the breastfeeding experience.

Peer counselor social support. A peer counselor for breastfeeding is a person who is trained to provide assistance to mothers before and after childbirth. Research has examined the benefits gained by mother when a peer breastfeeding counselor or equivalent. Schmied, Beake, Sheehan, McCourt and Dykes (2011) found that the

practical support offered to a mother by peer counselors was especially important to adolescents and disadvantaged mothers. A peer counselor can offer one-one assistance that is not always available from other sources such as grandmothers, partners or other family members (Schmied et al., 2011). Arlotti and colleagues (1998) examined breastfeeding peer support on duration and exclusivity with a low income population during the first three months postpartum. The study found that when peer counselors were present there was a higher likelihood of breastfeeding initiation and duration. This finding was also supported through Rozga, Kerver, and Olson's (2014) work within a secondary analysis of data and also supported by Ferguson and Vanderpool's (2012) study of the HANDS program. The HANDS program provides home visits and works with mothers and the family with lifestyle behaviors and mental health, coping skills and support systems, stresses, and anger management skills. Participants in their study had a breastfeeding rate of over 84%, which is higher than national levels (Ferguson & Vanderpool, 2012).

Darwent and Kempenaar (2014) found that peer counselors had more positive attitudes towards breastfeeding and a greater knowledge about breastfeeding than mothers. This greater attitude and knowledge could positively impact the mother ability to initiate and sustain breastfeeding. As Feldman-Winter (2013) discusses, the advantage of having a trained peer counselor is that these individuals have experienced breastfeeding themselves and have additional training that allows them to extend knowledge beyond their own experiences into best practices. Ultimately, a peer counselor can provide a sense of shared experience, has the time and knowledge base to support the mother, and additionally offers practical support that would be helpful for all new

mothers, not merely the ones that have a lower breastfeeding rates (HHS, 2013). Still, there is scant research on the communicative interactions between these counselors and mothers.

Lay leaders. When a peer counsel program is unavailable, there may be a lay leader program that is able to fill a similar role for a breastfeeding mother. A mother may utilize a group of this nature to provide informational, emotional, or even tangible support. One commonly mentioned group is the Le Leche League. The Le Leche League was created by a group of women in one community that gathered at each other's' homes to provide support for one another in regards to their breastfeeding experiences (Rossman, 2007). Buckley (1992) conducted initial research on what mothers who utilized Le Leche League had to say about their assistance. This work concluded that every mother whom participated reported that Le Leche League leaders and support groups helped to answer questions, provide informational support, and ultimately extended the duration on the breastfeeding experience (Buckley, 1992).

Tiedje and colleagues (2002) however found that when asking participants about resources of support that only a handful of breastfeeding mothers discussed their utilization of community resources for breastfeeding support and only two mentioned La Leche League specifically. Rather, the mothers centered on general community assistance through home visits with lactation consultants and the lack of information available to them after initial contact when the infant was born (Tiedje et al., 2002). Lenrow and Burch (1981) noted that the variety and availability of "mutual aid workers" and resources that are available for individuals provide support who are coping with a stress provide greater support. The researchers define mutual aid workers as community based

informational resources and self-help groups that support its members (Lenrow & Burch, 1981), such as the Le Leche League. With the variance among communities, there may be concerns that areas that serve low income populations have limitations in numbers of leaders available and limited funding to support the mothers as needed (HHS, 2011).

Overall, these types of lay leaders allows for the mother to have interactions with trained individuals that can provide increased social support and resources that cannot be covered by traditional healthcare providers. The idea that the lay leader could provide a rich source of support for a new mother can be a relief for some healthcare providers who feel as though they do not have the time to offer mother the attention necessary for mothers who have breastfeeding challenges.

Doulas. Another type of non-medical support that may be available for a mother is a doula. A doula is an individual that is trained specifically to provide emotional and tangible support to mother from pregnancy, during childbirth, and throughout the postpartum period (Kozhimannil, Attanasio, Hardeman, O'Brien, 2013). Although there is limited evidence that doula care influences breastfeeding outcomes, Feldman-Winter (2013) stated that doulas can be beneficial for mothers who are underserved or considered high-risk. Gilliland (2002) studied the role of a doula and delineates how doulas can support a mother in the birth of her child including assisting in breastfeeding questions and answers. Kozhimannil and colleagues (2013) found that when a mother had doula support the breastfeeding initiation rate was 97.9% compared to the general breastfeeding are of 80.8% among the studied Medicaid population. In their study, when examined in terms of race, African American mothers had a breastfeeding initiation rate of 92.7% when there was a doula available to support the mother compared to 70.3% of

the general population of African American mothers. This indicated that doula's support was significant in increasing breastfeeding initiation rates among African American women and further demonstrates the positive influence that doulas can have on breastfeeding and the importance of their work for better breastfeeding outcomes (Kozhimannil, et al., 2013).

Healthcare professional. Healthcare professionals such as obstetrician-gynecologists, pediatricians, and family practitioners have an opportunity to encourage and support breastfeeding mothers (HHS, 2011). One may even assume that the one on one interaction between a mother and a healthcare provider would always be supportive for breastfeeding especially with the evidence that breastfeeding is the best choice for infant first food and the support that AAP gives to breastfeeding (AAP, 2012). Indeed, research conducted by Cross-Barnet, Augustyn, Gross, Resnik, and Paige (2012) found that mother commonly believed their healthcare provider to be their primary educator and supporter for their breastfeeding experience. However, research conducted by Cross-Barnet and colleagues (2012) found that mothers felt that their healthcare providers did not meet this expectation; yet, the participants were hesitant to look for support from other avenues. Powell Davis and Anderson (2014) found that almost 75% of the mothers in their study reported negative or no support from their clinician or staff at the hospital. Further, some participants reported that they perceived a lack of honesty from the healthcare provider about the possible difficulties and possible problems with breastfeeding. McInnes and Chambers (2008) offer a synthesis of research concerning mothers and healthcare providers. Their review demonstrated that mothers' rated social support as more important than services that they received from their healthcare

providers. Here, mothers' described their experiences with health care providers as negative – specifically feeling a lack of availability of healthcare provider when assistance was needed, the provision of conflicting advice, offering guidance that was perceived as being unhelpful, and feel that the healthcare provider does not have the time to assist them. Perhaps one of the most striking finds of the meta-analytic study was that this lack of breastfeeding support from healthcare professionals was found across countries of all socio-economic backgrounds (McInnes & Chambers, 2008).

Looking specifically at the experiences of African American mothers, breastfeeding, and healthcare providers, the research conducted by Cottrell and Detman (2013) showed that in their population, most of the women received information about breastfeeding during their interactions with healthcare providers before the child was born. The study also found that when the healthcare provider encouraged mothers to breastfeed, the mother was more likely to do so. Other support by the healthcare provider such as the provision of breast pumps and the suggestion of breastfeeding classes or supports groups also resulted in more breastfeeding by mothers (Cottrell & Detman, 2013).

There is recognition that there could be a lack of education for the healthcare provider on best breastfeeding practices. However, the education on breastfeeding is limited and textbooks often have incomplete or incorrect information (HHS, 2011). Feldman-Winter (2013) state that although many of the healthcare providers see themselves as a critical component to the breastfeeding network that a mother has, there is a considerable lack of education that negatively influences their ability to affect breastfeeding mothers in a consistently positive way. Jacobson and Wetta (2014) found

that when professional staff was trained on how to best promote breastfeeding to the mother, there was an increase in the encouragement of breastfeeding among the participants and better breastfeeding outcomes. This was confirmed through Labarere and colleagues' (2005) work, which provided healthcare providers with a five-hour training and found evidence of improved breastfeeding outcomes among their patients. Unfortunately, this type of training is not widely available and utilized among healthcare professionals.

In summary, the research literature establishes there is a clear connection between having a positive support for breastfeeding from individuals whether they are partners, family, friends or professionals and the mothers' breastfeeding outcomes. However, there is still a lack of research about the communication that is occurring between a mother and these interpersonal connections.

Community Level

Ecological models suggest that the best way for health behavior change to be enacted and sustained is through a combination of individual level changes and community and environmental supports (Stokols, 1992; Stokols, 1996). Community can be constructed through the community institutions that help create community health norms (CDC, 2014; Jacobson & Wetta-Hall, 2014; Ferguson & Vanderpool, 2013; HHS, 2011; Shala, Fahy & Kable, 2010; Bentley et al., 2003; Meeks, 2002; Tiedje, et al., 2002; United States Department of Agriculture, n.d.). Through the examination of the organizations available to women, or the lack thereof, researchers also can better understand the support systems in place for African American breastfeeding mothers.

Community organizations. The availability to community organizations that support breastfeeding has been linked to higher breastfeeding initiation and duration outcomes (Goodman, Majee, Olsberg & Jefferson, 2016; HHS, 2011). Research conducted by Goodman and colleagues (2016) found that, overall, mothers who successfully were able to breastfeed attributed that success to community organizations such as Le Leche League, WIC and certified lactation consultants. As an organization, Le Leche League works to provide pregnant and breastfeeding mothers support throughout their breastfeeding experiences (CDC, 2014; HHS, 2011). This organization offers a structure through their leaders that allows for continuing education and up-to-date information regarding breastfeeding that can then be distributed through their network (Le Leche League, 2016; HHS, 2011). Because the organization trains lay leaders, the communities which are served by the organization vary.

Online communication. *The Breastfeeding Call to Action* also supports the use of websites and online support forums and as way for mothers to interact with other breastfeeding mothers and get answers to specific questions they may have (HHS, 2011). Drentea and Moren-Cross (2005) examined the social capital and social support that was found on the internet from a mother message board site. The researchers found that in this format emotional support, informational support and a sense of community was developed and communicated. Gray (2013) also examined social support online noting that there is little understood about breastfeeding in the context of communication and the information regarding online support is nil. Indeed, online communication is yet to be fully explored in the realm of breastfeeding support. Yet one can expect that online

communities could be a place that breastfeeding mothers feel that they can go no matter the hour of the day and therefore can be a strong support.

Breastfeeding programs that offer support. Programming efforts have increased to support breastfeeding mothers and their families. United States Department of Agriculture's (USDA) national breastfeeding program *Loving Support Makes Breastfeeding Work* utilizes peer-to-peer support through WIC counselors. This program was created to help women feel comfortable about breastfeeding, to learn about maintaining breastfeeding while working, and the overall engagement of family and community in breastfeeding efforts. *Loving Support Makes Breastfeeding Work* has conducted some formative research about the successes of their program; however, they continue to explore the quantitative ways that their program has impacted both the individuals that they serve and the community at large (USDA, n.d.). Programs such as "It's Only Natural: Mother's love. Mother's milk." focus on African American women. This program was created to help African American women and their families understand the health benefits of breastfeeding as well as where to get help and support. The program contains racially appropriate videos and support materials (HHS, 2013).

When the community supports breastfeeding mothers there is a higher likelihood of breastfeeding initiation and sustainment. The communication provided about breastfeeding through these organizations offer mothers emotional, informational and tangible support that they may not otherwise receive. This study seeks to better understand the role that these organizations have in providing breastfeeding support.

Environment Level

The outer most level of the social ecological model, the environment, is best understood through the application of breastfeeding policies that effect the environment surrounding a breastfeeding mother. Although this research project does not focus the environmental level influences, due to the nature of the model and the understanding of how the levels have dynamic interaction, the constructs of the environmental level are described including hospital policies, governmental legislation and cultural impacts.

Hospital policies. Hospital policies can have a large influence on a mother's breastfeeding initiation experience. There have been many researchers who have found that hospitals do not prioritize breastfeeding and breastfeeding education, they do not have appropriate routines at birth, and provide fragmented care for mothers and babies in relation to breastfeeding practices (Hawkins, Stern, Baum & Gillman, 2015; CDC, 2014; Cross-Barnet, Augustyn, Gross, Resnik & Paige, 2012; HHS, 2011; Cimo & Cook, 2001). Cross-Barnet and colleagues suggested that hospitals need established guidelines to ensure that a mother who has positive intentions of breastfeeding is supported in that choice and is not derailed at any point through the birth and hospital stay. Additionally, they recommend that hospitals embrace the guidelines led by the Surgeon General's Call to Action to Support Breastfeeding and the Baby Friendly Hospital Initiative. The Baby Friendly Hospital Initiative is a global program that is support through the World Health Organization (WHO) that encourages hospitals and other birthing centers to provide care in such a manner as to best support a breastfeeding mother. It is based on the WHO/UNICEF publication Ten Steps to Successful Breastfeeding (CDC, 2014; WHO, 1998).

Governmental legislation. Policies that are established by the government can also influence breastfeeding initiation and sustainment choices. President Obama signed the Patient Protection and Affordable Care Act (ACA) into law in March 2010. This law is designed to provide access to affordable, quality health care. Within it are also provisions allowing for employees that need to be able to express breast milk the right to do so. The law requires “reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child’s birth each time such employee has need to express the milk.” Employers are also required to provide “a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk” (Garvin et al., 2013; HHS, 2013). Drago and colleagues (2010) found that the ACA most often protects mother who are lower income, young, have not completed a college degree, and or either Hispanic or African American.

Culture. The cultural context in which the support is given and received has significant implications for understanding the mechanics for social support. Ethnic groups have different attributes which function within American society, but have their own distinctions that delineate them and offer identity separate from those who are not part of the group (Dilworth-Anderson & Marshall, 1996). A culture influences the beliefs, attitudes, expectations and behaviors of those who belong. A culture offers a vocabulary and symbols that allow for the expressions and meanings to be established that directly affect the social aspects between individuals, families, groups, and communities. When one understands the cultural influences of interactions that members

have then there is also the provision of a foundational understanding of how social support is given and received (Dilworth-Anderson & Marshall, 1996).

Within African American families, Dilworth-Anderson and Marshall (1996) note the support is primarily provided through the relationships that consist of both consanguine and non-kin persons. There is a fluidity of the boundaries that set a family unit and as such, there is an allowance for multi-generational households. Traditionally, all persons under the roof of a home, kin or not, help with childcare, and share household duties (Dilworth-Anderson & Marshall, 1996; McAdoo, 1982).

The SEM provides scaffolding for which to better understand why breastfeeding rates are not higher among the population as a whole, and within the African American population specifically. Despite the evidence gathered about breastfeeding initiation and duration, the disparities among breastfeeding rates suggest that there is a need to further explore the basis for this discrepancy. The role of social support communication is a critical component in understanding influences on African American mothers in regards to breastfeeding.

Research Questions

This dissertation begins with the assumption that breastfeeding mothers require support in some capacity to be able to successfully initiate and sustain breastfeeding. The birth of a new child can cause stresses that were not present before the child was born (Aubuchon-Endsley, Kennedy, Gilchrist, Thomas, & Grant, 2015; Brown, 2014; Mezzacappa, 2004, Groer, Davis, & Hemphill, 2002; Alpert, Richardson, Fodaski, 1983) and may require assistance from partners, family members, and others in the community that was not required before the birth of the child (Mikucka & Rizzi, 2014; Tiedje, 2002).

The examination of the mothers' experiences with receiving support in tandem with the grandmothers and breastfeeding champions' experiences in offering support may shed light onto the reality of mothers trying to successfully breastfeed yet unable to meet the recommendations. There are many complexities to be considered for the delivery and acceptance of social support (Goldsmith & Albrecht, 2011; Goldsmith, 2004). With the foundational understanding that partners and grandmothers can be effective sources of support, there is a need for exploration into what that support actually consists of and if it is meeting the needs of the mother (Banks et al., 2013; HHS, 2011; Pierce, et al., 1996). Additionally, support from outside of the family can be instrumental for sustaining breastfeeding (Jacobson & Wetta, 2014; Shala, Fahy & Kable, 2010; Hurley, 2008; Arlotti, et al. 1998). Gaining insight into the interpersonal interactions of these mothers around the issue of breastfeeding may help future researchers build more effective interventions and educational programs that assist African American mothers in their choice to initiate and sustain breastfeeding.

The analysis of the mother's accounts may offer insight into the gaps in support that they need to have success with breastfeeding initiation and sustainment. The additional analysis from the grandmother's and breastfeeding champions' perspective provides foundational awareness and further exploration of the dynamic influences these important people have in the breastfeeding mother's life and how to best meet the needs of a breastfeeding mother. Although there are some accounts of breastfeeding mothers' support (Arlotti, et al., 1998; Grassley & Eschiti, 2008) these do not inspect the social support that occurs between mother and influences. Further, there is no empirical data that exists in health communication literature that explains the experience of

breastfeeding as an African American mother and the impact that interpersonal communication and organizational support systems have on the breastfeeding initiation and sustainment.

Thus, this research sought to study the communication of social support between mothers and their social network, with deeper exploration of the communication between mother and grandmother regarding breastfeeding. Additionally, there was a consideration for breastfeeding champions who assist these mothers. Examining the nature of social support from these various levels of influence can enable the researcher to better understand how African American mothers make the choice of whether or not to breastfeed and if breastfeeding, sustaining or not sustaining that feeding choice. Social support is one way in which a mother adjusts to the “new normal” now that she has an infant to care for (Goldsmith, 2004). This communication of support may encourage breastfeeding, or it may hinder it. As such, the overarching research question is, **what are the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed; and, how is that support communicated through interpersonal relationships and support from community based breastfeeding champions?**

To address this question, the study utilized the social ecological model as a framework from which to examine the communication between an African American mother and her social network at the interpersonal level. Additionally, this study examined the communication of a breastfeeding supporter that is working at a community level. First, this dissertation seeks to examine social support communication from various interpersonal relationships by asking,

R1: In what ways do African American mothers report receiving social support about their choice to breastfeed from their peers, family, health care providers, and strangers?

Research has also demonstrated that grandmothers can be a direct influence on a mother choice to breastfeed. The research is split in the support for breastfeeding and the negative influence (Mikuka & Rizzi ,2014; Mannion et al., 2013; HHS, 2011; Bently, et al., 2003; Arora et al., 2000). As such, this project explores the communication and actions of grandmothers in depth with research question 2:

RQ2 a: In what ways do African American mothers report receiving social support about their choice to breastfeed from their grandmothers'?

RQ2 b: How do grandmothers' report providing social support for their daughter's choice to breastfeed?

RQ2 c: How do mothers and grandmothers' accounts converge and diverge?

To further examine the support that is offered to a mother in the community, the project also examined a third avenue of social support thought by researchers to be potentially influential to new mothers seeking assistance for breastfeeding. The third research question asks:

RQ3. In what ways do breastfeeding champions report providing social support about their choice to breastfeed for their clients (mothers)?

There are many applications of social support within communication research, however, there is limited understanding about social support in the context breastfeeding. For breastfeeding, the implications for not breastfeeding reaches beyond the economic and physical health of an individual or household; indeed, the impact reaches the

workplace and community. The examination of the communication and experiences African American mothers' have had may offer insight to way to improve the lagging breastfeeding outcomes. Additionally, the investigation of how breastfeeding champions report offering support offer insight into ways to improve current practices inside a mother's interpersonal network.

Conclusion

Gottlieb (1981) argues that to understand the social support that is being given and received, one must examine the specific interactions that occur and use this information as a guide to subsequent action. Burleson et al. (1994) further explains there is a critical consequence to understanding social support in communication, as it is able to assist in understanding the culturally shared values that are supporting individuals and further, communities at large. There are many applications of social support within communication research, however, there is limited understanding about social support in the context breastfeeding. For breastfeeding, the implications for not breastfeeding reaches beyond the economic and physical health of an individual or household; indeed, the impact reaches the workplace and community. The examination of the communication and experiences African American mothers' have had may offer insight to way to improve the lagging breastfeeding outcomes. Additionally, the investigation of how breastfeeding champions report offering support offer insight into ways to improve current practices inside a mother's interpersonal network.

CHAPTER THREE: STUDY 1

This chapter provides the methodology used to address the research questions 1 and 2 as identified in Chapter One. In so doing, it identifies the qualitative methodology and protocols relevant to answers the questions of how African American mothers report receiving social support about their choice to breastfeed from peers, family members, healthcare providers and strangers; the deeper inquiry into the influence of a mother and the grandmother and the support communication regarding the daughter's choice to breastfed. The chapter will provide a justification for the qualitative approach to the research, the benefits of utilizing interview methodologies to address the research questions, as well as the limitations of this approach. Next, the chapter will review the methods guiding Study 1 for this dissertation. This includes a description of the characteristics of the individuals who participated in the study, how they were recruited, the procedures that were utilized in the study, and details of the measurements, which incorporated the participant demographics and interview protocols used in the data collection. Next, there is an account of how the data was analyzed to draw conclusions. And finally, the findings are reported.

The Qualitative Approach.

Qualitative research and methodologies seek to understand and provides depth to a phenomenon and often centers on the question of "why?" an occurrence happens. Often there is a study into the motivations of individuals, groups and communities through the qualitative lens (Jackson, et al., 2007). Additionally, research approaches situated under the qualitative umbrella seek to recognize experiences, knowledge, and circumstances within their social meanings (Du Pre & Crandall, 2011; Lindlof & Taylor, 2011).

Lindlof and Taylor (2011) describe qualitative researchers as studying the “performance and practices of human communication” (p. 4). The discovery of new scholarship is found through the various conversations which then provide material that the researcher can document and reflect on in developing a deeper understanding and making sense of the phenomenon. These documented experiences that assist in theory development should be developed inductively, which means that the research is continually testing the knowledge gained and their potential explanations against other group members’ interactions (Lindlof & Taylor, 2011).

The collection and analysis of qualitative data is conducted through a laborious regimen that seeks to demonstrate a deeper understanding of human action, motives, and feelings that is described and conceptualized based on the recorded communication. To accomplish this objective, a qualitative researcher must make decisions based on data management, data reduction, and conceptual development to best explicate the findings. Qualitative approaches to research certainly cannot address every scholarly inquiry. The use of this methodology would not be appropriate when examining very large populations, seeking to study a causal relationship through limited variables or utilization of surveys and experiments (Lindlof & Taylor, 2011; Jorgensen, 1989).

For this research study, qualitative methods permit the researcher to not focus on breastfeeding as a biological assumption, or medical occurrence/process in which a mother and child must work together. Rather, breastfeeding is choice that a mother must make among many options for infant feeding and that choice can be influenced by a variety of factors. This study sought to understand what support systems are in place for African American mothers who are breastfeeding and how the communication between

the support and the mothers is conveyed and accepted. Moreover, the study was designed from the perspective of an applied public health researcher interested in improving breastfeeding promotion efforts targeting African American women to reduce the disparate uptake and continuity of breastfeeding in this subpopulation compared to all U.S. women.

The broad dissertation project required the participants come from three different groups of individuals: (a) African American mothers (mothers who self-identified as African American, above the age of 18 and have and a child within the last 12 months), (b) African American grandmothers (grandmothers who self-identified as African American and have a daughter or daughter-in-law that had an infant under the age of one year). Before contact was made with any potential participant, Institutional Review Board (IRB) approval was obtained.

Study 1

The primary objective in Study 1 is to better understand and explain how African American mothers receive social support about their choice to breastfeed. Specifically, the study asked: what social support communication is received by African American women from their peers, family members, healthcare providers and strangers? Exploring further, the study identified the social support that African American mothers receive from grandmothers and asked how do grandmother's report offering social support to the mothers of their grandchildren considering breastfeeding. To address the objective and to answer research questions 1 and 2 from the previous chapter, focus groups were utilized with African American mother and grandmothers. The following sections describe the

participants in Study 1, explain the procedures for the collecting the data, and report the findings.

Participants

To address the research question, African American mothers and grandmothers were recruited to participate in six focus groups (3 focus groups of mothers and 3 focus groups of grandmothers), which offered a variety of times and days to potential participants (Kruger & Casey, 2015). The researcher aimed to have 4 to 8 individuals participate in each focus group as suggested by Kruger and Casey (2015). The mothers' focus groups ranged from 5 to 6 participants (Group 1, n= 5; Group 2, n = 5; Group 3, n = 6) however each group had higher numbers that were recruited for the study (Group 1, n= 8; Group 2, n = 9; Group 3, n = 11). The grandmother focus groups had lower recruitment (Group 1, n= 6; Group 2, n = 8 Group 3, n = 6) and had 4 participants per focus group. As this study was looking for in-depth insight, smaller groupings allowed for time to gain understanding of the participants' situations and experiences (Kruger & Casey, 2015).

Mothers

Inclusion requirements for the mother participants were that a mother was to have had a child within the past twelve months, the mother was African American and she was over the age of 18 years. This timeframe was selected due to the recommendation of twelve months of breastfeeding the American Academy of Pediatrics (AAP, 2012). The AAP recommends that a mother exclusively breastfeed for the first six months of the infant's life and slowly introduce solids while breastfeeding for the first year and beyond as desired (AAP, 2012). Additionally, mothers with experiences through this time period

allowed for discussion on the various transitions of infant feeding and addressing various transitions when support is needed. If the study had only included participants who had a child within 6 months or less, narratives that discussed the challenges of breastfeeding a child beyond the initial phase and communication concerning the sustainment breastfeeding beyond “infant” years may have been missed.

Purposive sampling techniques and snowball sampling were utilized to gain the mother participants. Fliers approved by the IRB were placed at hospitals, doctor offices, WIC offices, and libraries in the county of recruitment. All disseminated materials included information regarding who was being recruited and a brief statement about what would be discussed with the participants should they qualify for the study. Materials also included a phone number to contact the researcher for further inquiry or to sign up for participation.

When the researcher was contacted, the purpose of the research was described (i.e. exploration of a mother’s choice to breastfeed or bottle feed and the family’s support for that choice (mothers)), the focus group format that would be utilized, and the remuneration for participation (i.e., one \$25 gift card per participant). All mothers were screened for eligibility based on their self-identified race, age, and the presence of a child under the age of one year.

The final sample of mothers included 16 women. The mother participants were an average age of 26 years (*range* = 18 – 36), 63% (n=10) had attended childbirth classes; 44% (n=7) were living with a partner but not married, 25% (n=4) were married and 31% (n=5) were single. The mothers varied in their education; 19% (n=3) had some high school, 6% (n=1) had completed high school but not gone onto college, 6% (n=1) had

some college education but not a degree, and 69% (n=11) had a completed undergraduate degree. There were seven mothers (44%) that had one child, 38% (n=6) had two children, and one mother had 3 children, one mother had 4 children, and one mother had 5 children. Of the mothers, 38% (n=6) had been breastfed as a child, 56% (n=9) had not been breastfed and one mother did not know if she had been breastfed or not. The mothers were split in their own breastfeeding practices with 50% (n=6) having breastfed and 50% (n=6) who did not breastfeed their children.

Procedure. Focus groups were chosen as the method for data collection because of desire to find a wide range of opinions, perceptions and feelings that these mothers had during the first year of their child's life. As Kruger and Casey (2015) explain, focus groups should be considered when the purpose is to “uncover factors that influence opinions, behavior and motivations...insight into complicated topics when opinions or attitudes are conditional or when the area of concern relates to behavior or motivation” (p. 21). As this study was looking for in-depth insight, smaller groupings allowed for time in each focus group to explore the participants' situations and experiences. Focus groups ideally are small enough for all participants to be able to contribute significantly to the conversation and diverse enough to bring a range of insight (Kruger & Casey, 2015).

For the mothers, data collection occurred through a series of focus groups led by a trained interviewer. A trainer interviewer was selected to facilitate the focus groups due to the racial differences between the researcher and the participants in an attempt to allow for comfort of the participants (Kruger & Casey, 2015). As this project sought to understand specifically African American mother's experiences, the researcher

determined that interviewer should be an African American woman herself, offering homogeneity with the participants. The interviewer was briefed about the project 2 weeks before the first focus group and given the questions for the focus group so that she could familiarize herself with the questions being asked. This interviewer was the lead for all four of the mother's focus groups.

The focus groups were held in public library meeting rooms. The library was chosen due to its location neutrality and access to public bus service line. Participants were offered several dates and times for the focus groups to allow for one that best fit the potential participants schedule. Participants were told to allot two hours for the focus groups.

At the selected starting time, the focus group time began with refreshments in one main gathering space. This offered the opportunity for the researcher to introduce herself to the participants as well as allow time for mothers to meet and talk with one another. Next, the group went to a separate room that had paper and pens for all participants, a white board, and a facilitator.

Before beginning the actual focus group discussion, the participants were given a detailed explanation of the study and approve their participation through the informed consent process. The informed consent process provided a detailed description of the study, the benefits, risks and the voluntary and confidential nature of study. Further, the informed consent reminded participants of the purpose of the study, that this was a focus group and what a focus group was, and that there was going to be an audio recording of the discussion. Once participants were able to ask questions and signed the informed consent, the researcher left the room to allow the facilitator to begin.

First, the facilitator gathered information about the participants through a demographic questionnaire (Appendix C), which offered some baseline data for understanding the group of mothers as a whole. At the end of the questionnaire included space requesting contact information for follow up 4 to 5 days after the focus group. Next, the facilitator utilized a discussion guide (Appendix A) to lead the discussion with the mothers about their views of infant feeding and the support they received or did not receive. Once the focus group was completed, all mothers received a \$25 gift card to Walmart. Last, 5 days after the focus groups, the researcher made a follow-up phone call to determine if the mother had any additional thoughts or experiences that she would like to share regarding the conversation at the focus group session (Appendix E) as well as an opportunity to corroborate the initial findings from the focus group. Of the 16 mother participants, only ten were reached via phone call. Six mothers did not return the call after messages were left. None of the ten contacted participants said that they had additional information to share.

Measures and Instruments. A focus group guide was used during the sessions (Appendix A). The questions were focused on the perceptions and conversations about support for the mothers' infant feeding choice in order to answer the research questions. The mothers' open-ended questions focused on gathering information about the social support systems that assisted her with infant feeding support since the infant was born. The questions broadly asked about communication and the supportive actions received by the mother regarding infant feeding.

The first question, "I would like to hear words or phrases from each of you that first come to mind when you hear the following words: infant feeding, breastfeeding,

bottle feeding,” was utilized to get the group focused on the topic as well as offer important words and/or themes to look for through the transcripts.

The second question: “Tell me a story about how you ending up making the decision for your feeding choice. Do you feel like you had enough information for all feeding choices before you made your decision?” is asked to address how the discussion about feeding the infant developed and if it was a solitary choice or had outside familial influences. The third question “Can you remember and share with us about the last time that you talked to someone about feeding your child?” with prompts regarding where the conversation was held and who the conversation was with (doctor, nurse, grandmother, partner/spouse, friend) is asked to determine who the mother talks to about feeding and if there was support in that conversation or discouragement in a feeding choice.

The next question: “Who do you consider to be most important in supporting you when you are feeding your child and why?” offered the researcher information regarding members of the support system and further information about why that person is perceived to be so supportive of the mother. The fifth question asked “Can you tell us about a time when you were supported in your infant feeding choice?” and the sixth question “Can you tell us about a time when you were not supported about your infant feeding choice?” was asked to gain insights about the situational social support that has been offered and help to better understand the conversations around support and conversations lacking support. The next question asked “What other types of support for your feeding choice do you feel like you needed but did not receive?”, followed with the prompt “What information or help/support would make infant feeding easier for you?” to directly address the missing supports. Last, the question, “What do you think your

support people need in order to better support you?” requested that mother’s comment on their perceptions of needed support or reasons why people that should be supportive are not able to do so.

Grandmothers

Inclusion requirements for the grandmother participants were that a grandmother had a grandchild within the past 12 months and that the grandmother was African American. The delineation of a grandchild under the age of 12 months was selected based on the recommendation for twelve months of breastfeeding from the AAP. The AAP recommends that a mother exclusively breastfeed for the first six months of the infant’s life and slowly introduce solids while breastfeeding for the first year and beyond as desired (AAP, 2012). The research clearly demonstrates that this is an important time for support for the mother (CDC, 2014; Declercq, 2013a; HHS, 2011).

Purposive sampling techniques and snowball sampling were utilized to gather grandmother participants. Fliers approved by the IRB were placed at hospitals, doctor offices, WIC offices, and libraries in the county of recruitment. All fliers included information regarding who was being recruited and a brief statement about what would be discussed with the participants should they qualify for the study. Materials also included a phone number to contact the researcher for further inquiry or to sign up for participation.

Once the researcher was contacted, the purpose of the research was described (i.e., exploration of your thoughts about the feeding choice of the daughter or daughter-in-law and how you help and support her); it was also explained the focus –group format would be utilized and the remuneration for participation was stated (i.e., one \$25 gift card

per participant). All grandmothers were asked to confirm eligibility based on their self-identified race, age, and the presence of a grandchild under the age of one year.

There were twelve grandmother participants. The average age of these participants was 49.5 years ($n = 11$; *range* = 41 – 62). One participant chose not to share her age. Five of the grandmothers (41.67%) had three grandchildren, three (25%) had two grandchildren, two (16.67%) had one grandchild and two participants (16.67%) had four grandchildren. The majority of the grandmother participants were single (83%, $n = 10$) with only two (17%) that were married. The education level of the grandmothers was mixed; there were 4 of the grandmothers (33%) that completed an undergraduate degree in college, seven participants (58%) who had some college but did not complete a degree, and one participant (8%) who completed high school but did not continue in college.

Procedure. For the grandmothers, data collection also occurred through focus groups. Focus groups were chosen as the method for data collection because of the desire to find a wide range of opinion, perceptions, experiences and feelings that these grandmothers had during the first year of their grandchildren's lives. As Kruger and Casey (2015) explain, focus groups should be considered when the purpose is to explore influences on behaviors and motivations or when there are complicated topics that are can be explained as being “conditional or when the area of concern relates to behavior or motivation” (p. 21).

The focus groups were held in public library meeting rooms. The library was chosen due to its location neutrality and access to public bus service line. Participants were offered several dates and times for the focus groups to allow for one that best fit the potential participant's schedule, and participants were told to allot two hours for the focus

groups. At the selected starting time, the focus group time began with refreshments in one main gathering space. This offered the opportunity for the researcher to introduce herself to the participants as well as allow time for grandmothers to meet and talk with one another. Next, the group went to a different room that had paper and pens for all participants, a white board, and a facilitator.

Before beginning the actual focus group discussion, the participants were given a detailed explanation of the study and then walked through the informed consent process. The informed consent process provided a detailed description of the study, the benefits, risks and the voluntary and confidential nature of study. Further, the informed consent reminded participants of the purpose of the study, that this was a focus group and what a focus group was, and that there was going to be an audio recording of the discussion. Once participants were able to ask questions and signed the informed consent, the researcher left the room to allow the facilitator to begin.

First, the facilitator gathered information about the participants through a demographic questionnaire (Appendix D), which offered some baseline data for the group of grandmothers. The end of the questionnaire offered a space to include contact information for a follow-up phone call 4 to 5 days after the focus group. Next, the facilitator utilized a discussion guide (Appendix B) to lead the discussion with the grandmothers about their views regarding their daughter or daughter-in-law breastfeeding, and the support they offered or did not offer and their role in helping with the child. Once the focus group was completed, all grandmothers received a \$25 gift card to Walmart. Last, four days after the focus groups, the researcher made a follow-up phone call to determine if the grandmother had any additional thoughts or experiences

that she would like to share regarding the conversation at the focus group session (Appendix F). For the grandmothers, seven out of the twelve either answered or returned the follow-up phone call. None of the grandmothers had any additional comments or information to add.

Measures and Instruments. Just as with the mothers, a focus group guide was utilized to gather information pertaining to how grandmothers felt about their daughters or daughters-in-law's infant feeding practices as well as perceptions, experiences and conversations in regards to breastfeeding (Appendix B).

The grandmothers' open-ended prompts and questions were designed to gather information about their own feeding choices and providing social support to their grandchild's mother. The first question asked grandmothers to tell a story of a conversation they have had with the mother of the grandchild about feeding the baby. This was chosen to first determine what type of feeding choice the mother was using and second, to start the participants thinking about conversations that have occurred about infant feeding. The second question, "Share with us how you fed your own babies. Probes: How did friends and family react to your choice? Was there anything that you may have done differently? Were you supported in that decision?" provided information about how the mother fed her children as it may impact her advice and/or informational support to the mother. The third question asked a participant to "Tell us about conversations you have had with others about how your grandchild would be fed before the baby was born?" was used to inform about social support for the grandmother.

Next, the grandmothers were asked to talk about the grandbaby's mother and observations or actions that have been noticed surrounding infant feeding. The question

“Can you tell us about a time when breastfeeding/ bottle feeding seemed like the right choice for the mother?” was aimed at understanding some of the positives that are seen from the infant feeding choice and the grandmothers’ perceptions of that situation. The answers in respect to breastfeeding were of utmost importance, but those who had bottle fed grandchildren also offer insights into infant feeding that are relevant. Grandmothers were also asked “Can you tell us about a time when breastfeeding/ bottle feeding seemed like a difficult choice for the mother?” to identify some of the perceived negatives about the infant feeding choice, again focusing on the breastfeeding experiences but compiling information about bottle-feeding as well. The sixth prompt asked the grandmothers to “Tell us a story about a time when you gave support to the mother or you helped her in some way with infant feeding” and was used to understand what types of support have been given. The seventh and last prompt “How did the grandbaby’s mother react to your support?” was asked to better understand if the support from the grandmother was accepted or rejected. Four days after the focus group, each participant was called and asked if there was anything further that they had thought about or had experienced since the focus group that they would like to be included. This conversation offered an opportunity to validate the initial findings from the focus group (Appendix F).

Data Analysis for African American Mothers and Grandmothers

Once these data were collected, the researcher worked to label and break down the raw data so that categories, patterns, themes and concepts can be turned into “findings” or “results” that offered a useful contribution to knowledge about human communication (Lindlof & Taylor, 2011). Once all of the focus groups were completed, all of the audiotapes were transcribed into Word documents. The transcription was

contracted to a professional transcription service and once returned they were verified for accuracy. To verify accuracy, the researcher followed along transcripts with the recording for three minutes at five different points in the focus group recording. The places selected for listening to the focus group recordings were random. When the transcription was received, and confirmed, the actual recording from the focus groups was deleted. The researcher then read through all transcripts multiple times to allow for familiarization with the information within the documents.

These data analysis procedures in qualitative research required raw data for the purpose of sense-making and understanding the actions, motivations and feelings offered in the language collected (Lindoff & Taylor, 2011). As these research questions focused on the reports of social support, specifically reports of emotional, tangible and informational support (Price, Price & McHenry, 2009; Goldsmith, 2004; Match & Sims, 1992; House, Umberson, & Landis, 1988), the researcher utilized an inductive thematic analysis to sort through the data with these three large themes for the initial read through of the transcripts.

After the initial reading of the transcripts, the data was coded for examples of emotional support (e.g., actions that demonstrate empathy, concern for herself/ the mother, caring, and love), tangible support (e.g., actions of providing money, time, and/or assistance in the form of an explicit action directed towards the mother), and informational support (e.g., communication of advice, suggestions, and directives which offered assistance to the mother in response to her need) as well as primary coding of whether those examples contributed towards a positive or negative communication about breastfeeding. Additionally, the researcher noted the source of the communication (e.g.,

grandmother, partner, friend, family-member, health-care provider, etc.). These data were organized from the larger categories of social support (emotional, tangible, and informational support) into positive or negative interactions, and then further delineated into the source of that interaction. Beyond the coding described above, outstanding examples of support that were not expected were gathered separately. These “odd” data provided information that potentially could enrich the story.

For this study, a total of three coders were utilized (the researcher and two additional coders) to ensure that these data were understood and categorized appropriately. The auxiliary coders were briefed about how the data generated themes and categories. Additionally, these coders were informed on the three types of support, emotional, tangible and instructional. Next the added coders were instructed to read through the transcripts and begin with notations regarding the type of support that was being demonstrated, as well as if the comments were perceived to be positive or negative toward initiation and sustainment of breastfeeding. Lastly, the added coders were asked to highlight any words or events that exemplified social support for breastfeeding. When each coder sorted through the transcripts and made notes, the researcher and two other coders met to discuss and compare the categories. When the researcher and coders met to discuss the categorization, the session started with the comparison of each individual’s categorization that emerged from the transcripts. Through detailed conversations, a consensus was achieved regarding the demonstrations of social support and categories were then utilized to draw findings.

Findings

The purpose of this study was to identify the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed and

how that support is communicated through interpersonal relationships. These findings address the first two research questions: 1) In what ways do African American mothers report receiving social support about their choice to breastfeed from their peers, family members, healthcare providers and strangers? And, 2) in what ways do African American mothers report receiving social support about their choice to breastfeed from their mothers? How do grandmothers report providing social support for their daughter's choice to breastfeed? How do mothers and grandmothers accounts converge and diverge?

To answer these questions, mothers recalled communication and experiences that have occurred within the interpersonal level of the social ecological model (SEM). The interpersonal level of the SEM situates the interactions that a mother has with her social network (family and friends) as well as interactions with her healthcare providers and strangers. The argument has been made that interactions at the interpersonal level could have the greatest influence on individuals and their decisions (Dunn, Kalich, Fedrizzi & Philips, 2015; Golden & Earp, 2012; Bronfenbrenner, 2009; Stokols, 1996). Gottlieb (1981) contends that to understand the social support that is being given and received, one must inspect the specific interactions that transpire and use this evidence as a guide to subsequent action.

Interpersonal communication received by mothers. To address the first research question, the researcher identified the positive and negative social support interactions that mothers recalled occurring between themselves peers, family members, healthcare providers and strangers. Social support is constructed from emotional support (empathy, concern, caring and love demonstrated to the mother), tangible support (money, time of actions that assist a mother) and informational support (the offering of

facts, evidence, or stories and advice). Likewise, some of the interactions can prove to have an effect on the choice to breastfeed and/or sustainment of breastfeeding (Goldsmith, 2004; Goldsmith & Albrecht, 2011; Quick et al., 1996). As research demonstrated that interactions at this level can have great influence on an individual and his or her decisions (Dunn, Kalich, Fedrizzi & Philips, 2015; Bronfenbrenner, 2009; Stokols, 1996), these findings describe the recollections of mothers from these communication and actions.

Peers. Peers were perceived by most of the mothers as a source of positive support. The recollections of communication and actions from peers centered on the informational support received and a general sense of support. The informational support varied across the mothers. Terri stated what she and her friend discussed: “she told me about temperature stuff for breast and bottle, but she, [also] shared with me her experience with her child and how emotionally attached [breastfeeding] helped her.” Elizabeth also described that her friends provided her information about timing of feeding: “we just talked about, you know, when she feeds, when she nurses, and I felt supported in that.” Maya admitted that her friends were more supportive than her family. “My friends were definitely helpful. More helpful than my-my family.” Nicole described her friend who is her child’s godmother:

“her [the baby’s] god-mom was mostly my supporting person, she was—either it was her or my HANDS worker. So I really had those people to support me, but on the other side, the people that I really wanted to be supportive of me was not supportive of me.”

The use of technology to connect with friends was also illustrated in the discussion.

Sydney shared with the group about her conversation with her friend utilizing GChat:

“I just was talkin’ to a girlfriend via GChat [laughter] the other day. We were just talking cuz I’m goin’ back to work on Monday, so I was like, “Oh, what happened when you went back to work?” And she is pregnant again, so we were talking about pumping and like how much time off we were taking from work and all that stuff. It was very encouraging. Lots of words like liquid gold were tossed around.”

Katie stated that she liked talking to friends and other mothers about her breastfeeding struggles with breastfeeding and the “Breastfeeding is best” nomenclature. She explained:

Talking to friends or other mothers and stuff, that was really helpful. Because I think I’ve tried to go out of my way to not frame breastfeeding as like its the best, if I’m talking to other people about it.

She further explained “Not because I don’t believe it, but I think sometimes there’s a judgment implied with that when you’re like, ‘Oh, it’s the best.’ If this implication that you’re not doing it, then you get out of here.”

There were also several mothers did not feel as if they had the support of friends or did not have friends that understood what they were going through. One mother, Liz, discussed her needs right after birth “it was really hard, like the first two weeks, learning how to nurse my baby, and you know, you don’t have a peer you can go to...” Sam described misplaced support, “If your support people don’t fully understand, you know, what’s big about doing this[breastfeeding], then it can be easy for them to maybe act in ways that might be considered insensitive.” Zoe added that:

“if I had people near me that would understand about breastfeeding and how much it—how much it takes from you, you know? Like, maybe they woulda maybe come or—came over to my house more often or like call me up, like, how’s things doin’?”

Gina wondered aloud to the group:

“I think when you feel like you’re the only [laughter] one, you know? And you don’t have anybody to go to, to ask, is this normal? What did

you do in this situation? You know? You just don't—you don't have anybody to ask”

Loved ones. Mothers had differing experiences with support received from loved ones, either family members or partners. While a few of the mothers spoke of the positive emotional support that they received from family members and partners and the tangible support received from partners, most mothers spoke of the negative emotional experiences that they withstood from their families.

One of the commonly described supportive relationships came from sisters of the mothers who had either breastfed or at least had children previously. Michelle described her sister's support of breastfeeding when they both had children: “We did not talk about it much until I got older and started havin' more kids, and thinking [breastfeeding] was like ‘It's so beautiful. It's natural.’ So, yeah. We was all supporting each other about decision on breastfeedin’.” Maya spoke of how her sisters supported her even though they did not breastfeed their children:

“my sisters support me with it [breastfeeding] because they didn't breastfeed with their kids—they had kids when they were younger. And so they're looking at me now like they wish they had done it. It makes them realize how important it was for them.”

Some of the mothers also spoke of the tangible support they received from their partners.

Nikki explained how her partner helped after a hard day:

I guess what happened was around the two week growth spurt [laughter], which is the period of time in which the baby might wanna eat like every hour. He [the baby] was eating like every 40 minutes or something, and that particular day, I just—I was goin' kinda crazy. I had been on the couch almost all day. I wasn't able to take any naps. I had no water, which is like really important for breastfeeding. You need to stay hydrated. I had no water. I hadn't eaten anything in almost ten hours because he was also just so fussy. He wanted to eat, and every time I tried to move he would

wake up again and then start crying. So he was fussy. He wouldn't eat. Or he, you know, he wanted to eat, but then he was being weird about latching. And so-so it was just like a not good day. And when he [the partner] came home, I was kinda freakin' out. And his first response actually was like, is this—it was like, "Is this that postpartum thing? Are you postpartuming right now?" And I was like, "No, I haven't eaten right now." And I haven't had a shower. I stink. This is "I stink right now. I'm hungry right now." It was so like wildly new to the both of us. So he decided to run an errand, and it was like 10:00 at night, and I hadn't had anything to eat since very early that afternoon. I had not been able to move from that couch. So in that period of time that he took the baby with him, cuz he was also fussy, so he was like, "I'll put him in the car and we'll see what's up with the car ride." So they ran their little errand. In that time I was able to like wash up and have a peanut butter and jelly sandwich and get my mind right. And when he came back, it was fine.

Liz also shared how her partner supported her by taking the baby when she felt like she needed a break and to do things for herself, including the morning of the focus group:

He's been awesome and I mean, even today, like you know, I needed to wash my hair so bad. It was so bad. And he's [the baby] been in this thing lately where like he doesn't really wanna be put down, and he's had gas. So I found that wearing the wrap helped that a lot. Well, I mean, today, we woke up kinda late. We woke up late and he was just like, "Yo, show me how to put that things on." And so he [laughter] put it on and I did my thing, and he and the baby would play video games or whatever and I was doing my thing and you know, that was great.

She further described the day-to-day tangible support the partner provided:

I mean, ever since we're together, it's [laughter] life, the day, you know, the day-to-day, you know, makin' sure like I have water if I need it or, you know like when I am stuck on the couch, he'll get whatever is needed to get and watch the baby... I would try before to pump at least one bottle so that he could feed the baby a couple times a week, but I think we were both like, let's just save it for the daycare. And, you know, eventually, once I have even more milk, he'll just be feeding him, too.

Although there were a few examples of positive support discussed by the mothers, many of them discussed their negative experiences with loved ones that affected their breastfeeding experience. Ella described how she did not seriously consider breastfeeding as an option due to the family's behavior: "My uncle's baby mom, she breastfed, and

people kinda didn't like that, so it kinda what kept me in the direction of bottle feeding because of how my second family reacted toward her breastfeeding when she would come around." Katie concurred with Ella and shared with the group about her cousin's reaction to her breastfeeding and wished that she had been more supportive:

My cousin was negative Nancy. When I had first had my son. you know, I had let her know that I was breastfeeding, so she's been real negative about it, but she's just a negative person.... she could've just been like, "Well, you know, that's your thing, and that's good that you're doing it," versus, you know, "I don't know why you're doing that?"

There was also discussion about what families said to mothers that they are breastfeeding. Zoe described her family's reaction "They tell you that your baby's not growin' enough. The baby's not eating enough, that you're starving your baby and it made me stressed out." Several mothers described also how their families' made fun of them. Terri said:

Once my son got past a year, and especially now that I'm nursin' her [a second child], the questions they ask I think are sometimes offensive when they ask questions about my breasts and how are they hangin' and that type of thing."

Natalie added that her family makes comments about her weight: "And I get that from them all the time. 'You just ate. What? You gonna eat all that? You can't eat all that. Are you pregnant again? 'It's like, "What the?"

When describing how families communicated to the mother about breastfeeding, a large majority of the mothers discussed how breastfeeding with the family members around brought embarrassment, especially when out with the family in a public place. Jenni shared how she told her partner that she needed to nurse the baby before they left the house:

Cuz I was gonna go to a store one time, and I was like, “Well, I’m gonna feed and then I’m gonna go.” And he’s [the husband] like, “You can’t just go to the bathroom over there?” And I’m like, “I don’t wanna breastfeed on the toilet.” It’s nasty.

Restaurants seemed to be a place where breastfeeding was a common issue. Sam described her sister’s reaction to breastfeeding in a restaurant:

My sister, like I said, how she’s a new mother and she was just like ‘it’s crazy to go in a restaurant and watch someone breastfeed. You know, do you think it’s okay?’ Yeah, we’re sisters. We supposed to support each other on those type of topics. But she was very discouraging. There was teenage girls in there, as well. And I don’t wanna discourage them to have kids. It’s like, you aren’t even breastfeeding? ‘Nuh uh. No, that’s just nasty, or to go and look at somebody—to leave my house and go see somebody breastfeeding.’ Or, ‘Girl, look how breastfeeding just bein’ right out obnoxious and seein’ something.’ You know, we have to be role models, as well, to the upcoming mothers. We don’t know if they’re gonna have kids if they was to get pregnant the day after, but we don’t want discourage them, as well.

Ella described her experience with her family at a restaurant:

It was all of my future in-laws, the whole family. And I started nursing uncovered at the table. And I remember when my fiancé’s brother and his wife, who also, well, I thought she was nursing at the time, but I found out that she had stopped at that point. And her child was probably a month old. And so we had both babies there, And they started laughing, like the moment like that I pulled my breast out to nurse. They started laughing at the table. And I said, “What’s wrong with y’all?” and they said, “You know, well, you have your breast out at the table.” And I said, “Well, everybody’s eatin’ at the table,” And my future father-in-law told me that I need to take the baby in the bathroom and nurse in the bathroom. And there was a very tense stare-down because I respect him. I respect that man, but I was so embarrassed and I felt so ashamed. I will never forget that feeling that this[breastfeeding] is not welcome—

Last, mothers conferred about the presumption of sexual associations with breastfeeding.

Jenni recalled an interaction with her sister:

Like my sister, my older sister is pregnant now with her first. And she was like, “Well, I will definitely be breastfeeding, but I’m definitely gonna be pumping because I definitely don’t think I really don’t think I want

anybody suckin' on my boob." You know? And that is so [laughter] offensive to me, in a way, you know? Cuz it's like you think I just do it because I like to have somebody suckin' on my boob? You know? There's somethin' sexual that comes, that I get a sexual implication from that? It would be nice to not feel that sort of—that judgment.

Nikki added, "Exactly, I'm not breastfeeding because I'm an exhibitionist and I'm not nursing because I get sexual pleasure from it." Gina described how frustrated she was that males in her family seemed offended when she breastfed her child. She stated:

As if any of you really have trouble—have a problem seein' breasts. I mean, I know his brother watches porn. I know his dad does, too. Like, I know for a fact they all do. You have a problem with seein' a female breast? I don't think you do. I don't think you do. I think that when that breast is out and it is not for—consumption, and when it's not for your sexual pleasure— you have a problem with it.

Maya attempted to explain to the group why she thought this sexual connotation of breastfeeding was occurring. She said:

I was talkin' to someone about how people seem offended by breastfeeding and when they're not offended when they go see this Victoria's Secret models with their breasts hanging out or different clothing that has breast out. I'm like, you're not offended by that but yet, you're offended if I take my breast out to feed my child? You know, I think just the whole image of the breast and what they have been seen as for in our culture. It's more for sexuality, not so much for feeding your baby. It has multi purposes, and I think that in our culture, just—they just confuse it.... So people, they're taking the sexuality part of breasts and they're confusin' it with the feeding part.

Last, Sam summed up the effect of her family on her decision for infant feeding, "I feel like I had to go outside of my family get more information because my family wouldn't have had any kind of knowledge on what to do—." Family members and partners can be valuable in providing support to mothers, however, they also can be critical and lead a mother to second guess her breastfeeding decision. Mothers in the focus groups shared experiences of both positive and negative social support.

Healthcare providers. Healthcare providers, such as doctors, nurses, and public health professionals, can be a significant influence on a mother's choice to either breastfeed or bottle feed due to their knowledge of the subject and the fact that interaction is already centered around the baby. Mothers described a majority of the support received from healthcare providers as being informational support and tangible support. Michelle explained her experiences in receiving information before the baby was born and in the hospital nurses right after birth. She described, "At the hospital, the first thing they ask you or tell you about is breastfeeding. And they talk about the kangaroo care. And right after I gave birth, I mean, they [the nurses] handed her to me and was like, 'Do you wanna breastfeed?'" Nicole shared all of the healthcare places that she encountered information about breastfeeding:

"when you are in WIC, they [the healthcare providers] suggest, like breastfeed before you give formula. They [healthcare providers] give you lot more information. And then I went to Central Baptist [to have the baby] and they give you information on breastfeeding."

Jenni described how the nurse talked to her about some of the issues that can occur during breastfeeding. She shared, "she was showing me pictures of like the things that could happen to your breast and how they can, I guess get infected - it was [laughter] just—it was disgusting." She further explained that she did not like seeing all those pictures and perhaps too much information was being shown to her:

I didn't wanna see that, and she told me like, 'I'm not tryin' to lead you in the wrong direction. Like, if you still wanna breastfeed, you can, you know?' —okay, like I don't want my boob to be like that. And then she wanted to show me about the poop, and I'm just like, "Okay, look, I don't wanna go there..."

Breastfeeding classes lead by trained nurses was also a common source of information for mothers. Terri, who attended breastfeeding classes, explicated "I didn't

have any information about feeding. I went to—I took a couple classes that they talked about breastfeeding—and they gave information on breastfeeding.” Nicole described how she was able to use the information gained from the class could help explain to others about how much milk an infant needs after birth. She said:

“when they’re newborns and they cry a lot anyways, one of the things that I was helped to see in the breastfeeding class was that how small their stomachs are when they first come out. That was a big explanation as to why they feed so much and why, you know, when you’re worried if your milk is gonna come in and things like that because their stomachs are tiny. So I think that explanation right there in itself could help a husband understand why. Cuz, you know, they might be like, “Keep feeding him because he’s not eating enough and that’s why he keeps waking up.” I’m like, “He’s eating enough. It’s just his stomach’s the size of a pea,” [laughs] you know?”

Tangible support from healthcare providers was also commonly discussed as helpful in managing the potential struggles in breastfeeding. Nikki explained that having that having a healthcare professional as a resource offered her encouragement which lead to her feelings of confidence in handling breastfeeding. She stated, “Knowing that there are people that specialize in breastfeeding who gonna come to your house and like help you. That was encouraging, cuz I didn’t know—before you have your child, you don’t know what your body can do.”

Alternatively, several of the mothers felt that they did not have access to a healthcare provider that could answer their questions or concerns. Elizabeth stated:

“If maybe they could do like home visits that would be awesome. because, bringing a newborn out, nobody wants to bring ‘em out for at least six weeks if not longer. You know? And especially when you’re going to a clinic where there’s other germs, kids and just everything.”

Katie suggested:

“Because breastfeeding is such an intimate kind of thing and so if you had a person that knew you and knew your baby and could maybe do like after

like a month you've been home and you're having some issues, you could call 'em and they could do an in-house session with you. And then you could keep in touch with that person via text or online or whatever."

Only one of the mothers spoke of emotional support received by her healthcare provider. Natalie spoke of how she felt like her provider, a doctor, wanted her to be successful and that, "you can see the emotion from comin' from people. And you can feel that emotion comin' from people, and I don't think you get that from someone just doin' their job [of telling you to breastfeed]." However, there was not a saturation on this type of social support and, overall, the mothers did not describe their interactions with healthcare providers as having emotionally supportive communication or actions. This is significant because as Chapter 5 describes, the breastfeeding champions often described how emotionally supportive they are for mothers.

Strangers. Several of the mothers had encounters with strangers while they were breastfeeding. These encounters were described as sometimes having a positive effect and other times affecting a mother negatively. Zoe shared the emotional support that was felt by those people that they did not know, "I'd just be out and somebody be like, you know, 'That's good,' you know? 'You're breastfeeding.' Or just random moms, you know, just be like, 'Yeah, you know, way to go.'" Nicole concurred explaining, "it's strange cuz strangers are always supportive, and it's like [laughter] the people who are closest to you are [laughter] not." Sydney described her experience:

He had his son with him, who was probably eight to ten years old. And he came up to me and he said, "You're doin' the best thing for your child." He said, "I don't mean to bother you," he said, "but my wife, you know, she nursed all four of ours, and you're doin' the best thing for your child, and I just love to see—I love to see that," and they went on about their way.

And she added, “He was supportive, very supportive.” Not all mothers felt this kind of support from strangers though. Ella described how she felt while breastfeeding at a restaurant, “Why is she watchin’ my table, anyway, while I’m breastfeeding. How do you know I’m breastfeeding? You’re supposed to be there eatin’ dinner as well, so why are you watchin’ me eat dinner and breastfeed my child?”

Some mothers described the discomfort they feel when in public and breastfeeding. Jenni described an encounter with a stranger:

A white man that I did not know- He came up to me. I mean, I know he saw me. We made eye contact, and I nurse without a cover, and so I was really bracin’ myself for a confrontation of some type. You know, it was a time that I was, at the time didn’t feel like I needed support, but then when I saw him I thought I might—you know, it would have helped to have somebody there.

Katie described her feelings about being in public, and supposed what it would be like if she had her child with her at the focus group and if she had wanted to breastfeed. She clarified:

Us bein’ mothers and women, and bein’ comfortable in sitting in here and sitting in this room with glass windows and, say I brought my child and I wanna breastfeed, I’m more closer to this window than they are. And for somebody to walk by and just boom, probably stop, or catch a glance or somebody’s turn and me havin’ to second guess like “should I turn,?” I mean, where you can breastfeed and how it’s lookin’ ... Like she said, [I’m worried] about the image that they’re takin’ from it.

The discussion of strangers’ reactions to their infant feeding practices turned into a frank conversation about the lack of space to breastfeed in public places and not seeing other black women breastfeeding. Maya explained at her focus group her frustration with lack of places to breastfeeding while away from the home:

I don’t think there’s enough like breastfeeding areas in public places. Like I feel like you always have to be like anchored to your home. Which I mean is fine for a new baby, but like no one wants to—I don’t wanna be

out and have to go into a restroom stall, a nasty old restroom stall, and breastfeed my baby.

At another focus group, the mothers reflected on not seeing other African American women like them breastfeeding in public. Zoe stated, “It would have been really nice to see, in general, I think it’s supportive to see other women nursing.” To which Nicole added, “Especially other black women nursing.” And Terri continued, “Especially other black women nursing in public and uncovered.” And the room all nodded their heads in agreement.

Grandmothers. This next section describes the data gathered to answer Research Question 2, asking how do African American mothers report receiving social support about their choice to breastfeed from their mothers? How do grandmothers report providing social support for their daughters’ choice to breastfeed? How do mothers and grandmothers’ accounts converge and diverge? Previous research has shown that grandmothers can be an abundant provider of support for breastfeeding mothers (Bentley, Dee, & Jensen, 2003; Grassley & Eschiti, 2008) but has also shown that grandmothers can negatively influence a mother’s breastfeeding choice and duration (Emmott & Mace, 2015; Pikuskas, 2014; Susin, Giugliani & Kummer, 2005).

The mothers of these focus groups describe their communication and experiences with their mother, the grandmother, in a wistful manner. Three main themes emerged from the daughters’ discussions about the support from the grandmother: the lack of emotional support, the constant questioning of the ability to feed the child enough through breastfeeding, and the last, incorrect informational support given to mothers.

The participants commonly described the lack of emotional support for breastfeeding and the desire for that type of support from the mother. Nikki started by

saying, “I at least want support from my mom with the tryin’ to breastfeed.” Michelle described her desire for her mother to be more supportive,

like with her [my mom] always bein’ near me, there was a time where I was like, I don’t know if I’m enjoying breastfeeding, you know?... I felt like, during that time, I needed the most support, and I didn’t have it. If I had more support, I don’t think I would always been thinkin’ in back of my mind, ‘I really wanna quit breastfeeding.’ I feel like if I had the support I would have enjoyed it more.

Jenni recalled a conversation with her mother when she was struggling with breastfeeding. She shared, “Well, you know, there’s always a bottle to give. Who cares? I’d just as soon do that’...I just-just wanted her to say it’s gonna be ok.” Additionally, Sydney shared with the group how her mother reacted to her complaints about breastfeeding, “she was like, “You know, breastfeeding is not that big of a deal. Go on, give the baby a bottle. It’s not—,” you know, “You don’t have to get a trophy.”

Many of the mothers discussed the negative informational support they received from the grandmother. Elizabeth explained that she could go to her mother, but not always get the advice she was looking for, “I always feel I can go to my mom—because she had a lot of kids. But—I feel like she’s gonna tell me what she did rather than all the options that I do have.” Several other mothers discussed the pressure to give the baby a bottle instead of breastfeeding. Gina detailed her experiences with her mother and grandmother and the stress she felt when they tried to offer her advice. She said:

I remember when it came to like my mom and even my grandma, they stressed me, cuz they would keep sayin’, “Are you sure he’s gettin’ enough?” or “Maybe you to put a little rice in the bottle.” And it stressed me out so much that my milk dried up. And I went to the doctor - and she was like, “Yeah, stress can affect your milk supply.” And so I was like, “Oh my gosh,” so when they would come, I would just go upstairs and feed.

Tina described a similar experience that her mother-in-law expressed constant concern for how much the baby was eating and how it started to weigh on the mother's mind. She illustrated with the story:

My mother-in-law was real big on, "I don't think the baby's gettin' enough." Like, she bought me like this big tub of formula and told me to feed my first child the formula. And she just kinda put a little fear in me, the thought that, "wow, is my baby gettin' enough? And is everything okay?" And my baby was gaining weight and everything. Just the thought of is my baby gettin' enough? Cuz when you breastfeeding, you can't see it, you know?

Ella recalled that the grandmother told her, "'That baby's still hungry. You didn't give it enough.'" After hearing this, Jenni reinforced her experience by sharing, "My mother-in-law never wanted me to breastfeed, and she said, "I don't know how you have that much milk, and I don't know how you're still feeding her," and just really not supportive."

There are many other myths and poor advice that mothers received from the grandmothers. Katie described, "my mother told me to just give cow's milk, like when she [*laughter*] was six months old. Had I listened to those things, especially the cow's milk, woulda been bad for my daughter." Gina described her mother's reaction to the choice to breastfeed before bedtime. She shared, "my mom be like "If you breastfeed and only hold the baby, nurse the baby to sleep, it's never gonna sleep on its own. Just give it a bottle, put it in bed."

Only one mother spoke of her mom being the most supportive of her breastfeeding choice and emotionally supports her daughter even though she did not breastfeed herself. Liz described, "even though she didn't breastfeed me, I'm really trying to be more health conscious, and so she is as well...but she's just kind of just amazed what breastfeeding is." Overall, mothers reported receiving criticisms and

negative informational support from the grandmother and only one mother reported feeling positive support from her mother. This does not mean that the grandmothers did not intend to be positively supporting their daughters (Goldsmith, 2004) but there is a clear discrepancy between the two perspectives.

The Grandmother's Perspective

Grandmothers have been shown to have both positive influence on breastfeeding (Bentley, Dee, & Jensen, 2003; Grassley & Eschiti, 2008) as well as negative influence (Emmott & Mace, 2015; Pikuskas, 2014; Susin, Giugliani & Kummer, 2005). As such, only hearing from the mothers' perspective may not offer a full understanding of the communication and actions that occur between a mother and the grandmother.

Grandmothers shared ways that they provided emotional, tangible and informational support. The grandmothers also shared their discomforts with breastfeeding and the challenges that they faced when a daughter or daughter in-law chose to breastfeed the grandbaby. The following section demonstrates the grandmothers' perspectives of the various ways that support was provided or not provided.

The provision of emotional support, the demonstration of empathy, concern, caring and love demonstrated to the mother, was shared among the focus groups. Dolly began by stating, “nobody knows your daughter like you know your daughter” and went on to explain how she provided emotional support when her daughter was having a hard time with breastfeeding the baby. She recalled, “I just gave her a hug, and told her sometimes—it all goes with it. Breastfeeding has a lot to do with stabilizing you in regards to your physical health, you know, really and truly. You just have to kind of go with the flow.” Another grandmother, Nita, concurred and stated that she had to tell her

daughter something similar. She told the group that she told her daughter, “The number one thing is to remember—that you have to take care of yourself in order to take care of the baby.”

The grandmothers also discussed various communications that they shared with the mothers. Leslie stated that she told her son and daughter-in-law that “they was—well, she’s doing a good job with the baby.” Additionally, Nancy shared that she often tells her daughter, “‘You’re the most beautiful woman in the world.’ because I wish someone woulda told me that.” Michelle spoke to the group about how she told her daughter to be patient with breastfeeding. She recalled telling her daughter, “‘I know it’s a task. You know, but it can be done. Stay positive.’” Nita also shared with the focus group her response when her daughter asked her if she should supplement breastfeeding with formula. She said, “ [I tell her] it’s coming. You don’t have to worry about that.[the breastmilk].” However, not all mothers offered positive reinforcement when breastfeeding challenges arose.

Some grandmothers offered support in a seemingly positive manner, but their attempts at support may have been construed as supporting or suggesting the conclusion of breastfeeding practices. Georgina described how she responded when her daughter asked her about breastfeeding. She explained,

My daughter now, the one that just had the baby, she was asking about it. I said, “I didn’t like it, so—I mean, I can’t tell you need to do it or not to do it.” And I just told her, I said, “You’re busy, on the go like me. It didn’t work for me, ‘cause I was busy on the go.” I just told her, “I didn’t like it.”

Bobbi talked to the group about what she said to her daughter who was struggling with breastfeeding and had decided that she would go to formula. She shared, “I was like, you

know, the main thing is connecting and loving your child. And if it was stressing you out too bad, doing breast feeding—then you made the right choice, because your child wasn't getting what they need.”

Grandmothers also discussed how support was offered when mothers were stressed about feeding the new child. Debbi explained what she told her daughter about being stressed while feeding. She shared, “I told her, ‘The only thing about breastfeeding, you have to be like dedicated and focused, because if you tense up or whatever, that baby feels that.’” Connie detailed how she spoke with her daughter after a cesarean section, when she seemed to be stressed about feeding the child. She stated,

One of the things that my daughter went through was she had two kids, and both of them were C-section...she felt like it was one thing that she could do, you know, to make her feel like she was a good mother that was breastfeeding. So she was like, “Now I gotta do this. I gotta do this. I gotta get it right. I can't do one or the other.” But I told her it didn't make her a bad person, you know, ‘cause everybody's body is designed different. So, you know, I'm constantly, you know, telling her that.

These types of expressions do not necessarily lead to formula feeding or the termination of breastfeeding, but they could influence how a mother perceives she should proceed when facing breastfeeding challenges.

There were grandmothers at the focus groups that did not know much about breastfeeding when their daughters had children and felt uncomfortable with breastfeeding. Missy shared:

I just couldn't get into the breastfeeding thing. She started breastfeeding. I was surprised, ‘cause she was the first on in the family to breastfeed. When we went to the hospital to pick her up, she said, “I'm breastfeeding.” You know, it was like she had to give me emotional support, ‘cause I kind of—[chuckles]—she had to reassure me. Instead of me give her emotional support, she had to give it to me, ‘cause I'm like, “That's different.”

Connie concurred about feeling uncomfortable and explained what happened to her,

I'd go over, and she knew how I felt. And she said, "I'm gonna feed the baby, mom." And I said, "Okay." It's not a big thing, but when she'd just whip it out and show me how it'd squirt. I was like—you know, um, uh, you know...

Similarly, Beth described how she felt like her daughter was uncomfortable breastfeeding in front of her and she needed to leave the room when the mother was nursing. She told the groups about her experience,

I visited a little baby who was just born. I guess he was maybe three days old. And the mother was breast feeding, and father was in the room. And so she asked me if I wanna hold the baby. I said, "Yeah, you know, I'll hold the little rascal." And then he started crying. She said, "Well, he's probably hungry." So I gave him back to her and I could tell she wasn't sure she wanted to pop it out in front of me. You know, whatever, so I said, "Well I'm gonna leave now, I'll leave now," or something. So then she started unpacking stuff, and just pops it in there.

Several grandmothers discussed how they perceived that breastfeeding kept them from having time with the baby or bonding with the baby. Leslie commented, "I wanted to feed baby 'cause I wanted to spend more time with my granddaughter, you know, but I can't on account of not having the breast." Michelle agreed with Connie adding, "I couldn't hold her [the granddaughter] cuz she's breast feeding her and stuff like that." A third grandmother, Leslie, commented, "I didn't get to feed her initially. It's like I wanna feed her, you know." Last, Michelle shared her disappointment with the group that she was not getting time to bond with her grandchild because of breastfeeding. She said, "The only thing about the breastfeeding part is the bond time with the grandparents. When she was breastfeeding Jaylee, I didn't get that. I got it when she [the grandchild] got a little older and stopped breastfeeding."

Although some of the grandmothers lamented not being able to feed the baby, there were other tangible support opportunities that were discussed. Dolly explained all of the items that she bought for the grandchild. She said, “the firstborn gets a lot of stuff. A lot of diapers, a lot of, you know, baby wash and all that. You know, I made sure he had the works.” There were also purchases made for the mother to assist with breastfeeding. Debbi explained, “And they have special shirts and bras now [for breastfeeding]. You know, I went out and got her some and, you know, so she would be able to do it easier.” Nita described how she cleans the house for her daughter after her grandchild was born. She shared, “I would go to her house and clean. She tell me, she said, “Mom, don’t worry about that. You need to relax. Let the house go.”

Additionally, Bobbi described how she wanted to let her daughter take care of things on her own and to not be in the way with the new baby, but stepped in when she saw how exhausted the mother was. She shared,

She was in the hospital, I was there with the oldest child. Then she wanted me to move in. I’m like, “Oh, no, I don’t think so.” [Chuckles] No, I think you better just adjust and I’ll go home and then I can come back. But, you know, I looked at her the other night I was there, and she looked so tired she’s like sitting up asleep. I said, “Give me the baby. You lie down, you get you some rest and I’ll sit up with the baby.”

Nancy takes her grandchild to the doctor for the mother because the mother is working and cannot always make all of the different appointments that are needed within the first year. She explained, “I takes [the baby] to the doctor...for my oldest daughter, I’ve gone to all her WIC appointments for her kids. Her schedule does not permit her to go.” She further describes what she does, “I make sure they go to their doctor’s appointments, dentist appointments, ‘cause my schedule is more flexible. So I’m gonna make sure they

make all their appointments, get their shots, everything.” This is especially important for a mother who is working a job that does not allow paid time off for doctor appointments.

Some grandmothers discussed how they end up doing everything for their daughter, and suggested that the daughter relied too much on them. Missy was leaving town for a few days and shared what she told her daughter. She said, “See for me, with my daughter living with me, I took a four-day trip, and I told her, I said, “You’re on your own.” I said, “I’m not gonna be washing bottles, washing clothes, cooking, cleaning after you all.” She further explained that “[my daughter] wash the bottles... And I do it because when I wash the dishes, I automatically just do the bottles.” Regina agreed and recalled what she told her daughter after the baby was born. She shared:

“I’m not doing your job. I raised my kids.’ But at the same time, I see little things that she does and she’s not doing, then I step in. Okay. And she doesn’t have a clue... I keep telling her, “You’re going to realize how good you have it right now.”

Grandmothers often provided informational support to their daughter and daughters-in-law through advice and personal experiences. Grandmothers started much of their advice by reminding the mother to relax. Nita explained that she started talking to her daughter about how important it is to relax. She shared what she would say to her daughter,

I would say just to relax. And I think every baby, they know what to do. It’s not that you have to teach anything, because, you know, that was essential. They knew how to get that breast, and you just have to learn and be patient and put that baby at the right level and hold them there.

Georgina added that she told her daughter-in-law something similar. She shared that she told her, “You can prepare yourself” I told her to pace herself to prepare herself. Keep

herself calm, ‘cause this is a test, you know.” And finally, Dolly spoke of sharing breastfeeding information that was passed down from generations before:

I figured my granny knew pretty much what she was talking about when she explained to me some things about breastfeeding. She was talking to me about some things that come natural. You didn’t really know it...Breastfeeding’s a task. It’s not like—it’s not easy. It’s just as much a commitment as it is being a parent.

Several of the grandmothers discussed how they responded to the questions that they got from their daughters and daughters-in-law. Leslie explained, “I’m dealing with that with my daughter now. She has a six week old, and she’s also breastfeeding...Every day it’s a new question. It’s a new experience. And you just have to be patient, be patient with ‘em [the mothers].” However, Missy described how answering the daughter’s questions every day is not always easy and that she thought that one day the other grandmothers would get tired of the questions too. She shared:

She [the daughter] says, “Mom, how do you cook this?” “Mom, [the baby] is doing this. What should I do? How do I?” I’m telling you, your phone is on, you’re gonna have a day where you’re gonna be like—you look at the phone like, “Ignore, ignore, ignore.”

Grandmothers also discussed how well their advice was received. At one of the focus groups Debbi complained,

She thinks she knows everything right now. That’s the thing. I felt like that she didn’t know, but she thinks she knows, but she don’t know. Soon—[chuckles]—that’s where we have a problem. You think you know everything? Okay...”

The grandmothers laughed and the above situation led to Nancy concurring, “You know, they have that resentment. ‘It’s my baby, I’ll do it my way.’ You know what I’m saying?”

There was discussion among the grandmothers about how they suggested that their daughters or daughters-in-law get the information they needed about breastfeeding. Further, many grandmothers discussed their encouragement for the daughter or daughter-in-law to educate themselves on breastfeeding. Nita explained, “I got her books and the DVDs and told her, you know, to read different sides...and I read to help her, and gave her that information.” This led to Beth sharing that she did something similar. She said, “My motto is just keep reading everything I find on breastfeeding...I’m like, “Okay, this is what they say you should be doing.” Additionally, Leslie stated, “Just get them informed, get the information, all that you can about the benefits, the pros and the cons so they can see if its [breastfeeding] right for them.” Regina noted, “There’s just so much more information out there now, you know, kids—I mean the mothers are seeking it for themselves.” Contrasting the other grandmothers though, Missy admitted, “I never did have to give her information on breastfeeding, because I didn’t even know. She taught me. You know, she taught me the different factors of breastfeeding.”

Converging and diverging recollections between mothers and grandmothers

While there was an expectation that there would be some convergence of received messages with the sent messages, the findings of this study demonstrate a different outcome. There was, however, much divergence between the reported support messages received and given. Mothers spoke collectively about the lack of emotional support that they felt from their mothers and how they desired more. Comments received from the grandmother such as “you don’t have to get a trophy” could inadvertently demean the work that the mother feels that she has put forth for breastfeeding and cause the mother to cease earlier than intended. Paradoxically, grandmothers reported providing emotional

support through encouragement of “you are doing a good job”, encouragement for the mother to stay positive and suggesting that the mother relax.

There are also disagreements between mothers and grandmothers about the informational support offered. Mothers spoke of the advice received coming from stories not facts such as suggesting that the mother put rice or cow’s milk in the bottle.

Additionally, the comments from the grandmothers that the mother did not have enough breastmilk to feed the baby were reported as creating stress. Research and biology have proven that the amount of milk a mother produces is not linked to breast size and that except for the rare few, most mothers are able to more than sufficiently provide milk for their child (American Academy of Pediatrics, 2012). Although some grandmothers did report passing on information gained through discussions with previous generations of mothers, many of the grandmothers spoke of researching breastfeeding on their own or suggested that the mother do her research.

Perhaps most interestingly, the mothers did not speak of tangible support from the grandmothers at all. There was mention of tangible support from healthcare providers (through specific assistance with breastfeeding) and from partners (taking child so mother had time for herself and assisting with the care-taking), but the grandmother was not mentioned as part of this support even with prompts of the different sources that may be applicable. Grandmothers, on the other hand, spoke of providing diapers and other needs, taking the child when the mother was exhausted, and even doing dishes for the mother. There is clearly a discrepancy between what the mothers report as receiving from the grandmother and what the grandmothers report as providing for the mothers. Recognizing that there are different perceptions from the receiver (the mother) and the provider (the

grandmother) offers an important distinction for researchers whom have previously labeled grandmothers as positive influences on breastfeeding outcomes, specifically for African American women.

Conclusion

This study sought to understand the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed and how is that support is communicated through interpersonal relationships and support from community-based breastfeeding champions. This chapter provides the data and discussion that addresses the first two research questions: 1) In what ways do African American mothers report receiving social support about their choice to breastfeed from their health care providers, peers, loved ones and strangers? And, 2) in what ways do African American mothers report receiving social support about their choice to breastfeed from their mothers'? In what ways do grandmothers' report providing social support for their daughter's choice to breastfeed? How do mothers and grandmothers' accounts converge and diverge?

Mothers reported that they received informational and emotional support from healthcare providers and peers, both positive and negative. Mothers also reported that strangers gave them emotional support through words of encouragement and looks of support. Family members were reported to be critical of breastfeeding and most likely to question breastfeeding as sufficient in providing enough milk for the baby or act in a negative manner towards breastfeeding making the mother feel ashamed. Last, mothers reported the desire for more emotional and factual informational support from the grandmother.

The recollection of support from the grandmother is different from the support grandmothers report providing. Grandmothers reported providing emotional, tangible and informational support to the mothers. This divergence of accounts could be critical for understanding the impact the grandmothers have on mothers. The various relationships that the mother has with the interpersonal interactions may contribute significantly to the interpretation the mother has of the support given. Acknowledging the difference in receiver and provider interpretations cannot be ignored in the development of messages or programs aimed at supporting the mother.

Given answers to Research Question 1 and Research Question 2 which consist of conflicting perspectives for the reception and provision of social support, this dissertation also examined a third avenue of social support thought by researchers to be potentially influential to new mothers seeking assistance for breastfeeding. Breastfeeding champions are defined as those at the community level that provide women with support with breastfeeding initiation and sustainment. Chapter 4 reports the findings from Study 2, which focused on how breastfeeding champions report providing social support for breastfeeding mothers.

CHAPTER FOUR: STUDY TWO

This project also completed a second study to examine a third avenue of social support through the perspectives of breastfeeding champions. Breastfeeding champions are defined as individuals who work (paid or volunteer) to provide assistance to mothers with infants. The objective of study 2 was to recognize and explain how breastfeeding champions provide support for breastfeeding to their clients. To address the objective and to answer research question 3 from the previous chapter, in-depth interviews were utilized. The following sections describe the participants in study 2 and explain the procedures for the collecting the data.

Breastfeeding champions were recruited through phone calls to the local listings of lactation consultants and other organizations that provide breastfeeding support or through emails when email address was available to use for contact. Information gathered from these participants was through in-depth interviews (IDIs), either over the phone or in person as determined by the participant. An IDI was utilized to better understand the breastfeeding champions experiences and perspectives about assisting mothers through their stories and accounts of interactions and communication (Lindlof & Taylor, 2011) through the development of detailed descriptions about their experiences (Weiss, 1994). This choice of qualitative methodology was chosen for this study due to the wide range of ways that breastfeeding champions assisted their clients and the objective of understanding the detailed interactions with clients. IDI also allows for the researcher to grasp breastfeeding support from the perspective of the breastfeeding champion and examine the community level of breastfeeding support (Weiss, 1994). A full justification for the qualitative nature of this study can be found in Chapter 3.

The breastfeeding champions did not fill out a demographic survey as most of the interviews were conducted over the phone. However, the sample consisted of thirteen individuals who were all female. The breastfeeding champions' average age was 47 years (*range* = 22 years to 64 years). On average, the breastfeeding champions worked 13.4 years (*range* = 6 months to 26 years). The participants assisted mothers through work opportunities, both volunteer and paid: nurse, WIC coordinator, HANDS worker, doula, business owner, Le Leche League Leaders, online support group facilitator, and peer breastfeeding counselor. Additionally, the participants had several breastfeeding certifications: Certified Lactation Counselor (CLC) and *International Board Certified Lactation Consultant (IBCLC)*.

Procedure. The researcher started by looking at brochures for Certified Lactation Consultants, health department breastfeeding assistance, businesses that supported breastfeeding mothers, and Facebook page support groups for mothers. Once breastfeeding champions returned contact, the researcher worked with the individual to determine whether a phone call or a face-to-face interview would be best for the participant. Additionally, the researcher detailed how the interview would last approximately 90 minutes and worked with the breastfeeding champion to determine which day and time would be best suited for the interview.

Before beginning any interview, each participant was given a detailed explanation of the study. Although there was a waiver of informed consent, the researcher talked through the same points that would traditionally be covered on an informed consent form. All participants were informed about the study and the purpose, the benefits and risks that

may be associated with participation, and the voluntary nature of the study. Further, confidentiality was discussed and that the interview would be audio-recorded.

For the breastfeeding champions, the interview focused on their experiences in regards to how they provided support for breastfeeding mothers, their beliefs on the best practices, and some of the challenges that they face in offering support for breastfeeding mothers. Once the interview was completed, participants were asked for the mailing address to send a \$25 gift card for O'Charley's. Ten interviews were conducted via phone and three interviews were conducted face-to-face. The average interview time was 63 minutes (*range* = 46 minutes – 113 minutes).

Instruments and Measurements. An interview guide was used during the in-depth interviews (Appendix G). The breastfeeding champions' questions were focused on their perceptions of, and experiences in, supporting breastfeeding mothers in order to answer the research questions. The open-ended questions started with framing their current expertise and situate for which they provide support. The first set of questions included questions that provided information regarding the current way that the champion provided services to assist breastfeeding mothers, including where those services are offered, how long the breastfeeding champion had been working in that manner, and how much time is spent each week in the provision of breastfeeding support.

The second section focused on the participant's personal experiences related to providing breastfeeding support. The first question in the section, "Can you share with me a story about how you got started assisting breastfeeding mothers?" and the second question "Can you tell me a story about why you wanted to start this type of work?" were utilized to better understand why the participant got involved in this type of work. Next,

“Could you share with me your usual approach to encouraging mothers to breastfeed?” and “Can you walk me through what a typical appointment/time with a mother is like?” were asked to better understand what were the practices that the breastfeeding champions used regularly. The fifth question “Can you share with me a story about a time when you ensured that a conversation with a new mother is productive?” and follow-up questions, “Can you describe to me how you ensure that your conversation is positive with a breastfeeding mother? Can you tell me a story about a time when you had to use [those methods] with a mother?” offered insights about the conversational tone that may be used with mothers as they seek support.

The next set of questions focused on determining the different support that is offered a mother and how she would respond to such efforts. Question seven asked “Can you describe to me how you best determine what a mother needs/wants in terms of support for breastfeeding?” and the eighth asked “Can you share with me a story of a time when you offered emotional support? What did you do or say? How did the mother respond?” This questioning was followed by a request asking participants: “Can you share with me a story of when you offered tangible support? What did you do or say? How did the mother respond?” and “Can you share with me a story of when you offered informational support? What did you do or say? How did the mother respond?” Additionally, the interview guide asked the breastfeeding champion “Which type of support do you think is the most important for a breastfeeding mother and why?” and “Which type of support do you see yourself providing the most? Why?”

The following questions were asked to gain insight into some different personal experiences of the breastfeeding champion: “Can you tell me a story about the most

personally rewarding breastfeeding situation you have assisted with? What made this a personally rewarding experience?” Probing questions followed that asked about advice-giving related to how they helped women overcome barriers to breastfeeding: “Can you share with me a story about a time when you encountered a breastfeeding mother who was having a lot of trouble and how you got her back on track?” and “Can you share with me a story about a time when you had to engage a mother that seemed shy or distant? What did you say or do? How did the mother respond?”

The next question “What do you think is your biggest challenge is helping breastfeeding mothers? How do you work to overcome that challenge? Can you share with me a story when you addressed [that challenge] with a mother?” and “In your experiences, what are the most common issues that breastfeeding mothers are having? Can you tell me a story about when you assisted a mother with [that issue]?” offered insights about the difficulties breastfeeding champions may encounter when they are working to provide a mother with support.

Additionally, three questions were asked to increase insight into how a breastfeeding champion reacts when a mother maybe resisting breastfeeding or not receptive to the support that has been given. The questions were: “Can you tell me story about a time when you encountered resistance from a mother?”; “Can you tell me a story about when you had a difficult conversation with a new mother?”; “Can you share with me a story about a time when you had a mother who was not receptive to your assistance and how you proceeded with assisting/ or not assisting? How did the mother respond?”

The next set of questions focused on the breastfeeding champion’s current application of techniques of support and best practices when working with mothers. The

first question asked “What do you think are the most important ways that a (person in your position) helps a breastfeeding mother?” The intent of this question was to establish what the breastfeeding champion thinks of as important reasons for their work. Further, the second question asked directly what the breastfeeding champion believed the best practices are: “Can you describe to me what you think are the best practices when it comes to assisting a new mother?” The third question asked “What do you think are the best techniques to establish relationships with mothers? Why?” to offer insight into the ways in which the champions work to create trusting relationships. Additionally, the question “How have you seen the programming/assisting change over the past 5 years?” was asked if appropriate to participants that have been assisting breastfeeding mothers for five or more years. For those who may not have been working in this field for that long, the question was adjusted to reflect the time spent working in the field. This question was not asked to those who have been working with breastfeeding mothers for less than one year.

Follow-up and probing questions asked the breastfeeding champions to reflect more on the challenges that they face in their current practices. These questions were: “Describe to me what you think are the biggest barriers for mothers to breastfeed? How do people in your job specifically address [these barriers]?” and “What do you think is the most stressful part of breastfeeding for mothers? Can you share with me a story that reflects why you think that?” An additional question was asked to gain insights about the assumed value breastfeeding champions feel about their work. The question was: “Why do you think that people in your position are so important for breastfeeding mothers?”

Then, the research asked, “Overall, what do you think are the biggest rewards for helping breastfeeding mothers? Can you share with me a story about when you felt most rewarded?” offers the researcher information regarding the feelings of success that a person of this perception may feel. The next question “As a (person in your position), what advice would you give someone who was starting out in the same job as you?” was asked to determine other areas not previously mentioned that relate to the challenges a breastfeeding champion may encounter when working with breastfeeding mothers. Additionally, the researcher asked a question regarding a time when a breastfeeding champion has to go against their support for breastfeeding in the best interest of the mother. The question was asked “Can you tell me story about a time when you have helped a mother although it may not have been exactly by the book?” Finally, the last question asked, “Lastly, what else would you like to share with me to learn more about your perspective or approach to supporting breastfeeding mothers?” in order to ensure that the breastfeeding champions did not want to add any information to the discussion or to allow for the addition of any information that the breastfeeding champion viewed as being pertinent.

Data Analysis for Breastfeeding Champions

Lindlof and Taylor (2011) explain that data analysis procedures in qualitative research requires raw data to make sense of and understand actions, motivations and feelings. Once all of the IDIs were completed, all of the audiotapes were transcribed into Word documents. The transcription was contracted to an outside entity and once returned the transcriptions were verified for accuracy. To verify accuracy, the researcher followed along transcripts with the recording for three minutes at five different points in each IDI

recording. The places selected for listening to the focus group recordings were random. When the transcription was received and verified, the actual recording from the IDI was deleted. The researcher read through all transcripts multiple times to allow for familiarization with the material contained within the documents. As this research question focused on identifying and explaining how breastfeeding champions provide support for breastfeeding to their clients, the researcher began with an inductive thematic analysis of sorting through the data searching for communication and actions that demonstrated emotional support, tangible support, and informational support.

After the initial reading of the transcripts, the data collected was coded for examples of emotional support (e.g., actions that demonstrate empathy, concern for the mother, caring, and love), tangible support (e.g., actions of providing time and assistance in the form of an explicit action directed towards the mother), and informational support (e.g., communication of advice, suggestions, and directives which offered assistance to the mother in response to her need). The data was then organized from the larger categories of social support (emotional, tangible, and informational support) to positive outcomes from the interactions and negative outcomes from the interactions. The data then was further delineated into the reaction of the breastfeeding champions and how she handles the positive or negative interactions with the client, as well as the limitations felt by breastfeeding champions in their efforts to support breastfeeding women. Beyond the coding described above, other outstanding examples of how the breastfeeding champions support their clients were gathered independently. This data provided information that could potentially enrich the explanations of the qualities of social support.

An additional independent coder was utilized to ensure that the coded data does in fact represent the categories reflected in the researcher's work. For this study, two coders (the researcher and an additional independent coder) were utilized to ensure that the data was understood and categorized fittingly. The additional coder was informed about how the data collected generated themes and categories. Moreover, the auxiliary coder was educated on the three types of support, emotional, tangible and instructional and was instructed to read through the transcripts and begin with notations regarding the type of support that was being demonstrated. Next, she was asked to code whether the outcome with the mother was a positive or negative towards initiation and sustainment of breastfeeding. Last, the additional coder was asked to take note of words or events that exemplified social support for breastfeeding. When the coder sorted through the transcripts and made notes, the researcher and coder met to discuss and compare the categories confirming initial coding choices. Through exhaustive dialogues about the transcripts, an agreement was achieved regarding the various demonstrations of social support and categories were then utilized to draw findings.

Findings

The overall purpose of this study is to better understand the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed and how that support is communicated through interpersonal relationships and from community-based breastfeeding champions. This chapter provides the methods and findings from Research Question 3, which asks: How do breastfeeding champions report providing social support about their choice to breastfeed for the clients (the mothers)? Breastfeeding champions are defined as individuals who work (paid or volunteer) to

provide assistance to mothers with infants and are in the community level of the social ecological model (SEM).

The community level of the SEM is defined as the various community institutions which help create community health norms (CDC, 2014; Meeks, 2002). For breastfeeding, these institutions include the hospitals in which the mothers deliver and the nurses that assist them, locally limited social media based support groups, Le Leche League, public health departments and the programs they house such as HANDS, and breastfeeding peer counselors. The availability of these institutions can be critical for any breastfeeding mother, but especially if there is a lack of social support in other areas such as interpersonal relationships (Goodman, Majee, Olsberg & Jefferson, 2016; HHS, 2011).

To answer research question 3, breastfeeding champions recalled their various communication and experiences with breastfeeding mothers. This chapter describes the social support interactions that consist of emotional support, tangible support, and informational support. Additionally, due to the divergence between mothers' and grandmothers' perceptions of support offered and received, the breastfeeding champions provide their observances of interaction between mothers and grandmothers.

Emotional Support

With the changes that accompany the arrival of a new child in a mother's life, emotional support is an important part of coping (CDC, 2013). Breastfeeding champions provided emotional support through the recognition that the mother is stressed, reassurance, empathy, empowerment and congratulations offered to the mother. The section below offers descriptions of emotional support offered to mothers through communication and actions of the breastfeeding champions.

Recognition of stress. Breastfeeding champions have a unique insight to the stress that a mother may be feeling with the birth of a new child. Whereas people that the mother is usually surrounded by may not recognize the stress that the mother is experiencing, a person who is outside of the interpersonal network may recognize the strain of a new child and breastfeeding. Lily, who works at a health department, made an overall observation about the stress that mothers seem to be under. She states:

I do believe that there are some women who have no additional support. Either their families are not here, their partners have to go back to work and they are home alone with a new baby, and if they have other children, other constraints...I believe in some cases they're overwhelmed.

The breastfeeding peer counselor, Heather, made the observation that mothers she sees are overwhelmed as well and described how she asks the mothers to call her so that she can assist. She shared:

Being a new mom is difficult anyway and so it's very overwhelming. You got all those hormones, and you're emotional. Actually moms sometimes call me and sometimes it's 10:00 at night, 11:00 at night, whatever, and I always let all my moms know, "I don't care what time of day or night it is. If you need me, call me."

She continued to describe how she can be reached at any time and how that availability can be relief to an overwhelmed mother. She said:

I know that breastfeeding troubles don't always come in regular business hours. I think that is probably the most helpful thing... You really don't have to make an appointment; you know? If you need to talk, just give a call. And if a mom needs a home visit or something like that, sometimes it takes me a day to work it out, but typically, I can be there the same day, she don't always get that kind of convenience with a medical professional.

Kay recognized that a component of the stress that a breastfeeding mother feels is from frustration; and she describes how she talks with a mom that is feeling frustrated.

She said:

They'll call me, and sometimes they just need to vent to me and just express their frustrations, what they're doing, and just hear me say, "Let's just take it for tonight, minute-by-minute if you need to. Let's make it through this night and we'll reevaluate in the morning."

In addition to just recognition that there is stress and frustration, breastfeeding champions ask mothers a lot of question so to better understand what the mother is feeling and how the transition with the new baby is going. Sarah explains how she inquires with mothers:

So [I] go into the home within one to two weeks after the baby is born, and sit down with them and just say, "[Name], how are you feeling? How are you doing? "How is the adjustment period been?" Because some of them have older children. "How is that going? How is the dog handling things? How are you handling things? How is your relationship?" And we talk about all of that, but then we move into, "How's feeding going?"

Edith identified her last interaction with a mother and the questions that she asks so that she would be better able to help the mother and allow the mother to talk about anything related to the baby, not just breastfeeding. She described her interaction:

And I sat with here for probably an hour and a half. Slowly talking to her, asking her questions about, "Well, how is motherhood to you? How are things going? Not even just breastfeeding," and just asking her a few questions on how she was. You know, letting her know, "Hey, I'm here to help you. I care," those kinds of things.

Heather sometimes communicates with the new mothers via text, which is an avenue that is not an option for all breastfeeding champions but she feels works well for her and her clients. She said:

I like having my cell phone, when I work from home, being able to talk to them often. And I know not all health departments do it this way, but I'm allowed to text. So in today's times, that's the best way to [laughter] get a response, it seems like. I can text a mom and just be like, "Hey, how are things goin'?" Things like that. Being able to get that kind of communication with them, just a little bit like, "Hey, I'm thinking about you, I just wanna be sure you're alright."

Katie discusses how she tries to prepare the mother during the pregnancy for breastfeeding. By asking the mother what her fears may be at this time, the hope is to alleviate some of the stress that may come when there is a newborn baby. She shares how she starts the conversation with mothers:

[I ask] “What questions do you have? What can I tell you now about it? Did you know this? Did you know this? About this? I just found this out.” “Just with that baby sucking his thumb now at this age, gestation. Do you know what that means in the way of transferring actually to breast in the future?” “Do you know this? That?” Those kind of things.” She adds, “Tell me what you’re thinking. What are your fears? What are your concerns? What can we do to help you maybe dump those fears before you ever even deliver?” So that she approaches this with no fear because that seems to be the most fearful thing, actually. If I had a nickel for every time I hear a mom go, “I wasn’t worried about labor and delivery. I was worried about breastfeeding.”

Breastfeeding champions have observed that mothers seemed stressed about breastfeeding and use questions to learn about how the mother is feeling, what concerns she may be having. This allows the breastfeeding champion to apply the information that she has learned to reassure the mother.

Reassurance. Breastfeeding champions often have had to provide reassurance to mothers. This was demonstrated in their communication that the mothers’ experiences were normal and they were doing a good job. Carrie stated, “I try to let them know that what they’re goin’ through is normal. You know? Certain situations that moms may not have ever heard of regarding breastfeeding. Makes them feel like they’re the only one.”

Christy shared:

If I know that I have helped her identify that she’s experiencing strong emotions and helped her release some of those emotions, and usually the way that we handle that situation is to just let the mom vent and let her

know that it's a safe space to get that out and that it is perfectly normal, and moms do it all the time.

Kay discussed how she interacts with a mother that is having a challenging time with breastfeeding. She stated, "I always try to reassure them that they're doing a great job, because that's something I know every mom is worried about, you know, they're concerned about their baby." Natalie shared how she works with mothers to make and meet goals while providing reassurance. She shared, "And to meet those goals—and it's all reassurance to her, that what she's doing, she's doing it right, she's doing it well. As a mom, she is succeeding in what she wants to do."

Rita discussed that when mothers call in tears worried about their child, she reassures the mothers that they are doing a wonderful job. Further, she said it is a good call when "a mom is tears when she calls, [and] is laughing by the end." Sarah explained how she reassures mothers who are concerned about being able to breastfeed or who are having a hard time with breastfeeding. She said:

I like to encourage women who think that they aren't able to do it, so whatever it is, I talk to them. I don't like to push it. Some people just aren't comfortable with it for whatever reason. But I do like to encourage and reaffirm any reservations they may have about it, try to make them feel more comfortable. I would just try to be reassuring to them that what they're doing is best for them and their baby.

Many of the breastfeeding champions also described their job as being on the "team" of the mother, and that they are there to support her. Nicole shared, "you just kinda have to make yourself available and be very sensitive to the mom. And assuring her, you know. I mean she needs to know that we're on her team." Elizabeth described her job as a cheerleader and why it is so important, "We are kind of mom's initial cheerleading squad. We are the ones who are there encouraging her, supporting her,

affirming her. Laying down that good foundation in the beginning is important for overall success.”

Empathy. Empathy is demonstrated through the breastfeeding champions’ understanding and sharing of the feelings of the mother during the joys and challenges of breastfeeding. Breastfeeding champions work hard to demonstrate to the mother that they understand the challenges that the mother is facing. Heather shared:

I feel like when I go to a doctor or things like that, it makes me feel uncomfortable because I always feel like I’m being looked down upon because they have this degree and that they’re over me kinda thing. I really try to relate to them [the mothers], mom-to-mom, not peer counselor and patient, or whatever. Like mom-to-mom, “I’ve been here.” “This is what I’ve been through. Let me try to help you,” kinda thing.

Lily described how she shows empathy for the mothers that she works for through every interaction with her. She said:

Definitely being respectful and not judging, of course, and making her feel calm, making her feel like she’s the only person you talk to. Like, she’s not just another number that you’re helping or another person. You actually care. You actually want to help her. You want to do the best for her and her child, of course. And you’re really there. You’re really listening. You’re really there to assist her in her struggle or whatever the issue is.

Carrie, the Le Leche League leader describes how important listening is to the mother and further, that empathizing with the mother is just as important as any technical assistance that they may provide. She shared:

We take a step back and say that in addition to being a source of technical breastfeeding information, La Leche League really emphasizes that the emotional wellbeing of the moms is really key to the success of the breastfeeding relationship. And so being emotionally supportive of the mom is almost as important as the technical expertise of a leader.

Empowerment. Breastfeeding champions provide emotional support through empowering breastfeeding mothers which allows them to enhance their self-efficacy and

achieve their goals for breastfeeding. Elizabeth described her feelings about the mothers who are not sure if they want to breastfeed or not and what is at the heart of her efforts to support the mother. She said:

You don't have to breastfeed. Like I am not one of those people that say, "You have to do it this way," but if that woman wants to do it and she wants it badly, then we wanna uplift her and help her in any way possible.

Meghan shared:

I really do feel like it's a very empowering thing to do - to support mom and baby. And I think that's what my role is ultimately, I'm supposed to support a fellow woman in her choice and in her need of how to care for her child. And there's a lot more to it than just providing breast milk.

Katie described the work she does as just assisting the mother, and believes that the mother should recognize that she is the one who is doing all the work. She explained:

And I get a lot of thanks for helping, I couldn't have done this without you and I always tell the mother, "Actually, you did all the work. You know, I just gave you the information and you're the one who did it all, so you don't owe me anything." You did it. And you know, and they just kinda get that smile. They're like, you know, "Yeah, you're right. I did do this. I am pretty cool."

Some mothers may not be sure about breastfeeding. Edith explained how she handles an unsure mother who is in the hospital just after birth. She shared:

I typically do a lot of just encouragement and re-affirmation of how good they're doing and how this is difficult in the beginning and it gets easier over time. And I discuss with mothers, especially who weren't planning on doing it, a lot of times they sometimes aren't aware of how difficult it can be in the beginning. They have this ideal of you know, babies sleep and wake up and eat every three hours and go to sleep and sometimes, especially in the first week or so, that's not necessarily true. And you know, babies are kind of breastfeeding around the clock the first few days.

Nicole identified her observations of mothers and her interactions with them after birth.

She shared:

They can be pretty tired after delivery and the mother who is really motivated they will just you know get up and meet that baby's needs. No matter how tired they are, because it's just that important to them. And yes, mothers who you really feel like you're empowering and they're doing good, they just get this smile, you know. It's a wonderful feeling to give a mother that level of confidence in her ability to mother her baby. And you can tell that they just feel more confident in what they're doing.

Natalie described the involvement she had with a mother who was experiencing challenges and continued to work through them and ultimately, empowered other mothers. She said:

A mom began coming to meetings when her baby was new, she was struggling, and expect that she would come again next month. She would stick it out another month. And then she would stick it out another—and at the first meeting she would cry because she was so frustrated. And then eight months later she's still coming back and is offering kind of a hypothetical shoulder to cry on to the other new moms who are very frustrated. I think that that is probably the most gratifying situation that I've seen, where a mom realizes that she not only met her own goals, but is now equipped to help other moms who are in the same situation.

Empowerment can be a powerful tool for motivating mothers who are tired and frustrated that they can breastfeed and many breastfeeding champions use that tool to assist breastfeeding mothers. Once mothers have overcome a challenge or met a goal, the offering of congratulations can be used to provide emotional support for their efforts.

Praise / Congratulations. The use of congratulations for a mother who has overcome a challenge or worked through an issue, or even just continuing breastfeeding, was a component to the emotional support that breastfeeding champions provided.

Heather discussed how she works to offer praise for a mother. She shared:

I always try to congratulate moms every time I talk to them, whether they've made it a week or they've made it a year. I really try to celebrate with them, congratulate them, let them know what they're doing is a big deal. And then sometimes they get discouraged because they think, "Well, it's just a week," but I do try to let them know "That's a great thing for

your baby.” That formula can never give them the colostrum and things. And I do try to congratulate every mom and let them know, I am proud of them when they succeed.

Kay discussed how congratulating the mothers when they have gotten through challenges helps when they have made progress:

And when they do have problems, I get back with them, I follow up with them the next day. So I can check with them and how they’re doing that day to see if they’ve made progress. And then obviously, you wanna congratulate ‘em on the progress and then work on the next day.

Katie spoke about her postpartum visits and shared, “at the postpartum visit, and most of the time, I give them a hug when I’m leaving. I tell them congratulations [and] enjoy their baby.”

Emotional support is one of the three main components of social support.

Although friends and family often provide this type of support, breastfeeding champions also provided a significant amount of emotional support.

Tangible Support

Tangible support, also known as practical support, is the hands-on assistance that is given such as in helping a mother with positioning the baby or the baby’s latch, physical assistance with other problems or issues that arise concerning breastfeeding, and the provision of resources that directly help the mother with breastfeeding.

Latching on / Positioning the baby. The latch for a breastfeeding mother is important, not only for the ability of the baby to get the milk, but also for the physical comfort of the mother. If there is not a good latch, there can be problems with weight gain for the baby and pain for the mother. Breastfeeding champions assisted mothers with the baby’s latch and positioning through hands-on work of actually moving the baby so that he or she could get breastmilk properly. Kay shared:

I do want to like not overstep boundaries. But a lot of times actually helping position the baby the correct way helps moms to understand, “okay, this is the way the baby needs to be held.” This is what needs to happen.

Similarly, Lily commented, “if I had a woman who was havin' particular difficulties and she was becomin' very discouraged, I would go to her home and work with her one-on-one and show her the correct positioning and help with the latch-on.” Nicole discussed how she assists with newborn babies and mothers:

After baby is born and mom comes in for the mom and new baby appointment, sometimes they'll bring babies. Sometimes they won't. It just depends cuz it's up to them, but if they're having trouble with latching and they bring baby, then, if they're comfortable with it, we'll try to latch baby right here, and do it in-office, put baby to the breast and teach mom how to hold baby.

Meghan described how she actually assisted with her sister who was having trouble with the position of her child:

My sister actually, with her last one she had trouble at first... She was told the wrong way to hold the baby and how the baby should latch and things like that. And I had went over and showed her how the baby should latch, and how to get in different positions, nurse more comfortably. And she was ready to give up at the beginning. She said she couldn't do it. She was in pain. It was sore. He wouldn't latch, she would continue to cry. And I was able to show her how to get him latched on correctly.

When a mother is having trouble with breastfeeding, the doula may work with the mother to make sure that the mother and baby are both getting what they need for successful breastfeeding. Elizabeth shared:

Based on baby's output, weight log, vigor at breast, milk transfer. and we kinda go from there on where to go, with breastfeeding. If breastfeeding is going well but mother has some sore nipples, we'll deepen the latch or show her techniques to deepen the latch. If baby's not drinking very well, we'll show her how to massage the breast during feeding to increase milk intake.

Katie shared how she works “hands-on” with mothers. She describes her role and how she works with moms to position the baby:

Pretty much all of my support is hands-on, technical. A lot of times we have mothers who just aren't quite sure [about breastfeeding]. They come out and they're like, “Oh, this-this should be natural, it should happen easily.” But sometimes how you hold a baby to breast feed and how a baby comes through it doesn't really feel that natural. It can feel very awkward. It can feel like you and baby are working against each other instead of with each other. So there's a lot of hands-on support and technical assistance in showing the mother how to position a baby to breast feed. How the alignment of baby's body with mother's body works best with breastfeeding. And how to position the breast before baby goes to latch and position the nipple to allow for an optimal latch, especially if the baby is kind of shallow on the latch. And showing the mom how to hold her breast, how to position her nipple. We show moms how to hand express their milk, to feed baby cuz every mother should know how to get her milk out of her breast without baby should the need arise.

Rita explained how she assists with mothers to ensure that breastfeeding is going well shared:

Often we observe the baby nursing. And then may provide provisioning suggestions and during the course of a nursing session, intervene and suggest modifications to the way that the mom is approaching nursing, or involving the way she holds her breast or position of the baby.

In addition to latch issues and position problems, a mother may have other issues that a breastfeeding champion may assist with to ensure a better breastfeeding experience.

Assisting with other breastfeeding problems and issues. A mother may encounter problems during breastfeeding that make breastfeeding difficult or painful to do. As such, breastfeeding champions discussed the various tangible support that they have offered to mothers who are experiencing issues beyond just a latch or a positioning of the child.

Sarah described how she handles mothers who may be having trouble with some of the challenges of breastfeeding. She said, “I give recommendations for comfort measures and

what she [the mother] could do to help alleviate breast engorgement or leaking, cracked nipples, whatever the case may be.” Carrie tells how she works with the mother to create a plan to handle feeding, especially when the infant is new and the mother may not know what to do:

Depending on the complexity of the situation, sometimes we [the mother and breastfeeding champion] draw up a plan of action. A feeding plan moving forward and how to approach the situation. And it’s very important to leave things written down for newborn moms who have to rest because it’s very difficult for her to retain information otherwise.

Katie described her efforts to assist a new mother while in the hospital by actually hand expressing milk for the baby. She shared:

I’ve even hand expressed time like mom do you want me to just hand express some milk for your baby? And she’ll be there, she’ll say, “Yes, please,” but she’ll be falling asleep so I’m kind of hand expressing and she’s kinda just snoring for a little bit. She’ll wake up every now and again and try to help, but some of them just really exhausted. They just can’t or just in one minute, out the other.

Heather discussed how she assisted a mother who was having problems getting a breast pump and the outcome of her assistance:

And she [the mother] was in a situation where really she was having trouble getting a pump from WIC because she was a stay-at-home mom. And so I was able to make contacts in the community and offer some suggestions of how to approach that. And ultimately after she put in a lotta hard work, and I think after meeting with her at the meeting we had probably three different phone calls and two home visits after that. And she was after that able to fully breastfeed her daughter who continued to gain well.

Christy also discussed how the peer counselor could be of great tangible support though the one-on-one assistance that she is able to offer mothers. She described the importance of that role and how the community is enhancing it to make the peer counselor more available for mothers:

What we're doing to enhance that [the role of the peer counselor], we're gonna have her actually work onsite cuz the way it's written up in her contract is that it is an at-home job, and she can do a lot of her things at home. But then, she can meet with patients one-on-one if they want, but her new contract now states she's going to be in our Health Department once a week. So what we can do now is we can say, "Hey, come on this day," it's probably gonna be on Tuesdays. "Come on Tuesday. [The peer counselor] will be here." That way, it takes out the worry of, "Well, when's that? Do I have to call her?" They can just come. They don't have to have an appointment. They just come, and she can chat with them. They will know that she's always here on that day. She can host little fun things. She can do like, more support group system—more support groups than she already is. So more availability to them and less, I guess, less barriers of them worrying about, "Oh, well, I don't want [the peer counselor] to come to my home," or, "That date won't work for me." So linking-up with [the peer counselor's] schedule, their schedule, we can take all that out of it, and just say, "Hey, she's here on Tuesdays from this time to this time. Come any—anytime between that time. It's up to you." That way, if they're late, they don't have to be late because they don't have to have an appointment. They just come. Now, if she's talking to someone else, they're gonna have to wait a few minutes, but, for the most part, they don't have to worry about, "Well, I have to pick my daughter up," or, "I had to do this." so it takes out that guesswork of just, "I was gonna be 15 minutes late, so I didn't come."

A doula has a unique role in assisting a mother. Elizabeth described the tangible support that the role requires:

And so they know for the first six weeks, or however often they wanna hire, that someone's gonna come to their home three days a week during the day for five hours, and they're gonna have real, adult interaction, and they're gonna be able to shower, and they're gonna have someone fixing them snacks and pampering them and going out with them the first time that they go to the grocery store by themselves, with the baby and taking the baby to the pediatrician's visit. Like, people don't think about, "How am I gonna do that? What do I need in the diaper bag?" so having that support, knowing that people are gonna come twice a week in the night and stay for ten hours and hold the baby and soothe the baby and just bring the baby to you for breastfeeding if you're breastfeeding, take the baby back out of the room and take care of the baby for a full ten hours so you can sleep well because if you sleep well, you're gonna do better, you know?

Provision of resources. Breastfeeding champions also demonstrated tangible support through the offering of resources to mothers. Rita described the various jobs that she does to make sure that mother and child will have all the equipment they need for successful breastfeeding experience. She shared:

I work with durable medical equipment (DME) supply companies. I'll get the prescriptions. I'll get the face sheets, the insurance information. I'll fax it to the DMEs for the mothers now. We get 'em delivered before they go home, nine times out of ten. We do it all like that. We've made it very easy that way, one stop shopping. We teach 'em how to use the pump. We set it up for 'em. In fact, sometimes I feel like that's all I do, out of a 12-hour day.

Edith also commented on the importance of getting the pumps. She stated, "we support the pumping. We get 'em the pumps. We make sure they've got everything they need."

As for community efforts, Carrie described their Rock N' Relax station that provides a place for breastfeeding others when at a local festival. This station allows breastfeeding mothers the opportunity to enjoy the festival and feel like they can stay and have a safe place to take care of their newborn. She explained:

We currently provide a Rock and Relax station at certain events in [XXX] County, which is a place where moms can go in a private area and feed baby, nurse baby et cetera, to diaper change also...like I said it is a feeding station for moms that nurse. I mean, obviously, we'll let any mom come in there and feed their baby, no matter how they're feeding their baby, but that's what it's primarily for. It's just a quiet [place]. We've supplied diapers, wipes, water, just a nice little area that moms can chill out with their babies for a little bit.

Tangible support is offered by the breastfeeding champions in a variety of ways, from providing assistance with positioning to providing a place to breastfeed. The provision of this type of social support offers mothers access to tools that without the breastfeeding champions support, the mother may not otherwise have had.

Informational Support

The last area of social support provision is informational support. Breastfeeding champions provided this through the provision of information through various sources including face-to-face interaction, the addressing of myths of breastfeeding that mothers hear, and the impact of the information that is shared.

Provision of information. Breastfeeding champions provided information to mothers through a variety of mediums: visuals, brochures, books, face-to-face interaction. Visuals were commonly used among the breastfeeding champions to illustrate how to latch or proper technique for breastfeeding, which can be important before the baby is born or when the baby was not with the mother during the interaction with the breastfeeding champion. Handouts gave mothers information as Natalie recalls, “We’ve got visuals on handouts that talk about how to latch baby, or we’ll pull up videos on our computer to show mom and continue to follow-up with mom.” Carrie described how the health department has a bulletin board that provides information to mothers. She described the visual aids at the office, “We have, on both of our bulletin boards, breastfeeding information. We have breastfeeding posters throughout our Health Department. [Laughter] So we just really want them to see that message.” She further describes the bulletin boards:

It’s just looks like the Legos that are built up, and it says on one side what breastmilk has. And it’s actually in our WIC approved food list, too. It’s actually from the California Department of Health Services, so that’s where it originally comes from. But it’s Legos, and it has ingredients that formula has - the basic ingredients for that. And then it has the all the components of breastmilk, the antibodies, the anti-cancer, the enzymes, the hormones, the anti-allergy, probiotics, all the things that breastmilk can supply that formula never can supply and never can replicate.

Videos were also provided as a way to visually share information with mothers. Kay shared, “Sometimes I’ll even pull up YouTube on the computer because there’s all kinds of wonderful resources on there that you can find that shows a baby latching for nursing purposes.”

Breastfeeding champions present information to mothers in the form of brochures, handouts, and books. Sarah described the large amount of information that she and other HANDS workers provide mothers, “It’s a big packet of information, so what we’ll do is we’ll get that packet out, and we’ll go over a few of those handouts, especially the handout about the benefits of breastfeeding.” Lily described the book that she, and others working with her, provide to mothers who have just had a baby. She said:

We have a nice printed book that’s about this thick that has everything you wanna know but was afraid to ask. It has our phone number on the very front of it to the office... It talks about everything about the very beginning of life, and then, as you go further out, breastfeeding, all about nutrition for mom, and pumping and milk storage. If they would read the book, it would be fabulous... when I first started, two and a half years ago they were given a bunch of handouts, too, those handouts from WIC here in Kentucky, and all very nice, but they were photocopying all that. I’m just like, “Oh, my god, guys, this is just repetitive. Please don’t do this.” So we have backed off from a lot of handouts. But it [the book] talks about positioning and latch. It talks about like dry dirty diapers in the first seven days of life. It talks about those kinds of things that everybody’s so worried about. “How am I gonna know my kid’s okay?” And then the rest of the book, I tell ‘em, “Hey, this is a really good resource. Hang onto it. It’s better than Googling at 2:00 in the morning.” I do highlight [parts of the book] on days of discharge, engorgement, sore nipples because I’m like, “Don’t bother Googling engorgement. The treatment plan’s right there, page 20.” I still get phone calls, 2:00 in the morning. There’s a message on the machine. “I’m engorged. What do I do?” Page 20. Then I highlight our office number and say, “If nothing else, just rip the front of book off and save the office number. Put it on your refrigerator and call us.”

Breastfeeding champions also provided information to mothers through one-on-one communication. This consisted of talking to the mothers about the information they had received as well as providing personal stories and advice. Sarah discussed how she goes to talk to new mothers at the hospital. She said: “I actually go to the hospital three days a week...and we [HANDS workers] visit with every new mom that just had a baby on the maternity floor.” Katie talked about how they she first approached mothers. She shared:

Cuz I see sometimes, when I talk about breastfeeding to moms, that sometimes you can just kinda see the panic [laughter] in their face. So trying to tell them that, “Hey, you know, I know this is new and any time we try something new, there’s definitely gonna be a learning curve, but that’s why we’re here.

Similarly, Meghan discussed how the information in a resource packet is used to start the conversation. She explained:

One of the things in that initial visit, when I am going through the resource packet with them and I bring up the breastfeeding, I ask “How do you feel about breastfeeding?” or, “What do you know about breastfeeding?” A lotta times, in those initial visits they’ve either just learned about their pregnancy or they just had a new baby. I feel like the prenatal moms I have that opportunity to plant that seed, as I mentioned before. And so just kinda opening up that conversation; how do you feel about it? What do you know? Did you know that there’s lots of benefits for mom and baby? and that kinda sparks that conversation and it gets them thinking.

The information that breastfeeding champions provide to mothers is rooted in the need of the particular mother that they are assisting. However, there is certain information that breastfeeding champion consistently offer all mothers that they see. The champions discussed various information that is shared with mothers in their face-to-face communication. This communication starts right after acknowledging pregnancy of the mother for Carrie. She describes how she starts talking to the mother early in the process:

We talk about breastfeeding many times throughout the pregnancy. In their initial screening when they're first—on their appointment here, when they have a positive pregnancy test, we talk to them about breastfeeding and tell them the recommendations of the American Academy of Pediatrics, World Health Organization, throughout the pregnancy, of course, we reinforce that information at their usual visits.

Edith talked about the information that she provides mothers. She stated, “I just tell them about the recommendations of the AAP, some of the benefits, and then later on we get into more of the sustainability of breastfeeding, how supply and demand and positioning, latch on—all that is helpful.” Nicole shared:

I let them know that the American Academy of Pediatrics recommends that they breastfeed exclusively for the first six months. And, of course, we talk to them about the skin-to-skin or kangaroo care. And [the hospital] is a baby-friendly hospital, talk about those benefits of breastfeeding early on and how it helps reduce the incidence of childhood illnesses and also helps mothers to help lower the risk of breast and ovarian cancer and lots of other benefits that—that we talk about at various times.

Sarah also explained that she often discusses the benefits of breastfeeding with mothers. She said:

Going through some of the benefits, “Did you know that if you breastfeed your risk of ovarian cancer later in life goes down?” One of the biggest benefits I think that people can really relate to that's more tangible is that breastfeeding's free. That's a big one that kinda sparks their attention, talking about the cost of formula.

In addition to the research-based information that breastfeeding champions provide mothers, they also provide personal stories and advice to assist in supporting mothers through their breastfeeding experience.

Personal information was also shared with mothers. Carrie shared story about a time when she thought that telling a personal story helped that mother:

Just recently I had a mom tell me that she was nervous. And I thought she was talking about delivery, but she was talking about breastfeeding. So

that allowed me to open up and talk to her a little bit about my experience, and I feel like sometimes letting them in on my personal story makes them feel a little bit more of a connection with me.

Rita echoed Carrie about establishing connection with mothers through the use of personal stories. She discussed how she uses both factual information and personal experiences:

I try to use facts [but] I'll use personal experience if I can. I think a lot of people relate to somebody who's had personal experience rather than, "Oh, I read this from a book." But I also try to give if I can, some kind of factual evidence. –For example, this is from the La Leche League. This is from the American Academy of Pediatrics and such and such... But I will say I think personal experience helps a lot when you tell somebody, and I think they feel more apt to trust you because you opened up to them.

Last, Christy described how she related to the mothers. She said:

Honestly feel I can give 'em the information, but they like hearing personal stories. I feel like they do because I feel like my patients, especially if it's after the initial, or if they've been one of my moms for a while, and this is their third pregnancy or what have ya, I feel like I know them, know them because we see them every three months, and sometimes even more, depending on what's going on... And I feel like because I did have issues with feeding my second child, I know what they're going through. I can definitely relate to them if they've breastfed before and had problems. Cuz some of 'em will say, "Oh, I breastfed my first baby, and it was a nightmare," or, "It was this," or, "I couldn't do this." Then that's where I will tell them or tie in my personal story, and with my first child and then on working with my second —just personalization helps.

Breastfeeding champions also have to make suggestions to the mothers for handling unsound advice they received. Katie explained, "A lot of times mothers are getting information from other mothers and sometimes that can be a beautiful thing and sometimes that can be an awful thing because they're just comparing their own experiences and not what evidence says [is best]". Additionally, Natalie described the

difficulty that occurs when the wrong advice comes from another medical professional.

She explained:

It's a fine line, and it depends on who it comes from. If it's comin' from another lactation consultant, what I'll typically say is something like, " I wasn't there during the counseling session so I don't know everything that she would've said to you or "I don't know what she would've said to you. This is what we know about how human physiology works." So I'll try to provide neutral information instead of saying something like, "Well, that's full of crap," although I wanna say that.

Further, Meghan explained how she is cautious about contradicting information that was given to the mother by a doctor:

When information that is countered to the standard advice and understanding of the professional lactation community is presented by someone who is in the position of authority, it's very difficult. And has to be handled sensitively, because on the one hand you don't wanna go contradicting what a physician has told a mom.

There are times when a breastfeeding champion has difficulty talking to a new mother about breastfeeding or the provision of social support is not warmly received. Heather lamented:

It's hard because if I don't know they're having a problem, I can't help them work through it...I know some people are just never gonna open up to me, and I'm okay with that. But you know, I wish people would, just for the simple fact that I could be so much more help to them if they actually opened up to me.

Another breastfeeding champion shares analogous feelings. Katie explained, "It's hard especially when they don't open up to you...So, [I'm] just trying to find ways to reach out to mom." Nicole discloses, "Many [mothers] are appreciative, but there's also those that they're gonna believe what they want to believe no matter how much information you give them." In a likewise situation, Lily shares her experiences with mothers not as receptive to the information she is trying to give:

I think, maybe, after baby's born, sometimes certain people will want to rely on their doctor. And that's fine as long as their doctor's giving them the right information. [Laughter]... Before I can even go over breastfeeding, they'll say, "I'm not breastfeeding." And the way I'll handle that is I'll just say, "Well, do you mind if I ask why that you don't wanna breastfeeding?" And then, just depending on what they tell me is how I cater my next thought to them. But if they won't give me a reason—cuz some moms are closed off, and they'll just say, "Just cuz I just don't want to," then I will continue. I'll say, "Well, that's okay, but I still wanna chat with you just a little bit about that today, if that's okay with you, because I don't want you to miss an opportunity to learn about all the wonderful benefits of breastfeeding. And then I go into my spiel, because I still want them to hear it because there might be some part of my education piece that we give them that changes their mind. So, even if they say, "No, absolutely not," I don't stop. [Laughter] Now I won't like I won't beat it into the ground and say, "Well, now do you wanna breastfeed?" But, I still want to give them that information.

Addressing myths. When a mother is breastfeeding the child, she may hear or believe myths that she has encountered about breastfeeding. The breastfeeding champions talked about addressing myths related to milk supply. Meghan shared how she discusses milk supply when a mother comes in and says that she is not producing enough milk. She shared:

I hear, "I'm not producing enough milk." And then we [the mother and I] go through, "How often are you nursing?" If they're nursing and they're pumping, how frequent is that? We talk about milk supply, supply and demand. We talk about mom taking a prenatal vitamin or multivitamin? Is she drinking lots of water? Is she eating well? Is mom smoking? Because smoking, of course, it decreases breastmilk. Talk about what other medications mom might be on. If she's on any, we talk about those, and if that affects breastmilk supply.

Additionally, Rita recalled her experience:

Somebody messaged me not knowing if their child was getting enough breast milk. They felt that he was eating a lot and wasn't getting full. And I would begin asking, how many times are you breastfeeding? About how long? And then I would ask are they having wet diapers? - Just asking simple questions at first and then I would ask what are your concerns? Is

the baby crying uncontrollably? Does the baby seem like it's in pain? Things of that nature. And if they answer no to those questions, then I would continue and say a lot of women will say, "Well, I pumped, and I only got two ounces." And I would explain that pumping does not signify how much you're making or how much the baby is able to get. And I would just reassure them that as long as they're having wet diapers, gaining weight, they are able to sleep, they feel like they're getting satisfaction, then they are more likely getting enough.

The worry that the baby is only getting as much milk as a mother pumps is a common myth. Kay discussed how her clients, too, worry about the baby not getting enough to eat.

She shared:

I think that seems to be one of the biggest concerns that I see from women [milk supply]. And then they'll say, "I pumped, and I only got, say, two ounces," and trying to explain to them that the pump does not signify how much you're actually making because a baby sucking is a lot different than the actual pump working. That's a big concern for mothers.

Christy also sees this concern and uses it as an educational opportunity to provide accurate information regarding how baby's stomach is so small and the mothers' bodies are made to be able to feed the baby:

I think one of the biggest things that I see continually when moms have a new baby that is formula feeding you can see how much you're feeding your baby. You can see the bottle that you've made. You can see how much they've eaten. With breastfeeding you don't see that, and so that's a really great opportunity to educate mothers on the fact that their bodies know how much to feed their baby and that newborns' stomachs are so tiny and they only need that little bit. And so I think that that's something that it's not just one mom who asks that, but that's something that I continually see is "how do I know when my baby's getting enough." Or "I can't see if my baby's getting anything"; "I don't think he's getting anything". Just really educating them about the fact that their bodies really are amazing and that they can if their baby seems satisfied, that they're getting enough"

Sarah describes a myth that she hears often:

Especially in Kentucky, in this area, you hear a lotta people say, “Don’t you pick that baby up when it cries. You’re gonna spoil him.” And so we talk a lot about that. And people will sometimes be like, “[Sarah], you’re a liar,” when I say you can’t spoil a baby under six months of age. They’ll be like, “[Sarah], he is spoiled. You’re lying,” so sometimes there’s things like that...I mean I just reiterate I’m not. This is research-based, evidence-based information. All of the information in our curriculum is evidence-based and research-based, and so I’ll be like, “No, I’m not,” and I just kinda joke with them from there, but being serious, like, “No, it’s true.” And then we again just kinda give them the information that we can.

And last, Carrie discussed how important correcting these myths is as she explained:

The biggest thing that I address is the myths surrounding breastfeeding... I think it’s important that my patients, my moms, I wanna correct them and let them know the truth about breastfeeding, but even more so they can go and tell the next person. And then the next person tells the next person. And I would love to see a time when all of those myths that we see surrounding breastfeeding are just gone. You know? The breast size issue not making enough milk, all these different things. I wish that no one would hear those things. It’s so discouraging, and most of it not even true in the slightest bit.

Mothers may hear lots of different information while they are pregnant and after the birth of the child. Breastfeeding champions have important insight to correct information and in relaying that information, they may be addressing myths and inaccurate information. Over all, when breastfeeding champion have been able to either share new information or correct inaccurate information, the impact can be sustaining for breastfeeding mothers.

Influence of provided information. Breastfeeding champions do see mothers influenced by their informational support. Many described their experiences with mothers who have successful outcomes due to their education. Heather shared this experience with a newly pregnant mother who had told her that she did not want to breastfeed:

I sent her some information in the mail - Some of my favorites [handouts/ brochures] on the benefits and things like that. In the end of the next month I called her to check in on her, and she was still pregnant. And she had told me that she had looked over it and she had considered it, and that when she got to the hospital, she wanted to try. So when she had her baby, I stayed real close with her as far as talking to her often in a hospital visit. And she actually ended up breastfeeding for four or five months. Now, typically, we wanna aim for a year but that mom, all her goal was to try. And so, from going to absolutely not to four to five months, that's great.

Nicole talked about how the information provided about the benefits of breastmilk versus formula sometimes just clicks with a mother, "when I show them that [information] and explain that to them in detail, that's when you'll see sometimes the light bulb go on and they'll say, "Wow, I did not know there was such a difference. I'm definitely gonna breastfeed my baby." The ability to get the information to the mother makes a great impact on the initiation of breastfeeding. She continued, "I've heard more than one mom say, "Well, I never knew that." And it is wonderful to see that change, they are willing to try [breastfeeding] now."

Kay described an experience she had with a mother who was not going to breastfeed but changed her mind when the baby latched on its own:

We had a mother, she was actually an African American mother and she was not planning on breast feeding, so we had to do a lot of informational support. And what happened is we, at our hospital, do skin-to-skin initially, right after birth, after baby is born they're placed on mother directly for warming up. This baby just happened to latch and breastfeed during that transitional period, and the mother found that she was okay with it. Where initially she didn't think she would be. And this mother needed a lot of information about breast feeding. Just probably stuff she didn't think she would need before because she wasn't planning on breast feeding, and so we did a lot of talks and just talking with her about the benefits of breast feeding the baby, the benefits of breast feeding to her body. And you could just see that she was just really absorbing this information and running with it...just really processing it. I followed up with her and she was still breast feeding and she's still very motivated about it. And she said she was starting to talk to her friends about it. I'm

hoping that she went out into her community and shared her excitement over this. Someone who had formula-fed her other children, didn't think she would like breast feeding, started to do it, found out it was a lot nicer than what she had assumed and ran with it.

Similarly, Elizabeth explained how rewarded she feels when there have been successful effects on a mother breastfeeding, no matter how small:

I love hearing from somebody that, "I took that advice, and I was able to breastfeed. My child latched correctly, and we breast-fed, and he slept all night," or "He's finally gaining weight." That's for me personally, rewarding just to know that I've helped somebody be able to do something, and something that that a lot of people think is so minuscule. It's such a small thing, but for me, that's a huge thing.

Clearly, informational support is a large part of the support that breastfeeding champions provide their clients, the mothers. To summarize, Carrie said, "We just wanna equip all moms with breastfeeding knowledge when they leave our facility, whether she be pregnant, postpartum, or in between."

Handling Family

As Chapter Three demonstrated there was a divergence in the description of social support given and received between mothers and grandmothers. Further, research has shown that some grandmothers can be of great support but there have also been indications that the grandmother can have a negative impact on breastfeeding sustainment. As such, the researcher also asked the breastfeeding champions to describe what they see and hear in relation to family, specifically grandmothers' interaction with the mothers. Breastfeeding champions had a wide range of encounters with families and grandmothers of mothers.

Breastfeeding champions reported that many mothers encounter a lack of support at home. Nicole shared, "I've noticed a lot of breastfeeding mothers will say "My family

doesn't support; they say just give the baby a bottle. The baby's eating too much, you can't get anything done. Just give the baby a bottle.'" This is also reported from Christy. She said, "I hear a lot of the other outside influences, either friends or family that say, "Well, you don't have enough milk," or you know, "Your breasts aren't big enough," or you know, just comments like that."

Lily discussed an encounter that she had with a mother and the grandmother:

I did have one mom once and the grandma, they're all, "Well, neither one of us can make enough milk," and so she was really discouraged [from breastfeeding] and she was like, "There's no way I'm gonna be able to do this..." And so she had heard basically that it hurts, that your baby's gonna be spoiled. You know? Everything that she could possibly hear negative about breastfeeding, she had heard it all.

Lily then continued to describe how she worked with this mother to encourage breastfeeding despite the negative information she had received from her mother, "And I talked to her and I explained things, because pretty much everything that she heard was just a myth. And so we had talked on the phone for about an hour and the mom slowly had come around." Edith described how she handles a grandmother who may question breastfeeding:

I've heard before, "Well I formula fed my babies, and they were fine." I don't want to insult them, I say, "Yes, yeah, they probably were fine, but wouldn't you love for baby to have such a barrier of protection from viruses, from colds and things like that?" That's when we link in all the benefits that breastmilk can supply that formula can't. I'll use personal stories, especially with my son, about how healthy he has been, being a breastfed baby and how just because I was only able to breastfeed my daughter for seven weeks, versus continually breastfeeding him, about the difference that has been even with my two children. So I'll try to link in personal stories with breastfeeding to moms and to grandmas in our session.

Carrie also shared how she works to educate the family about breastfeeding. She explained:

Well, it's a big part of our job, really, is also educating the family. Because a lot of times when the family comes and they make these comments, they're not typically doing it because they're being mean. Everybody wants what's best for the baby. So a lot of times we spend time educating the father or the mother-in-law or the mother's mother. And that you know that's how we have to do it. We have to educate everybody because everybody's gonna be a part, likely, of this mother's breast feeding journey. Whether it's a good part or a bad part.

Christy described that grandmothers sometimes want to challenge what she says and how she continues to provide facts about the benefits of breastfeeding to combat the lack of knowledge:

At the follow-up visit that I've had grandmas come. And sometimes they'll still say things and want a rebuttal or they want to not challenge. Sort of challenge what you're saying. And just the way I deal with that is just sticking to the message of the benefits. Bringing out that list of benefits of breastfeeding for mom, for baby, just basically being a resource for them. Because I think it's just the knowledge base that they lack.

Sarah discussed her feelings about the mothers' family and she works to educate them just as much as the mother:

A lot of times, it's just fear and that's why they're not supporting them [the mothers] because they just don't know how to support them. So teaching them how often that they can support them would be something that we talk about. A lot of times though, just bringing out that same knowledge, that same information that we've given to mom initially, and just talking like that, the same way that I would talk to mom about breastfeeding.

However, as Nicole notes, educating the family does not guarantee that they will actually listen to what is being said. She explains, "We educate the family, too. But again that after you inform and educate then you can't strong arm 'em so—you know, a lot of times family members will lean towards their family regardless."

Breastfeeding champions recognize that families may not provide mothers with support that is needed for successful breastfeeding outcomes. The reported communication and actions from the breastfeeding champions align more with the reports that the mothers offered about the negative comments and actions from family and grandmothers.

Conclusion

The purpose of Study 2 was to gain a deeper understanding of how breastfeeding champions provide social support to breastfeeding mothers, specifically addressing research question 3 that asked: How do breastfeeding champions report providing social support about their choice to breastfeed for mothers? Breastfeeding champions, who are defined as individuals who work (paid or volunteer) to provide assistance to mothers provided their clients with emotional, tangible, and informational support.

The data collected demonstrated the variety of ways that breastfeeding champions provide social support. Emotional support was provided through recognition that a breastfeeding mother is stressed, empathy, empowerment, and recognition of achievements. Tangible support was demonstrated through the hands-on positioning of the baby to the mothers' breast to get a better latch and therefore, more comfortable for the mother. There were also reports of assistance with other problems and issues related to breastfeeding. Last, the provision of breast pumps was a common tangible provision through the breastfeeding champions. Informational support was reported to be provided through various mediums such as brochures, bulletins boards, handouts, and videos. Face-to-face interaction allowed breastfeeding champions to tailor their information to

meet the specific needs of a mother and also correct inaccuracies and myths that hindered the mother's breastfeeding success.

Additionally, due to the divergence of accounts between mothers and grandmothers, the breastfeeding champions reported their perspective to the mother / grandmother and family communication. Interestingly, the breastfeeding champions account strongly mirrored the mothers, in that the grandmothers were worried that the child would not have enough to eat as well as other myths surrounding breastfeeding that have been debunked. The findings from this study support the literature that community organizations and institutions that support breastfeeding have a positive impact on a breastfeeding mother; this data offers insight into how they provide that support.

CHAPTER FIVE: CONCLUSIONS

This study examined social support provided for African American mother's infant feeding experiences situated within the social ecological model. The overarching objective was to better understand the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed and how that support is communicated through interpersonal relationships with grandmothers and breastfeeding champions. The dissertation consisted of two studies: the first determined how African American mothers reported receiving social support about their choice to breastfeed from an interpersonal level including persons such as their health care providers, peers, loved ones and strangers. Furthermore, the study examined how African American mothers report receiving social support about their choice to breastfeed from the grandmother specifically, and how grandmothers' reported providing social support for their daughters' choice to breastfeed. The second study of the dissertation examined how breastfeeding champions reported providing social support about the choice to breastfeed for their clients (mothers).

A mother's choice to breastfeed may be affected by her interpersonal network and people in the community who work to support breastfeeding mothers. To better understand the dynamic nature of influences, the social ecological model was utilized as a lens for which to understand social support from the interpersonal and community level. When the social ecological model is applied as a framework for understanding the various levels of social support that may affect a health behavior, there is evidence that the various levels of influence can have both positive and negative influences on behavior decisions, one of which could be breastfeeding. As Moran et al. (2016) asserts, the use of

an ecological model in the examination of a health behavior allows for a more comprehensive view of the multifactor aspects that influence the behavior. As African American women's breastfeeding rates are significantly lower than the U.S. average for all breastfeeding women, this dissertation provides an examination of the mothers' experiences with receiving support in tandem with the grandmothers and breastfeeding champions' experiences in offering support in the effort to understand the reality of mothers trying to successfully breastfeed yet unable to initiate or sustain breastfeeding to the recommended levels. This chapter will discuss some of the major implications of the dissertation's main study findings and the limitations of the studies. Finally, the chapter will conclude with some ideas for future research and potential directions for health interventions.

Implications

The goal of this dissertation was to answer three research questions that explored various ways that emotional, tangible, and informational social support was communicated to breastfeeding mothers. Several perspectives were examined including that of the mother, herself, grandmothers, and community workers who work for organizations that support breastfeeding mothers (or, community organization-sited breastfeeding champions). These data reported in Chapters 4 (Study 1) and 5 (Study 2) provide descriptions of the variety of ways that mothers are supported, including both in positive and negative messages.

Study 1. The findings from this study provide foundational understanding of the support communicated by African American mothers concerning breastfeeding. The communication from African American mothers add to the understanding of

communication surrounding breastfeeding that has not been previously explored in this manner, specifically what is being communicated to breastfeeding mothers from peers, family members, healthcare providers, and strangers. The described communication taking place between a mother and her interpersonal relationships offer a clearer picture of the influences on her initiation and sustainment of breastfeeding, and this effort can be utilized as a foundation for message and program development concerning the support of breastfeeding, specifically for African American mothers.

These findings also demonstrate the different communication and actions that mothers received from healthcare providers, peers, loved ones, strangers, and their mothers or mothers-in-law, the grandmother. Healthcare providers and peers seemed to have the largest positive impact on a mother's initiation and sustainment of breastfeeding. This finding is consistent with the previous literature that determines healthcare providers are a main source of informational emotional support (Garner, Ratcliff, Thornburg, Wethington, Howard & Rasmussen, 2016; Ingram, Rosser, & Jackson, 2004; Rossman, 2007) and that when peers are present, they provide informational and emotional support (Brown, 2016; Eidelman, 2012; Match & Sims, 1992). These interactions could be seen as positive influences on the breastfeeding for the mother. Although there were positive accounts of interactions with family, there were more negative experiences who discounted breastfeeding that caused embarrassment and discomfort for the mother recalled by women. The positive influences of healthcare providers could be due to the agency that a person such as a doctor, nurse, or lactation consultant has over the mother. The lack of communication history could offer the mother more receptive to the healthcare providers support.

This study also provides evidence of negative communication and actions of support with family members and the grandmother, which allow us to better understand how these influences affect the mother. For example, family members and the grandmother were likely to suggest that the baby was not getting enough nourishment from the mother and potentially plants a seed of doubt into the mother's ability to take care of her baby's basic need of milk. Family members were also critical of the mother breastfeeding in a public place and made comments on the sexualization of the breast. This is consistent with Eidelman (2012) and confirms his statement that, "advocating the breast as an organ for the benefit of an infant may be at odds with its cultural image and actual use" (p. 555). This study offers evidence for what is actually being said to mothers and the feelings of shame and frustration after hearing them. This point in particular is deserving of further study, with the potential for developing of messages or information that would be directed at various family members.

Interestingly, mothers and grandmothers had differing accounts of their communication around breastfeeding. Mothers stated plainly that they wanted more support from their mothers, the grandmothers. There were very meager recollections of how the grandmother positively influenced breastfeeding from the mothers' perspective, and when there was informational support offered, the mother felt that it was based off of personal experiences and opinions, not facts, thereby decreasing the value of the support offered. However, from the grandmothers' perspective, they had provided tremendous support in all three areas: emotional, tangible, and informational support.

There has been research that has shown that grandmothers can exert a positive influence on health behaviors related to breastfeeding (Bentley, et al., 2003; Grassley &

Eschiti, 2008), but there has also been evidence that shows that grandmothers have a negative impact on breastfeeding sustainment (Emmott & Mace, 2015; Pikuskas, 2014; Susin, et al., 2005). This discrepancy could be due to the different perceptions of the mothers and grandmothers to what is helpful versus unhelpful support. Goldsmith (2004) discussed the differences between helpful and unhelpful enacted support and how that even though support was offered by the grandmothers, the support was not perceived as being effectual in assisting with the demands or stress of breastfeeding.

This study found that mothers clearly wanted signs of helpful support. Goldsmith (2004) described as reassurance, encouragement, and praising abilities, as well as information deemed as useful by the recipient among other demonstrations of support. Goldsmith (2004) describes unhelpful support as being support that minimizes or does not recognize the difficulty in the task (i.e., “I just-just wanted her to say it’s gonna be ok.” and hearing a grandmother say “breastfeeding is that not big of a deal.”); overly concerned, over protective or expressing fear (i.e., “she bought me like this big tub of formula and told me to feed my first child the formula” and “I don’t know how you have that much milk, and I don’t know how you’re still feeding her,”); and the grandmother’s underestimation of how much knowledge the mother actually has (i.e., “If you breastfeed and only hold the baby, nurse the baby to sleep, it's never gonna sleep on its own.”). Goldsmith (2004) also explains that there could be disagreement between the mother and the grandmother that the support that was offered was “useful.” While one grandmother relayed information about breastfeeding to her daughter, the daughter could have determined that because the information was not “factual” that it was not useful. Thus, it is

unsurprising that mothers report counterfactual information as not providing informational support, or as negative informational support.

This discrepancy between the perception of support received and support given could also be addressed through understanding the history of the mother grandmother relationship. Pierce, Sarason, Sarason, Joseph, and Henderson (1996), described influences on the ability of a child to receive support from a parent. This work posits that individuals develop rich schemata about others around them and that these schemata include not only the expectations about the future behavior of those others, but also conjecture about their motivations and intentions. This finding becomes particularly salient when thinking of children and the impact of parents on the child's support schemata. If a child had interactions with parents who are supportive and well matched to their needs, it is more likely that the child will develop positive expectations about the ability of people to provide support when needed. However, should a child not experience a supportive upbringing, she may have developed a more general idea that people are not willing to provide support (Pierce et al., 1996). This could be particularly salient to mothers who are having trouble with breastfeeding. If they have positive support schemata it may be easier to ask for help when needed, with the positive expectation that help will be received, especially from a parent. For those who may have had a support system that was lacking during childhood, they may be more likely not to trust that there is help available when it is most needed and that a parent would not be able to provide support (Pierce et al., 1996). For a new mother, if there is a history of negative support schemata, then mothers may have a skewed view of the help provided by others if she even asks for assistance from the mother at all.

As the *Surgeon General's Call to Action for Breastfeeding Support* requests that further research focused on identifying barriers to and supports for breastfeeding among African American mothers, this study offers a unique lens into the social-cultural communication patterns situated in the interpersonal communication – and specifically the mothers and grandmothers. As demonstrated with the data, the communication did not always provide positive support breastfeeding. The report of what is being said to mothers has brought insight to the various antecedents to breastfeeding or barriers created through communication with others, which could be utilized to improve on the existing breastfeeding outcomes.

There are also practical implications that are gleaned from the data. As mothers demonstrated that support was not “received” from the grandmothers, perhaps communication and programs regarding support should be shared with others beyond the grandmother in the mother social network. Further, communication about giving social support should not be targeted to the mother and limited to matching mother’s need for support. Rather, this research suggests that including strategies and tips for support should be offered to all individuals who interact with the mother on a regular basis. As indicated by some of the breastfeeding champions, even when champions provided facts about breastfeeding, myths were often encountered, from both the mother and the grandmother. The provision of support strategies may offer grandmothers and other individuals specific ways to assist a new mother.

This study also brought to light the disconnection between the support “given” by a grandmother and the support “received” by a mother. This discrepancy may indicate that the grandmother is not the best person for whom communication strategies of

support should be developed. Given that mothers often did not perceive positive support from their grandmothers, regardless of grandmothers' best intentions and efforts, the evidence suggests that program development should focus on sources of positive support that may be received by mothers from friends, partners, and healthcare providers.

Study 2. These data gathered for this study sought to offer introductory consideration to the communication that breastfeeding champions report to be exchanging with breastfeeding mothers in an effort to provide social support. Results of this study can improve the understanding of the emotional, tangible, and informational social support that is offered to mothers from breastfeeding champions within the community through a communication perspective that has not been previously explored. The clarity of the emotional, tangible, and informational social support that is described by the breastfeeding champions can be utilized to better understand effective social support communication at the community level and serve as scaffolding for health communication program development in order to assist mothers in their choice to initiate and sustain breastfeeding.

The findings identify the communication and actions provided by breastfeeding champions that bear upon conceptions of social support. Breastfeeding champions offered a variety of information and emotional support strategies. This finding is consistent with previous literature, which shows that breastfeeding champions such as peer counselors, HANDS workers, lactation consultants, and Le Leche League leaders are sources of social support (Buckley, 1992; CDC, 2013; Darwent & Kempenaar, 2014; Feldman-Winter, 2013; HHS, 2013). However, what this study conveys is an understanding of the typical messages that are given by the champions to the mother and

the potential for effecting breastfeeding initiation and sustainment. For example, through the provision of information, via bulletin boards, that clearly illustrates the variety of nutrients a baby gets through breastmilk versus formula and a mother expressing that she never knew the difference and would try to breastfeed after seeing that information. The exchange of information in a face-to-face meeting with the mother most commonly offered breastfeeding champions an opportunity to directly address the informational need of the mother, whether that was filling in gaps of the mother's understanding about breastfeeding or addressing misinformation that a mother may have received. These findings were supported by the literature that suggests that breastfeeding champions are common sources of expertise for breastfeeding (CDC, 2013).

The emotional support provided by the breastfeeding champions is supported in the literature (CDC, 2013) however this study brings understanding to *how* this is done through the communication that the breastfeeding champion has with the mother such as the recognition of the stress and frustrations that were occurring for the mothers, as well as asking the mother questions to establish trust and further lines of communication, reassurance for the mother, provision of empathy, and empowerment. These data collected clearly demonstrate the breadth of emotional support that is supplied. Although tangible support was not as commonly discussed, there was certainly provisions on tangible support through hands-on assistance for positioning and latch, addressing other issues and problems that a mother may be experiencing, and the provision of requested or required medical equipment such as breast pumps that assist a mother who is breastfeeding and has to go back to work or is cautious about having the baby at the breast.

In addition to the foundational description as to what is being communicated as emotional support, tangible support, and informational support; this study addressed the dissonance that was found within the mother and grandmother recollections of support given and received through the lens of the breastfeeding champions. Breastfeeding champions saw the negative pressure that some grandmothers and families can have on a mother who is trying to breastfeed. As social support indicates when there are stresses in life, there is a need to turn to others who can provide helpful information, empathy, comfort and assistance (Goldsmith, 2004) and these champions are able to fill that charge for breastfeeding women. These breastfeeding champions clearly demonstrate the characteristics of being a buffer and social resource for breastfeeding mothers in which they provide meaningful assistance that is intended to assist the mothers with initiation and sustainment of breastfeeding (Goldsmith, 2004). These persons continue to vital supporters of breastfeeding mothers through their actions.

Limitations

There were many limitations to this dissertation that the readers should be aware of as they consider the findings of this dissertation study. The limitations center on recruitment of the participants and methodological concerns.

First, the sample was constructed from mothers that had a child within the past year and grandmothers who had a grandchild within the past year. This one-year mark was chosen because of the one-year recommendation by the American Association of Pediatricians' recommendation for breastfeeding. However, many mothers breastfeed beyond a year and could have added information about social support challenges that were encountered as a mother is not nursing a "baby" anymore.

Next, since study one was conducted at a library, mothers and grandmother had to have transportation to the site. Although the site was selected to be accessible by public transportation, there were no travel vouchers available, which may have hindered participation. Additionally, since the participants were mothers, childcare may have limited participation. If a mother wanted to participate but would have had to bring the child, the mother may have felt that she should not participate because the child may be an interruption. Although childcare was not provided, mothers were told that they could bring their child to the focus groups if needed. This concern was not discussed until the potential participant was on the phone with the researcher and may have affected potential participant's willingness to reach out to the researcher.

There are also limitations to using focus groups for eliciting women's experiences and communication about breastfeeding and provision of social support. One or two dominant people in the group in particular can dominate focus groups. Although trained moderators were utilized for data collection and a bias in this way was not demonstrated from the transcripts, there is the potential that one or two outspoken or influential participants could influence the discussion or make others uncomfortable to share opposing views. Some participants may not have felt as though could have fully shared their experiences. Another limitation to the use of focus groups for this research is that the data cannot be projectable in a manner similar to quantitative data. This data was collected to represent a specific group of people and may or may not be representative of a larger group of people with similar characteristics. Next, as participants were recalling communication and events related to their breastfeeding experiences, there is a recall bias that should be acknowledged. Last, there should be considerations for the environment in

which Study 1 was conducted. This research was conducted in a meeting room and therefore participants could have behaved differently than they would have had they been in a different setting, such as interviews at their own home.

The in-depth interviews utilized in Study 2 also had limitations. A researcher has to be aware that reports could reflect perceptions of what the participants think that the researcher wants to hear or a more socially-desirable response. Additionally, there is recall bias in that the participants were describing communication and events from their recollections. Further, reports from Study 2 could reflect only the positive encounters that breastfeeding champions had and less of the negative communication and actions or that negative situations may have been portrayed in a more positive manner than the original encounter. It should also be noted that the breastfeeding champions were asked of all of their encounters with clients, not just African American mothers.

Areas for future research

There are two areas for future research in regards to this study. The first are several opportunities in regard to the research design and secondly, this information gathered could provide evidence for utilizing Inoculation Theory to protect mothers from negativity they may encounter about breastfeeding.

Perhaps one of the most valuable finding of this study is the dissonance between mothers and grandmothers in their reports of support given and received. As such many programs and interventions that utilize parents as a conduit for health improvement may not be successful. Moving forward health communication research should take into consideration the value of the parent and if that interaction would bring about positive or negative change. This study clearly demonstrates the dissonance between the mother and

the grandmother perceptions and as such, further program development should not assume that the grandmother is the best person to support the mother in her breastfeeding journey. The focus group dynamic provided the researcher with group specific data that delved into the experiences of both the mothers and the grandmothers. An area worth exploring may be dyadic interviews with the mother and grandmother together. This type of interviewing would offer insight into the relationship between a specific mother and grandmother and their discussions around breastfeeding. The investigation of the mother/grandmother dynamic would assist in further understanding the dissonance between the two.

There is also opportunity to explore the phenomenon in which the mother and grandmother are not aligning in their assessment of the social support given. As the mother does not describe the grandmother as being supportive, and the grandmother does describe herself as such, could this be an example of invisible support? Invisible support is support being given without the receiver recognizing the action.

Study 1 also suggests that alternative theoretical perspectives may offers divergent understanding of some of the negative communication received by the mother in regard to her choice to breastfeed. For example, the application of inoculation theory for mothers could be different way to explain and theorize how to help protect a mother's choice to breastfeed even when encountering negative interactions with individuals in her social network. Inoculation theory, posits that a mother could be "inoculated" against communication against breastfeeding. McGuire (1961) explored ways that an individual could employ persuasive messages to resist influence from others. He speculated that an individual could receive a message before an interaction that would act as an inoculation

against what was said - in the same manner a person could get a vaccine and be inoculated against a biological attack on the body.

Following the biology metaphor, just as inoculations are given to healthy people who are not already sick with the virus, similarly an inoculation message works on an individual who already holds the attitude to ensure that the attitude stays in place even when faced with an attack and the individual is able to defend the held attitude (Pfau, et al. 2004, 2006). For a mother who has a positive attitude towards breastfeeding, the mother would be “inoculated” against attacks on her breastfeeding decision. Thus, although this dissertation considered social support from a socioecological perspective, future research and alternative research could consider ways to inoculate new mothers against difficulty or undermining communication related to breastfeeding. Such research would explore educational strategies for identifying attacks and navigate through them through either action of verbal responses. For example, if a mother is asked, “Why are you doing that [breastfeeding]?” understanding the appropriate blocking communicative response to reply with the reasons why she is breastfeeding may protect her attitude towards breastfeeding. Additionally, an inoculation study could focus on attitudinal attacks for initiation and sustainment of breastfeeding as a whole, as well as examine the strength of inoculation messages against different sects of people that a mother encounters (i.e. the grandmother of the child, the partner, a friend, or supervisor at work).

Conclusion

When a mother chooses to breastfeed, the people that she has to offer her support can have a significant influence on her choice to not only initiate but to sustain the choice. The purpose of this study was to understand social support thorough the

examination of infant feeding communication and actions for African American mothers. The overarching objective is to better understand the mechanisms for social support that African American mothers report receiving in regard to their choice to breastfeed and how is that support communicated through interpersonal relationships with grandmothers and breastfeeding champions. This dissertation consisted of two studies: the first examined how African American mothers reported receiving social support about their choice to breastfeed from an interpersonal level including persons such as their health care providers, peers, loved ones and strangers. Additionally, the study examined how African American mothers report receiving social support about their choice to breastfeed from the grandmother specifically, and how do grandmothers' report providing social support for their daughter's choice to breastfeed. Due to the divergence reported in support given to and received by mothers, study two explored the community level of support for breastfeeding mothers. Specifically, the second study of the dissertation examined how breastfeeding champions reported providing social support about the choice to breastfeed for their clients (mothers). The findings of this study identify breastfeeding social support communication from the perspective of African American mothers, grandmothers and community members.

This dissertation extends health communication and social support research through an exploration of what ways African American women are receiving communication regarding breastfeeding. Practically, this research offers a unique lens into the social-cultural communication patterns that may be influencing breastfeeding outcomes among this population. The findings may be used to identify communication interventions that utilize current evidence demonstrated from the social experiences of

African American mothers, grandmothers, and breastfeeding champions. The many sources of communication have an impact on the initiation and sustainability of breastfeeding for African Americans and the foundational information gathered with this dissertation will provide a platform from which to further explore that social-cultural communication and its application to improve breastfeeding outcomes.

Appendix A

Focus Group Facilitator Guide for Mothers

Thank you all for joining us today. A focus group is a small group discussion that focuses on a particular topic in depth. In a focus group, there are no right or wrong answers, only opinions, and I'd like to hear from each of you. It's important that I hear what each of you think, because your thoughts may be similar to those of many other people who aren't here. Please feel free to speak up even if you disagree with someone else here. It's OK to disagree, because it's helpful to hear different points of view.

We want to hear how you feel about your infant feeding choices and the support that you feel for those choices. Remember that support can be given in many ways: physical support like helping around the home or buying something for you or the baby; Emotional support like reassurance that they will be there if you need them or the feeling that you can come to them when you need help; Informational support such as providing you with suggestions and guidance with your child, or telling you how they handled a similar situation.

I'm not an expert in the topics we'll be discussing tonight, and I'm not here to give you information. I'm here to listen to your ideas and thoughts on these issues.

As a reminder, after we finish today you will get a \$25 gift card. Does anyone have any questions before we start?

As you are aware, we are here to talk about infant feeding. To start, I would like to hear key words or phrases from each of you that first come to mind when you here the following words:

- Infant feeding
- Breastfeeding
- Bottle feeding

Now I would like to hear more about your feeding choices.

- How did you end up making the decision for your feeding choices?
- Do you feel like you had enough information on research and resources for all feeding choices before you made your decision?

Can you remember and share with us about the last time that you talked to someone about feeding your child?

- Where was the conversation?
 - o Home, doctors office, hospital
- Who was it with?
 - o Doctor, nurse, partner, mother, friend
 - o Do you feel like that person supported you in your decision? Was there anything they said or did that discouraged you from a different feeding choice?

Who do you consider to be the most important in supporting you when you are feeding your child?

Of those of you who intended or attempted to breastfeed:

- Can you tell us about a time when you were supported in your breastfeeding decision?
- Can you tell us about a time when you were not supported about your feeding choice?
 - o What support did you need and not receive? From whom?
 - o If you had more support, would you have tried to continue breastfeeding?

Of those who did not intend or attempt to breastfeed,

- Can you tell us about a time when you were supported about your feeding decision?
- Can you tell us about a time when you were not supported about your feeding choice?

What other types of support for your feeding choice do you feel like you needed but did not receive?

What info or help/support would make breastfeeding/formula feeding easier for you?

What info or help/support do YOUR SUPPORT PEOPLE need to be more supportive of you?

What is the easiest way for you to get the info/help you need?

- In-person clinic appointment
- In-person mom's support group
- On-line mom's support group

Thank you all for sharing your stories and experiences with us. If you marked that we could contact you on the pre-focus group survey, we will be in touch with you in approximately 5-7 days.

Thank you.

Appendix B

Focus Group Questions for Grandmothers

Thank you all for joining us today. A focus group is a small group discussion that focuses on a particular topic in depth. In a focus group, there are no right or wrong answers, only opinions, and I'd like to hear from all of you about equally. It's important that I hear what each of you think, because your thoughts may be similar to those of many other people who aren't here. Please feel free to speak up even if you disagree with someone else here. It's OK to disagree, because it's helpful to hear different points of view.

We want to hear how you feel about your daughter, or the mother of grandbaby's feeding choices, and how you help her with that choice. Remember that support can be given in many ways: tangible or physical type support which would be described as providing help around the home, buying something for your daughter or the mother of your grandbaby or the baby, or giving her a hug to make her feel better; Emotional support which may be shown when you make her feel cared about, reassurance that you will be there if she needs you, or the feeling that she can come to you for help; Informational support would be providing your daughter or the mother of your grandbaby with suggestions and guidance, or you sharing with her how you have handled a similar situation.

I'm not an expert in the topics we'll be discussing tonight, and I'm not here to give you information. I'm here to listen to your ideas and thoughts on these issues.

As a reminder, after we finish today you will get a \$25 card.

To start, can you remember and tell us about a conversation that you had with the mother of your grandbaby about feeding the baby?

Now I would like to talk more specifically about infant feeding choices.

Share with us how you fed your own babies.

- Tell us how your family and friends reacted to your choice.
- Tell us anything you might have done differently
- Were you supported in your decision?

Can anyone tell us about a conversation you had with others about how your grandbaby would be fed before the baby was born?

For anyone whose daughter or grandbaby's mother intended or attempted to breastfeed:

- Can you tell us about a time when breastfeeding seemed like the right choice or the easy choice?
 - Prompts
 - For the mother?
 - The grandmother? (Yourself?)
 - Others?

For anyone whose daughter or grandbaby's mother did not consider or did not attempt to breastfeed:

- Can you tell us about a time when formula feeding seemed like the right choice or the easy choice?
 - Prompts
 - For the mother?
 - The grandmother? (Yourself?)
 - Others?
- Can you tell us about a time when formula feeding seemed like a difficult choice?
 - Prompts
 - For the mother?
 - The grandmother? (Yourself?)
 - Others?
- Can you tell us about a time when breastfeeding seemed like a difficult choice?
 - Prompts
 - For the mother?
 - The grandmother? (Yourself?)
 - Others?
- How do you feel about your grandchild being breastfed/ bottle fed?
- Tell us a story about a time when you gave advice to the mother or you helped her with a feeding.
- Tell us a story about how your daughter or grandbaby's mother reacted to your advice or help.
- Tell us a story about how you have helped the mother without her knowledge?

What info or help/support would make breastfeeding/formula feeding easier for you as a support person?

Thank you all for sharing your stories and experiences with us. If you marked that we could contact you on the pre-focus group survey, we will be in touch with you in approximately 5-7 days.

Thank you.

Appendix C

Pre-Focus Group Survey Mother

Thank you for taking the time to talk with us. Before we begin, please tell us a little about yourself:

Did you attend birth classes before your child was born? Yes No

Number of children you have had: _____

Your current age: _____

In which zip code do you currently live: _____

Relationship Status (Please circle one): Married Single

Living with Partner but not married

Which best describes the level of education that you have completed?

- Some high school
- Completed high school
- Some college
- Completed undergraduate degree

Were you breastfed as an infant? Please circle one Yes No I do not know

How likely are you to get information about parenting and infant feeding from the following sources :

-	Very Likely	Somewhat Likely	Not Likely
- Family			
- Friends			
- Doctors, nurses or other healthcare providers			
- WIC			
- In person support group			
- Online websites			
- Online support group			
- church			
- Other			

Where did you learn about this study? _____

May we contact you in about 1 week to follow up on the focus group? Yes No

If yes, please provide your first name only

What phone number would be the best to reach you?

Appendix D

Pre-Focus Group Survey Grandmother

Thank you for taking the time to talk with us.

Before we begin, please tell us a little about yourself:

Number of children you have had: _____

Your current age: _____

In which zip code do you currently live: _____

Relationship Status: Married Single

Living with Partner but not married

Which best describes the level of education that you have completed?

- Some high school
- Completed high school
- Some college
- Completed undergraduate degree

Did you breastfeed your child? Yes No I do not know

How likely are you to trust information about parenting and infant feeding from the following sources:

-	Very Likely	Somewhat Likely	Not Likely
- Family			
- Friends			
- Doctors, nurses or other healthcare providers			
- WIC			
- Online websites			
- Online support group			
- church			
- Other			

Where did you learn about this study? _____

May we contact you in about 1 week to follow up on the focus group? Yes No

If yes, please provide your first name only

What phone number would be the best to reach you?

Appendix E

Follow Up Script: Mothers

We appreciate you taking the time to come and talk with us on XXXX. If you recall, we were discussing infant feeding choices.

In the days since, have you had a conversation about feeding your child that you would like to share with me?

In the days since, have you had an experience in feeding your child that you would want to share with me?

Is there anything that you have thought about that you would like to add?

Appendix F

Follow Up Script: Grandmothers

We appreciate you taking the time to come and talk with us on XXXX. If you recall we were discussing infant feeding choices.

In the days since, have you had a conversation with your daughter or mother of your grandchild about how she feeds her child that you would like to share with me?

Is there anything that you have thought about that you would like to add?

Appendix G

Interview Guide for Breastfeeding Champions

Good Morning/ Afternoon [Name],

Thank you for agreeing to talk with me. As we briefly discussed previously, I am talking with you today to better understand your experiences in assisting mothers with breastfeeding. I am interested in this information to better understand the complexities for breastfeeding women and the support they get. . It is the hope that this information will help communities better understands possible disconnects between community support for breastfeeding and family based support. This call should last approximately an hour to an hour and a half. The information gathered on this call will be recorded and transcribed, however no names will be included in transcripts, nor in any publication that may come out of the information gathered. There are no foreseeable risks however there could be discomforts since we are talking about your personal experiences. Although we have tried to minimize this, if you feel uncomfortable you may choose not to answer them. This is a voluntary conversation and so we can stop at any time if you should wish and there will be no penalty for choosing to do so.

If you would like to see the final report that written I would be happy to share it with you. If you should need to get in touch with me after this conversation you can reach me at 859-257-3802, or Kate Eddens at 859-218-0111. Do you have any questions before we start?

Questions for breastfeeding champions:

Where are you currently working?

How long have you been working there?

How many hours a week do you on average work with breastfeeding mothers?

On average, how many mothers would you see in a week?

Do you only work in Fayette County?

Personal Experiences:

Can you share with me a story about how you got started assisting breastfeeding mothers?

Can you tell me a story about why wanted to start this type of work?

Could you share with me your usual approach to encouraging mothers to breastfeed?

Can you walk me through what a typical appointment/time with a mother is like?

Can you share with me a story about a time when you ensured that a conversation with a new mother is productive?

Can you describe to me how you ensure that your conversation is positive with a breastfeeding mother? Can you tell me a story about a time when you had to use [those methods] with a mother?

Can you describe to me how you best determine what a mother needs/wants in terms of support for breastfeeding?

Can you share with me a story of a time when you offered emotional support? What did you do or say? How did the mother respond?

Can you share with me a story of when you offered tangible support? What did you do or say? How did the mother respond?

Can you share with me a story of when you offered informational support? What did you do or say? How did the mother respond?

Which type of support do you think is the most important for a breastfeeding and why?

Which type of support do you see yourself providing the most? Why?

Can you tell me a story about the most personally rewarding breastfeeding situation you have assisted with? What made this a personally rewarding experience?

Can you share with me a story about a time when you encountered a breastfeeding mother who was having a lot of trouble and how you got her back on track?

Can you share with me a story about a time when you had to engage a mother that seemed shy or distant? What did you say or do? How did the mother respond?

What do you think is your biggest challenge is helping breastfeeding mothers? How do you work to overcome that challenge? Can you share with me a story when you addressed [that challenge] with a mother?

In your experiences, what are the most common issues that breastfeeding mothers are having? Can you tell me a story about when you assisted a mother with [that issue]?

Can you tell me story about a time when you encountered resistance from a mother?

Can you tell me a story about when you had a difficult conversation with a new mother?

Can you share with me a story about a time when you had a mother who was not receptive to your assistance and how you proceeded with assisting/ or not assisting? How did the mother respond?

Current Application

What do you think are the most important ways that a (person in your position) helps a breastfeeding mother?

Can you describe to me what you think are the best practices when it comes to assisting a new mother?

What do you think are the best techniques to establish relationships with mothers? Why?

How have you seen the programming/ assisting change over the past 5 years?

What do you think are the best ways to stay connected to a mother you are assisting?

Describe to me what you think are the biggest barriers for mothers to breastfeed?

How do people in your job specifically address [these barriers]?

What do you think is the most stressful part of breastfeeding for mothers? Can you share with me a story that reflects why you think that?

Why do you think that people in your position are so important for breastfeeding mothers?

Overall, what do you think are the biggest rewards for helping breastfeeding mothers?
Can you share with me a story about when you felt most rewarded?

What do you feel are the biggest challenges in doing this job? Can you share with me a story about having to handle [these challenges] with a mother?

As a (person in your position), what advice would you give someone who was starting out in the same job as you?

There may be time when the assistance that you are giving may not be exactly in line with best practices- can you tell me story about a time when you have helped a mother although it may not have been exactly by the book?

Lastly, what else would you like to share with me to learn more about your perspective or approach to supporting breastfeeding mothers?

Thank you so much for your time and sharing with me your experiences.

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