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**Breastfeeding and Maternal Decency: A Qualitative Investigation of
Infant Feeding Decisions among Low-Income Mothers**

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Breastfeeding is an act that is intimately connected to the mother-child dyad but is also a topic of considerable public health interest (Wolf 2003). Reports from the lay press, health communities, and maternal organizations, such as La Leche League¹, are largely supportive of breastfeeding (Schmied and Lupton 2001). The slogan “breast is best” is ubiquitous in medical discourses and public health promotional campaigns, backed up by a litany of studies that link breastfeeding to numerous protective health benefits for infants, and in more recent years, to health benefits for mothers (American Academy of Pediatrics 1997, Eiger and Olds 1987, U.S. Department of Health and Human Services 2000, Wolf 2003, Zheng et al. 2001).

Yet many mothers in the U.S. choose to formula feed their infants, particularly low-income and minority mothers (Kurini et al. 1988, Guttman and Zimmerman 2000, Haider, Jackowitz and Schoeni 2003, Miller 2001, Ryan 1997, Ryan et al. 2002). An important question for many public health advocates has been why, given the epidemiological evidence, do low-income mothers still engage in feeding practices that are apparently sub-optimal for infant health protection? The nature of public health campaigns suggests that women lack knowledge about breastfeeding and its many benefits (Blum 1999). Thus, promotional efforts have focused on informational dissemination of the health benefits of breastfeeding via media and health care providers, particularly to poor and minority women who “fail” to breastfeed (Ryan 1997).

However, a growing number of studies have demonstrated that low-income women are not ignorant about the merits of breastfeeding (Blum 1999, Guttman and Zimmerman 2000, Hoddintott and Pill 1999, Libbus et al. 1997, Zimmerman and Guttman 2001). These scholars have emphasized that the decision to breastfeed is far more complicated than simply knowing about the benefits of breast milk and is constrained by socio-economic circumstances.

¹ La Leche League is a maternalist organization founded in the 1950’s and is dedicated to “good mothering through breastfeeding” (see Blum and Vandewater 1993 for an ethnographic study). It has since expanded and now includes many chapters.

Breastfeeding is also a behavior that is embedded within larger socio-cultural ideologies of the body and sexuality, maternal identity, and notions of appropriate and “good” mothering (Blum 1993, 1999, Carter 1995, Murphy 1999, 2000, Schmied and Lupton 2001, Stearns 1999). These socio-cultural contexts are often not adequately captured in large-scale surveys but may be integral to understanding why low-income women formula feed, despite mounting recognition from health communities and the lay public that breastfeeding is a protective health behavior.

This paper presents an in-depth description of how social context and cultural ideologies shape and inform low-income, inner-city mothers’ infant feeding decisions. Drawing from semi-structured interviews and a focus group discussion among low-income women in Philadelphia, I illustrate how competing forms of knowledge and normative ideas of breastfeeding influence maternal decision-making, particularly highlighting mothers’ perceptions about the acceptability of breastfeeding in the public realm and in their private lives. The analysis places the mothers’ narratives within the context of the contradictions (Hayes 1996) that breastfeeding embodies, where women must balance the demands of motherhood, medical advice that proclaims “breastfeeding is best,” and social taboos against public exposure of intimate body parts.

Background

Prior research has consistently shown that breastfeeding rates tend to mirror socioeconomic inequalities, where breastfeeding is more common among highly educated and higher income women than among other mothers (Guttman and Zimmerman 2000, Hirschman & Butler 1981; Ryan 1997). The literature suggests several explanations for disparities in breastfeeding practice, including socio-economic or structural barriers, ambiguous or vague messages from medical professionals, maternal autonomy and resistance to breastfeeding mandates, and lack of social support or encouragement for breastfeeding. This study contributes

to the extant literature by describing in further detail how poor, inner-city mothers make infant feeding decisions based on diverse and, at times, competing sources of knowledge and how predominant socio-cultural ideologies of appropriate and “decent” maternal behaviors comprise important contexts within which decisions are made.

In past qualitative research, scholars have noted that women’s rejection of breastfeeding is a way to assert ownership over medical mandates that inform mothers on how they should appropriately care for their children (Blum 1999, Carter 1995, Murphy 1999, 2000, Schmied and Lupton 2001). Although these studies highlight the tensions between maternal autonomy and public health mandates, the topic of how low-income mothers negotiate various discourses regarding infant feeding has not been fully explored. Anthropologist Jordan (1997) argues that in diverse domains, there are different or competing forms of knowledge systems from which people draw upon to decide how to behave and interact with others. She argues that “authoritative knowledge” is knowledge that takes precedence, typically by consensus, and “comes to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both” (Jordan 1997: 56). Often times, Jordan notes that the knowledge of medical professionals yields authority, as it is shrouded in scientific legitimacy. At the same time, given that breastfeeding is not a common practice among low-income women, there may indeed be other forms of knowledge and ideologies operating that either counter the idea that “breast is best” or qualify it in some manner. Moreover, the extent to which “breast is best” is internalized and subscribed to by low-income mothers or how low-income mothers react to this knowledge has not been adequately described.

Ironically, while breastfeeding was once viewed as the practice of poor, immigrant, working mothers who had no infant feeding alternative (Blum 1999), several recent studies have found that lower class women today are keenly aware that breastfeeding is related to socio-economic advantage (Blum 1999, Guttman and Zimmerman 2000). For instance, Guttman and Zimmerman's (2000) study of low-income mothers in the U.S. revealed that bottle feeding mothers perceived breastfeeding as an inconvenient practice, particularly given their work or school considerations, health behaviors (e.g. smoking cigarettes) and poor health status. Blum's ethnographic work and Guttman and Zimmerman's piece illustrate that low-income women believed that breastfeeding was much easier if one had certain lifestyle privileges, such as the ability to stay at home, flexible maternity leave, and more spacious living conditions. These studies suggest that low-income mothers' decision to breastfeed may not only be constrained by poor health or limited resources, but may also be influenced by women's perceptions of breastfeeding as an act that reflects social class privileges in U.S. society.

A consistent thread in the qualitative literature on breastfeeding and maternal decision-making is that social factors may be more important than informational gaps. Numerous studies have documented that social support and social influence play salient roles in low-income mothers' infant feeding decisions. For example, in a study of working class mothers in England, Murphy (2000) found that women who formula fed looked to the experiences of other mothers in their social networks (family and friends) who had "successfully" bottle fed their infants for both advice and reassurance. Studies on social factors and breastfeeding decisions also suggest that the role of social support and the nature of social influence may vary by social class and racial or ethnic background (Baronowski et al. 1983, Bryant 1982, Freed 1992, Giugliani et al. 1994, Libbus et al. 1997, Matich and Sims 1992).

These studies on social support and influence underscore how decision-making and behaviors are largely informed and shaped by social contacts and through interactions (Horowitz 1977, Kincaid 2000, Pescosolido 1992, Watkins 1995). However, these studies often point to associations but tend to lack in-depth insight into why some social networks are more important than others in infant feeding decisions or how mothers balance multiple forms of advice and opinions from various sources. Studies on the role of social networks and breastfeeding decisions often do not describe how broader socio-cultural beliefs about breastfeeding and sexuality shape the ways in which information and knowledge through social networks is communicated.

Cultural contradictions between breastfeeding and sexuality may be an important aspect of infant feeding decisions, but, as noted above, are often not fully recognized in public health and medical discourses. Breastfeeding, after all, reveals part of a woman's body that is strongly linked to sexual connotations in American culture (Saha 2002). In addition, because breasts are cultural symbols of female beauty and identity, women's fears of how breastfeeding would change the appearance of their breasts may also be salient barriers (Blum 1999, Carter 1995, Stearns 1999). Blum (1999) astutely observes that due to these pervasive associations, mothers may acutely feel the need to keep breastfeeding private, which in turn restricts women's options (also see Carter 1995, Stearns 1999). For instance, Hoddintott and Pill (1999) and Morse (1992) have both noted the difficulty that women, even those who breastfed, faced in viewing their breasts as an infant feeding method versus sexual objects. These studies point to the idea that feelings of embarrassment and social taboos against public breastfeeding, real or anticipated, may be substantial obstacles to breastfeeding. Yet few studies to date have explored in an integrated way how competing forms of knowledge, social influence, and cultural contradictions are manifested in low-income mothers' infant feeding decisions.

Data and Methods

The analysis in this paper draws on data from three sources: 1) a longitudinal survey of low-income women in Philadelphia, PA (N=1,451), 2) a focus group discussion with 6 women enrolled in the longitudinal study, and 3) qualitative in-depth, semi-structured interviews with a sub-sample of 29 women who were also enrolled in the longitudinal study. The survey data were collected between 2000 and 2003. The focus group was conducted in the spring of 2002 and the in-depth interviews were conducted from July 2003 to April 2004.

Description of the Longitudinal Study

The purpose of the longitudinal study was to examine the joint effects of individual and contextual-level factors on maternal and child health among low-income, inner-city women in Philadelphia neighborhoods. Women were enrolled into the study at the time of their first prenatal care visit at a consortium of public health centers. The first interview (Wave 1) was conducted at the time of enrollment. Both English and Spanish-speaking women with singleton, intrauterine pregnancy were eligible for participation. Women were followed and interviewed at three subsequent time points after birth (see Culhane et al. 2001 for details of the larger study).

In this paper, I use data from the first postpartum interview of the longitudinal study (Wave 2, 2000 to 2003). I draw on information regarding the mothers' infant feeding methods and reasons mothers gave for not breastfeeding their infant, based on forced-choice questions asked only of women who formula fed. These survey responses provide an overview of low-income formula feeding mothers' reports on why they did not breastfeed.

Qualitative Study: Sampling Design and Analytic Strategy

The qualitative study was motivated by questions of how low-income, first-time mothers make infant feeding decisions and how mothers perceive the merits of breastfeeding versus

formula feeding. One of the strengths of this study was the ability to recruit and sample women who participated in the longitudinal survey. This strategy ensured the incorporation of women from different racial/ethnic backgrounds and avoids the inherent biases of snowball sampling. Because I recruited women who had participated in the longitudinal study, I also had access to detailed information collected from the surveys and was able to compare the consistency of reports revealed during the qualitative interviews with those from the longitudinal survey.

Before conducting the in-depth interviews, I conducted a focus group discussion with six first-time mothers (two Puerto Rican, three African American, one white mother) on the topic of infant feeding. The main purpose of the focus group was to shape the questions for the semi-structured interview guide. The participants were randomly selected and recruited among a potential sampling pool of respondents who participated in the longitudinal surveys. After the discussion, salient themes were identified and explored in greater detail through the interviews.

For the qualitative, in-depth interviews, a random sample of women who participated in the longitudinal study was drawn, stratified by race/ethnic background, among a pool of women who met the criteria described below. The sample was stratified by race/ethnic background to ensure the incorporation and representation from three main groups: non-Hispanic, U.S.-born African Americans, Puerto Ricans, and non-Hispanic, U.S.-born whites. I restricted the sampling pool to include women who (1) were first time mothers, (2) ages 18 to 30, (3) spoke English, (4) were living with their child, and (5) had singleton, healthy (i.e. normal weight, full term) births.

The above sample restrictions were made for the following reasons. I chose to focus on the experiences of first-time mothers in order to understand the *transition* to motherhood and to explore decision-making for the first time (first child). I excluded young teenage mothers (< 18 years old) because they do not face the same household, work, and economic circumstances as

non-teenage mothers (Furstenberg 1980). I also excluded older mothers (30 years or older at birth) because in this study population, few women became first-time mothers after 30, and these women constitute a unique group among low-income mothers in Philadelphia. I further excluded women who gave birth to a pre-term or low birthweight infant, as these infants are likely to have health complications that could restrict the mother's infant feeding options.

Twenty-nine women participated in the in-depth qualitative interviews, representing 11 African American, 10 white, and 8 Puerto Rican mothers.² The index child was usually around two and a half years old and was often present during the interviews. Interviews typically took place in the respondent's home, were audio recorded, and lasted anywhere from about one and a half to three hours. To protect anonymity, I refer to each woman by an alias in the analyses.

The interview data was analyzed using a qualitative software package (QSR N*Vivo). Preliminary coding was organized along the main themes and topics of the interview guide. A coder and I conferred about preliminary "open" codes and themes that each of us independently developed from a review of the first five transcripts. A common working set of codes was then established based on these discussions. Through subsequent coding of the transcripts, I then developed broader conceptual categories, which were generated from the transcript data, and then were followed with focused re-coding of the transcripts (Strauss and Corbin 1990).

Findings

Results from Longitudinal Survey

Before I discuss the results from the qualitative study, I first present a summary of low-income mothers' responses regarding reasons for why they did not breastfeed their infant,

² Three women declined to participate in the qualitative study (two black mothers and one white mother) because they were "too busy" or did not want to be bothered. Also, three women (two Puerto Rican and one black mother) had initially agreed to be interviewed but the interviews were never completed due to several missed appointments and failed attempts at further contact.

obtained from the first postpartum interview (Wave 2) of the longitudinal study. Note that the survey results are drawn from all mothers who were interviewed at Wave 2 and did *not* breastfeed the index child. Some of the reasons for not breastfeeding may thus be informed from prior infant feeding experiences with older children.

About 39% of low-income mothers in the longitudinal study reported they never breastfed their infant at the first postpartum interview. In this interview (mean age of children = 3.4 months), respondents who did not attempt to breastfeed (N=563) were asked to respond positively or negatively to a set of reasons that might explain why they did not breastfeed. Table 1 displays the most common reasons mothers reported for not breastfeeding. Although these responses are not mutually exclusive, 87% of formula feeders identified only one reason.

One of the main reasons for not breastfeeding related to the mother's health behavior. Twenty-nine percent of formula feeding mothers reported that they did not breastfeed because they did not want to pass harmful substances (e.g. nicotine, alcohol) to their child through breast milk. The second most common reason (27%) mothers gave for not breastfeeding was that they simply "did not want to" or did not like the idea of breastfeeding (N=154). Although uninformative on the surface, this response hints at complex and intricate notions about meaning and acceptability of breastfeeding in private, interpersonal, and public spheres. I explore this issue further in the analysis of the qualitative study.

Another dominant explanation for why mothers chose formula feeding concerns their own health (e.g., mother believed she was too ill or weak to breastfeed). Additional reasons for not breastfeeding included beliefs that breastfeeding would be too inconvenient and time-consuming (13.3%), feeling unsure about/not knowing how to breastfeed (6.4%), having insufficient (or fearing that they had insufficient) milk (6%), and feelings that breastfeeding

would be “uncomfortable” (6%), although the reasons for perceptions of discomfort were not clear. Also, as seen in Table 1, a small number of women reported that their partner/ spouse did not want them to breastfeed and others stated they had body image issues with breastfeeding.

These survey results provide some insight into why low-income mothers choose to feed formula to their newborns, but they do not tell us in greater depth the circumstances that surround low-income mothers’ choices. Why is it that women “just don’t want to” breastfeed? What is it about breastfeeding that makes the practice “uncomfortable” and “inconvenient?” These are questions that I address through the qualitative interviews. The analyses focus on the similarities and differences found between breastfeeding and formula feeding mothers.

Findings from Qualitative Interviews

Description of the Qualitative Sample

Table 2 presents some of the demographic characteristics for the women who participated in the qualitative interviews. The information for the mother’s race/ethnic background, age at birth, and educational attainment at the time of pregnancy was obtained from the longitudinal survey data. The information for mother’s employment/schooling status, welfare (cash assistance) receipt, relationship status with the child’s father and household/familial composition was collected during the qualitative, in-depth interviews (2 ½ to 3 years after the child’s birth).

All twenty-nine participants in the qualitative study can be characterized as low-income, inner city mothers. All women had relied on public health centers for prenatal care and all but two had enrolled in the Supplemental Nutritional Program for Women, Infants and Children (WIC) either before or after their child’s birth. Most of the mothers were in their early twenties when they gave birth and only 8 women had schooling beyond high school when they entered prenatal care. Almost all were working full-time when I interviewed them, often as cashiers or

managers in supermarkets or stores, medical or nursing assistants, secretaries, or child care workers. Two mothers had returned to school after their child's birth. Seven mothers were receiving public assistance, five of whom were working to meet welfare work requirements.

About half of the sample lived with other extended family members. Nine mothers were no longer in a relationship with the baby's father, and for some, their relationship with the child's father was conflict-ridden. Yet the majority of mothers are still involved with the father of their child: five mothers report that they are "together" but do not live in the same house, seven mothers are living with their child's father and eight women are married.

As seen in Table 2, formula feeding was the dominant infant feeding practice among this group of low-income mothers. Twenty-two out of twenty-nine mothers formula fed their infants from birth. Ten out of the eleven African American mothers, four out of eight Puerto Rican mothers, and eight out of ten white mothers chose to formula feed. It should be noted that seven of the twenty-two formula feeders said that they attempted to breastfeed in the hospital but switched to formula feeding before returning home. Four of the seven breastfeeding mothers were Puerto Rican (and all but one was born in Puerto Rico), two were white, and one was African American. Mothers who decided to breastfeed typically weaned their child by 3 or 4 months (mean breastfeeding duration = 3.5 months).

In the remainder of this paper, I discuss the mothers' explanations for their choice of infant feeding method, their beliefs in the merits of breastfeeding and formula milk, and the social factors that influenced their decisions, comparing breastfeeding mothers to formula users. I then turn to a more detailed discussion of the socio-cultural norms regarding breastfeeding, illustrated through the narratives of these low-income women.

Breastfeeders: “Doctors say it’s the best and they say it in magazines, on TV, everywhere...”

During the focus group discussion, mothers who breastfed (N=2 of 6 participants) echoed public health campaign messages that promote breastfeeding as the optimal infant feeding method. These mothers were both Puerto Rican (island-born) and had support and encouragement to breastfeed from the child’s father. For instance, one of mothers recounted:

#4: My boyfriend, like, he was all for it. And he was always taught that breastfeeding was good for a child. I don’t know, in school or something they told him that for some reason, they [breastfed children] come out more healthy and intelligent...

Breastfeeding mothers from the focus group believed breastfeeding was best because it was “natural” and that “you’re eating healthy, you’re eating good things...and that’s going into the baby.” As discussed below, these reasons were also echoed among the seven breastfeeding mothers who took part in the in-depth interviews.

The breastfeeding mothers interviewed shared their belief that breast milk was healthier for the infant and that breastfeeding brought them closer to their children (N=7). Thus, in many ways, these mothers subscribed to the dominant medical knowledge that “breast is best” (Jordan 1997). Breastfeeding mothers often mentioned that doctors, family members and fathers had supported or informed their decision to breastfeed. All of these women were either married (N=4) or still romantically involved with the baby’s father (N=3). The joint support from doctors, the babies’ fathers, and kin was an important element in these women’s decision.

Aaliyah, a petite, Puerto Rican mother who was born and raised in Philadelphia, stated that she had talked about breastfeeding with her doctor and “how it would help infection, ear infections, and no sicknesses and all that good stuff.” Aaliyah supplemented breastfeeding with formula milk, because her son was “greedy” (i.e., he fed frequently) and weaned him after 3 months. Aaliyah’s mother (who she co-resides with) had also breastfed her, but supplemented

with formula: “My mother said, ‘Breastfeed.’ She did the same thing I did. She went back and forth with the bottle and the breast.” Interestingly, Aaliyah notes that her infant feeding practices replicate what her mother did with her. Aaliyah also had the support of the child’s father (they are still romantically involved), but in the end, “he just left it up to me. It was my choice.”

In fact, most breastfeeding mothers (N= 6 of 7) reported that the babies’ fathers encouraged or were supportive of their decisions to breastfeed. Chyna, a young African American woman who works as a certified nursing assistant, was the only black mother in this sample who breastfed. She recounted that her boyfriend (the child’s father) was “mad” at her decision because he felt that he could not participate in feeding the baby:

A: But then I explained to him about later on when I was working that he could help. I guess he didn’t want to miss his bond with him [the baby]. They [men] so clueless.

Q: If I’m hearing you right, he wanted to feed [the baby] and if you breastfed he thought he couldn’t do that?

A: I had to explain to him that he still could. Like when I pumped the milk. Or when I switched to formula. I had to explain it to him like he was a child.

After Chyna explained to her “clueless” boyfriend that he could still feed their son, the baby’s father eventually supported her decision and even helped her when their son needed to nurse during the night by bringing the baby over from the crib to her bedside.

Brielle, a married, Puerto Rican mother, was working to meet welfare requirements and was also expecting her second child when I interviewed her. She breastfed her daughter exclusively for four months and explains her decision to breastfeed in the following manner:

Well, I always heard from the different, you know, little brochures you read and the doctors that breast-feeding is the best thing. And my husband, he’s stuck on something that he seen -- I think it was like some research thing he seen on T.V. that said breastfed babies end up more intelligent or with a higher IQ than others who are not. Whether it has been proven or not, I don’t know. But he always said that breast-feeding is the best thing.

So he also encouraged me to breast-feed...I didn't know why but doctors and stuff always say it's good to breast-feed but I figured I want the best for my child.

Brielle illustrates how infant feeding decisions are not just information based but are intrinsically social in nature. Her husband had cited information about breastfeeding and child intelligence, and she understands this with a slight dose of skepticism. Yet both her husband and doctor offered encouragement, and she relied on their opinions the most. In addition to the information Brielle had garnered on her own, these trusted individuals helped to reinforce the belief that breastfeeding "is the best thing." Brielle exemplifies how authoritative knowledge is both internalized and communicated through both formal and other informal social ties.

Most breastfeeding mothers enjoyed the experience of breastfeeding and felt it was more convenient than formula feeding (N= 5 out of 7). For instance, Jasmine, a married, Puerto Rican mother who breastfed both of her two young children, told me that she felt "it was amazing, you know? That you're producing milk and give it to the baby." However, Shawn, a white mother, expressed the sentiment that breastfeeding is inconvenient at times. She was forewarned by her own mother that breastfeeding would prohibit her from "going out" and that she would have to balance nursing in public, a task that Shawn found difficult and embarrassing. But like all of the breastfeeding mothers, she subscribed to the belief that breastfeeding is best, telling me "Doctors say it's the best and they say it in magazines, on TV, everywhere." At the same time, no matter how firmly these women believed in the importance of breastfeeding, it also presented some logistical challenges and involved rules of etiquette. I return to these issues in a later section.

Formula Feeders: "That's just not for me...I just couldn't do it"

It became apparent during the focus group discussion that some mothers believed that formula feeding was more convenient and easier because fathers and other family members can

assist with feedings. Four out of the six mothers who participated in the focus group decided to feed their infants formula. The following excerpts illustrate why mothers chose to formula feed and how perceptions of convenience were important elements in their explanations:

#5: My boyfriend had a decision in it. I felt like he wanted to be a part of feeding our child. And you know? And so for doing that, it's easier to do the bottle...he helps me out and my mom can help me out. I mean everyone can help me. (*White mother, formula feeder*).

Another focus group participant noted the inconvenience of breastfeeding:

#3: I didn't even try. That's just too inconvenient. You be taking your baby out, lifting your shirt up in public, packing breast milk, that just too much. I'd rather just go mix the formula and be on my way. (*Black mother, formula feeder*)

As the quote from participant #3 illustrates, breastfeeding is perceived as an act that entails hard work, a finding that is consistent with the studies reviewed earlier (Blum 1999, Carter 1995, Guttman and Zimmerman 2000). One of the mothers from the focus group (#5), quoted above, noted that her husband encouraged her to bottle feed so that he could also feed the child. This also implies that there is less "feeding work" for the mother. Thus, women's beliefs of the inconvenience of breastfeeding may stem from the advice they receive from social networks, as well as from their observations that breastfeeding in social settings involves considerable negotiation of space, time, and privacy. These insights also emerged in the narratives of the 22 formula feeding mothers from the in-depth interview study.

One of the primary findings that surfaced from the interviews is that the vast majority (N=21 out of 22) of formula feeding mothers were aware and informed of the benefits associated with breastfeeding, a theme that is consistent with prior literature (Blum 1999, Guttman and Zimmerman 2000, Murphy 1999, 2000, Schmeid and Lupton 2001). Yet despite the knowledge that "breast is best," these mothers chose not to breastfeed for reasons that mirrored their reports from the responses in the longitudinal survey. These reasons included perceived inconveniences

associated with breastfeeding, the influence of social networks (fathers, friends, and family members), maternal health behaviors, and their own strong resistance to breastfeeding.

Echoing findings from the focus group discussion, Elizabeth, a white formula feeder, spoke of her beliefs regarding the convenience of formula milk versus breastfeeding:

I frankly don't see how breastfeeding is all that convenient...my girlfriend [who breastfed her child] also said that when you breastfeed -- I don't know if it's true for everybody -- that when the baby gets hungry, the breasts leak around the time of feeding. So I wouldn't think that would be convenient for a woman, especially if she works.

Kendall, a young African American mother, noted that “if you have a busy life or if you have other kids to take care of, I think using a bottle [formula] is better. It's just more convenient and less time-consuming.” These comments highlight how beliefs of “convenience” regarding breastfeeding reflect economic and lifestyle conditions. Yet it should also be noted that these perceptions of breastfeeding as time-consuming are not informed from mothers' own personal experiences, as they are all first-time mothers.

Not surprisingly, fathers, friends, and other family members contributed to women's perception that breastfeeding is a cumbersome task. Seven out of twenty-two mothers reported that the baby's father disapproved of breastfeeding. Dakota, a white formula feeder, described how her daughter's father actively discouraged her from breastfeeding:

He didn't want me to do it...He said, “Why would you want to do that [breastfeed] when you could easily do it in a bottle, and it's so much more convenient?” ... It just wasn't something he was comfortable with me doing around his brother and his mother and all them. So we both decided [to formula feed].

Dakota provides an insightful example of how mothers' perceptions are shaped and validated by the observations and opinions of others, particularly the baby's father. Her partner's resistance to breastfeeding also illustrates how beliefs that breastfeeding is an inconvenient behavior are partly rooted in social norms regarding breastfeeding in public situations.

Some mothers were quite adamant in their decision to formula feed and no amount of persuasion could have changed their preference. Monique, a single, black mother, noted that although her doctors had discussed the benefits of breastfeeding, she knew she was going to use formula. She noted that the baby's father had little input into the decision and when I asked whether a nurse/lactation consultant talked to her about breastfeeding in the hospital, she stated:

Yeah, but there wasn't no point. I told them just like I'm telling you now, I was not going to do it. Nooo! [Laughs]. They [nurses] tried to get me [to try breastfeeding]. But I told her, look lady, it's not gonna happen so don't even bother.

It is clear from this account that Monique, like the majority of formula feeding mothers (N=14 out of 22), have decided before birth that breastfeeding is not for them. Dasia (African American, formula user) also noted that, "I just didn't want him sucking on my breast...Even though they [doctors] said it was healthy...I just couldn't do it." Dasia, unlike Monique or Dakota, reported that her son's father had encouraged her to breastfeed, having heard of the health benefits when he accompanied Dasia to her prenatal care visits. But Dasia and other formula feeders often reported that the act of breastfeeding was almost inconceivable to them. Although few mothers spontaneously stated the reasons, when probed further, almost half of the formula feeders described how the thought of a child "sucking on the breast" was very uncomfortable to them.

Formula feeding mothers were sometimes affronted by health care providers or lactation consultants who questioned their decision not to breastfeed (as one woman dubbed them, "the breastfeeding Nazis"). Gabrielle, a single white mother, recounts:

I'll never forget when I was in the hospital and I said I wanted to use formula, one of the doctors - she wasn't even my doctor - came in and was like, "Why? Breast milk is so much better." I said, "Because I'm the mother and that's my decision." ...and I know what the benefits are. I know that the baby could develop immunities from my milk and blah blah blah, you know? But I just don't feel as though I could do it. Plus I had to work all the time so for me -- I couldn't just sit around home pumping. And I just said, it's my decision and I choose to give her formula. I was on formula. I came out fine.

Gabrielle acknowledges the dominant knowledge of medical professionals -- that a baby can benefit from the immunological properties of breast milk -- but she counters this knowledge by asserting ownership over the decision (Jordan 1997, Murphy 1999, 2000). Furthermore, she frames her decision based on personal observations that breastfeeding may not necessarily be healthier. This speaks to the fact that Gabrielle is aware of practical concerns (such as returning to work) in juxtaposition with her own assessment that formulas fed babies are healthy.

In addition to Gabrielle, several other mothers (N=5) noted that their infants “were getting the same nutrition” as breastfed babies. Nisha, a 22 year old, African American mother reported that “my mother fed me bottle [formula], you know, that’s what they did back in the day. If it was good enough for me, it sure is good enough for her [daughter].” Mothers who formula feed seem to counter the discourse that breastfeed is best by drawing from their own observations and knowledge. Their observations lead them to believe that in actuality, the health benefits of breastfeeding may be minimal. The low-income mothers I spoke with draw from an alternative knowledge base, informed from their upbringing and observations, that 1) many infants have been fed formula without ill consequences, including themselves, and that 2) their own formula fed children are “healthy” and “big.” In fact, all but three of the mothers who used formula were also fed infant formula from birth. Four of the breastfeeding mothers were breastfed as babies. This suggests that beliefs about appropriate infant feeding methods are transferred across generations. Ideas of convenient and healthiest practices are informed not only through social contacts in the present, but also may become engrained and reinforced over time.

However, a small subset of mothers who formula fed did attempt breastfeeding in the hospital after birth (N=7). Some of these mothers planned to breastfeed their infants, sincerely believing in the discourses that breastfeeding was “best for the baby” (N=4). Christy, a white

mother, had intended to breastfeed, but after experiencing frustrating problems with the baby latching (even with a nurse's aid), she decided to formula feed stating that ultimately, "it's the same thing" as breastfeeding. Melanie, a Puerto Rican mother, recounted that she felt rejected when the baby wouldn't latch on. Melanie, however, received more encouragement than Christy to breastfeed from the baby's father and her sister (who had breastfed her own child), but both women felt disappointment when they were not able to breastfeed. These accounts highlight the guilt and blame formula feeding mothers may feel for not breastfeeding and their subsequent need to justify their decision (Blum 1999, Murphy 2000).

The other women (N=3) who attempted to breastfeed in the hospital but quit shortly afterwards initiated as a response to social pressure from nurses or lactation consultants in the hospital rather than from a personal desire. Cindy, an African American mother, attempted to breastfeed due to pressure from her extended family (her grandmother breastfed and urged her to do so as well) and also from the nature of her job. She had recently become a registered nurse, worked in the neonatal, intensive care unit [NICU] of a local hospital, and even taught breastfeeding to new mothers as part of her profession. Yet, she was not able to nurse her son:

Yeah, and that was so weird, like my grandma was like, "That baby was meant to have breast milk." But when he was born and I put him to my breast, I felt like that was the yuckiest thing. And oh, God, we shouldn't even be talking about this because I teach breast-feeding to women [in the NICU] and I teach 'em how to do it, but me, myself, I cannot do it [laughs]. Like that feeling was just, it grossed me out. Like I couldn't do it anymore. It felt like, oh my God, horrible. I just couldn't do it.

In contrast to Christy and Melanie, Cindy did not express feelings of guilt over not being able to breastfeed. Ironically, Cindy, more than any mother I interviewed, had the strongest medical knowledge base regarding the benefits and the "how to" of breastfeeding. Yet, she uses words such as "gross," "horrible," and the "yuckiest thing" to describe the experience of breastfeeding. In the following section, I explore in further detail the social norms that underlie such feelings.

Breastfeeding Etiquette: Keeping Bodies Private

As illustrated in the previous section, social networks and upbringing play important roles in understanding the decision to breast or formula feed, but do not fully capture the nuances of this process. There are clearly larger cultural and social ideologies that influence how women perceive the act of breastfeeding, particularly concerning breastfeeding in public spheres. Because breastfeeding exposes part of a woman's body that is fetishized in Western societies (Saha 2002), both men and women often view it "as a behavior prohibited in public because it uses what they perceive as a sexual organ" (Rodriguez-Garcia and Frazier 1995: 112). Blum (1999: 165) comments that many women intimately feel "the need for vigilance in keeping their...bodies private," but that these beliefs are more acute among lower class women who do not have the same social or moral legitimacy and entitlement of middle and upper class mothers.

Both low-income formula feeders and breastfeeders in this study spoke about the "rules" of breastfeeding – when and where breastfeeding is appropriate and the necessity of keeping the body private. Within these discourses, one can see how breastfeeding directly touches on women's socialization and feelings about body image and comfort in their own skin. They also speak to how difficult it is for mothers to think about their breasts in non-sexual ways. Several formula feeders noted that they would not breastfeed because "that's [my] sexual spot," illustrating how some mothers viewed breasts as literally and solely for their partners' satisfaction (Hoddintott and Pill 1999, Morse 1992).

Laquanda (an African American mother) and three other formula feeding mothers reported that the baby's father actively discouraged them to breastfeed because they wanted to help in feeding the infant, but also gave reasons that touch on issues of sexuality and ownership of the breast. One of the reasons why Laquanda did not breastfeed was because the baby's father

“didn’t want me to...He told me that the baby would tear my nipple off...and that my breasts would droop.” Fears of sagging breasts and bloody nipples hint at the idea that breastfeeding would somehow disfigure her body, and consequently, the couples’ sexual gratification. Similar to Laquanda, Elizabeth (white formula feeder) also noted that breastfeeding would be “weird” because breasts “are a man’s thing” and that “I just didn’t feel comfortable just whipping my stuff out to everybody... You’re going to see [the breast] and that’s just, that’s personal.”

Sadie, a heavy set, mainland-born Puerto Rican woman, told me that she felt uncomfortable with her body and never let her partner see her fully naked. Sadie remarked that she would never expose her breasts in public, not even for the purposes of feeding her child. Her private body image reflects larger cultural norms about what constitutes a beautiful body, but also illustrates how public and private notions of breasts and beauty influence mothers’ beliefs about the feasibility of breastfeeding. The “doability” and acceptability of breastfeeding is shaped not only by women’s misgivings of how others might view their bodies, but also reflects how women judge and conceptualize their own bodies. These stories also speak to larger taboos against nudity and exposure of the breast, and how breastfeeding directly breaches this norm.

Decency and Discretion: “You gotta be careful ‘cause there some perverts out there”

During the focus group discussion, there were often times when women seemed to be aware of the ways in which mothers who breastfeed are judged by others in their community.

The following excerpt, in which participants discuss breastfeeding in public, illustrates this:

#3: I don’t have nothin’ against it [breastfeeding] but I know that if I’m going on a bus and someone’s sitting in the back and she’s breastfeeding, I’m gonna look at her like, now why you didn’t put it in a bottle? I just don’t think you should be doing it on a public bus. (*Black mother, formula feeder*).

Q: How come? What’s so wrong...?

- #3: It just, it just looks awkward...
- #5: I don't even know why we think it's not right. Like, to be honest, I don't even really know why. (*White mother, formula feeder*).
- #4: That's what I was gonna say. A lot of people probably see it as something you should keep behind closed doors, but if something is natural, it's probably right. I think it's just the mentality of different people. I think that's what it's all about. (*Puerto Rican mother, breastfeeder*)

On the one hand, there is the idea that breastfeeding is a natural product and thus, the best feeding option for the infant. Yet there is also a powerful normative belief that breastfeeding is “something you should keep behind closed doors.” Women who break this “rule,” as demonstrated by participant #3's remarks, are subjected to censure and criticism.

The social norm of “covering up” was a salient theme and an important element in the narratives of both breast and formula feeding mothers who participated in the interviews. For instance, Lisette, a 27 year old, white mother who lived alone with her daughter, stated that although she enjoyed breastfeeding, it also involved considerable negotiations at times:

Sometimes like I would be embarrassed but I would still do it. Like if the baby was really crying. I just put the blanket over me and hide it, like if I'm on the train or a bus or something...It was pretty uncomfortable but I didn't have nobody coming up to me saying, “Oh go do that somewhere else.” Because I covered, so they usually didn't know.

Brielle made similar comments, stating that she always covered herself when breastfeeding in front of other people, even in front of her in-laws: “I think people shouldn't just expose themselves right in front of everybody...I guess it has to do with a lot of American society, you know, feeling shameful.” It is important to note that none of the breastfeeding mothers could point to concrete incidences of censure when they breastfed in public. These “shameful” feelings stemmed from their perceptions of what others might think and how they would be judged.

Most breastfeeding mothers expressed the idea that breastfeeding is an inherently “natural” behavior. The contradictory idea that public exposure of the breast, even for the

purposes of infant feeding, was a “shameful” act was noted most particularly among formula feeders. Although most felt that breastfeeding was fine in general, exposure of such a private part was described as “not lady-like,” “indecent,” and “nasty.” Dakota captures these sentiments:

I think that is nasty [not covering up]. I think they need to just cover it, like cover it up. If you cover it up good, your baby’s hungry and that’s what you’re doing, so your baby needs to eat. But I don’t think you should [pause]... I think it should be covered up because that is a part of your body that’s exposed...It’s just wrong [not to cover].

She goes on to describe the problem of public exposure that breastfeeding, at times, calls for:

There are some perverts out there, that’s, I don’t know, they’re probably like, “Ooh, look at her breasts!” They’re looking at her breasts as breasts instead of food for the baby.

Breastfeeding in public opens a mother up to societal scrutiny and perhaps even danger. It is a “nasty” behavior because it invites the unwelcome gazes of “perverts” and outside judgments, and subsequently calls into question the mother’s decency. Although almost all mothers, both breast and bottle feeders, stated that they would feel comfortable breastfeeding in front of their husbands (“they’ve already seen it”) and female kin or close girlfriends, breastfeeding in front of strangers (particularly, strange men) was considered an indecent act. These sentiments may be intricately tied to prevalent notions of women’s respectability. Feminist scholars have observed that breastfeeding disturbs us because it violates “compulsory heterosexuality” where women’s bodies are sexual “but are expected to signal only sexual availability to men” (Blum 1999: 128). Women must keep the heterosexual body separate from the maternal, breastfeeding body, but in everyday situations, these spheres often clash (Blum 1999: 129, Carter 1995, Stearns 1999).

The irony in the mothers’ beliefs about indecency and breastfeeding is that they also perpetuate these conceptions. Narratives of “nastiness” rely on a rather limited definition of the female body and its purposes. These low-income mothers were aware of the fact that they sometimes self-regulate according to a divide of breastfeeding and decency. And women at times

questioned why they accept these broader ideologies and are cognizant of the cultural contradictions (Blum 1999, Carter 1995, Saha 2002). Yet the stigma against public breastfeeding as a violation of maternal decency was alluded to by many mothers, even though it is not entirely clear why others perceive this behavior and why they themselves believe it to be wrong.

Conclusion

Infant feeding decisions reflect broad ideologies of health, expert advice, maternal identity, and sexuality. In this study of low-income, inner-city mothers, the decision to breast or formula feed can be seen as a window through which to view how competing forms of knowledge and beliefs about “breast is best” operate. The experiences of the low-income mothers in this study also exemplify many of the socio-cultural ideologies that breastfeeding embodies (Blum 1999, Carter 1995, Murphy 2000), and how breastfeeding can be simultaneously considered both a very natural act and an indecent one.

Breastfeeding directly touches on public perceptions and private conceptualizations about female bodies and the role of breasts in western society (Blum 1999, Saha 2002). Formula feeding mothers struggled with viewing their breasts in non-sexual ways and often viewed breastfeeding in public as a “nasty” behavior. The women in this study, from different racial and ethnic backgrounds, mentioned the strong symbolic link between breasts as an erotic, sexual organ, which suggests that this view is highly normative. Many formula feeding mothers framed their decision to not breastfeed using the rhetoric of choice and autonomy. Yet ironically, women’s inability to see breasts as more than sexual organs for their own or their partner’s pleasure constrains their degrees of “choice.” Narratives of maternal autonomy (Blum 1999, Carter 1995, Murphy 2000, Schmied and Lupton 2001) regarding breastfeeding options must be

considered within a larger atmosphere in which breasts are narrowly but chiefly construed as objects of female beauty and sexual gratification.

The sample in this study is not representative of low-income mothers and therefore, the findings cannot be generalized. Yet we can draw some implications for health care professionals interested in increasing breastfeeding practice among disadvantaged mothers. I found that what women plan to do during pregnancy is typically what they end up doing, and in most cases, they could not be persuaded to change their intentions. However, exceptions include the cases in which women told stories of their desire to breastfeed, but due to problems with their initial attempts at nursing, they quickly switched to formula feeding after returning home. These women would have been open to and probably benefited from instructional and emotional support in the form of home visits from community-based nurses or lactation consultants – a practice that breastfeeding advocates encourage but is often lacking in underserved communities.

Breastfeeding advocates have suggested that one way to increase breastfeeding rates among low-income mothers is to incorporate fathers and other informal social networks in discussions about breastfeeding (Baronowski et al. 1982, Freed et al. 1992, Wright 2001). My findings suggest that extending breastfeeding education to influential social support networks might encourage breastfeeding by creating an immediate social environment that allows women to feel comfortable with this practice. At the same time, this study also suggests that barriers to breastfeeding extend beyond lack of social support. Normative socio-cultural ideas about beauty, breasts, and bodies are deeply embedded and much harder to change, but these ideologies are an important aspect of understanding why low-income mothers “just don’t want to breastfeed.”

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Table 1. Reasons Why Mothers Did Not Breastfeed (N=563), Philadelphia Longitudinal Study of Low-income Women

	Percent of respondents reporting following reason	Number reporting reason
Mother's health behaviors: <ul style="list-style-type: none"> • R. did not want to pass dangerous things through milk 	28.8%	162
Mother did not want to breastfeed	27.4%	154
Mother's health-related problems: <ul style="list-style-type: none"> • R. was too ill/weak (N=44) • R. had breast/nipple problem (N=73) 	20.8%	117
Mother's beliefs about inconvenience/time-consuming nature of breastfeeding	13.3%	75
Mother did not know/was unsure about how to breastfeed	6.4%	36
Mother thought breastfeeding would be uncomfortable	6.4%	34
Mother thought she did not have enough milk	5.7%	32
Mother thought breastfeeding would be painful/ fear of pain	5.3%	30
Other reasons <ul style="list-style-type: none"> • Unspecified (N=17) • Child-related reasons (child rejected breastfeeding or child too ill/weak to breastfeed) (N=13) • Partner did not want R. to breastfeed (N=10) • R. bottle fed other children (N=7) • R. is too scared to breastfeed (N=7) • R. has body image issues with breastfeeding (N=3) 	10.1%	57

Table 2. Characteristics of Participants in Qualitative Study by Infant Feeding Method (N=29)

	<i>Total Sample</i> N=29	<i>Breastfeeders</i> N=7	<i>Bottlefeeders</i> N=22
Race/Ethnicity ¹			
Non-Hispanic white	10	2	8
Non-Hispanic black	11	1	10
Puerto Rican	8	4	4
Age at Birth ²			
18-19 years	7	3	4
20-24 years	19	4	15
25-30 years	3	0	3
Education level during pregnancy ¹			
Did not finish high school	7	2	5
Completed high school or GED	13	4	9
Schooling beyond high school	9	1	8
Employment/Schooling at qualitative interview ³			
Not working	4	1	3
Working	23	5	18
In school/ job training	2	1	1
Received cash benefits from welfare at qualitative interview ³			
Yes	7	2	5
No	21	5	17
Relationship status with baby's father at qualitative interview ³			
Married	8	4	4
Living together	7	0	7
Romantically involved but not living together	5	3	2
No longer involved	9	0	9
Lives with other family members at qualitative interview ³			
Respondent lives with extended family	14	4	12
Respondent does not live with extended family members	15	3	10

¹Information from Wave 1 (prenatal interview) of Longitudinal Study

²Information from Wave 2 (first postpartum interview) of Longitudinal Study

³Information from qualitative interview, conducted two and a half to three years after child's birth