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Abstract approved:

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In this thesis, I examine the experiences of breastfeeding mothers who chose to give birth with Certified Professional Midwives at a free-standing birth center, and the factors that influence their known high rates of breastfeeding initiation and duration. Using grounded theory and data collected from participant observation, semi-structured interviews, and an open-ended survey, I describe the functioning of the birth center and the breastfeeding explanatory models of the birth center staff as well as how the birth center's model of care affects client-participant's experiences of breastfeeding in community that rejects medicalized models of birth and breastfeeding. Findings interpreted from a biocultural perspective reveal how women utilize previously constructed breastfeeding convictions to navigate support and difficulties in a way that allows 92% of client-participants to report overall happiness about their breastfeeding experiences. There was, however, a small subset of women who were disappointed in their breastfeeding experience. Recommendations include changes in care practice to further support breastfeeding women in this community.

Women's Experiences of Breastfeeding in an Out-of-Hospital Birthing Community

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Lindsay J. Marshall, Author

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Chapter 1 – Introduction

Breastfeeding and human breast milk are widely recognized as optimal nutrition and feeding practice for both mother and baby (ABM 2008; AAP 2005; CDC 2010; WHO 2009), thus encouraging mothers to nurse their infants is a major public health priority. National breastfeeding rates and goals are outlined annually by the Centers for Disease Control and Prevention's (CDC) Breastfeeding Report Card (BRC), and display information specific to each state on five outcome and nine process indicators related to infant feeding practices, as outlined in the national Healthy People 2010 program (CDC 2010). As illustrated in Table 1, the nation as a whole is not meeting the BRC's objectives. Breastfeeding, however, is much more than a question of what babies eat, and is influenced by many biological, cultural, psychosocial, and societal factors (ABM 2008; AAP 1997; CDC 2010).

Outcomes	Ever Breastfed	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive breastfeeding at 3 months	Exclusive breastfeeding at 6 months
Goals	75.0	50.0	25.0	40.0	17.0
U.S. National	75.0	43.0	22.4	33.0	13.3

Table. 1 National Breastfeeding Goals (CDC 2010)

The purpose of this community based participatory research project was to examine determinants of breastfeeding success at a free-standing, midwife-led birth center in the Pacific Northwest. A free-standing birth center (FSBC) is defined as a maternity unit that is geographically and administratively separate from a hospital that has no routine labor involvement of medical staff and no facility for medical intervention

(Turkel 1995; Walsh and Downe 2004). But why study a population of breastfeeding women at a free-standing birth center run by midwives in the Pacific Northwest? What makes this population so different and why is it of interest in regards to breastfeeding research?

This site was chosen for two reasons: 1) it is an out-of-hospital birthing environment where care is provided by Certified Professional Midwives rather than obstetrician/gynecologists (OB/GYNs) and 2) this community was reported to have very high rates of breastfeeding initiation and extended duration as compared to the larger U.S. population. This research aims to provide an ethnographic account of the culture of the Bright Life[1] Birth Center, while answering three primary research questions:

1) How do the midwives at the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients?
2) What are women's experiences of breastfeeding and breastfeeding support at the birth center?
3) How are women's breastfeeding experiences shaped by the birth center's approach to breastfeeding, and how might this information be used to improve services both at the birth center and, more generally, for U.S mothers at large?

The out-of-hospital (and non-hospital affiliated) Pacific Northwest setting of Bright Life is the first characteristic that sets it apart. According to the National Vital Statistics Reports from November 2011 (Martin et al. 2011), of the over four million births in the

[1] This is a pseudonym, as are all names of participants who appear throughout.

U.S. in 2009, 98.9% took place at a hospital or hospital affiliated birthing center. Out-of-hospital births (births that take place at a FSBC or at home) accounted for 44,121 or 1.1% of all births in the United States, with the states in the Pacific Northwest recording the highest percentage of these births. Of the 1.1% of out-of-hospital births, birth centers represented 26.7% - in other words, only 12,169 of 4 million births (roughly 0.003%) took place at free-standing birth centers (Martin et al. 2011).

Free-Standing Birth Centers

Women choosing FSBCs are typically in good health and considered low-risk for obstetrical complications (Khoury, Summers and Weisman 1997; Turkel 1995; Walsh and Downe 2004). FSBCs have been found to provide a more comprehensive range of primary care and pregnancy related services, both clinical and nonclinical, than either hospitals or hospital-sponsored birth centers (Khoury, Summers and Weisman 1997). Clinical services include prenatal and postpartum exams, various screenings for mother and baby, and vaginal deliveries. Free-standing, midwife-led birth centers also boast high rates of successful vaginal birth, vaginal birth after cesarean (VBAC), intact perineums, babies staying with their mothers after birth, and low rates of episiotomies and cesarean sections (Walsh and Downe 2004). Nonclinical services can include childbirth and parenting education classes, support groups, printed health information, and community and physician referral services. Additionally, FSBCs have been found to follow a woman-centered model of care that promotes prevention over intervention, trust, shared-decision making, empowerment, holistic approaches to care, and women's reproductive rights (Khoury, Summers and Weisman 1997; Turkel 1995).

FSBCs can be argued to occupy an intermediate or "mandorla space" in the current world of U.S. birthing culture. The mandorla is an ancient symbol of integration that consists of two overlapping circles, with the mandorla (the Italian word for almond) being the oval, almond-shaped middle space that is formed when these circles overlap (Dwyer 2003). A FSBC birth is one that allows women more power over their birth than in the average institutionalized, hospital delivery. As noted by Turkel (1995), women are not birthing in an unfamiliar environment where they have never been before. Prenatal visits have taken place at the center, family and friends are welcomed into the birth experience, and the spaces are more like a home environment in concept -- birthing rooms like bedrooms, common areas, kitchens etc. Thus, FSBC's are arguably situated in the shared space between home and hospital, as a mixture of both, though perhaps closer to homebirth than to hospital in most cases. However, FSBCs are not homes and therefore do not carry the same stigma as home deliveries (Cheyney 2008), and may be one of the reasons that women choose them (Turkel 1995). FSBCs may mitigate some of the fears surrounding childbirth (and especially those shared by extended family members) as a result of the medicalization of pregnancy and birth. As such, these centers provide a sort of "middle ground" option for those women who believe that childbirth is indeed a natural phenomenon, but who may not be able to fully embrace a homebirth and all of the values and judgments attached to them in the United States (Cheyney 2011).

Midwives and the Midwifery Model of Care

The second major characteristic that sets this FSBC community apart is the women who provide the care. Doctors of medicine or osteopathy attended 92.1% of

hospital births (Martin et al. 2011). If more than 90 % of hospital births in the United States are attended by obstetricians (Cheyney 2010), who is attending the other 7.9% within the hospital? And who is attending those births that take place outside of the hospital? There are two major categories of midwives in the United States, Certified Nurse Midwives (CNMs) and Direct-entry Midwives (DEMs). CNMs are registered nurses who complete additional training specific to midwifery and practice nearly exclusively in hospitals, attending 8-10% of hospital births. Additionally, CNMs are able to practice legally in all 50 states (Cheyney 2010).

DEMs provide care to a small subset of women in the United States who are typically critical of what they see as the over-medicalization of childbirth for normal, healthy women. DEMs do not go to nursing school, instead completing midwifery training though several pathways, including apprenticeships with senior midwives and attending formal accredited schools. DEMs are only legally able to attend births in 26 states (including the states in the Pacific Northwest) and do not have hospital privileges (or formalized relationships with obstetricians in general). In states where DEM practice is legal, there is the option to become a Certified Professional Midwife (CPM) that comes with additional rights and benefits, such as being able to carry oxygen and administer certain medicines such as pitocin (Cheyney 2010). To fully understand the important differences between these provider types, it is necessary to examine the philosophies that inform midwifery and more medicalized models of care.

There are two major models of birthing care in the United States, termed the medical and midwifery models by Barbara Katz Rothman in 1982. These models, later

refined by Davis-Floyd (1992), are also known as the technocratic and holistic models of birth, respectively. These models present,

> …beliefs about childbirth, ranging from the notion of the female body as a defective machine in need of medical management under the technocratic paradigm to a view of the body as a healthy organism inherently capable of giving birth with watchful and compassionate support (Cheyney 2010).

The medical/technocratic model of birthing treats pregnancy and birth as pathological phenomena and places the physical health of the baby over both the physical and emotional health of the mother (Davis-Floyd 1992). In this model, the most appropriate prenatal, intra-, and postpartum care is objective and scientific, and technology is seen as superior to nature. The medical/technocratic is the care model that is most often found in hospital settings, where OBGYNs are the primary providers of maternity care. Traditional, westernized medical training treats pregnancy as a disease and focuses on the inherent need for medical personnel and equipment. Physicians, rather than mothers, "deliver" babies, and birth is seen as needing to take place in a hospital just in case "something bad" happens (Cheyney 2008).

The midwifery/holistic model on the other hand, works to minimize technological interventions by providing individualized care that monitors the physical, emotional and social well-being of mothers throughout the prenatal, birth and postpartum periods (Cheyney 2011; Davis-Floyd 1992; Rothman 1982). It would be problematic to say that all health care providers exclusively adhere to one model or the other, as most fall somewhere within a spectrum of care models with few adhering to the extremes. However, as Cheyney (2010) points out, women in the United States who choose to give

birth outside of the hospital are pushing the boundaries of socially acceptable reproductive behavior, which is compounded by several generations of socialization into a birth-as-medical-event perspective. The free-standing, licensed, midwife-led birth center in this study most closely follows the midwifery/holistic model of care, as evidenced by Bright Life's home webpage:

> Welcome. Giving birth is one of the most miraculous and transformative events in a woman's life. Women have the innate ability to give birth with confidence and dignity. As women search for ways to reclaim the beauty and power of birth, more and more women choose to give birth with midwives.

About the Study and Positionality

Women giving birth in a freestanding birth center and the midwives who attend them can be considered "hidden" populations (Singer et al. 2001), or groups that exist outside of social institutions that are easily accessible, as in the case of those who choose hospital births (accessible via Vital Records, for example). These populations can be more difficult for researchers to identify, and as a result, they often remain under-studied compared to their counterparts who, in this case, choose a more socially normative place for delivery.

As 98.9% of women give birth in hospitals in the US, it is not unexpected that the current body of scholarly literature on breastfeeding focuses primarily on hospital protocols as they relate to or impact infant feeding practices. While the available literature on homebirth in the United States is steadily increasing thanks to scholars like Cheyney (2009, 2010, 2011) and Davis-Floyd (1992, 1994, 2001), there are still only a handful of studies that focus on care in FSBCs (most of which come from the United

Kingdom). Given that the numbers of hospital vs. out-of-hospital birth studies are enormously imbalanced, and that midwifery care only represents approximately "10 percent of deliveries in the hospital and only about 1 percent of deliveries at home" (Cheyney 2010:2-3), it is unsurprising that studies focused specifically on breastfeeding within midwifery led, out-of-hospital birthing communities in the United States are scarce.

For the purposes of this study, the sample of women who went into labor intending to deliver in the birth center were identified by their engagement in prenatal, intra-, and postpartum care with Certified Professional Midwives (CPMs), rather than Certified Nurse Midwives (CNMs) or obstetrician/gynecologists (OBGYNs). All study participants went into labor intending to deliver outside of the hospital, regardless of whether they actually completed the delivery at the birth center, as approximately 10% of women who plan home or birth center deliveries will transport to the hospital during labor due to non-emergent complications such as prolonged labor (Cheyney 2010). This project employed extensive participant observation that was made possible through an internship with Bright Life Birth Center and a mixed-methods approach that integrates data from survey questionnaires answered by Bright Life's clients with interview narratives from the birth center's staff.

This study will nuance breastfeeding research by adding an analysis of breastfeeding success narratives in terms of initiation, duration and overall happiness as a means of identifying factors that contribute to positive breastfeeding relationships. The ultimate aims are twofold: 1) to provide feedback to Bright Life Birth Center so they can

continue to improve their services and 2) to identify transferable strategies that may be applied in hospital settings to help improve breastfeeding success rates.

Finally, it important to address my positionality as a researcher and breastfeeding advocate. I am motivated in this work by my belief that breastfeeding is almost always the best option for both mother and baby. However, my intent is not to find new strategies for persuading all women to nurse, nor do I want to reify what might be experienced as an oppressive standard that adds to mother blaming when breastfeeding goals are not met. Instead my intent was to identify the key factors associated with high rates of breastfeeding initiation and duration in this community as perceived by the mothers themselves, with the hope that findings might be used to help women who do choose to breastfeed to do so in a way that feels adequately supported.

Chapter Two– Literature Review

In order to understand and contextualize the study results, I provide a brief overview of relevant literature. This chapter is divided into three sections: 1) the biology of the lactating breast; 2) medicalization of birth and the impacts on breastfeeding; and 3) providers' attitudes and self-efficacy. In this chapter I show how birthing practices, along with social relationships and self-perception, interact with and affect the biology of breastfeeding. Additionally, this chapter will highlight key gaps in the literature that this study focusing on women's experiences of breastfeeding at a free-standing birth center with Certified Professional Midwives will help to fill.

The Biology of the Lactating Breast

The American Academy of Pediatrics' Policy Statement on breastfeeding states that because human milk is species specific, it is superior for infant feeding when compared to alternative feeding methods such as infant formula (AAP 2005). Currently, the recommended timeline for nursing is exclusive breastfeeding for six months with continued nursing for at least one year and up to two years (ABM 2008). Exclusive breastfeeding is defined as an infant's consumption of human breast milk with no supplementation (e.g. no water, juice, nonhuman milk, formula or solid foods).

The human breast attains full, functional capacity through the expression of breast milk during lactation. Therefore, the breast does not go through all of the developmental stages unless a woman experiences both pregnancy and childbirth. During pregnancy, the ductal system of the breast undergoes extension and branching, and blood flow to the

mammaries increases by nearly twofold (Geddes 2007). During labor and birth a collection of hormones known as the reproductive hormones (estrogen, progesterone, placental lactogen, prolactin, and oxytocin) function to bring about milk secretion and milk delivery to the infant (Neville, McFadden, and Forsyth 2002). Nipple stimulation is the most important factor in the initiation and continuance of the let-down reflex, which is a psychosomatic mechanism that influences milk expulsion. When the nipple is stimulated by the suckling infant, the nervous impulses are sent to the posterior pituitary gland where oxytocin is released into the bloodstream. Oxytocin causes the cells that surround the alveoli to contract, forcing milk into the ducts where it becomes available to the infant (Newton and Newton 1950).

The newborn has two innate and natural suckling reflexes -- rooting and suckling (Woolridge 1986). The rooting reflex is elicited by the mother by skin to skin contact, especially around the infant's mouth. When this occurs, the infant will "gape", or open his or her mouth widely in anticipation of receiving the nipple. The suckling reflex is then triggered by the tactile stimulation of the infant's palate, which signals the infant to begin suckling. Because the tongue and lower jaw are the main drivers of milk expulsion, signaling that the nipple is correctly placed in the mouth by touching the palate may be adaptive. If the outer mouth and palate are not adequately stimulated early in the breastfeeding relationship, the infant may reject the nipple in favor of something that does provide the necessary stimulation to provoke the suckling reflex (i.e. artificial nipples on bottles). Infancy is the only time in life when a single food can provide adequate nutrition, as colostrum and breast milk contain carbohydrates, lipids, proteins,

macro and micro nutrients, as well as various vitamins and minerals (Picciano 2001). Due to the low ratio of carbohydrates and water to protein and fats in breast milk, and the easy digestion of those carbohydrates, infants must nurse frequently. Therefore, early stimulation, appropriate latch, and frequent, strong suckling by the infant are necessary to maintain adequate milk supply (Woolridge 1986). Additionally, optimal latching behavior of the baby -- including rooting, gaping, sealing, and sucking behavior -- are related to lower levels of reported pain resulting from sore nipples, mastitis or engorgement (Blair et al. 2003).

Mastitis is clinically defined as localized and painful inflammation of the breast that occurs in conjunction with flu-like symptoms. The occurrence is most common during the second and third weeks postpartum, which is problematic as this may lead to the discontinuation of breastfeeding (Spencer 2008). Risk factors for mastitis include cracked nipples (which can serve as an entry point for bacteria), poor latch, missed feedings, blocked milk ducts, and yeast infections. Treatment of mastitis often requires antibiotics, but one of the most effective treatments is to improve breastfeeding technique because this allows for more effective draining of the breast during a feeding episode. Mothers should be encouraged to persevere through mastitis, as breastfeeding can usually continue during the infection (Prachniak 2002; Spencer 2008).

Considering the nutritional properties and immunological protection that breast milk offers, one might ask how long the breastfeeding relationship should last. Dettwyler (1995) developed what she calls the hominid blueprint for weaning -- a model based on the lactation and weaning behavior of the Great African Apes, modern humans' closest

living relatives. Dettwyler uses non-human primate life history variables such as weight (multiples of birth weight), fractions of adult body mass and the eruption of the first permanent molar to determine the appropriate age at weaning. In addition to presenting information about duration, Dettwyler (1995) also cites the importance of breastfeeding in terms protection and development. Frequent breastfeeding keeps an infant close by, serving as means of protection from potential predators, especially in non-human primates. The carbohydrate heavy milk that primate mothers produce provides the brain with glucose, the only form of energy the brain can utilize, while promoting tactile stimulation and further brain development.

Based on non-human primate data and comparative studies of historical and contemporary accounts of hunter-gatherer and non-U.S. populations, she contends that if humans followed the primate pattern, disregarding cultural beliefs, most children would be weaned between 2.5 and 7 years of age (Dettwyler 1995). Dettwyler (1995) argues that the wide range in variation around weaning in humans is a result of the vast differences in the environments that humans evolved within. The cultural traditions of modifying foods, both chemically and mechanically, allows for diversity in normative weaning ages cross-culturally. Dettwyler (1995) frames her argument in the context of the contemporary United States, where although most health professionals and popular literature recommend that breastfeeding continue for one year, they do so in language that suggests that even one year is a long time and breastfeeding a child longer than that is unnecessary and therefore, abnormal. These seemingly contradictory messages are further complicated by the recent (in terms of human history) medicalization of human

childbirth that often works against the highly coordinated biological processes that have evolved in the mother-infant, early postpartum relationship.

Medicalization of Birth and the Effects on Breastfeeding

The medicalization of childbirth in Western societies has led to practices that can leave mother and baby vulnerable when attempting to establish a strong breastfeeding relationship (Davis-Floyd and Cheyney 2009). This has been especially true since the shift from home to hospital birth in the 1940s and the decrease in postpartum hospital stays from 7-10 days to 1-2 days (Montgomery 2000). Factors contributing to a successful breastfeeding relationship often start before the baby is born during labor and birth, as breast milk production is biologically regulated by both maternal and infant behaviors (Quandt 1995). Quandt (1995) identifies a "window of opportunity" in which breastfeeding must be initiated, where both mother and baby should be able to fully participate in the first breastfeeding as soon possible after birth. In contemporary western societies, there are medical/technological practices that inhibit the ability of both mother and baby to fully engage in the initiation of breastfeeding.

The AAP (2005) states that healthy, full term infants should be able to breastfeed unassisted within the first hour of life and should be put in direct skin-to-skin contact with the mother immediately after birth. Several researchers contend that certain birthing practices and delivery methods have an effect on the breastfeeding initiation of otherwise healthy infants (Baumgarder et al. 2003; Matthews 1989; Montgomery 2000; Ransjö-Arvidson et al. 2001). Montgomery (2000) has demonstrated that traumatic deliveries, such as caesarean sections and the use of vacuums or forceps, may affect the infant's

ability to learn to breastfeed for the first day or two after birth. Ransjö-Arvidson and colleagues (2001) present data indicating that several types of analgesia, most commonly epidurals, given to the mother during labor may interfere with the newborn's spontaneous breast-seeking and breastfeeding behaviors. Their study showed that all of the infants (whose mothers did and did not have analgesia during labor) made hand-to-mouth movements, touched the nipple with their hands before suckling, made licking movements, and sucked the breast. However, the infants whose mothers received analgesia during labor performed these actions significantly less often than their non-medicated counterparts. Nearly half of the infants whose mothers received analgesia had difficulty latching, suckling and swallowing for several hours after the birth (Ransjö-Arvidson et al. 2001). Studies by Matthews (1989) and Baumgarder et al. (2003) found similar results concerning the effect of analgesia on breastfeeding initiation in the early neonatal period.

It is common for women to experience pain when breastfeeding in the immediate postpartum period, as breastfeeding causes the uterus to contract (Holdcroft 2003). However, for women who have given birth via caesarean section where the infant is born by cutting through the abdomen into the uterus, uterine contractions during breastfeeding may be particularly painful and might discourage women from early nursing. Chein and Tai (2007) explored the effects of caesarian delivery on breastfeeding outcomes and found that mothers who underwent a surgical delivery had a significantly lower rate of breastfeeding initiation that ultimately lead to very low rates of any breastfeeding at one to three months. Caesarian delivery may also be correlated with a higher likelihood of

delayed onset of lactation (Dewey et al. 2003). In 2009, the average caesarean delivery rate for women in the United States was 32.9% (Martin et al. 2011); meaning 1 in 3 women experienced a birth that was likely to negatively impact the breastfeeding relationship.

Birth may be a stressful time for some women and psychological factors such as fear and anxiety can also negatively affect the breastfeeding relationship, manifesting both behaviorally and physiologically. A study by Thorley (2005) explores new mothers' fears of nipple pain and the poor latch that results from an excessively rigid body position when holding the baby to breast. Newton and Newton (1950) discusses fear effects on the let-down reflex, whereby as stress increases, the stress hormone cortisol increases. Cortisol inhibits the effects of oxytocin -- the hormone that stimulates the let-down reflex to release breast milk. Fear and anxiety also lead to increased levels of epinephrine, which decreases the circulation of oxytocin and constricts the blood vessels around the alveoli, inhibiting milk ejection (Quandt 1995).

Difficulty letting-down can sometimes lead to additional breastfeeding issues. If a mother perceives that her milk supply is low, she may believe that she is unable to produce enough milk for her baby. This perception has led to a widespread psycho-physiological phenomenon called "perceived insufficient milk" supply or PIM (Hill and Humenick 1989). PIM has been reported to affect between 30% and 80% of women and is one of the primary reasons women cite for weaning early, especially within the first 1-4 weeks postpartum (Ahluwali, Morrow and Hisa 2005; Binns and Scott 2002; Blyth et al. 2002; Gatti 2008; Heath et al. 2002; Kirkland and Fein 2003; Lewallen et al. 2006).

Several studies have shown that routine hospital policies and procedures are linked to PIM and early cessation, most specifically formula being given to infants during their hospital stay immediately postpartum and the inclusion of formula-feeding starter kits as part of discharge packets (Alikassifogglu et al. 2001; Chan et al. 2000; McCarter-Spaulding and Kearney 2001; Sheehan et al. 2001). Chan and colleagues (2000) found that 77% of infants in their study population were given formula due to PIM. The practice of giving formula during hospital stays and sending it home, "just in case" of low milk supply, sends the message to mothers that they are likely to fail and that it is okay to stop breastfeeding because at least they gave it a shot (Rosenberg et al. 2008). It is, however, important to note that PIM is based on maternal perceptions and actual milk supply is rarely measured. Therefore, the accuracy of maternal perceptions of PIM is still unknown. The perception of insufficient milk often leads women to choose to supplement breastfeeding or to exclusively feed with formula. Because milk supply is dependent on the frequency and duration of nipple stimulation, PIM, in as far as it leads to supplementation, functions as a self-fulfilling prophecy.

Although policy statements from professional and governmental organizations abound, touting the benefits of breastfeeding and the need to increase breastfeeding rates (ABM 2008; AAP 2005; CDC 2010; WHO 2009), medical practices may make it difficult for a mother-infant dyad to establish a strong breastfeeding relationship either initially or for the recommended duration. However, even if a woman is able to establish a strong nursing relationship with her child, the attitudes and opinions of care providers

and of key figures in a mother's social support network can greatly influence a breastfeeding mother. These aspects of breastfeeding are discussed below.

Attitudes of Others and Self-Efficacy

A mother's perception of attitudes extends beyond the general public and into her own support circle, where it is most influential. DiGirolamo and colleagues (2003) found that physicians' and other hospital staff's attitudes were perceived by the mother and had an effect on breastfeeding outcomes. Even in the absence of overtly negative attitudes towards breastfeeding, a lack of positively perceived messages or the presence of neutral attitudes had a negative effect on outcomes. The authors discuss public health implications, such as the need for training in effective and positive communication and research that addresses how messages are actually received by mothers in certain contexts. Such measures may help to alleviate communication barriers (DiGirolamo et al. 2003). Ekstrom and colleagues (2005) found similar results in terms of negative, neutral and positive connotations in provider communication in their study of breastfeeding attitudes among counseling health professionals. Health professionals who emphasized positive breastfeeding experiences for women in the immediate postpartum period had higher rates of breastfeeding continuation in their clients (Benson 1996; Graffy & Taylor 2005; Hailes & Wellard 2000).

Mothers who discontinued exclusive breastfeeding were found to have an increased likelihood to report that a health care provider recommended supplementation with infant formula (Taveras et al. 2004). Witters-Green (2003) argues that lack of trust and confidence in physician knowledge and support of breastfeeding are major barriers

for breastfeeding women. Physicians themselves have also acknowledged lack of education about how to care for breastfeeding mothers as a gap in their professional training (Arthur, Saenz & Replogle 2003; Bunik, Gao & Moore 2006; DiGirolamo, Grummer-Strawn & Fein 2003; Smale et al. 2006; Taveras et al. 2004). In contrast, research shows that midwives are knowledgeable about breastfeeding, and women often seek them out for breastfeeding advice and assistance (Miracle, Meier & Bennett 2004; Svedulf et al. 1998). Mothers identify providers, like midwives, who are perceived as non-judgmental, encouraging, reassuring, sympathetic, patient and understanding and who praise them and build their confidence to positively affect their breastfeeding experiences (McInnes and Chambers 2008).

Many studies recognize the importance of social support for the breastfeeding mother as an influential factor in her success. Support that has been found to increase breastfeeding success includes emotional, physical/tangible, and educational components that are facilitated by both personal (family, friends) and professional (physicians, educators) networks (Isabella and Isabella 1994; McInnes and Chambers 2008; Raj and Plichta 1998). Adequate social support helps breastfeeding mothers to overcome initial feeding difficulties and to experience less guilt, confusion and self-doubt (McInnes and Chambers 2008). Special attention given to breastfeeding mothers by support groups was also positively associated with breastfeeding success and self-efficacy, as are programs that support breastfeeding mothers (Vari, Camburn and Henly 2000; Forster et al. 2004; Lawellan 2006; Lamontagne, Hamelin and St-Pierre 2008; Mongomery 2000; Sheehan, Schmied and Barclay 2009).

Other studies indicate that breastfeeding self-efficacy, or maternal confidence in breastfeeding, is the most important predictor of a successful and exclusive breastfeeding relationship. Dennis (1999) has proposed the breastfeeding self-efficacy theory that refers to a mother's perceived ability to breastfeed her infant. Self-efficacy is an important factor related to duration as it predicts whether a mother chooses to breastfeed or not, how much effort will be expended, and whether she will have self-enhancing or defeating patterns of thought. It also predicts how mothers will respond emotionally to breastfeeding difficulties. Self-efficacy is influenced by four main factors: accomplishments (previous breastfeeding experiences), vicarious experiences (watching other women), verbal persuasion and encouragement from others, and physiological responses (fatigue, stress, anxiety, pain) (Dennis 1999).

There are numerous outside factors that influence the confidence and self-efficacy of the breastfeeding mother. The planned initiation and continuation of breastfeeding is an important predictor in whether or not women are successful, as women who plan to breastfeed before giving birth are more successful than those who are not committed to attempting to breastfeed before giving birth (Forster, McLachlan and Lumley 2006; Kronborg and Vaeth 2004; Scott, Shaker and Reid 2004; Vogel, Hutchinson and Mitchell 1999). The perceived negative attitudes of family and friends, have also been found to have negative impacts on breastfeeding initiation and duration (DiGirolamo, Grummer-Strawn and Fein 2003; Ekstrom et al. 2005; Ekstrom, Widstrom, and Nissen 2003; Hauk, Hall and Jones 2007; Flower et al. 2008; Boswell-Penc and Boyer 2007; Taveras et al. 2003).

A review of the literature on 1) the biology of the lactating breast; 2) medicalization of birth and the impacts on breastfeeding; and 3) providers' attitudes and self-efficacy, reveals that studies focusing on mothers' lived experiences are far less prevalent in the literature than baby-centered research that emphasizes the health benefits of breastfeeding for the infant. Furthermore, studies focusing on breastfeeding care in birthing centers are virtually non-existent. Most notably absent are studies with women who successfully, initiate breastfeeding and continue to do so for an extended duration, as the vast majority of studies focus on women who do not succeed or reach their goals. This study aims to begin to fill some of these gaps in the literature, while making applied recommendations for the improvement of services at Bright Life, as well as to those provided more broadly to women giving birth in the hospital.

Chapter 3 – Methodology

This study utilizes a mixed methods approach that integrates participant-observation (Phase I) with semi-structured, open-ended interviews with birth center staff (n=11) (Phase II) and client survey data (n=71) (Phase III). Client-participants were asked to recall past experiences (retrospective) and to potentially discuss current experiences. I used a Community-Based Participatory Research design (Israel et al. 1998, 2001) and a modified grounded theory approach (Charmaz 2006) in analyzing data. Prior to the start of the study, I obtained approval from the Oregon State University Institutional Review Board for the ethical and non-coercive treatment of research participants.

Community Based Participatory Research

Community-Based Participatory Research (CBPR) is a collaborative approach to working with and within communities where both the community and the researcher are actively engaged in all aspects of the research (Christopher et al. 2008; Israel et al. 1998, 2001). In this approach, the community serves as the co-investigator and high priority is placed on the ability of research findings to translate into community-appropriate applications. The research goals are met by building on the strengths and resources of both the community and the researcher. This type of work promotes a co-learning environment by which each partner benefits from the knowledge and involvement of the other, where partners will share and circulate findings in a way that proves to be mutually beneficial for all involved. Trust that is built from working closely together enhances the

quality of the research and allows communities to apply practices that will best suit their varied needs (Christopher et al. 2008; Israel et al. 1998, 2001).

Adhering to the principles of CBPR, this study was co-designed by me as the researcher and the midwives at the birth center. Although the Bright Life midwives and I each had some distinct ideas about what we wanted to gain from the study, our ideas merged nearly seamlessly into one coherent project. Questions were formulated together and the technical implementation of the study would not have been possible without the Bright Life staff's knowledge, information and willingness to engage in all phases of the project. Specifically, we worked together to explore the primary research questions of: 1) How do the midwives at the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients?; 2) What are women's experiences of breastfeeding and breastfeeding support at the birth center?; and 3) How are women's breastfeeding experiences shaped by the birth center's approach to breastfeeding, and how might this information be used to improve services both at the birth center and, more generally, for U.S mothers at large? Secondary questions that the midwives wanted to include were more specific such as: How do clients feel about their postpartum support, especially in the first 48 hours? How many mothers are experiencing difficulties? Do they feel prepared to breastfeed? Are women attending the support groups and if so, are they helpful? By working closely with the birth center community, I was able to answer the questions posed by the center's staff in a way that more fully engaged them in the research because we often had to pool our collective expertise to trouble shoot the project. The findings of this study have helped the birth center to

continue to promote breastfeeding among their clients and to evaluate their program based on client feedback (applied outcomes are discussed further in Chapter 8 – Recommendations and Conclusions).

Phase I: Participant Observation

Phase I of this study focused on using participant-observation with the purpose of building an ethnographic foundation for the project. Participant observation is a cornerstone of anthropological research; in so far as it facilitates rapport building and the cultivation of relationships with the research sample. It also allows the researcher to see how communities function within their own environment, enabling the collection of a wide array of data (Bernard 2006; Creswell 2007; Green and Thorogood 2004). As part of a six-month internship with Bright Life, I spent several days per week at the center in order to immerse myself in the center's culture. This allowed me to become familiar with Bright Life's philosophies, practices and policies. As a result, I was able to more accurately situate client-participants' perspectives and experiences when analyzing the study results (Bernard 2006; Creswell 2007). Participant observation is detailed more fully in Chapter 5.

Phase II: Semi-structured, Open-ended Interviews

Semi-structured, open-ended interviews are generally guided by a formal, written set of questions that allows the interviewer to stay on topic, while also providing interviewees the space to express themselves in their own terms and to include topics of personal importance (Bernard 2006). I used a purposive sampling technique, wherein interviewees were selected to serve a certain purpose in the study (Bernard 2006). In this

case, Bright Life staff were interviewed and asked questions pertaining to the care and services they provide for the mothers and families that they serve, with specific attention paid to breastfeeding philosophies and practices. The Bright Life staff consists of midwives, apprentices, postpartum staff and administrative staff. Study eligibility criteria for birth center staff were defined as staff who had been employed by Bright Life for six months prior to the start of the study. This restriction was chosen in order to insure that the staff was familiar with the policies, procedures and philosophies of Bright Life and could therefore answer interview questions more thoroughly than a recent hire might be able to.

While Bright Life staff participant population was not explicitly restricted by age, gender or ethnicity, and because there are no men currently working for the birth center, the interview sample of staff were women only. To invite eligible birth center staff members to participate in a semi-structured, open-ended interview, a recruitment letter was sent out via e-mail. Staff-participants who were interested in being interviewed were requested to contact me. I interviewed each birth center staff-participant for approximately one half of an hour to two hours at the location of the participant's choice (birth center, home, coffee shop). With permission from the participant, I audio-recorded each interview and the audio-recordings were accompanied by hand-written notes that I took during the interviews. I recorded non-verbal communication such as body language and made notes on significant or poignant ideas and quotations.

After transcribing each interview into a Microsoft Word document, Phase II interview data were analyzed following a modified grounded theory approach, directed

by concept (or theoretical) saturation. While there were certain a priori codes and concepts that I was looking for, such as what kind of difficulties were mothers experiencing and how do they viewed the support groups offered, new codes also emerged. Concept saturation is reached when gathering new data no longer provides novel theoretical understandings of the emergent theory (Charmaz 2006). Data were hand-coded whereby I read through narratives with the intent of identifying and categorizing the emergent themes. Codes were developed to identify key themes that helped to contextualize or explain relationships between themes (Green and Thorogood 2009).

I also engaged in extensive memo-writing throughout the research process. Memo-writing is a process of informal, analytical note-taking that allows the researcher to constantly compare and analyze data. This process can help to direct coding and to develop analytic categories (Charmaz 2006). Memo-writing, coding and visual schema development helped to guide my interpretation of the data, as I attempted to situate key findings within the larger ethnographic experiences of the study participants /co-researchers. This grounding of the research in staff-participants' experiences and words allows themes to emerge from their worlds and not from any preconceived ideas or categories held by the researcher (Charmaz 2006; Cheyney 2008). I spoke with a mix of midwives, apprentices, and postpartum staff in an effort to get a broad view of the birth center operations and care practices (four midwives, one non-clinical staff, three apprentices, and three postpartum staff).

Phase III: Client Survey

Anonymous, self-administered surveys served as the source of data for Phase III. Study eligibility criteria for client-participants were defined as women who had been in the care of Bright Life from July 2007 through July 2009. This two year timeline was chosen to coincide with the number of years the current group of midwives and staff had been working at Bright Life, as reporting on care given by someone who is no longer employed by Bright Life does not accurately represent the current care the birth center provides. The July 2009 cutoff for client-participants who were contacted was also deliberate in that the survey was distributed in mid-October so that client-participants who gave birth in July would have had 2 ½ to 3 ½ months of experience feeding their infants. While the participant population was not explicitly restricted by age or ethnicity, the participant population was explicitly restricted by gender because we were attempting to understand the mother's experiences of breastfeeding. Client-participants were not restricted by parity or previous breastfeeding experience in order to obtain a more diverse sample.

Anonymous, self-administered surveys gave client-participants the opportunity to answer questions without the presence of an interviewer. Anonymous self-administered surveys may encourage respondents to be more truthful in their answers because they would not be influenced by perceived judgments or biases from the interviewer, which could cause them to give a response that they felt the interviewer wanted to hear, rather than the truth (Bernard 2006). Although there are limitations to self-administered surveys, such as the potential for a low response rate and question misinterpretation, self-administered surveys proved to be an exceptionally useful data collection tool for this

study (Bernard 2006). The flexibility of the online survey format allows respondents to complete it when they had a free moment and submit easily online rather than having to mail it back in.

The survey was comprised of questions designed in collaboration with Bright Life staff. The survey included questions pertaining to demographics, maternal breastfeeding philosophies, breastfeeding experiences, and breastfeeding support resource utilization. All of the questions were set up with what are called "open text boxes" in the Survey Tool. This allows the survey taker to type their response into the text box rather than checking a provided answer. Depending on the nature of the question, some categories were nominal (yes/no questions, such as have you previously breastfed a child?), ordinal (questions asking about planned length of nursing, scales of opinion, etc.) or interval (like parity and age, for example). The survey was designed to encourage the survey taker to provide as much information as desired for each question (O'Cathain and Thomas 2004). Elicited texts provide a more in-depth survey answer than is traditionally given with a fixed answer format (Charmaz 2006). Most client-participants took advantage of the ability to answer without pre-set parameters, which provided rich data from each survey taker.

Using content analysis, I read through all of the surveys numerous times and by hand-coding, I developed a codebook, coded the text, and engaged in memo-writing based on the emerging themes utilizing a methodology that was similar to what I used to analyze Phase II staff interview data (Bernard 2006; Charmaz 2006; Moser and Dalton 1971; O'Cathain and Thomas 2004). Client survey data were also quantitatively

evaluated using basic descriptive statistics. Although survey questions were set up as open text boxes that allowed client-participants to provide as much or as little information as desired, all answers could be categorized into groups that were exclusive and mutually exhaustive and assigned a numerical value. Participant responses could be categorized into two to eight groups for each category. For each item on the survey, responses were tallied into the appropriate category, totaled and analyzed using *Statistical Package for the Social Sciences* (SPSS) v. 17.0. The resulting frequencies facilitated contextualization of the participant population.

The client survey was administered via email through the Oregon State University's Survey Tool, which is created and maintained by Central Web Services. The Survey Tool is a free, online survey service where university researchers are able to create and manage custom surveys through the internet. Internet, or World Wide Web, based surveys are relatively novel in survey research history, but are quickly becoming more popular due to reasons including low cost for researchers, accelerated speed of data collection, and ease of data entry as compared to more traditional methods (Couper and Miller 2008, Granello and Wheaton 2004; Truell 2003). The internet based survey was password protected (client-participants received the password in the recruitment email) to prevent non-client-participants from accessing the survey (because the survey was administered via the university, there were surveys from a variety of projects listed, so client-participants had to select the correct survey and provide the specific password).

If a client did not have an email address on file with Bright Life, paper copies of the letters of recruitment for the survey and a copy of the survey were mailed via the U.S.

mail system along with a stamped envelope, addressed to the researcher (Couper and Miller 2008; Granello and Wheaton 2004; Truell 2003). Bright Life staff volunteered to send the surveys out via email and standard mail in order to protect their client-participants' confidentiality. Because the identity of the client-participants who chose to participate in the survey were not known to me or to Bright Life staff, participation was voluntary and presumably without coercion. A total of 260 surveys were sent out online and10 paper copies were mailed. Of the online surveys submitted, 23 were returned within the first three hours of being sent out, and 64 were returned within the first week. In total, 71 of 260 were surveys were submitted and zero paper copies returned for a response rate of 26.2 percent. The survey was sent out to mothers from 2 ½ - 3 ½ months to two years postpartum, but the response rate from new mothers was especially low. Nearly all of the surveys returned were submitted by mothers who were at least six months postpartum.

Reliability and Validity

By answering primary research questions of about how the midwives at the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients, exploring women's experiences of breastfeeding and breastfeeding support at the birth center, and examining how women's breastfeeding experiences shaped by the birth center's approach to breastfeeding, the ultimate aims of this research are: 1) to provide feedback to Bright Life Birth Center so they can continue to improve their services and 2) to identify transferable strategies that may be applied in a hospital settings to help improve breastfeeding success rates. More specifically,

questions were asked to find out whether or not women were experiencing difficulties and, if they were/did, what they felt could have been done to better assist them. Results were returned to the birth center in the form of a summary of the experiences of clients in an effort to improve breastfeeding care in this specific community. Returning the result of a study to the study community is known as reciprocal ethnography (Lawless 1991) or "member checking" (Charmaz 2006) and is used to promote reliability and validity in qualitative research. Reciprocal ethnography works to ensure the appropriateness and accuracy of the data interpretation.

Participant observation was undertaken in an effort to enhance the validity of this study. Participant observation makes it possible to collect a variety of data, reduces reactivity (people changing their behavior when they know that they are being studied) because the researcher is consistently present and familiar to participants, helps the researcher to identify and ask culturally appropriate questions, and it gives the researcher an intuitive understanding of the culture and thus enables them to speak confidently about the meaning of the data (Bernard 2006). Participant observation is often combined with other data collection method such as interviews and survey because while ethnography is effective in describing a culture's processes and identifying problems, it is not as effective at showing how often a problem occurs or the effects of processes. The combination of these methods creates a more comprehensive picture of the birth center with which to situate the results.

Unfortunately, a non-response study (Bernard 2006) could not be conducted in order to account for the 73.8% of surveys that were not returned. For this to be possible a

group of the non-responding clients would have to be contacted and the survey (or a sample of key questions form the survey) conducted with them over the telephone. Responders and non-responders could then be compared in order to provide an estimate of the representativeness of the study sample. Due to the anonymous nature of the questionnaire and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that protects the privacy of individually identifiable health information, I was not able to know the identities of the clients to whom the surveys were sent. Additionally, because the survey left room for clients to be critical of the care they received at Bright Life, the midwives never saw the original surveys but only had access to findings in the aggregate. Thus, it would not have been possible for the midwives to contact non-responders.

Limitations

As this is a retrospective study and because the post-partum period may be a stressful time for client-participants, the results are subject to a recall bias (Bernard 2006). While the limitations of this study impact the ability of the results to be widely generalizable, they still provide important insights into the breastfeeding experiences of women who choose to birth outside of the hospital; they help to explain how this decision and the model of care the women receive can affects breastfeeding experiences and successes.

In addition, it is important to consider the role that power relationships may have played during the research process for this project. Empowerment is a key component of community based research models. Minlker and Wallerstein (2006) discuss the notions of

"power to" versus "power over." The underpinnings of "power over" models are domination, either through force or hegemonic values, while "power to" models are based on shared practice, integration and knowledge-based power. As a young woman, who has never given birth to, nor breastfed, a child, I do not have personal experience with the topic I am researching. This helped to position the Bright Life staff as experts on the topic, and thus enabled a "power to" relationship. While there may be some level of "power over" in that I am the researcher, I believe that as the community-based research model values a collaborative and trusting environment, a power balance was successfully achieved.

Chapter 4 – Theoretical Perspectives

This study is positioned within the larger context of medical anthropology and more specifically, within four principal theoretical frameworks. Medical anthropology, as a sub-discipline of anthropology, evaluates health, well-being, illness, disease, medicine and healing using anthropological methods and holistic, comparative, evolutionary and cross-cultural perspectives (Brown 1998). The theoretical frameworks utilized in this study are interpretivist perspectives and social constructionism (Kleinman 1988; Kleinman and Seeman 2000; Lupton 2000), feminist perspectives (Carter 1995; Galtry 2004; Hausman 2004; Inhorn 2006; Knack 2006; Oakley 1980; Reiter 1999; Smith 2008; Stearns 2009), critical medical anthropology (Baer 1990; Singer 1990,1995; Singer and Bear 1995), , and the new biocultural synthesis (Dufour 2006; Goodman and Leatherman 1998, 2001; Pike and Williams 2006). These theoretical paradigms guided the research questions, aims, methods, and interpretations utilized in this study.

Interpretivist Stances and Social Constructionism

The application of interpretivist stances, or meaning-centered approaches, requires the utilization of two major components: explanatory models and illness narratives (Kleinman 1988; Kleinman and Seeman 2000). Explanatory models (EMs) are personal accounts of a condition, a state of being, an illness or an illness event that may or may not be shared by other members of the local social world, which in this case would be Bright Life staff and clients. While breastfeeding is certainly not an illness, it is a state of being and a condition of the body that requires some sort of renegotiation at the

individual, communal and societal levels. EMs can reveal the ways a person's experience is understood and interpreted and often includes ideas about etiology, treatment and overall outcomes. EMs are a dynamic and useful tool in health care, for a caregiver who is able to understand a patient's EM is better equipped to understand the patient's interpretation of his or her illness, empathize with them and provide better overall care as a result.

EMs are identified through the collection of illness narratives or an individual's account of an illness that includes the patient's lived experience; they are stories that tell of hopes, fears, and personal and cultural histories. As EMs and illness narratives are specific to the person and community involved in the illness experience, eliciting these experiences and perspectives can provide valuable insight into how illness is lived and understood, and thus provide researchers and caregivers with the tools necessary to develop models of care appropriate to the patient (Kleinman 1988; Kleinman and Seeman 2000). EMs and illness narratives are constructed through discourse and these discourses hold meanings within larger sociocultural and historical contexts and can therefore be arenas where power struggles between dominant and marginalized discourses are negotiated. Discourse is defined by Lupton (2000: 51) as that which "brings together language, visual representation, practices, knowledge and power relations...[and is used to] denote the patterns of ways of thinking, making sense of, talking or writing about, and visually portraying phenomena." Discourse and EMs are important tools in this study in that while they discuss individual accounts of breastfeeding, they may offer insights into the specific experiences of women breastfeeding in this community and can provide

important information for the midwives who care for these mothers. These insights can then lead to changes in care practices.

Feminist Perspectives

A feminist approach to understanding breastfeeding in the contemporary Untied States requires researchers to situate women's experiences in relation to power, politics, gender differences and inequality (Carter 1995; Galtry 2000; Hausman 2004; Inhorn 2006; Knack 2006; Oakley 1980; Reiter 1999; Stearns 2009). Feminist writers stress the importance of discourses focusing on breastfeeding in that they incorporate and highlight women's needs as biological, reproductive, and social beings, as well as their needs and contributions as productive beings (Smith 2008). Feminist writers have called for research that examines critical counter-discourse to the dominant biomedical ones that promote breastfeeding, but often lose sight of the personal, social, and institutional issues that shape women's experiences of breastfeeding (Carter 1995; Hausman 2004; McDonald 2008; Wolf 2006). Yet, few feminist writers directly engage in infant feeding discussions.

As Carter (1995) has argued, there is a noticeable lack of feminist discussion of breastfeeding -- an absence that may be attributed to the issue of where infant feeding falls within the equality-difference paradox. The equality-difference paradox refers to the need to both accept and to refute essentialized sexual difference between men and women (Gerhard 2001), and it illustrates the complexities that feminists face when attempting to assess women's lives in relation to men. The equality-difference debate and the claim that to have equality is to eliminate difference and vice versa has, according to Carter

(1995), caused feminists to be ambivalent about promoting breastfeeding as the best infant feeding choice. She writes:

> Breast-feeding in fact represents one of the central dilemmas of feminism: should women attempt to minimize gender differences as the path to liberation or should they embrace and enhance gender difference through fighting to remove the constraints placed on them by patriarchy and capitalism, thus becoming more "truly" women? One might see bottle feeding as freeing women from the demands and restrictions of lactation or, on the other hand, as imposed on women by the manufacturers of baby milk depriving them of a unique womanly experience, based on centuries of skill and knowledge (1995:14).

This feminist conundrum of whether to support or lament breastfeeding as empowering or disempowering to women needs to be reconsidered. Instead, feminist discourses on breastfeeding should focus on supporting women's choices. The utilization of a feminist stance in this study means that I do not take one side or the other (i.e., asserting that women should or should not breastfeed their infants), though, in general, I am a breastfeeding advocate. This study represents an attempt to understand women's experiences of breastfeeding as biological, reproductive, social and productive beings and to identify how to most effectively support and inform those mothers who do choose to breastfeed their child(ren).

Critical Medical Anthropology (CMA)

Originating as a critique of traditional medical anthropology, critical medical anthropology (CMA) examines the differences in distributions of power, wealth, status and the structural and institutional inequalities that shape healthcare practices and social processes (Baer 1990; Singer 1990, 1995, Singer and Baer 1995). As a theoretical perspective, CMA is centered on the assumption that health and healthcare are

intrinsically political and that politics and power relationships involved in health and healthcare practices, procedures, research, programs and policy are inextricably linked. CMA includes a critical examination of the political-economy of health and focuses on relationships between both macro and micro level economic, social and individual processes (Baer 1990; Singer and Baer 1995).

CMA is also committed to uncovering hidden causes of poor health as they relate to capitalism and for-profit medicine (Singer 1995). When applied to the study of health and health care, the political economy of health may include ways in which policy impacts health and the delivery and availability of health services, and perhaps especially those services related to the provision of maternity care, as pregnant women and babies are widely considered to be vulnerable populations (Lott 2005; Ruof 2004; Schwenzer 2008). Breastfeeding support is a key component of perinatal care, and yet federal civil law, while prohibiting discrimination in the workplace based on pregnancy, childbirth or related medical conditions (Reiter 1999), offers women only minimal protection for breastfeeding. These laws are as narrowly defined as possible and limit women's time at home with their infants before they must return to work or risk losing their job, as the time off only accounts for women actually giving birth to their child/ren and for a short resting period after birth. In addition, contemporary business culture often views childbirth and parenting as "inconvenient deviations from a male or androgynous norm" and as such, pregnancy protection has been defined as narrowly as possible, ending at the delivery of the child (Reiter 1999). Infant feeding is not considered part of the pregnancy and birth spectrum. These policies and laws impact the health of infants as working

mothers may not be able to continue breastfeeding. CMA is committed to uncovering these relatively hidden contributors to poor health, or in this case, low breastfeeding rates and to advocating for solutions -- in this case, for the removal of structural barriers that limit women's choices about how to feed their infants.

CMA also argues that there are two types of reform --systems-correcting praxis and systems-challenging praxis (Singer 1995). Systems-correcting praxis refers to work done within existing, often hegemonic, systems. The goal is to tweak the existing system to generate improvements (in access to lactation support, for example), but it makes no claims about addressing the underlying power differentials that cause health problems in the first place (as in the lack of adequate support and paid leave for new mothers, and especially for mothers of color). A contemporary example of systems-correcting praxis is the Baby Friendly Hospital Initiative (BFHI), a global program sponsored by the United Nations Children's Fund and the World Health Organization. This initiative aims to recognize and encourage birthing facilities that offer optimal levels of care for breastfeeding. The ten steps to informing, supporting and encouraging breastfeeding in this program include training in lactation for all professionals working in the facility and establishing practices that keep mother and baby close (BFHI-USA 2004). While the BFHI is certainly a step in the right direction, it is still operating within a system that does not address the fundamental problems that cause a need for this type of program in the first place like medical interventions that remove newborns from their mother for extended periods of time after birth, poorly trained health care staff, the persistence of formula use in hospital care.

In opposition to systems-correcting praxis, systems-challenging praxis explicitly seeks to advance alternative and often marginalized discourses that attempt to critically examine those institutional and social inequalities underlying the dominant system (Singer 1995). Out-of-hospital birthing centers and homebirth fit the parameters of systems-challenging praxis in that they intentionally function outside of, and often in opposition to, the larger biomedical birthing and early parenting institutions. Out-of-hospital birthing and early parenting models and the women who embody them call "for the comprehensive transformation of an obstetric establishment they see as overly expensive, invasive and disempowering" (Cheyney 2010: 265). The use of CMA in this study allows for the critical inspection of breastfeeding discourses at the societal, community and individual levels and works to understand mothers' experiences of claiming an alternative discourse within in an out-of-hospital birthing community that actively engages in home and birth center birth as a form of systems-challenging praxis.

New Biocultural Synthesis

The new biocultural synthesis, as proposed by Goodman and Leatherman (1998; 2001), is based on the premise that examining biology and culture alone is not enough to truly nuance a social or health-related phenomenon. Proponents of the new biocultural synthesis are interested in "how sociocultural and political economic processes affect human biologies, and then how compromised biologies further threaten the social fabric (Goodman and Leatherman 2001:5). Biocultural perspectives seek to draw a more holistic view of health, one that nuances the traditional view of health that has often been defined simply as the absence of disease. By adding to a strictly clinical definition of

health and disease, proponents of the biocultural approach are able to include such factors as psychosocial stressors, power relationships and institutional processes that can work to inform and create better health care practices and policies (Dufour 2006; Goodman and Leatherman 1998, 2001; Pike and Williams 2006).

The new biocultural synthesis is a particularly appropriate lens to utilize in this study as breastfeeding is an inherently biocultural process. It can be enhanced or inhibited via the interactions between the biology of lactation and cultural beliefs and practices, as well as through psychosocial factors that shape a breastfeeding woman's experience. In addition, the cultural ideologies associated with a place of delivery may influence how women work through the physicality of breastfeeding. This ideology differs from westernized medical ideology and the political economy that serves it. Hospitals, for example, promote breastfeeding, but give out formula packets. Formula companies anticipate women to "failing" to breastfeed as it serves the company's economic interests (Knaak 2006). Conversely, the ideology at birth centers like Bright Life supports breastfeeding as a "natural" process for a woman's body; there is a strong and actively communicated belief that women can in fact breastfeed successfully. Breastfeeding cannot be reduced to a physiological process alone, and the utilization of the new biocultural synthesis works to integrate additional, relevant factors.

The utilization of these major theoretical perspectives - interpretivist perspectives and social constructionism, critical medical anthropology, feminist perspectives, and the new biocultural synthesis - helps to situate and interpret the breastfeeding experiences of client-participants as they seek support and negotiate the new role of breastfeeding

mother. By contextualizing breastfeeding and the birth center not only within biological and cultural contexts, but within personal, political-economic, power, and gender discussions as well, a more nuanced look into the experiences of the women in this study emerges. In the next chapter, I report key findings from this study.

Chapter 5 - Results: Participant Observation and Staff Interviews

In this chapter, I discuss findings from participant observation and semi-structured interviews with the birth center staff. These two methods of data collection work to address the first research question of how does the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients by: 1) providing an ethnographic account of the birth center by describing the center and how it operates; 2) investigating the roles and perspectives of different birth center staff. This chapter will help to situate the results of the client survey and to set up the third research question of how are women's breastfeeding experiences shaped by the birth center's approach to breastfeeding, and how might this information be used to improve services both at the birth center and, more generally, for U.S mothers at large?

The Birth Center

Bright Life is a free-standing birthing center in a large urban environment in the Pacific Northwest. The practice began with one location, but due to an expanding client base, the birth center now has two locations, one within the limits of the city and one approximately ten miles outside of the city. There are also two more centers under construction outside the city. Most of the staff members frequently move between both locations to serve families based on whichever location is most convenient for the client. The original birth center, outside of the city, is located on the top floor of a business building and is much smaller in size than the newer location within the city. While both locations have similar features, I will describe in detail the location in the city, as this is where most of the research was conducted.

The birth center is housed in a renovated colonial style, three-storied building. Walking in the front door, it feels like you are in the living room of a friend's home. The waiting area consists of two couches, two armchairs and a coffee table, with birthing photo books and literature, gathered around a fireplace (Image 1). On the opposite side of the room is a children's play area, stocked with toys and games for young children of all ages. Passing through the door of the entrance/reception area is a hallway with three birthing rooms, a kitchen, a walk-in linen and supply closet, and stairs to the basement and upper floor.

Each of the three birthing rooms have a large bed, tiled Jacuzzi tub, standing shower and bathroom, in addition to chair/s, couches, dressers, and nightstands. Each room is painted a bright yet soothing color, and decorated with artwork and plants (Image 2). Each birthing room has a Jacuzzi tub because Bright Life specializes in waterbirth, a common form of hydrotherapy used by midwives, where women immerse their lower bodies in warm water to ease labor pains (Cheyney 2011). The kitchen is small, but fully equipped with appliances and a small table, and is open to clients and staff to use. The basement holds the washer and dryer along with extra birthing and office supplies. The upper floor has one small bedroom and a large family room with a television (Image 3). This floor is primarily used as a meeting space for birthing classes and other gatherings; however, one may often find children watching a video while during their parents have appointments.

Figure 1. Reception

Figure 2. Birth Room

Figure 3. Meeting Space

Basic Operations

The center offers full prenatal care during all three trimesters of pregnancy, labor and delivery care, postpartum care from immediately after delivery until six weeks, as well as six weeks of well-baby care. Bright Life acquires most of their new clients from the internet or from referrals from previous or current clients. When a potential client is interested in Bright Life, they schedule an hour-long "interview" where they get a tour of the center, are shown a natural birthing video and get to sit down and talk with one of the midwives. If the client chooses Bright Life, they make their first appointment, which typically takes place around ten to twelve weeks gestation because, as one participant, a midwife named Susan[2] clarified: "That is when we can hear the heartbeat for the first time." In general, a client has appointments once per month until thirty-two weeks, once every two weeks until thirty-six weeks, and then once per week until the client gives birth. While clients typically follow this appointment schedule, there is no limit on the number of appointments a client can have. If a client feels that she needs to come more often during either the prenatal or postpartum period, the midwives will schedule her for additional appointments.

[2] All names are pseudonyms

All appointments are scheduled for an hour, "but often run over so we get a little backed up in appointments. But clients can schedule appointments for later in the day here, sometimes until seven or eight o'clock at night – and appointments don't start until nine or ten in the morning, usually" (Nicki, Staff). Due to the high number of births Bright Life handles and the unpredictable nature of birth, each client has two midwives in case one of the midwives is at another birth or is off call. Lena explained:

> We're all on three months at a time, then off for a month. And everyone has two midwives and one of those two midwives will be at their birth, along with the two apprentices. And when they're pregnant, there's someone to call. It's just a really nice system because it balances us being there for our clients and them knowing the people that are giving them care and it not being just the luck of the draw as to who is on call, with us [as the midwives] being able to keep our sanity and have time off. You don't take any clients for the month that you're off. For instance, I'm off in October - some of my September people might go late and some of my November people might go early. Because we do births at the birth center from four weeks early to three weeks late, and home birth from five weeks early to three weeks late, we have this eight-week span of time that we have to cover. So that's why everyone has two midwives.

To make sure each client gets to work with both midwives prenatally, appointments alternate between the midwives assigned to the birth. Ensuring that clients are comfortable with and trusting of their care providers is characteristic of the shared-decision making that is common found both in birth centers and the midwifery/holistic model of care.

When it is time for a client to give birth, either at home or at the center, the birth team consists of one of the midwives and apprentices that the client has seen throughout the prenatal period. The birth team generally stays for three hours after the birth, and then the postpartum staff comes in to take care of the client and her family, who can stay

at Bright Life for up to two days postpartum depending on their health insurance coverage. Nicki explained, saying "Most insurance companies will cover a 12 hour minimum stay after birth, so most families stay around 48 hours [total, including the labor and delivery]." The postpartum team is responsible for caring for clients after birth, providing meals and breastfeeding support. Clients then have a home visit from their midwife one day after going home and come back for postpartum visits at one, three, and six weeks with additional postpartum appointments scheduled if needed.

As part of their spectrum of care and commonly found in the FSBC model, Bright Life offers childbirth education classes, a breastfeeding preparation class and support group, children's play-groups, and social events for their clients and families. Childbirth education classes meet weekly for six weeks or once for an extended session, and are taught by Bright Life midwives, however the cost is extra and not included in the birth package (which encompasses all prenatal, birth, and postpartum care). Prenatal breastfeeding classes meet once per month and are taught by a certified lactation consultant from the local community. This class is also an extra cost. The postpartum, breastfeeding support groups meet weekly, are free of charge, and include a certified lactation consultant, although these are less instruction-based and are more informal and mother-led. All classes and groups meet at the birth center.

During participant observation, I spent several days per week over a six-month period at the birth center. Spending time in the reception area with the receptionists, learning about the business side of the birth center, I became familiar with the paperwork found in client charts, the informational hand-outs and new client packets given to

clients. I watched interactions between clients and staff, clients and midwives/apprentices, and clients with other clients. A lot of time was spent in the kitchen of the birth center, chatting with and listening to Bright Life's staff talk about clients and general happenings at the center. I encountered new mothers within hours after birth who would ask me to hold their newborns, and while I did not attend appointments or births, I was able to witness and hear all that goes on before and after. Additionally, I attended postpartum breastfeeding support groups and prenatal education classes.

Staff Roles and Dynamics

Bright Life employs two full time staff members who devote most of their time to the business side of running the center. These women act as receptionists, scheduling and rescheduling appointments, running insurance claims, processing billing, calling about testing results, and filing paperwork. They rotate between the two centers and know every client by name, cheerfully greeting them upon arrival.

All seven midwives at Bright Life are Certified Professional Midwives (CPMs), licensed in the state to practice midwifery. Most also hold other degrees such as a Bachelor of Science in Midwifery (from a midwifery school), a four-year degree from a post-secondary institution, or a nursing degree/license from previous work in the healthcare field. Practicing as primary midwives from five to thirty years, the Bright Life midwives have collectively attended over 3,500 births, and all had children of their own. The midwives meet once per month in the upstairs meeting area to discuss the

practice, clients and any other matters that arise. These meetings are closed, and as the researcher, I was not permitted to attend.

The midwives are responsible for prenatal, birth, and postpartum visits with their clients and generally have one, sometimes two, apprentice midwives. Apprenticeship, where a student works closely with a mentor to develop skills and knowledge, is common in midwifery training (Jordan 1989). The apprentice midwives are typically younger women who are formally enrolled in the local midwifery school and apprentice with the Bright Life midwives for their hands-on training, which usually lasts about one year. The apprentices accompany their mentor midwives to prenatal and postpartum appointments, as well as to the birth itself. Often, apprentices go to the beginning of an appointment alone when their midwife is still in the preceding appointment, to greet the client and do basic chart updates, but are not able to attend births by themselves. Apprentices also are not permitted to attend the monthly midwives meetings.

While the midwives are paid on salary, even on their months off, apprentices are paid approximately $50.00 per birth they attend. As a result, many of the apprentices also take on responsibilities as hourly postpartum staff members. Because the postpartum team is supposed to be available at all times to help the new mother and her family, postpartum staff work in six-hour shifts and rotate for the entire length of the client's stay at the birth center. The postpartum team helps with meals and other comforts, but is also the main provider of care in the immediate postpartum period, primarily breastfeeding support. While some postpartum staff are apprentices, others are

younger women who are interested in pursuing a career in midwifery, and do not generally have any formal training. None have children of their own.

Breastfeeding at Bright Life

When asked if breastfeeding was supported at the birth center, the answer was a resounding yes from every staff member at Bright Life. When asked what the basic breastfeeding philosophy at the birth center was, Allison explained: "It depends on who you talk to. It is very much supported and encouraged, but each midwife has differing opinions and approaches" (apprentice and post-partum staff). For some midwives, a woman's decision to breastfeed became a sort of "deal-breaker" for the potential of provider-client relationship. Helen said: "If I had a client say that they were not planning on breastfeeding, I would not be able to be their midwife. I would have to give them to someone else. I just don't know how to care for [a mother and baby] who are not breastfeeding." Encountering a client who did not want to breastfeed, however, was uncommon, as Lena claimed to have only, "had one client ever say that they didn't want to breastfeed, or at least try."

For other midwives, however, a woman's decision to breastfeed was not a deal-breaker, but rather something they hoped their clients would at least try to do. Midwife Elizabeth described a client who was unsure of whether they wanted to breastfeed and how she approached the situation:

> I said 'even if you don't breastfeed long term, why don't you just try it? If you don't like it, that's fine.' I was just hoping she would give the baby a little colostrum. She ended up breastfeeding for much longer than I thought she would – about two or three weeks - which is better than nothing!

Elizabeth's perspective of "at least try to breastfeed" is the most commonly held among the other midwives at Bright Life. If a client was having serious trouble breastfeeding and was not able to produce sufficient milk, other options were explored, including donor milk. Commercial formula is rarely, if ever, offered unless absolutely necessary.

> If we've tried everything and it's still not working, there is donor breast milk that some women choose. We're not a milk bank so it's nothing official, if we have a client in need and have someone we know who has extra milk, we hook the two of them up and they give milk to each other. I'm a fan of the goat's milk formula if people do have to end up supplementing, because at least its real food, and not powdered chemicals sitting in a can. The goat's milk isn't pasteurized and still has all the enzyme activity so it's a lot closer to nursing (Lena).

The birth center is very clearly, and sometimes adamantly, a pro-breastfeeding community, as evidenced by the importance that the midwives place on clients at least attempting to breastfeed.

While the basic philosophy of breastfeeding that the midwives at Bright Life Given embody – breastfeeding is important and should be encouraged – is consistent, given the group approach that the center offers, the occasional lack of congruity with the two midwives per client system sometimes posed a problem. The most obvious difference in the explanatory models (EMs) of breastfeeding care centers on whether or not midwives should talk to clients about breastfeeding prenatally. According to Susan, this is actually a point of contention among the midwives, and because there is no consensus on how to approach prenatal discussions about breastfeeding, the result is essentially no discussion: "It just doesn't happen." Interestingly, opinions on whether or not to discuss breastfeeding prenatally varied by the age of the midwife; the older midwives felt it was not necessary, and the younger midwives felt it was. Because Bright

Life had not reached an agreement on how to approach breastfeeding prenatally, each midwife is left to approach the subject as she sees fit, which seems to be evenly split between talking and not talking about it prenatally. Bright Life was well aware of this lack of consensus and potential gap in care and this, is in part, why the birth center wanted to partner on this project.

Why would the midwives not want to talk about breastfeeding prenatally? At first, it would appear that there was no talk at all about breastfeeding prenatally, but as the Bright Life staff elaborated on this question, it became clear that there was in fact information being shared about breastfeeding prenatally, both verbally and nonverbally. The health benefits of breastfeeding were discussed between Bright Life staff and clients, there were prenatal breastfeeding classes and postpartum breastfeeding support groups the birth center offered that staff directed clients to, clients were often seen breastfeeding their infants in the waiting area, as well as a library of childbirth and breastfeeding books that clients could borrow free of charge. Messages about the importance, and even necessity, of breastfeeding, both for the role it plays in health and in becoming a good mother abounded at Bright Life. It is misleading, therefore, for staff to say that there is no dicourse about breastfeeding in the prenatal period. Instead, prenatal breastfeeding conversation was actually defined by Bright Life as the discussion of breastfeeding mechanics and potential problems with clients.

Some of the midwives felt that presenting clients with a list of potential problems (many of which are physically painful and can lead to emotional distress) may cause them to change their minds about breastfeeding, especially if it is perceived as being too

scary or too difficult. Helen explained her point of view, this way: "There is no need to discuss [potential breastfeeding] problems and what might happen because they might not experience any problems, so why scare or worry them?" Joanie, a midwife, seconded this sentiment: "I don't necessarily think we need to add more 'what-if' concerns, especially as they're just trying to get through the birth, so I don't like to talk about what could happen." On the other side are the midwives who, like Elizabeth, felt that: "The prenatal period is where we could do more, pay more attention to breastfeeding." These midwives felt that although prenatal talk about breastfeeding issues and difficulties could possibly add more stress for clients, the discussion was necessary to provide the best breastfeeding care when their clients actually started to nurse their infants. As EMs are often reflective of personal experience, the breastfeeding discussion divide could be attributed the midwives own experiences of breastfeeding and whether or not they encountered breastfeeding difficulties. Furthermore, it is necessary to examine this major difference in the breastfeeding EMs of the Bright Life staff, as they often include ideas about etiology, treatment, and overall outcomes which affect how each staff member delivers care to her clients.

Lena offered a possible solution that would not only function to rectify the contention about prenatal breastfeeding conversation among the midwives, but would also benefit clients -- a breastfeeding plan, similar to the birth plan. The birth plan is a document that clients fill out in their third trimester that details what they want and do not want for their births. The birth plan asks about the atmosphere the client wants to have and how they would like the birth to go. Questions include: Where do you want to have

your baby? Do you want to use the birthing tub? Who do you want at your birth? Do you want any music or candles? Lena described how she thought a breastfeeding plan could be utilized:

> On the birth plan paper, which we give them the last couple months of pregnancy to fill out, one of the questions is 'do you plan on breastfeeding?' Everybody writes that yes, they plan on breastfeeding, but that's all they say. I think it would be great to supplement the birth plan and have a breastfeeding plan, where it tells [mothers] what the recommendations are for breastfeeding and asks them specifically, 'How long are you planning on to breastfeed? Are you going to have to return to work? Do you have a pump? Are you aware of our breastfeeding support group? Are you aware of the prenatal breastfeeding class?' Now we just kind of leave it without discussion…but I think plans are something we should talk about because afterwards we can go back and say, 'Okay, your plan was to do x, y, and z - you're doing this which isn't known to be helpful with that plan. So, let's try and fix this.' But instead, if we see someone giving their baby a bottle at two-weeks old, it's like well maybe they were planning on giving bottles from the beginning and the fact that they're waiting until two weeks is great. We have no frame of reference for what their plans were, and it just makes it harder to know where they're coming from.

She continued by recognizing that while not every client would want to utilize this kind of plan, offering it would at least open the door to have the conversation if the client wanted it. Lena hoped that by including this question on the client survey, she could gather information about whether clients would be interested in a breastfeeding plan. If so, the birth center could start to include it in client's forms.

While the midwives who supported prenatal breastfeeding talk about mechanics and potential problems felt that it was needed, the discussions were often not actually happening. In an effort to at least get some information to clients, midwives like Lena explored other, less obvious avenues. She described a breastfeeding tip sheet, saying:

> I made a handout that I give to people…and that in theory we all give people, but I don't know if in reality we do. It's just simple little tips saying here's what's normal and if you have any concerns, call us. My hope is that it can be something that you can put on the refrigerator.

Due to the lack of practical discussion prenatally about breastfeeding plans, goals, and potential problems, Bright Life is often not clear on what their clients expect to happen when it comes time to actually breastfeed their infants. Susan described how she felt most of her clients viewed breastfeeding: "Most people just figure they'll know what to do, even first time moms. I think they feel pretty secure knowing that after the baby is born, if there are any problems, [the midwife] will know how to help out." The other midwives shared similar outlooks on how they believed their clients saw breastfeeding happening. Helen commented that: "Most women don't have any major issues breastfeeding. We try and encourage moms by reassuring them that their bodies are meant to do this. They [the mom and baby] will figure out how to do it, usually on their own." Helen's statement emphasizes both the EM that because breastfeeding is a natural phenomenon, that women and babies are "built to do," they should be able to do so without issues and artificial interventions. The assumption is that most women will breastfeed without experiencing difficulties. The reality of breastfeeding for clients of Bright Life will be explored further in the next chapter.

The apprentices, however, were particularly aware of the missing practical discussion about breastfeeding mechanics and potential problems, especially those apprentices who also worked postpartum. As Jenny reflected: "Personally, I have not witnessed much breastfeeding preparation prenatally" (apprentice and postpartum staff). Gia agreed: "Prenatally, I have to say there isn't a lot of talk. We point them to the

breastfeeding class around 38 weeks [into their pregnancy] and ask if there are any questions, but even then, we just refer them to the class" (apprentice).

Breastfeeding in the Immediate Postpartum

The immediate postpartum period is defined by the midwives as birth to 72 hours after the delivery and it encompasses the time that clients and their families stay at the center after birth and the first day at home before the midwife comes for the postpartum home visit. As the birth team only stays with the client for three hours after the birth, the midwives, who have more experience both professionally from caring for more women, and personally from having birthed and breastfeed themselves, do not serve as an essential part of the immediate postpartum experience for clients. The midwives are in and out periodically during their client's stay at the center, however it is the postpartum team that provides the majority of the care for clients and their families. As a result of spending so much one-on-one time with new mothers and infants during the postpartum stay at the birth center, it was the postpartum staff (especially those who occupied both postpartum and apprentice roles), rather than the midwives, who appeared to take the most detailed and practical approach to breastfeeding care.

Because the first three hours after birth is quite a busy time -- from the actual birth of the baby, to the birthing of the placenta, to the newborn measurements and tests -- the midwives often did not center their attention on breastfeeding, other than encouraging clients to bring their baby to the breast as they facilitated skin-to-skin contact. They seemed to be leaving room for mom and baby to figure it out, and then left them in the care of the postpartum team. Many of the conversations with the women who worked

postpartum centered on how to give assistance and the importance of being both watchful and proactive, while still encouraging new moms that they are capable of breastfeeding. Penelope reflected, saying: "The biggest thing is trying to give [mom and baby] time to figure it out, but at the same time being diligent and watchful, interjecting when we need too." When it came to knowing when and how to interject and offer assistance, communication was a major factor in how well the immediate postpartum period went. The postpartum staff recognized that because most clients felt that breastfeeding should come easily and their babies would nurse without any difficulties, if issues did arise, some clients had a harder time asking for help. Sadie said:

> Of course, there are some moms who are breastfeeding like champs in ten minutes. But some moms can end up feeling pretty isolated. I had a previous client who needed help with her latch but didn't want to ask for it. It would have been so beneficial for her to know that it was normal and not to worry. If she'd just known, the whole thing would have been more normalized for her.

Sadie's story emphasizes the lack of prenatal discussion that happens with the midwives and the important difference that knowing about common problems could make for the morale of new moms.

Postpartum staff who were also apprentices had the advantage of knowing some of the clients well and therefore having a sense of might or might not be comfortable communicating a need for help: Allison, an apprentice and postpartum staff member, said:

> When we see them prenatally, we understand the dynamics, especially of the moms who we know might need help but won't ask for support. Some moms are asking for help and some aren't. Some do great right away and don't have any issues at all. You get to know which clients aren't complainers and who will say everything is fine when it isn't. You figure

> out which clients you might have to dig a little. But sometimes, if you don't know the client or if they aren't asking, they can end up leaving the center without getting any support and you don't want that to happen. It is so important to catch problems early on

Apprentice and postpartum staff member, Jenny, shared her experience with clients, saying: "Especially with first time moms, breastfeeding can be a challenge, so I try to empower moms to believe that they can accomplish this. I teach them to be aware of what their babies are doing and how to bring the baby to breast." Of the common difficulties that the postpartum staff spoke about, latching was seen as presenting new mothers with the most difficulty, as an improper latch can cause pain and issues with supply later on. Alyssa said that she tries, "to spend time observing the latch and watching how they're doing it. Then I talk to them about the baby's frenulum and show them how to latch and unlatch properly." Too often, the staff noted: "There is too much time spent without establishing breastfeeding and then the client arrives at a panic point at 24 hours with a baby who has not yet latched" (Allison, apprentice and postpartum staff). Reaching this panic point can make some moms who were under the impression that breastfeeding would come easily, feel, "frustrated, upset and like they are not competent mothers" (Penelope, apprentice and postpartum staff).

In conjunction with communication, the postpartum staff stressed the importance of education and learning, both during the prenatal period and in the moment. Since clients are generally aware of the health benefits of breastfeeding, education during this time centers on practical assistance and helping new mothers understand the physical aspects of breastfeeding. Initially, Allison said:

> It is focusing on the baby: is baby interested in nursing? Is baby rooting? Then trying to educate mom at that point about what baby's behaviors are. When the baby starts to root, say 'this is what your baby is trying to tell you,' letting her know how it is going to benefit her hormonally. Tell her about her uterus and how it is going to start contracting, so she knows when she feels it, so she's prepared.

The postpartum staff stressed the need for helpful, hands-on, accurate education. Ideally, this should happen in the prenatal period where midwives would talk about breastfeeding in the immediate postpartum and what to expect, as well as in the moment education during the first few days as individual circumstances arise. "Because breastfeeding is what most people plan on doing, there aren't really any questions asked before birth, so I think that the first few days is a big education time" (Jenny, apprentice and postpartum staff). It seemed that not only were clients not getting, or asking about information concerning possible difficulties and solutions, but they were also not fully clear on how breastfeeding would actually happen. According to the postpartum staff, clients often did not know what a proper latch looked like, how to properly release an infant's latch, how long it would take for their milk to come in after the colostrum, or different ways to hold an infant while nursing. This is not the kind of "scary" information that midwives were reluctant to give mothers, but practical information that new, breastfeeding mothers should be aware of, but were not necessarily getting.

Overall, while the postpartum period might present some unexpected difficulties for new mothers, the postpartum team is committed supporting and encouraging clients. As Alyssa explained:

> No matter how breastfeeding is going, the most important thing is to praise the mom and tell her how amazing she is, that she is capable of doing this new thing with her new baby - letting her know that it will be a

> process that she's going to learn, that baby is going to learn, that we'll be here to answer questions.

Improving Breastfeeding Care

While the midwives were aware that there was some division over how best to approach breastfeeding prenatally, they had varying ideas about what should be done about it. When they were asked if there was anything Bright Life could do to improve, the suggestions from the apprentices and postpartum staff illuminated a shared breastfeeding explanatory model that focused on consistency in practice, training, prenatal education, and practical assistance. The shared EM about consistency in practice was articulated best by Allison: "The most common issue is that not everyone is on the same page. We need a collective approach and a protocol to address breastfeeding problems, especially within the first three days." Bright Life did not have a consistent approach to handling breastfeeding issues. Penelope touched on this when she mentioned the importance of Bright Life working as a team and how helpful it would be to bring together all of the staff to discuss breastfeeding:

> Maybe every couple months [the midwives] could let the postpartum staff participate in the midwife meetings, set aside some time specifically for breastfeeding. Call everyone into the meeting to share experiences, where the postpartum staff could say 'we've run into this problem lately, this is how we've remedied it, what do you think?' That way we could know how the midwives would handle it and make sure everyone knows what is going on with each client and that we're handling everything appropriately and the same way.

Caroline (postpartum staff) offered another suggestion regarding protocols, suggesting:

> In the client's charts, we record everything that happens during clients' stays on the same sheet, but it would be nice to have a separate sheet in the charts just for breastfeeding, where we could record how long they are nursing, if they needed help, what kind of help they got and from who.

Caroline felt that having these separate charts would help communication between the midwives and postpartum team regarding each client, especially knowing what kind of advice they were receiving for certain problems. She continued by suggesting that the midwives make notes about which clients might be reluctant to ask for help. If the postpartum team knew the mothers who needed prompting to ask questions, it would help alleviate the number of moms going home without resolving their early difficulties.

Why would there be so much discussion about clients not feeling empowered to ask questions at a birth center that operates under a care model that emphasizes trust and empowerment? Arguably, the messages about breastfeeding being a "natural" process that women's bodies are do that Bright Life projects could make some women feel hesitant to admit that they need help to learn how to properly breastfeed. The postpartum staff also explicitly discussed their own lack of training and experience. Perhaps, because the postpartum team do not have children of their own and they themselves do not have personal experience knowing how to breastfeed, their EMs align more closely with clients than the then midwives. While some of the postpartum staff were apprentices, and were either familiar with the clients or still in midwifery school, about half of the postpartum team did not have any formal training in caring for mothers and babies, or were in the beginning stages of their midwifery education. This was of particular concern for them, as none of the postpartum team had children of their own, so could not draw from personal experience. Gia spoke about the importance of knowledge and consistency, asserting:

> All of the postpartum staff has to feel comfortable giving breastfeeding support. It is integral that we are all knowledgeable and comfortable. Some people aren't as comfortable, and it is a critical period, those first 24 hours, and when moms are given varied opinions on things it can make it very difficult.

Alyssa (postpartum staff) shared her thoughts on the subject:

> Well, for one, we need a breastfeeding protocol so everyone is doing the same basic thing. Secondly, I think it would be tremendously helpful for the postpartum team to meet with Sarah (the lactation consultant who leads the prenatal breastfeeding class), especially for those of us who haven't had babies of our own. It would be helpful to have more training with latching and to see videos, but also to have moms and babies coming in to show us what breastfeeding looks like at various stages.

Suggestions about more training for staff often turned into suggestions about "training" in terms of prenatal education for clients as well. All six of the apprentices and postpartum staff interviewed specifically mentioned the need for a greater focus on practical prenatal education for clients. As Jenny noted: "There is a lack of education, especially for first time moms. They aren't getting enough preparation and they don't know what to expect." Allison elaborated on this point, saying:

> It isn't just the first time moms - we forget education for multips, that they need tips for how to make time for just them and the baby. There needs to be talk about the differences in babies and how their second or third might not be the same as their first. Or if they had problems breastfeeding with the first and need to problem solve ahead of time. We need to have those conversations prenatally.

Overall, the postpartum team appeared to be more in touch with the importance of clear, consistent and obvious breastfeeding education and support than the midwives. However, the segregated nature of the prenatal, birth, and postpartum care – and the staff that provides care in each stage – is potentially problematic in practice. As demonstrated in this first results chapter, the Bright Life staff has differing explanatory models

regarding breastfeeding an as a result, take divergent approaches to discussing breastfeeding with their clients. Although it would seem that there is no talk about breastfeeding prenatally, there are in fact many verbal and nonverbal messages received by clients about the importance of breastfeeding, both for health and for becoming a good mother. The major divergence among the midwives is whether or not to discuss the mechanics of breastfeeding and potential breastfeeding difficulties with clients and thus there is very little practical discussion prenatally. As a consequence, the postpartum staff, who shares an EM that centers around the necessity of practical breastfeeding education, cares for clients who are unsure of how to breastfeed in the first few days, and because of the messages of breastfeeding being "natural" clients often do not feel comfortable asking for help. The next chapter will examine how the EMs that guides the staff's delivery of breastfeeding care impacts their client's breastfeeding experiences, especially within the immediate postpartum period.

Chapter 6 – Results: Client Surveys

The previous chapter addressed the first research question: "How do the midwives at the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients?" and described the attitudes towards breastfeeding held by the midwives, apprentices and postpartum staff, as well as how breastfeeding mothers are cared for at the center. This second results chapter addresses the second major research question: "What are women's experiences of breastfeeding and breastfeeding support at the birth center?" Due to the known high rates of breastfeeding initiation and duration that Bright Life boasts, the question concerning women's experiences also encompasses such a priori intentions of this research as "what kind of difficulties are clients of the birth center experiencing and how are they supported?"

As clients described their breastfeeding experience at Bright Life, three key themes emerged. The first major theme, breastfeeding convictions, describes client-participants' breastfeeding intentions, views on formula, and the connections between birth and breastfeeding experiences. The second theme, experiencing difficulties, describes client-participants' prenatal preparation and some of the difficulties they experienced once they actually began nursing. The third theme, support and confidence building, explores how client-participants negotiated breastfeeding with the help of others. Within each of these themes, there are smaller subthemes that help to explain how women think about and create meaning around their experiences of breastfeeding in an out-of-hospital birthing community.

Theme One: Breastfeeding Convictions

Client-participants in this study had very strong convictions that breastfeeding offers optimal nutrition for their infants and were confident in their own, and their infant's, ability to breastfeed. When asked about what their plans were prior to birth, client-participants articulated their intention to initiate breastfeeding and described how long they intended for the breastfeeding relationship to last. In addition, three subthemes associated with the larger theme of breastfeeding convictions emerged: 1) initiation and duration; 2) formula and mothering; and 3) connecting birth and breastfeeding. Together, these subthemes help to explain how client-participants view breastfeeding duration, formula and the impacts of their births on breastfeeding.

Initiation and Duration

The first subtheme focuses on client-participants' plans to initiate breastfeeding and to continue nursing for an extended duration. When asked whether or not they were planning to breastfeed before giving birth, 100% of client-participants responded that yes, they planned to breastfeed. When asked how long they planned to breastfeed in total, 93% of client-participants intended to breastfeed for a minimum of one year, although most hoped to breastfeed longer than one year. Of those who wanted to breastfeed for longer than one year, 25% set a minimum goal of two years. 15.5% of client-participants did not have a time frame and planned on child-led weaning, where the child "decides" when the breastfeeding relationship is over (Brown and Lee 2011). One client

remarked: "I plan on breastfeeding until my daughter self-weans; if that takes 5 years than I'll breastfeed for 5 years, it's really up to her" (Nancy[3], age 40, second child).

Mothers in this community are very decided in their choice to breastfeed, as demonstrated by Joyce who explained: "There was no need [to talk prenatally about breastfeeding]. I was committed and had no doubt that I would breastfeed. This is the only option that is appropriate for my children" (age 46, third child). Several studies have identified maternal intention to breastfeed as one of the strongest factors influencing breastfeeding outcomes, as mothers who plan to breastfeed before the baby is born have a higher rate of both initiation and duration (Chertok et al. 2011; Brodribb et al. 2007; Donath and Amir 2003).

Formula and Mothering

When client-participants were questioned about the use of infant formula, their reaction was telling of the overall view of formula in this community. Most were resolute in their rejection of infant formula, proclaiming statements like: "My child has never had formula" and "My children never had and will never have formula." Dana shared what seemed to be the general consensus among client-participants by saying, "yes [I planned to breastfeed]…I have the idea of it being a very important part of mothering" (age 26, first child). Studies have shown that for some women, formula feeding is experienced as an act that compromises their identity as a "good mother" (Lee 2008), as being a good mother means not doing anything that is considered unhealthy for the baby. Schmeid and Lupton (2001) have discussed the effects of the "breast is best" campaign in relation to

[3] All names are pseudonyms.

identity development, writing that some women set up and experience breastfeeding as "crucial to their identity as mothers."

This idea is striking in a community where breastfeeding is in fact considered to be an inherent and necessary part of mothering. This idea was reflected in Joyce's outlook, when she said: "The midwives should help women understand that their bodies were designed to breastfeed. The baby needs to breastfeed. That is one of the responsibilities of a mother" (age 46, third child). Olivia specifically cited health organizations as one reason she planned to breastfeed and to reach the recommended duration, saying: "I know that the APA suggests 2 years, and the WHO says 3, so I was determined to make it that long" (age 38, first child). This sentiment was echoed by Jamie: "Women need to commit to breastfeeding. Not just try, but have strong convictions, without the thought of a safety net of bottles and formula" (age 26, first child).

Client-participants also discussed how they viewed breastfeeding, or the lack thereof, as an overall societal concern. One mother stated: "Women need to teach their children at a very young age what breasts are for. Women need to be bombarded with information about the absolute necessity to breastfeed. Our culture plays a huge role" (Joyce, age 46, third child). Liza illustrated her position as both a breastfeeding mother and advocate, saying:

> Breastfeeding should be approached as a health/safety issue instead of a personal preference issue. Our society does not model the necessity of breastfeeding or motherhood in general. This vital health issue is treated so casually, as if formula and breast milk are interchangeable and nearly comparable (age 29, fourth child).

As this subtheme illustrates, mothers in this study are committed to breastfeeding and are against formula use whenever possible for a variety of reasons. They note their own personal viewpoints while recognizing the effect of culture on how infant feeding is approached in American society. The next sub-theme further explores these personal and societal influences and how the birth and breastfeeding experiences are not two separate events that have no impact on the other.

Connecting Birth and Breastfeeding

The third subtheme under Breastfeeding Convictions -- connecting birth and breastfeeding -- focuses on what client-participants saw as an inherent connection between birth and breastfeeding experiences. The holistic/midwifery model of care not only advocates for an unmedicated and empowering birth, but also considers breastfeeding to be an essential part of the childbearing cycle. As stated on Bright Life's website:

> We don't separate babies from their mothers. You'll have as much time as you want to bond with your baby and you'll be able to have anyone you want touch or hold the baby. We will do a newborn baby exam within the first two hours after birth, with baby right by your side. Since you are never separated from your baby, your baby will most likely begin breastfeeding within the first 15 minutes of birth. This sets you off to a great start in your breastfeeding relationship with your little one.

Some client-participants indicated outright that they felt their birth directly impacted their breastfeeding relationship, as illustrated by Kaitlin who said: "My child did not have any issues latching on. I believe that this is due to the quiet birth she had, and that I was able to allow her to breastfeed immediately after she was born" (age 29, third child). Babies born at the center are allowed to stay with their mother immediately and indefinitely after

birth and the importance of this simple practice did not go unrecognized by client-participants, as one client stated: “It was greatly beneficial to have him latch for the first time while we were still in the birthing tub” (Vicki, age 32, first child). A key component of the midwifery/holistic model of care is that the mother and baby are considered an inseparable unit, where the baby’s health is ensured by the mother’s physical and emotional health (Cheyney 2011; Davis-Floyd 1992; Rothman 1982). This can be seen in Jane’s recounting of her initial breastfeeding experience:

> After my son was born and I pulled him out of the water I held him to my chest and my midwife suggested that I put him to my nipple to see if he would suck a little. He did! After getting out of the tub, my midwife examined him and then gave him to me to feed. She showed me how he should look while feeding and how to hold him. Each time the postpartum staff checked on me, they asked how he was feeding. He fed easily and well and I didn't have any problems letting down. It was just awkward for me at first, holding him and getting used to feeding him so often. The postpartum staff and midwives were FANTASTIC. Looking back on it still brings tears to my eyes. I'm sure that they were checking on how my breastfeeding was going without saying so when they brought me tea or something. I never felt pressured to do it "right" or anything; they trusted that we were figuring it out, which I appreciated (age 29, first child).

As Cheyney (2010) has proposed, the birth and breastfeeding experience are happening in the same woman, the same body, mind and spirit. “Women who successfully internalize views of their bodies as sufficient to meet the demands of labor and delivery also tend to ‘frame’ their abilities to parent through such constructs” (Cheyney 2011: 50). As such, women who choose to birth under this model are more likely to consider their body capable of breastfeeding an infant. Breanna summed up this perspective in, saying:

> All I hear/read about is how hard breastfeeding is. That just can’t be true, or is it just like society has made childbirth hard, painful and scary so we

> have done to breastfeeding. I think the most important thing to stress to every woman is that just like childbirth is normal and safe most of the time, so is nourishing your baby (age 29, first child).

While all clients intended to give birth at Bright Life or at home with one of the Bright Life midwives, a small percentage of client-participants were transported to the hospital due to non-emergent complications during labor or after birth. For these women, the care they received and attitudes they encountered in the hospital were a striking, and therefore noteworthy, difference to the birthing and early postpartum models of care they embodied while receiving care at Bright Life. Lillian recalled her experience this way:

> [The first 48 hours were] in the hospital. [The support was] poor. Most of the nurses didn't really seem to want to help or didn't know what they were doing. I was encouraged to use a nipple shield within 24 hours. I was treated as if I was being tested, "you can't go home till you can show us that you can feed him." They kept waking us up every three hours and making me try and feed him even though I knew it was too early for that. When I told them so, they said, "the doctor has ordered it" (age 40, first child).

Lillian talked about "knowing" that it was not time to feed her child, despite the physician's and nurses' orders. This notion is referred to "embodied knowledge" where one relies on and seeks knowledge through intuition "…as a means of describing a way of knowing that [is] not intellectual, rational, or logical, but more bodily and experiential" (Cheyney 2011:61). Most midwives, like those at Bright Life, who practice within the holistic model of care, value this knowledge as complimentary to traditionally rational forms of knowledge such as biomedical testing (Cheyney 2011). The medical staff in Lillian's experience did not appear to value her embodied form of knowing and did not credit her as knowledgeable about what her baby needed. Another participant who transferred also experienced conflict regarding her intuition and subsequent ignoring of

her wishes by the hospital staff, saying: "I wanted to start pumping as soon as I could and the doctors and nurses wanted me to sleep and recover" (Abbie, age 34, first child).

The biomedical staff with whom these clients interacted was very concerned about knowing exactly when and how much the infant was eating. While wanting to know that a newborn has eaten is important for any care provider, the emphasis on measurable outcomes is indicative of the technocratic model of care and the importance of the health of the baby, rather than both the physical wellbeing of the baby and the emotional wellbeing of the mother. Rebecca explained how scare tactics were used to try and persuade a bottle and formula:

> [The support during the first 48 hours postpartum] was very poor. The doctor tried to intimidate me by telling me that he didn't want me to be a statistic, that the baby lost too much weight in the first 24 hours and that if I didn't give him formula he'd end up with tubes and IVs (age 33, first child).

Physicians who show concern about breast milk output may view bottle-feeding as safer than early breastfeeding because the quantities that the infant is eating can be measured, rather than estimated, and they will know with certainty that the infant had eaten (McInnes and Chambers 2008).

The feelings the mothers who transferred to the hospital in this study had of "being tested" on breastfeeding and "ordered to perform on cue" stand in stark contrast to the mothers who were able to stay at the center where the atmosphere was most often described as trusting, supportive, and encouraging. Client-participant's experiences in the hospital often reflected feelings of resentment towards their breastfeeding support -- or what they described as "non-support." Examining how long client-participants

planned to breastfeed, their opinions about formula, and how women connect their birth and breastfeeding experiences reveals an incredibly strong commitment to breastfeeding that was shared by the participants in this sample. In the next theme – Experiencing Difficulties – I examine how this commitment is re-negotiated when the reality of breastfeeding meets, and often clashes with, previously held expectations.

Theme Two: Experiencing Difficulties

Reality does not always align with expectations, as evidenced by 65% of client-participants who reported that they experienced unanticipated physical and/or emotional difficulties associated with nursing. Theme two - experiencing difficulties - highlights the breastfeeding difficulties mothers encountered after birth as well as a key gap that client-participants identified in their prenatal preparation. This theme involves three interrelated subthemes: 1) Physical Difficulties; 2) Misguided Support; and 3) Prenatal Hindsight

Physical and Emotional Difficulties

When it comes time to meet and feed one's baby, the reality of breastfeeding may not match up with expectations and many client-participants were distressed when they encountered difficulties. When asked if they encountered problems while breastfeeding, 65% said yes. Of those who responded yes, 91% specifically identified physical difficulties, which often gave way to emotional hardships. Establishing a good latch as soon as possible was a predominant concern for many participants; 56% of all client-participants mentioned latching specifically, whether or not they reported experiencing problems with it. As one mother noted in hindsight: "I wish I had realized earlier that I

didn't need to be in so much pain! Once I realized that I really just had to keep adjusting my baby's latch, breastfeeding went very smoothly" (Jordan, age 28, first child). Even for second-time mothers, latching proved to be an issue, as Gwen experienced: "he was my second baby so I figured it would be easy, but we had issues latching on. He did this weird thing with his tongue that my first baby didn't do" (age 31, second child).

An improper latch can cause subsequent problems with pain and supply, which can easily affect the mother mentally and emotionally (Cahill and Wagner 2002; Lawrence and Lawrence 2005), as Haley recalled, saying: "There was improper latching and lots of pain, and emotionally, I was completely frustrated to the point of being ready to give up. I ended every day sobbing because it was such a struggle. I had a LOT of pain until her latch was corrected" (age 25, first child). Mothers recognized the intimate tie between the physical and emotional difficulties that they experienced when breastfeeding. Brooke said: "Breastfeeding was not easy for my son or myself. It sometimes took 30 minutes just to get him latched on, and then all I seemed to do was feed because all he did was fall asleep, which is just emotionally draining" (age 26, first child).

Sore and cracked, bleeding nipples were also a common complaint from client-participants, causing many women to struggle with keeping up supply on the affected breast/s. Sore nipples can also be an indicator of impending mastitis (Spencer 2008), another frequently mentioned issue for those who reported physical difficulties. Mastitis is incredibly painful and can result in issues such as low supply from lack of consistent nipple stimulation (Prachniak 2002; Spencer 2008). Pain and lack of supply compound to

cause mothers emotional distress as breastfeeding is disrupted. 44% of client-participants tried to either regulate supply issues of these physical conditions or just proactively increase or keep up their milk supply through the use galactogogues like herbs, teas and tinctures -- the most popular of which were Traditional Medicinals' Mother's Milk Lactation Tea and the herb, fenugreek. Of the women who tried these remedies, 86% perceived that the herbs worked to increase milk supply.

The use of herbs to remedy health issues in pregnancy, birth and lactation have been used for centuries (Cahill and Wagner 2002;Walls 2009), and given the tendency to reject many biomedical interventions in Bright Life community, it is not surprising that the staff suggested and clients turned first to more natural herbal remedies as opposed to pharmaceuticals such as domperidone. Domperidone is a peripheral dopamine-receptor antagonist that increases prolactin concentration, and thus, increases milk production (da Silva and Knoppert 2004). While it has been show to produce positive results, it is expensive, tightly regulated, and requires access to a compounding pharmacy. Only 9% of women in this study took domperidone with mixed results when other herbal supplements proved insufficient.

Misguided Support

The second commonly occurring subtheme – misguided support – focuses on breakdowns in communication and support that attempted to be helpful but fell short, especially during the immediate postpartum period, which often added to the physical and emotional distress mothers experienced. Client-participants recognized that many of the issues they faced when trying to establish breastfeeding could have been addressed

within the first few days after birth, either during their stay at the center or within the first few days of being home. Much of the reported lack of problem solving appeared to be a result of miscommunication between birth center clients, the postpartum staff, and the midwives. This stemmed from a combination of client-participants not being clear that they needed help, Bright Life staff's lack of noticing or not "prodding" more about client-participants ' confusion or distress, being given conflicting information, or staff not knowing how to help. It is important for problems like these to be addressed, as women with anxiety or discomfort tend to have more breastfeeding problems (real or perceived) and to discontinue breastfeeding earlier than those without these traits (Hillervik-Lindquist 1991; Rondo and Souza 2007).

Some mothers would not ask for help in the beginning and needed the staff to initiate the conversation, as Dana described, saying: "I would've liked [the postpartum staff] to ask if any help or assistance is needed with breastfeeding after the birth. Some [mothers] won't ask and need to be asked if they need help" (age 26, first child). Similarly, another mother shared: "I feel like I said breastfeeding was great, but I wasn't really sure. I wish I had been prodded just a little more to show off breastfeeding in the first 24 ours even though I said I needed no help. For the first few days, I was really unsure of what I was doing" (Jenny, age 33, first child). When considering why client-participants might not have asked questions or questioned whether they were breastfeeding correcting, it is helpful to acknowledge the performative aspect of breastfeeding, as discussed by Shaw (2004). She argues that it is, "very easy to perform breastfeeding 'wrong' or 'incorrectly' and to be reprimanded for doing so…" (2004:

101). While reprimanding the mother is antithetical to the holistic/midwifery model of care, mothers in Bright Life community may feel extra pressure to "do it right" and without a lot of help.

Client-participants who were offered well-meaning attempts at support usually recognized the effort, but were still often left without solutions. Delaney (age 32, second child) shared her experience, which reflected the midwives' belief that mom and baby will figure out how to breastfeed without much help:

> The Bright Life midwives are incredibly supportive of breastfeeding and they checked in regularly to see how it was going, but feeding my first child was very difficult and painful. I didn't get told much more than, 'yeah, it will hurt for a while, but then will get better with practice' or that the baby would just figure it out on her own, but I was hoping for more direct and helpful advice.

Roberta recalled her experience working with the postpartum staff, saying: "They were trying and there was definitely encouragement, but I got the impression that the young ladies (night staff) didn't know any more than I did about breastfeeding. It still hurt and of course my milk hadn't actually come in until 2-3 days after birth (age 29, first child). The insufficient knowledge of the postpartum staff was often a factor in clients receiving misguided support, as Brooke experienced:

> The person taking care of us was very helpful in all other ways and she was trying, but she didn't seem to quite understand the best ways to get a good latch. She explained the different positions to hold the baby and how the latch should happen and look, but I was still having problems and she was not really able to tell me how to fix it. She should could tell me how it was wrong, which was still helpful, just not what I really needed (age 26, first child).

In general, the misguided support came from the postpartum staff in during the stay at the center, as these clients mentioned later that when their midwives came to their home visits, the support was more direct and helpful.

Prenatal Hindsight

Every mother at Bright Life is asked by their midwives if they plan to breastfeed. However, when client-participants were asked to recall if they discussed their plans to breastfeed in more detail, nearly all recalled that there was little to no discussion past the initial yes/no inquiry. As Mia put it: "It was just assumed that I was [going to breastfeed]" (age 31, first child). Others' experiences were similar, as many responded to this question with statements like: "From what I remember, I was asked if I planned on breastfeeding. I said yes. And that was it" (Ashley, age 27, first child). The midwives did not press for the details of this decision and the mothers did not elaborate.

As the midwives were curious about the usefulness of the breastfeeding plan that midwife Lena proposed, it was included in the client survey. Some client-participants were enthusiastic about the idea, as demonstrated by Ivy's reaction:

> "ABSOLUTELY [I feel that I would have benefited from a breastfeeding plan]!!!! I had researched the hell out of birthing, I knew exactly what to do and was prepared in every way, but with breastfeeding I had no idea how difficult it would end up being. I have said to everyone to this day that if I would have done more research about what to expect and do after birth, instead of just focusing on pregnancy and labor, I would have been able to breastfeed differently" (age 27, first child).

Many clients shared Ivy's interest in a breastfeeding plan, reasoning that if a plan were offered, they would be more knowledgeable and know what to expect when it came time to breastfeed, rather than just assume that they would know what to do – and not be so

caught off-guard if things did go awry. Of course, there were some mothers who did not feel that a breastfeeding plan would be beneficial, as one mother remarked: "It is too unpredictable and there is no way to prepare for [breastfeeding] with a baby you haven't met yet" (Emily, age 22, first child).

Overall, however, despite concerns about getting attached to a plan that might not happen exactly as it was laid out, most client-participants who noted potential drawbacks recognized the value of discussing goal setting and possible barriers to nursing during the prenatal period. Kelsey explained:

> It's hard to expect what will happen with the baby, and it would be another sort-of "downer" if things didn't go according to plan. However, it's not a bad idea to have a goal or an idea of what you want for yourself and your baby. And to know what support you will have available when the time comes" (age 30, third child).

Aside from a putting together a formalized plan, having more resources and information given in the prenatal period would have been very helpful for some. As Haley noted: "Bright Life should provide more education to their clients about correcting issues that arise, or at least provide the names of places to go. I did all of the legwork myself" (age 25, first child).

Breastfeeding may not go as smoothly as expected, however this does not take away from the fact that gathering information, helpful tips, and resources before potentially running into difficulties can help to mediate some of the emotional upheaval that may come later if a problem is encountered. Having a plan and being somewhat prepared for potential problems has been shown to prolong the breastfeeding relationship and give mothers more confidence (Donath and Amir 2003). As Tabitha put it, "The

preparation I received was ‘you have breasts - it will just happen.’ It would have been nice to know that breastfeeding is not always natural to moms or to babies - it takes a lot of work!” (age 31, first child). As this theme has shown, even in groups with high rates of intention and prolonged breastfeeding duration, mothers still struggle with establishing the breastfeeding relationship and acknowledge that they needed to and could have prepared differently. The next theme – support and confidence building – discusses the role of encouragement and support in work through difficulties.

Theme Three: Support and Confidence Building

The postpartum period is not only full of practical challenges, but emotional challenges as well. In the second theme, client-participants identified key gaps in their breastfeeding preparation and difficulties that they encountered. Theme three, support and confidence building, explores how client-participants found, or did not find, breastfeeding support from others. The first two subthemes: 1) Support Codes; 2) Normative Experiences and; 3) Coping with Disappointment

Support Codes

In this section –support codes – I discuss the three predominant codes of positive breastfeeding support that emerged from client-participant’s survey responses. The first code of support is considered to be reaffirming and hands-on, where encouragement is individualized and offered through practical problem solving and solutions, characteristic of the holistic/midwifery model of care. The midwives and postpartum staff were most often the providers of this hands-on support, with occasional outside help from others, such as International Board Certified Lactation Consultants (IBCLC).

As Michelle shared: “The midwives not only supported me in nursing the baby as soon as he was born, but helped with positioning, checked sucking, gave me tips to help attachment, encouraged skin-to-skin and answered any question I had” (age 33, first child). Holly specially mentioned a member of the postpartum team, recalling, “I received the most help from the woman who stayed with us the night he was born. She was so patient, calm and supportive. She helped to get him latched (at 2am!) when he fussed and neither my husband nor I could calm him” (age 32, first child). The mothers who felt that they were positively supported and encouraged agreed that Bright Life’s staff helped to build or maintain their confidence. “[The support] was great, and it actually got me and my daughter to get the hang of this new thing that we were doing together. I felt happy with the help that I got. It gave me the confidence that I needed” (Joanna, age 38, third child). Another mother, Nancy, discussed the effect that the staff had on her, saying:

> The midwives were full of praise and ready to offer assistance. They were very supportive and wonderful. They made me feel very good about how it was going and how I was doing. They helped me feel that I was a competent mother. The midwives increased my confidence in my ability to breastfeed and also reaffirmed my position that breastfeeding is the best possible feeding choice for my children.” (age 40, second child).

The second code centered on the availability of support. Many of the mothers, especially those who did not report experiencing problems, recognized that although they may not have felt the need for any hands on breastfeeding support, that they were clear that there was in fact support available if needed.. This was especially true for second time mothers. “Even though I knew what to expect from feeding my previous child for 14 months, they were very helpful and informative. They made sure that I had all the

necessary tools to be successful" (Chelsea, age 24, second child). Another mother shared: "I have been doing great without the assistance offered, but I know that it is there if I do start feeling the need for it" (Amanda, age 30, second child).

Nearly all client-participants reported receiving support for breastfeeding. While some support was misguided, as described above in the second major theme – experiencing difficulties - the third code within this subtheme -- lack of support – was actually discussed in a positive light. For some client-participants who did not report receiving support, it was *not* feeling the need for support that seemed to be a confidence booster rather than a detriment. These mothers expressed self-confidence in their abilities, saying things like" "I am a veteran breastfeeder" (Joyce, age 46, third child) and "I consider myself a pro at [breastfeeding]" (Liza, age 29, fourth child). Several client-participants said that they did not receive any support because they did not need or ask for it. As one mother expressed it: "I didn't receive very much support, but I didn't really need it. The baby latched on immediately and was a strong nurser. I think it was obvious to the midwives that all was well, and I didn't need any help" (Sarah, age 34, second child). The support that Bright Life staff provided -- or did not need to provide for some – presumably influenced the very high levels of confidence and overall happiness with their breastfeeding experiences that 92% of client-participants reported.

Reassurance of Normative Experiences

For many client-participants , a recurring theme involved finding reassurance and reconciliation around the range of possible "normal" breastfeeding experiences -- that is, that the relationship sometimes comes easily and sometimes it is an extremely difficult

struggle requiring extra help and encouragement. As discussed above, some mothers sought and found reassurance that their experience and difficulties were within the range of normal from their midwives and from other birth center staff. For others, some of the most impactful reinforcement came directly from other breastfeeding mothers. The postpartum breastfeeding support group offered by Bright Life was an important source of comfort and encouragement for some. As Amanda explained: "Finding others who were/are going through the same thing can be very helpful to deal with the stress and frustrations of breastfeeding" (age 30, second child).

If mothers were not able to make it to the group, most often due to scheduling, transportation or not feeling the need for support, they sought reassurance from friends, families and their midwives. Peer breastfeeding support groups have been shown to increase breastfeeding success and importantly, to normalize breastfeeding in a social environment. They offer a safe place to rehearse and perform breastfeeding in front of others, and mothers often find it easier to talk to other mothers about breastfeeding than health professionals (Alexander et al. 2003; Benton et al. 2007; Grummer-Strawn et al. 1997; Hoddinott, Chalmers and Pill 2006; Muirhead et al. 2006; Shaw and Kaczorowski 1999). Michelle discussed her experience with the post-partum group this way:

> They helped answer questions and most importantly, for me, it was a great place to get and give basic support as a new mother and to new mothers. It is just nice to be with other people that are at the same place as me. Even if I did not have questions, I could listen to others and have insight in case it was an issue for me later (age 33, first child).

Tessa echoed these sentiments, recalling: "The group was not only great for meeting other breastfeeding moms, but it was great to hear other people asking the same questions

I was asking, so when I would freak out thinking something was wrong, I knew that it was normal and things were okay" (age 25, first child). Not all women experienced the same difficulties, and this was acknowledged as helpful in its own right: "It's good to know that other moms had been experiencing the same things that I had, it is nice to get multiple perspectives on an issue since everyone's experience is so different" (Dana, age 26, first child).

The group was not just useful for first time mothers, as demonstrated by one mother of five who remarked: "I don't remember all the things that I did with my other children, so I found [the group] extremely helpful to get a refresher and some new strategies" (Valerie, age 33, fifth child). Overall, the support groups seemed to be serving the intended purpose of utilizing peers to help support and encourage breastfeeding mothers.

Coping with Disappointment

As Cheyney (2010) acknowledges, birth and breastfeeding do not happen to two different women. For many women, experiencing a strong and empowering birthing experience outside of the medical realm serves to affirm their belief in the ability of their bodies to birth and to care for their infants, without the application of routine medical technologies. While some client-participants were able to breastfeed without issue, 65% did encounter difficulties. Yet, despite the difficulties these women faced, 92% of mothers in this study expressed overall happiness about their breastfeeding experience. What did the remaining 8% of women say about their breastfeeding experiences, and why were they disappointed? This last subtheme addresses these questions.

Out of the 71 mothers who participated, six (8%) expressed overall disappointment in their breastfeeding experience. Interestingly, five of the six were first time mothers who planned to breastfeed exclusively for six months and for a minimum of at least one year. Each of these women's children received infant formula, either exclusively or as supplementation, within one week to three months after birth, and all stopped breastfeeding completely within four months. The major reasons these women listed as to why they stopped breastfeeding were low milk supply and fears of not providing enough for the baby. One mother, however, reported that her baby had been diagnosed with severe hypotonia, a state of low muscle tone that can affect motor nerve control and muscle strength that can inhibit the infant's ability to suckle (Lawrence and Lawrence 2005). In addition, six client-participants total were transported to the hospital during labor and as a result, the first 48 hours of postpartum care was not provided by their midwives or postpartum staff, however only half (3) reported being disappointed in their experience.

Only one of the -participants who reported disappointment reporting attending a prenatal breastfeeding class; all others reported not remembering if the classes were offered or were unable to attend due to work or scheduling. When asked what Bright Life could do to improve their breastfeeding care, preparation and problem solving were at the forefront of their suggestions. Similar to other client-participants, physical and emotional difficulties were intricately connected, but these mothers also reported that they felt as though they encountered the lack of support as a major difficulty. For example, Heather said: "I felt terribly guilty about the baby not gaining weight, like I was starving her to

death, and I felt that my midwives addressed my emotional distress far too casually" (age 29, first child). As a result of feeling under-supported at the birth center, all were referred to or sought outside help from care providers such as lactation consultants or pediatricians.

In addition to feeling under supported, some of these mothers also expressed appreciation for not feeling the same pressure or judgment from the outside providers as they had felt from the Bright Life staff. Lillian, the mother of the infant with hypotonia, shared that the outside lactation consultant, "was actually the person who finally said: 'Stop blaming this mother for not being able to breastfeed -- there may be something wrong with the baby.'"(age 40, first child). Feelings of frustrations were shared by all but one member of this small sub-sample of clients that if they had not been first time mothers, their concerns would have been responded to differently. Lillian continued by saying, "Well, if I were to have another child, I would be glad that it wasn't my first child to breastfeed so I wouldn't hear from everyone, including the midwives, 'It's your first baby, you just don't know how to do it, it takes time, there is nothing wrong with your baby.' At least I would be taken more seriously" (age 40, first child).

In communities such as Bright Life, where breastfeeding is expected and therefore becomes intimately connected with a "good mother" identity, it is perhaps not surprising that mothers who "fail" to breastfeed not only feel guilty, but seem to falter in or lose their identity as a "good mother" altogether, a state which Lee (2008) has called a "moral collapse." A moral collapse of sorts happens after mothers experience an unexpected change in their sense of self. This can be seen in Helena's experience:

> I would have liked to know that it is common to struggle with breastfeeding. It has been challenging for me with my baby's strange reactions, sore nipples, and never an excess of milk. It was difficult for me not to internalize this as a problem with me. "Why does my baby not like nursing? What is wrong with me as a mother?" (age 32, first child).

Some employed a different coping strategy and became defiant after not realizing their breastfeeding goals, reworking their previously held worldview that breastfeeding is the only option for their children: "I feel that there was enormous pressure to breastfeed at all costs and it did great damage to my mental health. I think that there is TOO much emphasis on it" (Lillian, age 40, first child). Another participant revamped her views on formula, suggesting that the midwives should, "give women the ok to use formula in emergency situations. I felt like I was doing something wrong when I supplemented. I shouldn't have felt that way, there was no harm done" (Ivy, age 27, first child).

One additional mechanism that these mothers utilized was to reassess their previous beliefs and plans and adopt a "plan B for nursing." These new plans most often involved pumping and utilizing a bottle, rather than actual breastfeeding. Because their babies were still receiving breast milk rather than formula, these mothers were able more likely to discuss themselves as "good mothers" -- just not in the way that they thought they would be:

> If you can't handle breastfeeding, there is nothing wrong with pumping instead and then dad, grandma, grandpa, friends and other relatives can help with baby and give mama a much needed break once in a while. Baby still gets the good stuff from mom, but mom doesn't have to deal with as much pain and frustration as can occur with actual breastfeeding. It made my relationship with my baby much happier, and I was less resentful of my baby (Megan, age 29, first child).

Coping with the disappointment that breastfeeding did no go according to plan can be extremely difficult for women, especially those in a community such as Bright Life where breastfeeding his held to the highest standard. It is a conceptual space -- a social domain -- that breastfeeding women have to negotiate, especially in the early post-partum period. This small subset of mothers used a variety of coping mechanisms to navigate their change in plans, as discussed in this last sub-theme.

Support and confidence building is the final emergent theme. Clients of Bright Life held strong convictions about the importance of breastfeeding and set goals that reflected those convictions. Some clients did not experience any breastfeeding difficulties; however, 65 percent of clients did and had to navigate these difficulties in relation to their ideas about breastfeeding. Most were able to utilize the practical support offered by Bright Life staff in the immediate postpartum period and by their peers in breastfeeding support groups. However, a small group of women were left to cope with the disappointment they experienced when faced with breastfeeding difficulties that they were not able to overcome with the help of the birth center staff. As a result, they did not meet their breastfeeding goals and had to redefine their previous held breastfeeding beliefs. In the next chapter, I discuss how these emergent themes relate to one another, integrating the totality of findings from this study with the larger body of literature on determinants of successful breastfeeding. I conclude with some key interpretations and recommendations regarding the outcomes of socialization and breastfeeding support.

Chapter 7 – Discussion

The purpose of this study was to examine several major research questions: 1) How do the midwives at the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients?; 2) What are women's experiences of breastfeeding and breastfeeding support at the birth center?; and 3) How are women's breastfeeding experiences shaped by the birth center's approach to breastfeeding, and how might this information be used to improve services both at the birth center and, more generally, for U.S mothers at large? In chapters five and six, I described the birth center, how it operates and how it approaches breastfeeding, as well as several themes that emerged from this qualitative inquiry into the experiences of clients of the birth center. The following discussion explores what factors influence successful breastfeeding beyond the intent to breastfeeding, as even women who intend to breastfeed and who are deeply committed need support. This is especially true of first time mothers and those who transport intrapartumly. Furthermore, how does the birth center's model of care impact and shape women's breastfeeding experiences and breastfeeding outcomes?

Bright Life is a free-standing birth center run by Certified Professional Midwives. The client-participants in this study chose to give birth outside of the hospital at the birth center, and thus, to receive care from midwives, rather than physicians. The midwifery or holistic model of care asserts that women's bodies are capable of birthing without the intervention of technology and the midwives adhere to this philosophy and either attempt pass this on to their clients, or for clients who already share this perspective, to further

reinforce the latters' beliefs and intentions. Client-participants used the *envivo* code "convictions" to describe their commitment to breastfeeding and to draw upon a strong sense of the "right way to feed a baby" as they make decisions about whether and for how long to breastfeeding. For the midwives at Bright Life, it follows that women will be able to breastfeed their infants as well without intervention, or even any discussion about the practical mechanics of breastfeeding or how to problem solve. However, while the apprentices and postpartum staff shared the confidence in a woman's capable body, they emphasized the importance of practical education for clients in order to avoid compounding difficulties and faltering confidence.

One hundred percent of client-participants intended to initiate breastfeeding, a common attitude in this community, as the midwives asserted that they rarely have a client who does not intend to breastfeed. The goals client-participants articulated in regard to duration greatly exceed the breastfeeding goals of the CDC's Health People 2010 initiative (CDC 2010) (See Table 2), which indicates both the strength of their convictions and the low bar set by the CDC. Some mothers explicitly stated that they would do whatever it took and nurse for however long their child wanted to breastfeed, while others commented on the lack of societal importance placed on breastfeeding. If Dettwyler's (1995) blueprint is accurate, than the goals outlined by the CDC's BRC are abysmally low. As demonstrated in the results, the women in this community more closely follow Dettwyler's blueprint than the CDC's BRC.

Outcomes	Ever Breastfed	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive breastfeeding at 3 months	Exclusive breastfeeding at 6 months
Goals	75.0	50.0	25.0	40.0	17.0
U.S. National	75.0	43.0	22.4	33.0	13.3
Bright Life	100.0	100.0	93.0	100.00	92.0

Table 2. CDC (2010) Goals vs. Participant Goals

Such goals, however, were rarely if ever discussed prenatally by most of the midwives. This omission can be attributed to the opposing explanatory models of breastfeeding that the midwives held and the structure of postpartum care that allows for a discontinuity in breastfeeding support, as support is being given by new caregivers who clients were not familiar with. Due in part to the disagreement about whether or not to discuss practical breastfeeding mechanics and problem solving prenatally, the midwives tend not to initiate a practical breastfeeding discussion beyond a "yes/no" response to the question of: Are you going to breastfeed? This lack of prenatal discussion prevents the development of a breastfeeding "plan" with the client that would indicate specifics regarding goals or how to initiate breastfeeding, or addresses any potential difficulties that might be encountered. Although the absence of practical breastfeeding discussion is purposeful by the midwives in an attempt to avoid creating more worry for clients, it often does the opposite when clients actually begin to breastfeeding and their confidence in their ability to breastfeed falters.

Due to their strongly held convictions about breastfeeding as a core component of "good motherhood," many women saw formula use as a failure and as an unnecessary and overused "fallback" option. The Bright Life staff tries to avoid any commercial

formula use, opting instead for supplementing with donor or goat's milk. While not made explicit to clients, some midwives feel so strongly that breast is best" that they would not take a client who did not intend to breastfeed. Messages about the importance of breastfeeding are undoubtedly noted by clients and may further instill the necessity of breastfeeding, in order to be perceived as a "good mother" in this community.

For the six women (8%) who transported to the hospital, all of their infants received formula during their hospital stay. These women were very unhappy about this, as most noted that formula had been given without their permission or that they were pressured into agreeing to give their infant formula. When clients return to Bright Life for the remainder of their postpartum care, the midwives work to reestablish or build the strong breastfeeding relationship that clients were expecting in the immediate postpartum period.

The grounded theory schema I devised to model my results (Figure 1) depicts the relationship between the themes identified from participants' breastfeeding and breastfeeding advocacy narratives. Breastfeeding experiences in this population begin with messages about breastfeeding as "good motherhood" and the midwifery model of care that believes in women's ability to breastfeed. Generally, client's breastfeeding goals and intentions, as described in the first theme, are developed prenatally through conversations about the health benefits of breastfeeding, the visibility of breastfeeding mothers and breastfeeding classes/groups, and breastfeeding literature, rather than practical "how-to" breastfeeding discussions that may also touch on common problems. According to Bright Life, after client-participants gave birth -- 65 (92%) at the birth

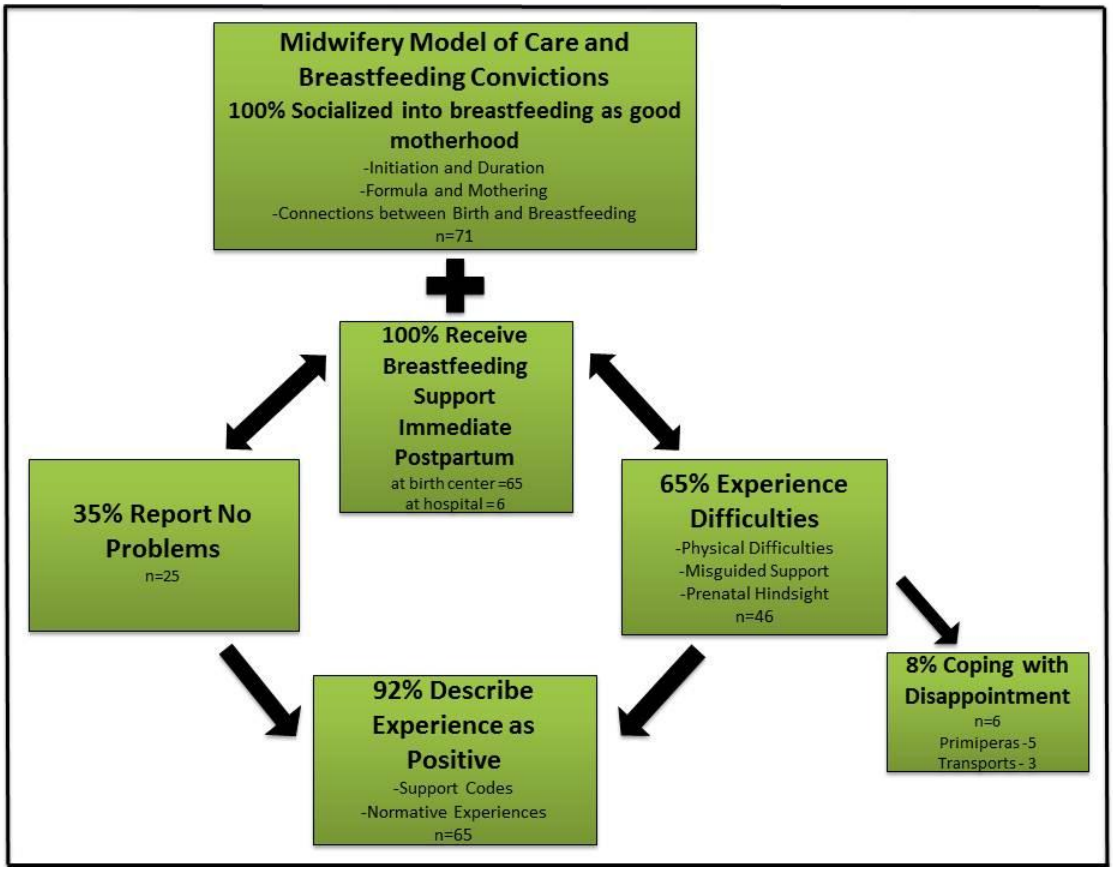

Figure 4. Grounded Theory Schema

center and six (8%) at the hospital – 100% received breastfeeding support in the immediate postpartum period, defined by the midwives as birth to 72 hours postpartum. The type and effectiveness of this support, however, was perceived differently between Bright Life staff members and among client-participants. In most cases, clients stayed at the center for up to 48 hours after birth and received care, not from their midwives, but from the postpartum team – a group of young women who did not have children of their own, some without any formal training – who they may or may not have met before. As the reality of breastfeeding met – or sometimes clashed - with expectations, client-participants fell into one of two groups -- the 25 women (35%) who reported

experiencing no breastfeeding difficulties and the 46 (65%) who did report experiencing difficulties. Of the 71 clients who participated in this study, 35 (49%) were primiparous, or first time mothers, and 36 (51%) had more than one child (multiparous). Table 3 illustrates the relationship between parity and breastfeeding difficulties among client-participants.

Participants	Primiparous (n=35)	Multiparious (n=36)	% of Total (n=71)
Difficulties	31	15	65%
No Difficulties	4	21	35%

Table 3. Parity and Breastfeeding Difficulties

The 35% who reported no problems subsequently viewed Bright Life's support as excellent and/or helpful. These client-participants were overwhelmingly multiparous women who had previous breastfeeding experience, many of whom reported "not needing any support." This statement indicates a level of confidence and was stated as an affirmation that their "body was well equipped to breastfeed." These client-participants did not experience problems and "figured it out" without issue. However, the role of previous breastfeeding experience seemed to play heavily into these women's experiences. Many client-participants mentioned having breastfeed a previous child, so they knew "how to breastfeed" or "what to expect." Thus, this subgroup had a knowledge base about breastfeeding before they gave birth with Bright Life midwives, but their information largely came from personal experience rather than information transmitted by the midwives. These client-participants flow through the left side of the schema and contribute to the 92% of mothers who described their support and encouragement as positive, expressing overall happiness with their breastfeeding experience.

However, more than half of the client-participants in this study (65%, n=45) reported encountering difficulties, a much higher number than I expected from a community that embraces breastfeeding and boasts such high numbers of initiation and duration. The postpartum staff were more acutely aware of how many Bright Life clients actually do encounter breastfeeding problems than were the midwives. An overwhelming 88% of first time mothers in this study reported experiencing breastfeeding difficulties. These women most often ran into common physical difficulties -- which sometimes gave way to emotional struggles -- such as improper latching, sore nipples, mastitis, and supply issues. Many of these difficulties are the kind that could have been addressed and remedied within the first few days after birth. Most common were latching problems which would have mitigated numerous issues that often occur as a result of an improper latch. Although the postpartum staff primarily talked about the needs of first time mothers, one-third of the client-participants who experienced difficulties were multiparous. Postpartum staff were well aware of this and were careful to point it out, because they believe it reinforces their conviction that more support is needed.

The postpartum staff was very much aware of the types of problems mothers were having and were readily available to offer assistance. They tried to use client's time at the center as education, teaching the new mother about her baby's behavior and showing them different ways to hold their baby to breastfeed. For many client-participants this assistance was helpful, as mothers complimented the postpartum staff on their assistance and encouragement. Other times, however, the postpartum team's efforts were noteworthy, but not necessarily helpful. The training that many of the postpartum team

lacked was visible to client-participants, and many had to wait until the home-visit with their midwife to receive effective support and guidance, making for an unnecessarily stressful transition to the early postpartum period.

Both client-participants and the postpartum staff recognized that communication breakdowns occurred during stays at the center. This was a result of postpartum staff not "prodding" enough to make sure mothers were doing, as well as they said they were and mothers not being forthright in their need for help. The postpartum staff was aware of this problem and offered suggestions on how to better catch the mothers who were not asking for help -- suggestions which required better communication from the midwives about their clients. Communication was a major emergent theme in this study, not only concerning the communication between the midwives and postpartum staff, but also the practical dialogue – or lack thereof – between the midwives and their clients about breastfeeding prenatally.

In hindsight, nearly all of those client-participants who encountered difficulties talked about or mentioned that they wished they had spent more time prenatally discussing or researching breastfeeding. For some clients, prenatal discussion would have been as simple as talking about or seeing what a good latch looks like or different ways to hold a breastfeeding infant. These conversations are ones that the midwives could have without "scaring" their clients or giving them more to worry about because they are "how-to" not "what-if" topics. For other client-participants, they wished that they had, in fact, had that "what-if" conversation about potential difficulties. They felt they would have been better equipped to handle them, or at least known that such

difficulties were common and easily remedied if such a conversation had occurred. Some client-participants ended up learning about common difficulties from attending the postpartum breastfeeding support group, where spending time learning with and from other breastfeeding mothers helped tremendously in reassuring them that their experiences were "normal."

As a result of the support they received from the midwives and postpartum staff and their convictions (as represented by double sided arrows moving back and forth between support and experiencing/not experiencing difficulties), the vast majority of client-participants reported an overall positive breastfeeding experience, largely because they were able to overcome difficulties. However, while an impressive 92% of client-participants described their breastfeeding experiences as positive and empowering, 8% of the mothers in this study were left to cope with disappointment. Of these six women, five were primiparous, and three had been transported to the hospital. These women could not reconcile their experiences of breastfeeding with their prenatal perceptions and convictions about infant feeding, and this became a deep source of stress and pain for them. Many felt that their midwives' stances on breastfeeding were *too* "pro-breastfeeding" or "breastfeeding at all costs," and that this left them feeling isolated and questioning their abilities as mothers. The breastfeeding message that the birth center explicitly or implicitly sends are in fact clear to clients, especially those who do not come close to reaching their breastfeeding goals.

For clients at the birth center, the simple fact that they are choosing an out-of-hospital birth and actively rejecting a culture that tells them they need interventions to

birth and feed their babies, means that selection bias likely plays a significant role in defining this sample. However, it is important to take a closer look at *how* the care model may function to strengthen breastfeeding convictions for some, and perhaps initiate a smaller percentage of clients (who want a birth center delivery, but may be coming with less developed ideas about breastfeeding, for example) into this way of seeing and performing infant feeding, while simultaneous leaving some women without sufficient care. Therefore, it becomes necessary to critically evaluate the processes of prenatal socialization, as well as the power dynamics embedded within the midwife-client relationship. The way that Bright Life practices the midwifery model of care affects their client's breastfeeding experiences.

Power Relations within Bright Life

Critical medical anthropology (CMA) recognizes that healthcare is intrinsically political, and that power relationships often affect the delivery of healthcare. Although not all of the midwives were against discussing breastfeeding prenatally, erring on the side of not engaging in breastfeeding conversation with their clients illuminates certain power relationships in play at Bright Life, both among the midwives and the postpartum staff. Status, one component of power relations addressed by CMA is evident here, as it was the younger midwives who deferred to the opinion of the older midwives, perhaps as not to upset the political balance within the midwifery team. As a result, an informal healthcare policy (not talking about breastfeeding prenatally) became routine, and thus, influenced clients' knowledge of breastfeeding.

Status and power also played heavily into the interactions between the midwives and apprentices/postpartum staff. Although they were part of the Bright Life staff and played an integral role in the care of their clients, neither the apprentices nor the postpartum staff were allowed in the midwives' meetings. A clear answer was never provided as to why the meetings were not all-inclusive. However, it can be assumed to have something to do with the notion that the midwives provide the majority of care for clients, and since the apprentices/postpartum staff are not fully qualified health care providers, their roles and opinions may not have been seen as essential to the functioning of the birth center. What was clear, is that the wealth of ideas that the apprentices and postpartum staff had about how to improve the breastfeeding care at Bright Life had not been discussed openly with the midwives. If midwives were aware of their concerns, they

had not acted on any of their recommendations at the time of this study. In the next chapter, I discuss how returning findings form this study to the midwives resulted in some center-wide changes to breastfeeding policy.

The apprentices and postpartum staff also specifically mentioned the lack of communication with the midwives. Although the postpartum staff spends the most time with clients during the immediate postpartum period, a time critical for establishing breastfeeding, most communication came from the midwives to the apprentice/postpartum staff, not the other way around. This lack of bi-directional communication may directly inhibit positive changes in breastfeeding care practices because the postpartum team's voices were either not being heard or not being valued. Again, the lack of communication directly affects the breastfeeding care given to the clients of Bright Life; as lack of communication leads to miscommunication, missed opportunities for help and assistance and misguided/unhelpful support.

Socialization and Shaping Women's Experiences

The breastfeeding convictions that these client-participants embody are likely a result of the intensive socialization that takes place before becoming pregnant and/or during the nine months of pregnancy. Client-participants spend their pregnancy working intimately, one-on-one with their midwives, who practice under the key principle that women possess an innate ability to give birth with confidence and dignity. Through their immersion in this discourse, client-participants presumably go through what Cheyney (2008) refers to as a "process of unlearning and relearning." She suggests that women who are cared for by out-of-hospital midwives come to acquire and value new forms of

knowledge, and thus, begin to question the validity of hegemonic, biomedical narratives (Cheyney 2008). In her study of ritual in homebirth, Cheyney (2011) describes:

> Through the rituals of pregnancy monitoring, knowledge sharing, and affirmation, midwives claim mothers as the ultimate authorities on their bodies and babies, and in the process, replace notions about the supremacy of technology with the sufficiency of nature. Repeated restylizations of the strong, capable, healthy pregnant body communicate connection, safety, and well-being. These reconstructed "natural facts," … are seen by midwives as essential components of the foundation of "trusting birth outside the hospital…" (528).

During the prenatal period, women learn to re-frame their anticipated birth and breastfeeding experiences with trust in their bodies, rather than seeing themselves as dysfunctional bodies that require invasive medical procedures to produce an infant (Davis-Floyd 1994; Martin 1987).

Perhaps it is due to the sheer quantity of discourses that surround a woman's ability to birth a child that most conversations at Bright Life focus almost exclusively on birth, rather than breastfeeding in the prenatal period. While infant feeding discourses certainly abound, most focus on the health benefits/detriments to the infant (ABM 2008; AAP 1997; CDC 2010), attitudes of provider and others (McInnes and Chambers 2008; Graffy & Taylor 2005; Hailes & Wellard 2000) or the benefits/detriments to a woman's autonomy (Carter 1995; Smith 2008), rather than her innate ability to breastfeed an infant. Ideas about whether or not a woman *can* breastfeed may contribute to the lack of conversation about breastfeeding at Bright Life, as it is assumed by all parties involved that women possess the ability to breastfeed and should be able to do so without major issue. There are, however, many different kinds of difficulties that breastfeeding women can encounter. Client-participants, and especially first time mothers, may not be aware of

the potential physical and emotional difficulties breastfeeding may present. The midwives at Bright Life, however, are fully aware of the possible problems a woman might encounter, as evidenced by their purposeful lack of discussion about it prenatally, as not to "scare" or "worry" their clients.

For those who practice maternal-infant healthcare and place value in the tenets of the midwifery model of care, the empowerment of the mother as an autonomous and competent authority on her own body, who is capable of making her own decisions about her healthcare, is of key importance. Woodcock (2011:496) asserts that health care practitioners often "face a dilemma regarding the information to provide to patients: offering certain forms of unsolicited information can lead to intimidation, but withholding information that may be relevant to their decision-making" is, he argues, "objectionably paternalistic". Medical paternalism has been defined as "interference by the physician with the patient's freedom of action, justified on the grounds of the patient's best interest" (Weiss 1985:184). How can the midwives at Bright Life be practicing within the midwifery model of care, yet arguably be practicing paternalistically with regard to breastfeeding (an essential part of the childbirth spectrum), by way of purposefully omitting detailed conversations and information sharing (an essential part of the midwifery model of care) at the same time?

Although 92% of client-participants in this study describe their overall breastfeeding experience as positive, the results of this study also show that mothers are not necessarily benefitting from the absence of potentially "scary" or "worrisome" information about breastfeeding, specifically within the immediate postpartum period.

The midwifery model of care does not advocate for the power dynamics exhibited by the midwives at Bright Life in regard to what they will or will not share with their clients. As healthcare professionals, the Bright Life staff, as well as any other provider,

> ought to possess a disarming 'bedside' manner that can initiate trusting relationships with patients and acute social skills that include sophisticated capacities for practical judgment that help to ascertain how much information to offer each patient without causing undue intimidation or inappropriately withholding salient details (Wiess 1985:502).

Is it not their responsibility as healthcare providers, regardless of whether or not they practice within mainstream or alternative healthcare, to ensure that their clients have the best information possible *and* to respect their choices if clients do in fact change their mind about breastfeeding?

The dynamics of the relationship between the midwife and mother have been referred to as "mothering the mother," whereby the new mother is "mothered" through support, care, and encouragement as she learns to navigate motherhood (Raphael 1981). Such a dynamic builds a deep level of trust between the midwife and the mother. It could be argued that because of the deep relationship women build with their midwives, client-participants rarely place blame on the midwives for not presenting them with breastfeeding information. Rather, the lack of practical prenatal breastfeeding information received from the midwives was not generally viewed as a purposeful gap in care, but rather talked about ambiguously or with the responsibility claimed by the mother - "I wish I had gotten more information." The exception, of course, lies within the experiences of the six mothers who were left to cope with the disappointment of feeling like breastfeeding "failures."

These women did, in fact, place blame on the midwives, saying that they "placed too much emphasis and pressure" on breastfeeding, in a variety of ways, that led to intense emotional distress and unhappiness with the care they received. Due to the intimate nature of the midwife-client relationship, the distress that these six clients had to navigate may have been more extreme than in a different type of provider-patient exchange. Due to the at least somewhat challenging nature of childbirth, it is likely to be a time where women are open to the guidance of others, most notably those who they would consider to be "experts," such as midwives Cheyney (2011). As such, because birth is a transformative event from one life stage to the next, it is likely to be a time where client-participants are open and vulnerable to the transmission of the core values and beliefs of a group, society or culture (Turner 1979). Therefore, pregnancy, birth, and early parenting may be times when women are particularly open to changes in behavior or in the ways of seeing or knowing about the world. The relationship with their midwife is one that client-participants in this study specifically sought out as an alternative to going to a physician, so when this relationship essentially fails the mother in such an essential aspect (adequate breastfeeding support), the resulting vulnerability mothers experience may cause them to critique the values and beliefs they had worked to relearn with their midwife's guidance.

Embedded in the intensive socialization and unlearning/relearning that client-participants go through during their pregnancy is the idea that "good motherhood" requires you to breastfeed your child/ren. While "good motherhood" in terms of breastfeeding seems to be attainable for the 92% of client-participants in this study who

reported overall happiness with their breastfeeding experience, there remains 8% of client-participants whose breastfeeding plans did not only not go as expected, but seem to derail completely. It is unsurprising then, that those who experienced such challenging difficulties found themselves coming into conflict with their socialized or relearned self. The words of these client-participants revealed an internalized struggle as they negotiated disappointment and sought what they found to be suitable explanatory models for discontinuing the breastfeeding relationship. They encountered the need for the construction of a new identity as a morally responsible citizen of the birth center community, as they had been socialized into holding close the idea that a good mother is a breastfeeding mother. This moral reworking is described by Ryan, Bissell and Alexander (2010):

> Deconstruction and reconstruction of the embodied moral self is part of the biographical repair work undertaken by people in their narrative retelling at times of crisis in order to restore equilibrium. In adjusting to motherhood or when their actions do not coincide with expectations, recommendations or the prevailing parenting ideology, women undertake moral work that may include redefining the self, repairing biography and restoring internal subjective stability (952).

Mothers articulated these reworkings in several ways, including going to a "plan B," seeking outside care, as well as a rejection of their previously held convictions that breastfeeding was the best option for both themselves and their children. Prior to giving birth, these client-participants identified as "good, planning-to-breastfeed mothers" who embodied and displayed the identity of a woman who has rejected the hegemonic discourse that imply a reproductively dysfunctional body. When the reality of

breastfeeding came into opposition with the identity developed at the birth center, moral reworking was required to repair it.

While the number of women who experienced disappointment in this study is small, they make up a key group in this community. If birth centers and midwifery care function to re-socialize and empower women in a community where the body is seen as powerful and unlikely to "fail," then these care providers must also take responsibility for helping clients to make sense of experiences that seem to reinforce the body as "incapable," "a failure," or "dysfunctional." There is no doubt that the midwives and staff at Bright Life are providing support for their clients, however there needs to be a greater recognition among these and other midwives regarding the role radically pro-breastfeeding ideologies may play in setting some women up to fail. Every precaution needs to be taken to ensure that mothers do not leave Bright Life's care with the stigma of being a "bad mother" who was unable to perform her identity as an out-of-hospital, good, breastfeeding mother whose body is strong and capable.

In addition, Bright Life also needs to recognize their client's breastfeeding experience as inherently biocultural. Although less severe than a "bad mother" stigma, by presenting messages that every woman can breastfeed without much trouble and refraining from talking prenatally about what to expect, potential difficulties, and how to work through them, Bright Life creates a culture that inhibits communication. As acknowledge by both client-participants and apprentices/postpartum staff, many new mothers will not ask for help because they are trying to, as the midwives have told them, "figure it out." Physically, they may be having trouble getting a good latch or

experiencing sore nipples, but they have been told that it will just take time to work those things out. Culturally, they may not feel comfortable asking for help, which can be viewed as admitting that breastfeeding is not as "natural" as they thought it would be. As a result of this silence, women do not receive the assistance and problem-solving they need early enough, so their breastfeeding problems often worsen. For some, the clash between the physical aspect of breastfeeding and the birth center culture cause clients-participants to reject the birth center culture they had adopted as part of a rejection of a culture that said their bodies were not capable.

In a sense, client-participants also exhibit their identity in a biocultural way. Foucault presents the idea of technologies of the self - devices that make possible the social construction of personal identity – which, he argues "permit individuals to perfect by their own means, or with the help of others, a certain number of operations on their bodies and souls, thoughts, conduct, and a way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immorality" (1997:225). These technologies can be influenced by others, such as the hegemonic forces that tell women that they are reproductively dysfunctional, or by the counter-hegemonic voices of the birth center and midwifery model of care. With the help of the Bright Life staff, client-participants are reconstructing their bodies to attain what they see as a state of good morality and doing the right thing -- that is, good motherhood through breastfeeding. How people socially construct themselves is made noticeable by the ways they represent themselves and govern their bodies, which, in turn, can reveal parts of our identities in relationship to others. Crossley clarifies this notion, stating that "the body

has become a primary resource for the building and merging of identity, as well as a vehicle for displaying conformity or non-conformity to social norms" (2002:84). In this case, the body allows the mother to both construct her identity as a breastfeeding mother and to display that identity as conformity to the social norms of the birth center community, by breastfeeding her infants.

The Intra-Partum Period

The results of this study also suggest the importance that parity and the intra-partum period play in the maintenance or disruption of client-participants' relearned identities. Of the six women who reported being disappointed in their experience, five were first time mothers and three had been transported to the hospital for birth and early post-partum care. The time spent at the hospital during this critical period of "opening and vulnerability" to cultural messages may have a significant impact on the outcome of breastfeeding, especially when messages stand in opposition to those client-participants have unlearned and relearned throughout the nine months of pregnancy. In the midwifery model of care, "The supremacy of technology takes a backseat to the sufficiency of nature as midwives capitalize on…triumph, joy, and celebratory feel[ings]…to enhance the maternal pride, power and love they believe are essential components of health bonding and empowered mothering" (Cheyney 2011:535) in the immediate postpartum period. Of those who transported to the hospital, all described the immediate postpartum support as poor, unhelpful and even coercive in some cases.

Mothers who transport to the hospital in labor or immediately following delivery generally return to Bright Life for the remainder of their postpartum care after their

hospital stays. An attempt to identify and then rectify client-participants' hospital experiences may be of the utmost importance in their breastfeeding success. Even if clients did not transport, the notion of rectifying difficult experiences may be especially true for first time mothers who have not had a previous, positive experience to draw upon, to pull them back to a place of "body confidence" and to propel them forward in the breastfeeding relationship with their infants. For the 65% of client-participants who reported difficulties, receiving useful and encouraging support as soon as possible facilitated most of them achieve happiness in their breastfeeding experience.

By investigating breastfeeding in a community that already has a high intent to breastfeed other important determinants of success are illuminated. This discussion has shown how women's breastfeeding experiences are shaped by the birth center's approach to breastfeeding and the explanatory models of the care providers. The socialization and unlearning/relearning processes that client-participants go through does positively enhance breastfeeding experiences by instilling a strong commitment to breastfeeding not only for health reasons, but for becoming a good mother as well. The structure of postpartum care is positive overall, but could be strengthened by consistent protocols, adequate training for staff members and shared problem-solving techniques. However, even with a strong commitment to breastfeed, new mother still need individualized, practical support and education in order to reach their breastfeeding goals. Furthermore, while this model of care does help mothers successfully reach their breastfeeding goals in a positive manner for most, this model can have immensely negative effects for those women who experience serious breastfeeding difficulties.

Chapter 8 – Recommendations and Conclusions

Due to the community based participatory research model this project was guided by, larger research questions about how the birth center approaches breastfeeding and how this approach shapes women experiences were answered, as well as more specific questions that were relevant to Bright Life's staff. These questions included: How do clients feel about their postpartum support, especially in the first 48 hours? Do clients feel prepared to breastfeed? How many women are experiencing difficulties? Are women attending the support groups and if so, are they helpful? By working together with the Bright Life staff, these questions were able to be answered and feedback from client-participants was transformed into tangible changes to better care and advocate for Bright Life clients.

Client-participants were eager to provide feedback when presented with the opportunity, but surprisingly, the apprentices and postpartum staff were as well. Both groups provided specific, applicable suggestions for changes in care that would benefit breastfeeding mothers. As a result, Bright Life has implemented several important changes to their practice to better care for breastfeeding mothers. These include:

1. A breastfeeding plan is now being offered to mothers as an avenue for discussing potential breastfeeding problems and subsequent problem solving skills and resources in the prenatal period. (Change in Practice)
    - By putting the choice back into the hands of the client, the breastfeeding plan should also help to ease the gap between midwives who wanted to talk about breastfeeding prenatally and those who did not.

2. New forms have been included in client charts that specifically track and record breastfeeding progress in the postpartum period to enhance communication and consistency in care between staff members and postpartum staff. (Change in Practice)
    - This should help postpartum staff to better communicate amongst each other as well as providing the midwife with information about difficulties their clients may have experienced in the immediate postpartum and how those difficulties were remedied/attempted to be remedied.
3. Provide resource lists with names and information about complementary care providers in the area such as lactation consultants. (Client Suggestion)
    - Having a comprehensive list readily available could prove helpful, as mother would not have to search for this information on her own when she needs it.
4. Do a "latch test" before clients are allowed to leave the birth center in an effort to ensure that latch is correct within the first 24-28 hours. (Client Suggestion)
    - As latching was the most prevalent problem that client-participants mentioned (as well as something that can lead to other issues), ensuring that clients have achieved a proper latch before leaving the center is of the utmost importance.
5. Have a previous client or "mentor mom" that new moms would be able to contact both prenatally and postpartum to talk about and see nursing in action. (Client Suggestion)

- This would be helpful not only for new moms, but for those postpartum staff who did not have children of their own.

In regard to protocol, it is necessary for Bright Life to come to a consensus about how to care for specific breastfeeding problems. Most importantly, perhaps, the definition of what constitutes a "difficulty" should be more clearly defined by the midwives. A difficulty, to them, may be something major, rather than a fairly common issue, whereas client-participants generally described everything from cracked nipples to full-blown mastitis or being overly emotional as a breastfeeding difficulty. It is the midwives responsibility to discuss difficulties with their clients and despite not wanting to scare women out of breastfeeding, it can be argued that in populations such as this, where the community and its members place such a high value on breastfeeding, knowing in advance about potential difficulties will not necessarily cause a mother to change her mind about nursing, but leave her better able to cope.

I also discussed with Bright Life staff some of the concerns raised for those clients who experienced more challenging breastfeeding difficulties. The changes in practice described above should help Bright Life to more quickly recognize those clients who are experiencing higher levels of breastfeeding distress and enable them to move into action. However, for these women to be most appropriately and effectively cared for also requires midwives to adopt less radical infant feeding perspectives that do not alienate women who choose to supplement or stop breastfeeding early than planned. In addition, Bright Life staff needs to become even more attuned to their clients' ways of describing their experiences, both prenatally and in the immediate postpartum, in order to

evaluate the most appropriate way to care for each client individually, so as not to risk their client's feeling abandoned or too harshly judged.

This can be achieved through the application of meaning-centered approaches to care with tools such as explanatory models and illness (breastfeeding) narratives (Kleinman 1988; Kleinman and Seeman 2000). Because explanatory models and illness narratives are personal accounts of the client's lived experiences that, importantly, may or may not be shared with other members of the local social world, they should prove to be an important tool in the provision of breastfeeding care. Birth Center socialization and unlearning/relearning processes hold the potential to be both empowering and disempowering for mothers. When breastfeeding goes according to plan or when difficulties can be worked through to the satisfaction of the mother, then the processes can be considered positive. If, however, there is failure to meet either or both individual- and community-level expectations, these processes hold the potential to be incredibly detrimental to the well-being of those mothers.

Conclusions

The purpose of this study was to answer three primary research questions that would provide feedback to Bright Life to improve their services as well as to identify strategies to help improve breastfeeding success rates:

1) How do the midwives at the birth center see breastfeeding in connection to birth and early parenting, and how is this information communicated to clients?

2) What are women's experiences of breastfeeding and breastfeeding support at the birth center?
3) How are women's breastfeeding experiences shaped by the birth center's approach to breastfeeding, and how might this information be used to improve services both at the birth center and, more generally, for U.S mothers at large?

What has emerged after synthesizing the results of participant observation, staff interviews, and client surveys, is not only a report on the experiences of women who breastfeed in an out-of-hospital birthing community, but a critical commentary on the way in which Bright Life provides breastfeeding care to their clients, and how this shapes women's experiences. In this thesis, I have described the birth center and its basic operations, as well as the explanatory models of the staff, which help to illuminate how breastfeeding is approached both prenatally and during the postpartum period. While the midwives at Bright Life support and encourage breastfeeding, the radically pro-breastfeeding ideologies that they convey to their clients and the lack of practical breastfeeding education have the potential to both encourage and hinder mother's early breastfeeding experiences.

As a result of the surveys, three themes emerged from this group of breastfeeding women with high rates of initiation and duration in an out-of-hospital birthing center. Client-participants' experiences were shaped initially by their intentions to breastfeed, the belief that breastfeeding is important, and the connections they felt between their birth and breastfeeding experiences – all of which were heavily shaped by the ideology of the birth center. Secondly, client-participants described difficulties and misguided support

that they experienced, while acknowledging the importance of prenatal preparation. Thirdly, client-participants negotiated breastfeeding with the support (or sometimes, seemingly without) the support of others. There was however, a small percentage of clients who did not feel that they had a successful breastfeeding experience and, as a consequence, had to cope with that disappointment. Overall, 92% of client-participants expressed happiness about their breastfeeding experience.

It is clear from the results of this study, that as 92% of women in this sample reached their personal breastfeeding goals, that they would be considered highly "successful" breastfeeders according to the CDC's (2010) Health People 2010 goals. As such, is it important to recognize what factors influence how this group sets and attains these goals. Breastfeeding is a biocultural act and one that cannot be considered solely from a physiological or clinical perspective. In this case, it is evident that the socialization into the birth center community and the unlearning/relearning of reproductive knowledge are key factors in the development of the breastfeeding convictions that client-participants demonstrated, and thus play an important role in the embodied experience of breastfeeding. Client-participants learn to place trust and confidence in their bodies and go into labor expecting to be able to breastfeeding their newborns without major issue. While some client-participants acknowledged that they might encounter difficulties, they nonetheless assumed that with the support of their midwives and the Bright Life staff that they would be able to overcome any obstacle that arose.

Several important lessons come from this study of breastfeeding in an out-of-hospital context.

- Regardless of where breastfeeding women seek their care, many women will encounter difficulties of varying degrees. Their beliefs about birth and breastfeeding do not mean that these women will not experience difficulties.
- These beliefs, however, do influence their perceptions of difficulties. If client-participants had not believed so strongly that they would be able to overcome obstacles and if they had not placed the utmost importance on becoming a "good mother" through breastfeeding, client-participants might not have been willing to persevere through difficulties and instead switch to formula use. As such, I contend, along with many others (Chertok et al. 2011; Brodribb et al. 2007; Dennis 2006; Donath and Amir 2003; Forster, McLachlan and Lumley 2006; Kronborg and Vaeth 2004; Shaker, Scott and Reid 2004; Vogel, Hutchinson and Mitchell 1999), that the absence of maternal confidence and a strong intention to breastfeed are major variables in predicting success and breastfeeding duration.
- Women's need for helpful and encouraging support does not end with birth. While Bright Life recognizes this and is providing clients a place to stay with round the clock assistance is certainly on the right track to making sure clients successfully feed their infants in the first few days after birth, having a staff that recognizes their own shortcomings in terms of knowing how to help struggling clients, does not utilize this service to its potential. Proper training for any postpartum staff is incredibly important, however appointing staff to serve women

specifically during the postpartum period is something to be considered by other care providers.

While much can be learned from this model and despite the overall happiness achieved by client-participants in this study, a critical eye must be cast on the workings of the birth center and the roles played by the midwives, apprentices and postpartum staff, and interactions with clients. In some aspects, Bright Life is practicing care in ways that are antithetical to the midwifery model of care. The purposeful withholding of information, or at least the choice to not engage in certain conversations with clients, the midwives are acting, maternalistic in the worse sense. They are acting as a parent figure, deciding what is best for their clients without consulting them, rather than a provider who treats her clients as experts on their own healthcare. Furthermore, power dynamics and a non- inclusive work environment are prohibiting the staff from working collectively to provide breastfeeding mothers with the best care possible.

Traditionally, the midwife serves as the primary care provider from the prenatal period through late postpartum, but due to the high volume of births at Bright Life, that care is disjointed in the immediate postpartum. Clients often see postpartum staff who they have never met and have not developed a trusting relationship with. While clients certainly appreciate the work of the postpartum staff, many aspects of care slip through the cracks because of the break in continuity. Considering how the birth center functions and how it compromises aspects of the midwifery model of care, future research should be directed towards discover what midwifery compromises when it is set up like an institution and place of business.

Future research should also continue to explore the experiences of breastfeeding women as a way to promote best practices in lactation care and support. Research has been conducted on providers who demonstrate positive outlooks on breastfeeding, however it may be important to also look at the effects of providers with *too* positive of an outlook, as evidenced by this study. One effort that would help to evaluate the widespread effects of different models of care would be to modify the CDC's BRC and include a category that delineates different providers (OBGYN, CNM, and CPM/DEM). Because these providers typically fall on different ends of the technocratic to holistic care spectrum, this information would ideally illuminate under which model women were cared for, as well as provide a numerical and visual representation of measureable breastfeeding outcomes.

Finally, future research should focus on the small percentage of women who felt that they had "failed" to breastfeed, and therefore, had to reinterpret their previously held convictions. How do these women redefine their intentions to be a "good," breastfeeding mother? How do they explain their "change of plans" to others who were aware of their breastfeeding goals? How do they navigate within a community where breastfeeding convictions run strong? Do these women abandon many of the birth center ideals, or do they "contextualize their experiences as exceptions, holding true to the tenets of midwifery…models of care?" (Cheyney 2010: 265). Exploring these women's stories in depth will lend greater insight into how to further improve this model of care to fully encompass the variety of experiences that even well supported breastfeeding women might anticipate.

As recognized by Drife (1997), postpartum care has been considered the "Cinderella" of maternity services, as it often fails to attract scholars as an area of high interest and research. In order to discover what makes these communities so successful in their breastfeeding initiation and duration, as well as what contributes to mothers' overall happiness despite experiencing difficulties, researchers must reach beyond the dominant biomedical maternity system and begin to learn from models of care outside of the hospital

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APPENDICES

Appendix A: Midwife and Birth Center Staff Sample Interview Questions

Name?

Credentials? What is your current job?

How many years have you been with Andaluz?

How many births of Andaluz clients have you personally attended?

What is the basic breastfeeding philosophy at Andaluz?

What happens in regards to breastfeeding education and preparation at Andaluz prenatally? What is your role in this?

What happens in regards to breastfeeding support and care during the post partum period?

What do you see the midwives' role being in the care and support of breastfeeding mothers and babies?

What are the most common breastfeeding issues you see arising for Andaluz clients?

How do you personally help clients work through these issues?

If you could make three recommendations that you feel would help facilitate a supported and successful breastfeeding relationship, what would they be?

Are there topics related to breastfeeding that are important to you that we have not addressed? If so, please feel free to add any additional comments now before we complete the interview.

Thank you.

Appendix B: Postpartum Staff Sample Interview Questions

Name? Credentials?

What do you currently do at Andaluz?

How long have you been with Andaluz?

How many Andaluz clients have you personally attended to (estimate)?

What is the basic breastfeeding philosophy at Andaluz?

What happens in regards to breastfeeding education and preparation at Andaluz prenatally? What is your role in this?

What happens in regards to breastfeeding support and care during the postpartum period? What is your role in this? (i.e. do you help moms/babies, how do you help them, do they ask for assistance, how often do you check on them, what do they say about BF, etc)

What are the most common breastfeeding difficulties you see arising for Andaluz clients?

How do you personally help clients work through these difficulties?

What do you see midwives' role being in the care and support of breastfeeding mothers and babies?

Do you think Andaluz could improve in any way?

If you could make three recommendations that you feel would help facilitate a supported and successful breastfeeding relationship for both mom and baby, what would they be?

Are there topics related to breastfeeding that are important to you that have not been addressed?

Thank you.

Appendix C: Client Survey

Breastfeeding Survey
*Please note that this survey is completely anonymous.

Section One:

1. Have you breastfed any previous children?

2. Did you ***plan*** to breastfeed before giving birth?
3. How long did you ***plan*** to breastfeed in total?
4. How long did you ***plan*** to breastfeed exclusively (no formula, no solids)?

5. How old was your baby when he/she:
    a. Received a bottle?
    b. Received infant formula?
    c. Ate solid food?

6. Did you have to return to work? If so, how old was your baby?
7. Are you still breastfeeding?
8. How old was your child when you stopped breastfeeding?

9. Why did you stop breastfeeding?

Section Two

10. Where was your baby born?
    a. Andaluz
    b. Home
    c. Hospital

11. During your care at Andaluz, were you invited to any prenatal breastfeeding classes?

12. Did you attend any prenatal breastfeeding classes?
    a. At Andaluz?
    b. Elsewhere?
    c. Both?

13. If you did attend prenatal breastfeeding classes, did you find these classes helpful? Why/why not?

14. Describe the quality of breastfeeding support that you received in the first 48 hours postpartum.

15. During your care at Andaluz, were you invited to a post-partum breastfeeding support group?

16. Did you attend any post-partum breastfeeding support groups?
    a. At Andaluz?
    b. Elsewhere?
    c. Both?

17. If you did attend post-partum support groups, did you find these groups to be helpful? Why/why not?

18. If you did not attend a post-partum support group at Andaluz, why did you choose not to attend?

19. Is there anything that the Andaluz staff could do or change to improve your breastfeeding experience? In terms of
    a. Education
    b. Preparation
    c. Encouragement and Support (prenatally and during the post partum period)
    d. Problem Solving
    e. No changes

20. Do you feel there is anything that the Andaluz staff should continue to do to support breastfeeding mothers?

Section Three

21. Did you experience any difficulties breastfeeding? (Physical, emotional?)

22. Did you use a nipple shield?

23. Were you referred to a lactation consultant? If so, did you find them helpful?

24. If you have another child, what would you like to be different?

25. Do you feel that it would have benefited you to have a breastfeeding plan, similar to a birth plan, to help you reach your breastfeeding goals?

26. Overall, if you chose to breastfeed, were you happy with your experience?