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*DARLE EL PECHO: A QUALITATIVE EXPLORATION OF MEXICAN
IMMIGRANT MOTHERS' EXPERIENCE WITH BREASTFEEDING*

Tessa M. Zevallos

73 Pages

August 2011

This study qualitatively examines the breastfeeding experiences of ten Mexican immigrant mothers living in the United States. It explores the intersection between immigration, breastfeeding, culture, and motherhood.

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Breastfeeding is widely accepted as a superior infant-feeding method, offering numerous benefits to both child and mother. However, not all women in the United States breastfeed their babies with the same frequency. Researchers have found Latina immigrant mothers to have among the highest breastfeeding rates of all racial/ethnic groups. However, their likelihood of breastfeeding decreases the longer they live in the United States and with subsequent generations.

In an effort to understand these mothers' breastfeeding experiences, a series of qualitative interviews were conducted with ten Mexican immigrant mothers of young children. The study explores the intersection between immigration, breastfeeding, culture, and motherhood. The findings reveal how these mothers interpret their breastfeeding experiences and the ways they have negotiated their own infant-feeding decisions within a transcultural context. This study finds a number of key differences in women's breastfeeding experiences in the United States and Mexico. It examines the variety of motivations for these women's breastfeeding decisions and the role of social support in

those decisions. This study also reveals the ways these women have constructed an identity for themselves through breastfeeding.

DARLE EL PECHO: A QUALITATIVE EXPLORATION OF MEXICAN
IMMIGRANT MOTHERS' EXPERIENCE WITH BREASTFEEDING

TESSA M. ZEVALLOS

A Thesis Submitted in Partial
Fulfillment of the Requirements
for the Degree of

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2011

DARLE EL PECHO: A QUALITATIVE EXPLORATION OF MEXICAN
IMMIGRANT MOTHERS' EXPERIENCE WITH BREASTFEEDING

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CHAPTER I

DARLE EL PECHO: A QUALITATIVE EXPLORATION OF MEXICAN IMMIGRANT MOTHERS' EXPERIENCE WITH BREASTFEEDING

There is widespread consensus throughout the health care community in favor of breastfeeding as the ideal infant-feeding method. Its immunological, nutritional, and cognitive benefits for infants and children are well-documented. Breastfeeding has been associated with reduced rates of diarrhea, ear infections, allergies, meningitis, asthma, and respiratory and urinary tract infections (Gartner, Morton, Lawrence, Naylor, O'Hare, Schanler, and Eidelman 2005). Breast milk's nutritional value for infants is unmatched. Breastfed children experience lower incidences of malnutrition, obesity, and diabetes (Gartner et al. 2005). Additionally, breastfeeding has been associated with intellectual development. In a research study conducted on 523 American sibling pairs with different breastfeeding histories, Evenhouse and Reilly (2005) demonstrated a strong positive correlation between breastfeeding and cognitive ability. Studies like this one provide a very persuasive argument for the benefits of breast milk by holding constant the potential effects of children's families and social environments.

The emotional and psychological benefits of breastfeeding have also been widely cited within the literature on the topic. The benefits to maternal bonding and the mother-infant relationship are listed among the top positive outcomes (Else-Quest, Hyde, and

Clark 2003). Breastfeeding has also been shown to be beneficial to the mother by reducing her risk of breast cancer. Any breastfeeding lowers a woman's risk of developing breast cancer, but the risk is lowest for women who have breastfed for at least 36 months during their lifetime (Hollander 1996). Due to the widely recognized benefits of breastfeeding, the American Academy of Pediatrics, the American Academy of Family Physicians, and the World Health Organization all recommend exclusive breastfeeding (*with no supplementation of formula*) during the first six months of a child's life and continued breastfeeding for at least the first year and beyond for as long as is "mutually desired by mother and child" (Gartner et al. 2005:499).

However, regardless of the numerous benefits and recommendations by the medical community, most mothers living in the United States today fail to breastfeed their children for the recommended length of time. According to the most recent national data available from the Centers for Disease Control and Prevention (2010), only 13.3 percent of mothers living in the United States are exclusively breastfeeding their infants through six months. This percentage rises to 43.0 percent when those infants being supplemented with formula are included in the estimate. By the end of their first year, 22.4 percent of American children are still breastfeeding. Furthermore, an estimated 25 percent of American infants are never breastfed. To place these statistics in context with other post-industrial nations, while 75.0 percent of mothers initiate breastfeeding and 43.0 percent continue through six months in the United States, these percentages are 76.7 and 48 percent in Germany (Lange, Schenk, and Bergmann 2007), 87.8 and 50.4 percent

in Australia (Amir and Donath 2008), and 90.3 and 53.9 percent in Canada (Chalmers et al. 2009), respectively.

Despite these low national estimates, breastfeeding rates have actually been on the rise in the United States since the 1970s. Breastfeeding rates began to decline in the United States at the start of the last century. With improvements in pasteurization and milk storage methods, the emergence of a middle class that valued scientific medicine, the early women's rights movement, and the appearance of the formula industry, women began breastfeeding less in the early 1900s (Thulier 2009). Improvements in infant formulas and growing support within the medical community for formula as an ideal infant-feeding method fueled this decline through the 1940s and 1950s (Fomon 2001). Women's increased presence in the workforce and continued growth of the formula industry added to the decline, and by 1972, breastfeeding rates reached an all-time low in the United States with only 22 percent of infants ever consuming breast milk (Wright 2001). Since then, the numbers have gradually been on the rise with increased awareness of the benefits of breastfeeding and more encouragement for breastfeeding by physicians (Ryan, Wenjun, and Acosta 2002).

While breastfeeding rates have increased overall in the United States during the last three decades, there exist a number of disparities between those mothers who choose to breastfeed and those who do not. Characteristics of the mother including race, ethnicity, income, education level, age, marital status, and immigrant status have all been revealed as predictors of her breastfeeding. Given these disparities, combined with the great benefits associated with breastfeeding, there is a need within both the medical and

social science communities to better understand the determinants of breastfeeding in the United States. For example, several studies have shown Latina immigrants to have among the highest breastfeeding rates of all racial/ethnic groups. However, second-generation Latina Americans have been shown to have much lower breastfeeding rates (Gibson-Davis and Brooks-Gunn 2006; Kimbro, Lynch, and McLanahan 2008). There is a need to understand what causes this disparity between first and second generation immigrants.

This study explores this disparity by qualitatively examining the breastfeeding experience of ten Mexican immigrant mothers. The study aims to answer the following research questions:

1. What are Mexican immigrant mothers' breastfeeding experiences in the United States?
2. What are these mothers' attitudes about breastfeeding, and have these attitudes changed with migration?
3. How do social support networks affect these mothers' breastfeeding decisions?
4. What barriers to breastfeeding exist in these mothers' lives, and what factors affect their infant-feeding decisions?
5. What is the cultural meaning these mothers associate with breastfeeding?

The contributions of this study are both theoretical and policy-related. The study enhances existing literature, which will be discussed shortly, by exploring the intersection between immigration, breastfeeding, culture, and motherhood. Also, by exploring the breastfeeding experience, this study provides a unique opportunity to deepen knowledge about how immigrant women perceive breastfeeding in a context outside their native

culture as well as how immigration processes might impact infant-feeding decisions. Equally significant, breastfeeding is a profoundly gendered experience, one that provides a unique bonding opportunity between mother and child. This study also sheds light on how Mexican immigrant mothers perceive this element of their mothering lives. Furthermore, given the countless benefits of breastfeeding for both child and mother, this type of research can have important implications for public health policies. By better understanding Mexican immigrant mothers' personal experiences with breastfeeding as well as the barriers to breastfeeding that exist in these mothers' lives, public health policies can be better designed to address these mothers' specific needs.

LITERATURE ON BREASTFEEDING AND MEXICAN IMMIGRANT MOTHERS

This review explores the existing empirical data and literature on Mexican immigrant mothers' breastfeeding experience in the United States. It begins by examining established breastfeeding determinants within the United States and Mexico. This is followed by a discussion of the research on Latina mothers' breastfeeding experiences and breastfeeding rates in the United States. Next, there is an exploration of the *Latino Health Paradox* and relevant theories of acculturation as a determinant of breastfeeding among immigrant mothers. Finally, there is a discussion of the gaps in the existing literature on breastfeeding and the ways in which this study aims to fill these gaps.

Breastfeeding Determinants in the United States and Mexico

A number of breastfeeding disparities have been noted among different populations living in the United States. Household income is among the top predictors of a woman's likelihood of breastfeeding. In general, mothers with higher household incomes are more likely to breastfeed and to breastfeed for longer than those with lower household incomes (Singh, Kogan, and Dee 2007). Also, among low-income mothers, participation in the Women, Infants, and Children (WIC) programs has been associated with a lower likelihood of breastfeeding when compared to those eligible low-income mothers who do not participate. This difference has been attributed to WIC's provision of free infant formula to participants (Ryan and Zhou 2006).

Furthermore, research conducted by Heck and colleagues (2006) suggests that, when compared to income, education is a much more significant predictor of breastfeeding. They found that those mothers who have or whose partners have higher educational levels are more likely to breastfeed regardless of other socioeconomic characteristics. A study by van Rossem et al. (2009) supported these findings. They found that a mother's education level was highly predictive of her initiating breastfeeding and continuing breastfeeding until two months, and after six months, the more highly educated mothers in their study were much more likely to breastfeed than the less educated mothers.

Several other predictors exist for a woman's likelihood of breastfeeding. Older mothers are more likely to breastfeed than younger mothers (Heck et al. 2006). Women living in western and northwestern states have higher breastfeeding rates than do women living in the rest of the country (Kogan et al. 2008). A study conducted by Gibson-Davis

and Brooks-Gunn (2007) revealed that married mothers are more likely to breastfeed than unmarried mothers. Moreover, they found that cohabiting mothers are more likely to breastfeed than mothers who are romantically involved but not living with their baby's father.

Finally, perhaps the most researched predictor of breastfeeding in the United States is a mother's race or ethnicity. African American women are the least likely racial/ethnic group to breastfeed (Forste, Weiss, and Lippencott 2001; Wiemann, Dubois, and Berenson 1998). Qualitative research suggests that this may be partly attributed to cultural perceptions within the African American community that breastfeeding is embarrassing or "nasty" (Hannon et al. 2000). White and Latina women breastfeed more than African American women and at similar rates, and Latina immigrant women are among the most likely groups to breastfeed (Gibson-Davis and Brooks-Gunn 2006; Kimbro, Lynch, and McLanahan 2008).

Just as breastfeeding disparities exist in the United States across a number of demographic factors, the same is true in Mexico. Interestingly, however, a number of the positive determinants of breastfeeding in the United States are actually negative determinants in Mexico. González-Cossío and colleagues (2003) examined national statistics to determine the predictors of breastfeeding in Mexico. They concluded that 92.3 percent of Mexican children are ever breastfed, with a median duration of breastfeeding of nine months. Also, 20.3 percent of infants are exclusively breastfed for six months. These figures are both higher than the United States estimates cited above (75.0 and 13.3 percent, respectively). Women in rural areas breastfeed for twice as long

as women in urban areas (14 months and 7 months, respectively). Additionally, indigenous women breastfeed three times as long as non-indigenous women (24 months and 8 months, respectively). Similar to the United States, women with a spouse present breastfeed longer than women without a spouse present.

Of particular interest are the factors that the researchers found to have an opposite effect on breastfeeding when compared to the same factors in the United States. Mexican women with lower household incomes are more likely to breastfeed than women with higher household incomes. Younger mothers are more likely to breastfeed than older mothers. Also, mothers with less education are much more likely to breastfeed and to breastfeed for longer than mothers with more education. A separate quantitative study by Flores et al. (2005) corroborated these findings.

González-Cossío and colleagues (2003) note that ethnicity, and more specifically indigenous descent, appears to be one of the highest predictors of breastfeeding in Mexico. Indigenous women are primarily concentrated in rural communities. Ethnicity remained a strong predictor even after controlling for the mother's socioeconomic status. As a result of this finding, the researchers argue that it is not only socioeconomic status that influences infant-feeding practices in Mexico, but other factors, including infant-rearing practices and culture, influence infant-feeding decisions as well. However, bottle-feeding is still on the rise among these mothers. In her discussion of the increase in bottle-feeding within rural, indigenous communities Brigitte Jordan (1993) noted, "Bottles constitute a status symbol, an expression of the parents' progressive attitude" (p. 43). In Mexico, not breastfeeding is associated with higher socioeconomic, more urban

mothers. Therefore, bottle-feeding can be construed as an attempt to emulate this “more progressive” group.

In summary, within the literature on breastfeeding in the United States, relevant demographic determinants of breastfeeding include: a mother’s household income, her participation in WIC, her education, her age, her marital status, her race and ethnicity, and her immigration status. Additionally, the demographic determinants of breastfeeding in Mexico are generally the reverse of the breastfeeding determinants in the United States, with younger, less-educated, lower-income, and indigenous mothers having the highest likelihood of breastfeeding. The next section examines the existing literature on the breastfeeding experience of Mexican mothers – and Latina mothers in general – after immigration to the United States.

Latina Mothers’ Breastfeeding Experience

The Centers for Disease Control and Prevention (2010) estimate that 80.6 percent of Latina mothers in the United States breastfeed their children – a rate nearly six percent above the national estimate. This estimate includes both Latina immigrant and Latina American mothers, so the breastfeeding rate is likely higher for Latina immigrants and lower for Latina Americans. Gibson-Davis and Brooks-Gunn (2006) found that 91 percent of the Mexican immigrant mothers in their study breastfed their children, whereas only 53 percent of the U.S.-born Mexican mothers breastfed. At six months, they found that these numbers decreased to 59 and 24 percent, respectively.

Moreland and colleagues (2000) identified several barriers to breastfeeding within the Latino community. These included: the early introduction of bottles and formula supplementation, a lack of maternal self-confidence, and lack of social support from family, hospital staff, health care providers, and the community. Ertem, Votto, and Leventhal (2001) also identified a mother's self-confidence regarding breastfeeding as a predictor of her early termination of breastfeeding. In a study of low-income Mexican Americans, Gill and colleagues (2004) conducted focus groups with pregnant women and new mothers. The participants identified three main barriers to breastfeeding: embarrassment, pain, and inconvenience. The mothers also identified a lack of breastfeeding support from hospital staff. In addition, the participants discussed cultural beliefs about breastfeeding which included what foods to eat and the avoidance of alcohol, smoking, and stress while breastfeeding.

In a similar qualitative study, Sussner and colleagues (2008) conducted focus groups with Latina immigrant mothers to determine the mothers' perceptions and practices related to early child feeding. The participants reported that their native countries promoted breastfeeding more than the United States and that the demands of work in the United States influenced women's decision to stop breastfeeding. Additionally, the mothers reported an increased sense of social isolation and a decreased amount of social support in the United States when compared to their home countries. An earlier study by de la Torre and Rush (1987) on Mexican migrant women also found lifestyle changes in the United States to affect breastfeeding rates. They concluded that

“non-traditional practices” including out-of-home childcare, birth control, and alcohol use reduce the mothers’ likelihood of breastfeeding (p. 738).

Clearly, a number of factors can affect Latina mothers’ breastfeeding rates and experiences within the United States. However, Latina mothers still have higher breastfeeding rates overall than many other groups in the United States. This fact is in spite of their being characterized by negative breastfeeding predictors such as lower income and less education (Ramirez and de la Cruz 2003). This is an example of what has been deemed in the health research community the *Latino Health Paradox*.

The Latino Health Paradox

The Latino Health Paradox (also commonly referred to as the *Hispanic Health Paradox*) has been the subject of widespread research in the medical community for thirty years (Franzini, Ribble, and Keddie 2001). The Latino Health Paradox is described by “the fact that Hispanics, especially recent immigrants, have remarkably good health outcomes given their low socioeconomic status and other classic risk factors” (Kimbrow, Lynch, and McLanahan 2008:184). Due to Latinos’ lower socioeconomic status, one would assume that they would have breastfeeding rates comparable to those of African Americans – a group with similar levels of income and education – and not whites. As breastfeeding is classified as a positive health practice yielding positive health outcomes, it qualifies as part of the Latino Health Paradox. Most of the research on the Latino Health Paradox involves Mexican immigrants and Mexican Americans. Along with the research showing better breastfeeding rates, Latina mothers of Mexican descent have also

been shown to have better birth outcomes (i.e., healthy infant birth weights) at similar or higher levels than those of non-Latino whites (Guendelman et al. 1990). Other studies have shown Latinos, particularly immigrants, to have lower adult mortality rates (Singh and Siahpush 2002), less illicit drug use (Vega et al. 1998), and lower risk of psychiatric disorders (Breslau et al. 2006).

Acevedo-Garcia and Bates (2008) recognize three main explanations for the Latino Health Paradox. First, it is possible that not enough data is available on Latino health or that the data available (such as number of deaths or reported health problems) is inaccurate. Second, the paradox may be due to *healthy immigrant selection*, whereby healthier Latinos are more likely to make the often difficult journey to the United States. The third, and perhaps most common explanation for the Latino Health Paradox, is that the paradox is “due to *cultural and/or social protective factors*... such as social support, familism, religion, and norms related to diet and substance use” (p. 106). This explanation goes hand-in-hand with the theory of acculturation, which is explored in detail within the next section.

Theories of Breastfeeding and Acculturation

Classical anthropologists Redfield, Linton, and Herskovits (1936) defined acculturation as that which “comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (p. 149). The notion is that immigrants with lower levels of acculturation will have better health

outcomes as they will be less likely to adopt unhealthy American habits – thus the low-income, low-education Mexican immigrant mothers' high breastfeeding rate. Studies have supported this theory by revealing that highly acculturated mothers of Mexican descent have babies with lower birth weights than those Mexican immigrant mothers who are less acculturated (Cobas et al. 1996). Additionally, high levels of acculturation among pregnant Mexican American adolescents have been associated with more health-related risk behaviors including smoking, drinking, and illegal substance abuse (Balcazar, Peterson, and Cobas 1996).

A study conducted by Kimbro, Lynch, and McLanahan (2008) looking at the influence of acculturation on breastfeeding rates revealed that low levels of acculturation made Mexican immigrant mothers less likely to formula-feed. They also determined that successive generations of Mexican immigrants were more likely to abandon breastfeeding altogether. Singh, Kogan, and Dee (2007) uncovered similar findings. Their study included immigrants from several ethnicities and nativities, but their results were the same – overall, higher acculturation equals lower breastfeeding rates. Gibson et al. (2005) found that not only was breastfeeding more prevalent among less acculturated Latina women; women cited different reasons for not breastfeeding depending on their level of acculturation. Whereas more acculturated women, similar to non-Latina whites, cited that their child preferred the bottle, less acculturated women cited their child's physical or mental condition as their reason for not breastfeeding.

This acculturation effect on breastfeeding appears to be time-related. Two studies discovered that the amount of time a Mexican immigrant mother has been living in the

United States affects her likelihood of breastfeeding. Harley, Stamm, and Eskenazi (2007) found that immigrants living in the United States for less than five years were more likely to breastfeed and to breastfeed longer than those who had been living in the United States for five to ten years. In addition, those living in the United States for over ten years were the least likely to breastfeed. Gibson-Davis and Brooks-Gunn (2006) estimated this acculturation effect to reduce immigrants' breastfeeding rates by 4 percent for each year of residence in the United States.

Very interestingly, Singh, Kogan, and Dee (2007) recognized the potential for a mother's income level to determine how her acculturation level affects her likelihood of breastfeeding. Similar to the aforementioned studies, they found that within lower income groups, breastfeeding rates declined with increasing levels of acculturation. However, unlike the other studies, they compared the acculturation effect across different income levels and found that higher income was related to lower breastfeeding rates among less acculturated recent immigrants. This finding is particularly relevant when you consider the above discussion of the determinants of breastfeeding in Mexico. As higher income women are less likely to breastfeed in Mexico, it makes sense that less acculturated, higher income immigrants in the United States would be less likely to breastfeed. Unfortunately, this finding is absent from most other studies on breastfeeding and acculturation. This absence is likely due to the fact that, as mentioned above, most Mexican immigrants are of a lower socioeconomic status, so, generally speaking, acculturation negatively affects their likelihood of breastfeeding.

The effect of acculturation on Latino health in the United States is indeed very complex. Lara and colleagues (2005) reviewed over one hundred articles and books relating acculturation to certain health and behavioral outcomes among Latinos. They determined that while the data was not in agreement across the board, they could identify a number of trends within the literature. The strongest finding was that acculturation had a negative effect on health behaviors overall, including nutrition, exercise, substance abuse, and behaviors during pregnancy. However, they also determined that acculturation had a positive effect on health care use and self-perceptions of health. In addition, of the numerous studies they reviewed, they found that the vast majority used very simplified measures of acculturation (e.g., language, generation, self-reported ethnic identity), which are “at best proxy variables and do not fully capture the construct of acculturation” (p. 385). This and the studies cited above show that while acculturation appears to have a negative effect on breastfeeding for Latinas in the United States, the concept of acculturation is very complex, and certainly there are far more factors at play than these studies are able to measure.

Gaps in the Literature

Clearly breastfeeding and infant-feeding decisions in general represent a very extensive and diverse body of research. The benefits of breastfeeding and the demographic determinants of breastfeeding are well established within the literature. There are also a number of empirical studies focusing specifically on the breastfeeding rates of Mexican immigrant mothers – many of which argue that these mothers’

breastfeeding rates are decreasing with increased time in the United States and with subsequent generations. The current literature on decreasing breastfeeding rates among Mexican immigrant mothers largely attributes this decrease to increased levels of acculturation. However, much of the research on the topic is quantitative in nature, so acculturation is measured by a mother's time in the United States, her ability to speak English, and other very general markers. Very little research has been done on the specific attitudinal or lifestyle changes an immigrant mother experiences in the United States that alter her desire or ability to breastfeed.

Additionally, there are very few in-depth qualitative studies of Mexican immigrant mothers' breastfeeding experience in the United States. Breastfeeding is a very personal experience and one that cannot be fully understood through the analysis of quantitative data. There is a need to better understand these mothers' personal experiences with breastfeeding and to understand the cultural meaning they attribute to those experiences. This qualitative study looks to fill these gaps in the research literature.

METHODOLOGY

This qualitative exploration employed interviews that are best described as a *semi-structured in-depth interview and ethnographic interview hybrid*. The decision was made to merge these two qualitative interviewing styles for a number of reasons. Berg (2009) describes semi-structured (or "semistandardized") interviews as being more or less structured but with a level of flexibility that allows the researcher to change wording, question order, or level of language and even add or delete probes between subsequent

subjects (p. 105). This was ideal for this research project because while there were several predetermined questions and topics, it was important to have the freedom to probe beyond the answers received to those questions. In addition, it was crucial to be able to adjust the level of language for each of the informants as they each had very different ways of understanding and expressing their own experiences with breastfeeding.

Furthermore, these interviews were somewhat ethnographic in nature as they focused on cultural meaning and how participants interpret their experiences. However, they were not in the true ethnographic interviewing style as time limitations did not allow for a high frequency of contact with participants or for the development of an on-going relationship with the interviewees (Heyl 2001). Nonetheless, despite time limitations, rapport-building was of utmost importance throughout the interview process. The ethnographic interviewing style lends to rapport-building with its focus on *descriptive questions* – broad open-ended questions seeking broad detailed descriptions – which keep an informant talking and make her feel at ease (Spradley 1979). This approach of using open-ended, story-telling type questions is similar to the approach of other feminist, qualitative sociological research whose primary goal is to fully understand the individual research participants – rather than only understand how they respond to specific questions (Reinharz 1992).

Interviews were conducted with ten Mexican immigrant mothers in Chicago, Illinois from October 2010 through January 2011. The informants were recruited via seven different personal acquaintances in Chicago. Two informants were recruited by other informants. This meant that only two pairs of informants knew one another and that

the women lived in eight different areas of the city, allowing for a wider range of experiences. The audio-recorded interviews took place in the homes of the informants and lasted between 45 and 90 minutes. The interviews covered five broad themes: migration experience, breastfeeding in family and in Mexico, personal breastfeeding experience, social support for breastfeeding, and breastfeeding here and there (see Interview Guide in Appendix). Interviews were conducted in Spanish and then transcribed verbatim.

The sample consists of ten immigrant mothers who grew up in Mexico and who had at least one child in the United States. The respondents range in age from 30 to 51, with an average age of 39-years-old. The respondents have spent an average of 18 years in the United States. The respondents each have between two and eleven children, and seven of the respondents have at least one child aged five or less. The maximum duration of breastfeeding for respondents ranges from never breastfeeding to 20 months, with an average maximum breastfeeding duration of about nine months. Three respondents are currently breastfeeding or have weaned within the last six months. The respondents are generally working class or lower-middle class. One respondent has no formal education, three respondents have finished primary school, four respondents have finished high school, and two respondents report studying for one year at a technical college in Mexico. Five respondents describe themselves as ‘homemakers,’ four respondents work full-time in factories or doing cleaning work, and one respondent works part-time in home health care. Different respondents will be identified by pseudonyms. See Table 1 (on next page) for respondent details.

Table 1: Respondent Details

Respondent ^a	Age	Years in U.S.	Children	Duration of Breastfeeding	Highest Education	Employment ^b	Home State in Mexico
Aurora	35	11	4 children (3, 5, 10, & 14-yr.-old)	8 mo. – 20 mo.	Some College	Homemaker	San Luis Potosí
Brigida	34	17	4 children (2-mo.-old, 12, 14, & 15-yr.-old)	6 mo. – 8 mo.	Primary School	Part-Time Home Health Care	Guerrero
Claudia	30	9	3 children (6-mo.-old, 2, & 5-yr.-old)	1 wk. – 1 yr.	Some College	Homemaker	México, D.F.
Elena	41	28	6 children; 1 grandchild (children: ranged 13 to 26-yr.-old)	Never Breastfed	9th Grade	Full-Time Factory	Guerrero
Flor	35	14	3 children (5, 8, & 13-yr.-old)	6 mo. – 1 yr.	High School	Homemaker	Durango
Guadalupe	50	35	2 children ; 3 grandchildren (children: 12 & 30-yr.-old)	0 – 15 days	Primary School	Full-Time Factory	Guerrero
Herlinda	31	10	4 children (1, 3, 5, & 7-yr.-old)	7 mo. – 15 mo.	High School	Homemaker	Guerrero
Luz	42	14	11 children (ranged 3 to 23-yr.-old)	4 mo. – 6 mo.	None	Homemaker	Morelos
Roberta	51	22	2 children (16 & 20-yr.-old)	3 mo.	High School	Full-Time Laundromat	Durango
Teresa	40	21	4 children (3, 6, 17, & 20-yr.-old)	6 mo. – 1 yr.	High School	Full-Time Cleaning	Guerrero

^a All respondent names have been changed.

^b Employment is at time of infant-feeding decision.

The transcribed interviews were analytically coded through an initial coding stage followed by a series of more focused coding. The initial coding stage involved line-by-line descriptions with numerous individual codes. The focused coding involved the filtering out of recurring codes and the identification of overarching themes (Lofland and Lofland 1995). The initial coding began with approximately ninety unique individual codes. Through the focused coding and with the assistance of the data analysis software Microsoft Excel, four overarching themes emerged from the data. These themes are: breastfeeding in two societies, the breastfeeding decision, social support and breastfeeding, and breastfeeding and identity. It should be noted that all transcriptions remained in Spanish throughout the analysis. Upon completion of the data analysis only certain passages were selected and translated to English for inclusion in this written report. Also, as this researcher is fluent in Peruvian Spanish, during a handful of instances when an unfamiliar dialectical word or phrase was used by a respondent, a Mexican American colleague was consulted for clarification.

FINDINGS

Nine of the ten women in this study made the decision to breastfeed their children. The women were open and sometimes excited to share the details of their experiences feeding and caring for their babies. Also, having grown up in Mexico, the women had the unique opportunity to observe and, in a few cases, experience breastfeeding in two very different societies. For some women this was the first time they had critically discussed their feelings surrounding breastfeeding. Other women had

already established opinions about what breastfeeding meant to them. Women discussed their experiences and the many factors that influenced their infant-feeding decisions. They also discussed the important role members of their social networks played in supporting those decisions. Finally, through this discussion, the women came to construct a sort of identity for themselves both as mothers and as Mexican women.

Breastfeeding in Two Societies

A common observation among the women in this study was that “almost everyone breastfeeds in Mexico” and that breastfeeding is not as widespread in the United States. All ten women reported that while growing up in Mexico, almost everyone breastfed in their communities. When asked why they felt breastfeeding was so much more widespread in Mexico than in the United States, women generally identified three key reasons for the difference: (1) breastfeeding is generational, (2) breastfeeding is motivated by a lack of resources, and (3) breastfeeding is encouraged by visible presence.

First, a majority of women identified breastfeeding as a cultural practice in Mexico passed down through generations. Women breastfed because their mothers and grandmothers breastfed. Aurora expresses this sentiment about why women breastfeed in Mexico:

Well, they base it on the beliefs that come from generations upon generations. What their mom and dad did – but based on the old beliefs from a long time ago. People believed that nursing a baby gave him more defenses. He was more – he wasn't as likely to get sick. You understand? He was stronger.

Roberta echoes this sentiment that mothers in Mexico learn about the benefits of breastfeeding from older generations:

Everybody knew, I think from their ancestors – from their grandparents and great-grandparents – that breastfeeding a baby is protecting him from premature sicknesses, with the colostrum from the milk. Then the child would be healthy even if the people didn't have a lot of money, but the child never had to go to the doctor because that child was healthy.

Women emphasized that this tradition of breastfeeding was deeply rooted in Mexican culture from many generations back. Herlinda traced the cultural roots back to the early peoples in Mexico:

It's a culture that we have in Mexico of breastfeeding because – if we're talking about the olden times, back then there weren't bottles. There wasn't formula. And, well, you could say, the cavemen when they had their babies, what they did – well, they didn't even wear clothes, but they breastfed their babies. The women even fed the men that way sometimes. (*laughs*) It comes from a culture from long ago.

The notion is that a woman's primary motivation for breastfeeding in Mexico comes from the fact that her mother and grandmother breastfed. However, some women recognized the difference between mothers whose own mothers had breastfed them and those who had not. Flor, a woman who reported that her entire family breastfed, elaborates on how a mother's family can affect her infant-feeding decisions:

I think it comes from our grandparents – and that they breastfed. Because many families, their ancestors didn't breastfeed, so they don't breastfeed either. It's something that comes from the family. Because the moms that breastfeed – well, they see it, and it instills in them from when they're small that breastfeeding is healthier. And the moms that don't breastfeed – I think that they don't talk much to their children about it, and they grow up thinking that it's the same to breastfeed or not breastfeed.

Like Flor, other women recognized that not all mothers in Mexico practice breastfeeding as a cultural tradition. For example, some women identified a difference between breastfeeding rates in rural and urban communities in Mexico, stating that women breastfeed more in rural areas. Most women self-identified their hometown as

being “mid-sized” and a few women identified themselves as being from a rural area.

Only one respondent, Claudia, reported being from a large city, and she explains how beliefs and practices are changing in urban Mexico:

I suppose that nowadays the woman living in Mexico today – the modern woman – it’s like, now more she’s getting the idea to give formula. But the people from rural areas, they stay with the first choice as breast. In rural areas the tradition is more to breastfeed, and now the modern woman in the city is opening up more to the formula.

She continues that this cultural shift towards formula is only a recent development in Mexico:

I feel like – well, I think that this is just now starting in Mexico. But it has a lot to do with the way that the moms talk to us now as the second generation. That they talk to us about how breastfeeding is still really important and all that. It’s very important what our moms tell us, but I think that now the next generation isn’t listening as much, and now people are thinking it’s time to give the breasts a rest.

This suggests that perhaps the cultural influence on a mother’s breastfeeding practices in Mexico may not be as strong with future generations.

The second key reason for the different breastfeeding rates in the United States and Mexico is that the lack of resources in Mexico motivates mothers to breastfeed. Women unanimously felt that mothers do not have the same financial resources in Mexico as they do in the United States. For some mothers in Mexico breastfeeding may be their only option. Aside from being a cultural practice, Flor reports that in Mexico “the moms also do it for necessity. It’s too expensive to buy milk. And my mom’s from a village where they didn’t even have milk, so they had to nurse when the babies were born.”

Some women suggested that mothers might bottle-feed more in Mexico if the resources were available. Aurora explains how some mothers must consider their finances when choosing to breastfeed:

A lot of people in Mexico breastfeed because sometimes there's not enough money to buy the milk or the formula. Then if the mom – let's say she has enough to buy some soup. Is she going to give up the soup to buy the bottle of milk? No, better to buy the soup and stick the baby on the breast!

Brigida agreed that mothers in Mexico consider their finances when buying formula. She argues that if mothers do choose to bottle-feed, it is kept to a minimum due to financial constraints, “There the people don't have much money to buy milk, so almost everyone gives only breast milk to the babies. And if they do give the bottle, it's only a little because they don't have the money for the milk. The milk is expensive.”

A lack of financial resources does not appear to be as strong of a motivation to breastfeed in the United States. All ten women mentioned that in the United States the Women, Infants, and Children (WIC) program gives free formula to mothers who want it, and almost all of the women noted that they had received formula from WIC at some point. This was recognized by the women as a major reason why women do not exclusively breastfeed in the United States. Previous research has confirmed that there is indeed a correlation between participation in the WIC program and a decreased likelihood of breastfeeding (Ryan and Zhou 2006).

The third key reason the women identified for the higher breastfeeding rate in Mexico was that its high visibility encourages mothers to continue the practice. Put simply, one sees breastfeeding more in Mexico so they feel more comfortable following suit. Breastfeeding in public is described as being more accepted in Mexican society than

in the United States. Guadalupe, a woman who had not breastfed in public herself but who had witnessed her daughter's experience breastfeeding in the United States, explained the difference:

But when you go to Mexico, you know, there it's not the same as here. Because here people keep covered up. No, there they take out the breast, and there's just the little mouth of the baby, but you see the whole rest of the breast, and they don't try to cover up. Almost completely exposed... Because there everybody breastfeeds. There's no shame about it, but here there is. Because here people cover up. My daughter would breastfeed her baby wherever she wanted. We'd go to where you sit, and she'd take out her breast – but she *always* kept it covered.

Other women made similar observations about the more open attitude about breastfeeding in Mexico. Flor relates her own experience breastfeeding in public in the United States to how it might have been different in Mexico and comments, “The thing is, that when you're out of the house and you have to nurse, it's more uncomfortable here. In Mexico I think it's more comfortable because here a lot of people don't breastfeed and they see you breastfeeding and (*she makes a shocked face*).” None of the women reported any specific negative encounters while breastfeeding in public, but the general feeling was that it could be uncomfortable in certain settings.

These women's perceptions of public breastfeeding in the United States align with previous research on the topic. In her discussion of breastfeeding and the good maternal body, Cindy Stearns (1999) finds that when breastfeeding in the presence of others, discretion becomes a primary goal of most mothers. She argues that “being an invisible breastfeeding mother [is] the goal for many women” (p. 313). Certainly, this perceived need to remain “invisible” or completely covered while breastfeeding in public in the United States was felt by many of the women in this study. Teresa describes the

pressure she felt to avoid breastfeeding in public with her first child, “Before, I never saw women breastfeeding, so I thought it was bad to do it in public. That’s why whenever I did it, I did it, like, hidden and only if the baby was really, really desperate. Like I was hiding as if I was ashamed.”

Claudia suggests that public breastfeeding is more common in Mexico than in the United States due to the difference in people’s lifestyles:

It’s more open. You see it more. I suppose it’s because the way of life there is that you’re always out of the house, outside. You’re walking in the park. And here the seasons are different, so I suppose that that’s it. Because there you go out. Plus, you see women that, without covering themselves, they’re like, as if it’s nothing, they take out their baby and that’s it. It’s more common there in Mexico than here.

Several women believed that the high visibility of breastfeeding in Mexico, both in the public and private spheres, was a major influence on mothers’ infant-feeding decisions.

Herlinda feels that in Mexico breastfeeding “is a custom more than anything.” When asked where women get the custom from, she responds, “I think that it’s something that they see more than anything else. Because it’s what most people in Mexico do.”

Similarly, Teresa comments about public breastfeeding in Mexico by saying, “I think that it’s normal there. For them it’s normal that they nurse uncovered even though you can see the breast. It’s normal.” When asked why breastfeeding is different in the United States,

Teresa explains the important role visibility plays in women’s breastfeeding decision:

Because of how you don’t see it usually here. I think that’s why. Well, I think it’s like how if I don’t see that they’re selling something over there, then I don’t go there because I don’t know if they’re selling that thing, right? ... So, sometimes a person has to see it to keep on doing it.

The argument is that a mother is much more likely to choose to breastfeed if she sees it. Furthermore, the visible presence of breastfeeding in a woman's life is described as having a perhaps greater influence on her infant-feeding decisions than being advised or learning about breastfeeding.

Women who grew up in Mexico but raised children in the United States identify a number of key differences between breastfeeding in these two societies. Overall, they express that breastfeeding is much more prevalent in Mexico. They explain that this prevalence is due to the practice of breastfeeding being passed down through generations. Additionally, Mexican women's lack of financial resources is seen as a deterrent to formula-feeding. Finally, the women believe that the high visibility of breastfeeding in Mexico contributes to the continuance of the practice.

The Breastfeeding Decision

The decision of how to feed and care for your baby is a very personal decision for many mothers. There are many factors that a mother must consider when deciding whether to breastfeed her child or not. Of the ten mothers in this study, nine mothers chose to breastfeed their babies. Each woman expressed different motivations for her decision. Additionally, each mother had a unique experience after making the decision to breastfeed, and each had very different reasons for eventually stopping breastfeeding.

The most common motivation for breastfeeding expressed by the women was the health of their babies. In fact, all nine breastfeeding mothers listed health as a primary reason for making the decision to breastfeed. Some women explained that breastfed

babies simply “get sick less” or that breastfed babies “have better nutrition.” Other women presented more technical arguments. Aurora explains why breast milk is healthier:

I think it’s because of the defenses that the children don’t get sick as much. The milk has more protein. Mother’s milk has more substance, more vitamins. Above all, more calcium. Well, my mom, she told us that we had to breastfeed the babies and my sisters all breastfed their children. We always talked about that – so that the children wouldn’t get sick. Because like 80 percent, almost 90 percent of babies when the moms breastfeed them, they don’t get sick so much. They have more defenses against the flu. My children almost never get the flu.

Like Aurora, multiple women noted that it is a proven fact that breast milk is healthier than other alternatives.

After health, the second most common motivation the women gave for breastfeeding was that it created a closer relationship between mother and baby. Flor explains, “When you nurse you feel like your baby is closer to you. You can cuddle them more and all that. They grow up closer to you. Babies with the bottle, they don’t get as close to the mom as when they nurse.” Many women experience breastfeeding as a way to increase maternal bonding. Teresa recognizes the specialness of this maternal bond:

You feel more bonded, a very special closeness, a beautiful sensation of having a child and being able to feed him and have him stuck to you. It’s something the dads can’t enjoy! (*laughs*) And I think that that’s where the maternal love comes from. That you have him in your stomach, and then you can nurse him, and you have most of the time with him.

Claudia was unable to breastfeed her oldest daughter, and she sees a real difference between the way her daughter interacted with her as a baby when compared to her interaction with her two younger daughters who were breastfed:

First of all, my oldest daughter who I didn’t breastfeed was like – she felt very distant. For example, when I wanted to hug her, I would be very loving and I

wanted to cuddle her like this (*hugs the six-month-old baby in her lap*), and she would cry. Then, for her it was food and crib – everything was like she wanted to be alone. Like if I grabbed her, and I squeezed her, then she'd get angry and didn't like it. And with the younger two it's different because it's like a communication. I mean, when you're breastfeeding them and they feel you, it's as if they get closer to you. The two of them are – well, *now* the oldest is loving but because she knows who we are and all that – but the younger ones, ever since they were tiny, whenever we'd get close – when I get close to this one, (*squeezes the baby*) I feel like an acceptance. I hug them, I touch them and all that, and they calm down when I do it. There's a difference. The oldest was like, "Give me my milk, and I'll calm down. If not, I won't calm down."

Eight of the nine breastfeeding mothers in this cohort described their relationship with their baby as something they liked most about breastfeeding. Even Elena, the one mother who chose not to breastfeed her children, believed that breastfeeding could improve a mother's relationship with her child. Elena describes how she encouraged breastfeeding when her daughter gave birth to her granddaughter Cristina:

I did try with her mom to breastfeed Cristina. I kind of, like, I made her breastfeed Cristina. But for some reason she didn't. It wasn't easy for her to... and I even got her the machine, but no... I don't think my daughter was ready for Cristina, and I kind of tried everything for her to get closer to Cristina. But it didn't work.

The third most common motivation for breastfeeding within this cohort of women was the belief that breastfeeding is easier than bottle-feeding. Several women agreed with Brigida who comments, "I like how he sleeps with me, and I don't have to get up to get him a bottle and heat it up. And he falls asleep faster, because I think that if I gave him a bottle he'd wake up more and wouldn't want to go back to sleep." Six women described the hassle of having to prepare and heat up bottles as a reason why they preferred the breast.

After the reasons of health, bonding, and ease, a few women said they preferred breast milk because it was a more natural way to feed one's infant. Roberta argues,

“There’s no milk in the world that is equal to mother’s milk. Nothing can replace it. Nothing from laboratories. It’s something that’s natural. It’s naturally warm. They say that a baby who breastfeeds is more loving... It’s the warmth from the mother.” Two women stated that their child’s early development was a factor in their decision to breastfeed. Herlinda describes the difference between her children’s development and that of her nephew:

The children are very active, and they learn – because when the child is only with the bottle or the pacifier, they don’t talk to you. They only want to be with the pacifier, and they don’t talk as soon. And my nephew – that only has pure bottle – his mom gave him too much formula. And he’s very, very fat. He almost can’t even sit down. And he is always with the pacifier. And he doesn’t talk. My daughter is the same age, and she says, “Mama,” “Papa.” And she’s very active.

Other less commonly mentioned motivations for breastfeeding included maternal weight loss and birth control. However, no woman felt that breastfeeding was a sure fire method of preventing pregnancy. Interestingly, only one woman noted cost as one of the reasons she chose to breastfeed, despite the fact that this was seen as a major motivating factor for women living in Mexico. Finally, and perhaps most surprising of all, even though a large majority of the women believed that breastfeeding was a practice passed down through the generations in Mexico, only one woman stated that she personally chose to breastfeed because her own mother breastfed. While the women believe that mothers in Mexico are primarily motivated to breastfeed by the fact that their mothers and grandmothers breastfed, almost none of the women openly recognize this as primary motivation for their own decision.

After making the decision to breastfeed, each woman’s experience is unique. While some women describe the experience as entirely positive, others encounter

difficulties and frustrations while attempting to breastfeed. Five of the women described breastfeeding as very painful at times. Some felt early frustrations when their baby was unable to latch on to their breast. Brigida describes her frustrations while breastfeeding her now two-month-old son:

Because with this one, he gave me so much work to get him to suck. With the others I didn't have to use the pump and try to pull out a little bit with the machine. And with them, they just latched on. They just sucked it out, and this one couldn't latch. He wasn't strong enough to suck. With him, it even hurt me. It stung because he couldn't latch. He couldn't suck out the milk.

Herlinda experienced a similar frustration breastfeeding her first child. She explains, "When I started to nurse, at first he didn't latch on well because I didn't have my nipples right to be able to nurse him. And the truth is, with the first one I didn't know how to do it, and I could only use the pump to get the milk out and then give it to him in the bottle."

After moving past the pain and early frustrations of getting the baby to latch on to the breast, a very common frustration among these women was the sense that they did not produce enough milk for their baby. Luz, a mother who breastfed all 11 of her children, jokes about her lack of milk, "The doctor told me that the breast is best, but nobody knows if you're going to have a lot of milk or a little... and I was one of those cows that gave a little. (*laughs*) I wasn't a fancy cow, just a common one... or who knows... (*laughs*)" Later, Luz is more serious when she explains how frustrating it could be when she didn't produce enough milk, "I was struggling. Yes, because it's a struggle when the baby cries and cries, and you don't know what he wants. Because you're nursing him... But if not enough milk comes out, where are you going to get it from?" After much frustration, Luz chose to supplement her breastfeeding with formula.

Combining breastfeeding with formula-feeding was a common decision among these mothers. In fact, the majority of the women in this cohort chose to both breastfeed and bottle-feed their children. The women gave a number of reasons for choosing this combination. First, like Luz, several women felt that the quantity of breast milk they produced was not enough for their babies. Previous research on Mexican mothers has found ‘Perceived Insufficient Milk’ (PIM) triggered by a baby’s crying to be the most common reason women in Mexico choose to supplement breast milk with formula. This research also suggests that this supplementation sets off a self-fulfilling prophecy where PIM actually leads to decreased milk production (Sacco et al. 2006).

Second, some women believe that by supplementing breast milk with formula, a mother is giving her baby the healthy benefits of both. Aurora explains, “Moms give both – give the formula and breastfeed – because you want your child to be healthy. Want him to be chubby, not to be malnourished. You struggle to do whatever you can to give your child the best.” This belief that combination feeding provides the ‘best of both’ to infants has been seen in other qualitative research involving Latina immigrant mothers. Bunik et al. (2006) argue that while there is little published on this combination feeding phenomenon, “there is a consensus that this appears to be more common in Latinas than in other cultures and in those who live in the United States as opposed to their Spanish-speaking, Latin American country of origin” (p. 226).

Another reason mothers choose to supplement breast milk with formula is because bottle-feeding is perceived as more convenient. Mothers describe bottle-feeding as faster. Brigida explains, “I don’t like that sometimes I’ll have something to do, but I

have to take the time to feed him. Nursing can take you sometimes up to a half hour for him to finish eating, but with the bottle it's only like five minutes and the bottle is empty." Others describe bottle-feeding as more convenient than breastfeeding when you're out of the home. While some women reported having no reservations about breastfeeding in public (as long as they were covered up), others made a point to bring bottles of formula whenever they knew they'd have to feed their baby outside of the home. Women complained that when breastfeeding away from home, you always had to find a private spot. Aurora comments, "That's one thing that I never liked – when you go out, because you have to cover up and look for a more private place to nurse – away from others. You always have to bring blankets to cover them. It's more uncomfortable." Women reported never feeling uncomfortable bottle-feeding in public, regardless of the setting.

Some women feel that by supplementing breast milk with formula, a mother is preventing her child from becoming too attached or too "glued" to her. Luz describes the valuable advice she received from another woman about this issue:

Well, you know, when I left my house at times, my husband took care of the kids for me. And I told him, "Here's their bottle," and he'd give them the bottle, and when I got back I'd breastfeed them. Because I made sure to give them both. Always. That was the only advice I got in this life that – a woman told me that you should never force your children to be always glued to you. She said that you have to feed them with both things.

However, Luz seems to be conflicted about this issue because later she admits, "Well, if I were a woman that could make a lot of milk, I'd prefer to give them pure breast milk and not give them any formula." Two of the women in this cohort did make the decision to exclusively breastfeed their children. Claudia says that with her second child she was told

at first that her milk wasn't enough for the baby. She felt like the baby was still hungry, so she tried to supplement with formula. Later she realized that it wasn't necessary, and she switched to pure breast milk. Now, with her six-month-old daughter, Claudia is proud to say the baby has never tasted formula.

Herlinda also chose to exclusively breastfeed her children. She explains why she decided not to feed her babies formula:

Because I *could* breastfeed. I wasn't working or studying. Because the doctor told me, "If you're going to breastfeed, breastfeed, and if you're going to formula-feed, formula-feed." I don't know why people give them both. They don't develop the same that way, and their stomach doesn't digest it the same if you breastfeed in the mornings and formula-feed at night. And there's nothing like breast milk to prevent gas, colic, stomach inflammation, to prevent so many things. So I decided if I'm going to breastfeed, I'm only going to breastfeed.

However, not all women have the same opportunity as Herlinda to exclusively breastfeed their babies. Many women have to return to work soon after having their babies. Some women express milk while they're away, but electric breast pumps can be expensive and not all women have the time to express milk at work. For many working mothers, exclusively breastfeeding is not a realistic option. When three breastfeeding mothers in this cohort had to return to work, two found combination-feeding to be their best alternative. Brigida explains her routine while working part-time and continuing to breastfeed her two-month-old son:

Well, I nurse him in the morning, and then I leave him at noon. Then later I come home in the evening, and sometimes when I get home I have time to nurse him, but sometimes not. Sometimes he's hungry before I get there, so they've already fed him and that's that. But when he gets hungry again, I'm *always* the one to feed him.

Aurora, a homemaker, shares her feelings about working breastfeeding mothers, “I imagine they come home exhausted from work with a sore back and all, and then, to have to stick the baby on there – I think about them, and, believe me, I admire them for keeping breastfeeding and working because that is hard work!”

Returning to work is a common motivation for mothers to give up breastfeeding altogether. When her three months of maternity leave were over, Roberta made the decision to stop breastfeeding each of her children. For Elena, work was the reason she never started breastfeeding. She states, “I started working when I was 17. Working, breastfeeding – It did not mix. I guess for me it was the simplest thing. Not breastfeeding.” For a mother who does choose to breastfeed, there are a variety of reasons besides work that she may eventually decide to stop. For some mothers it can be a simple decision, and for others it can be very personal and at times painful.

Flor breastfed her first child for six months, but she had to stop when “her milk dried up.” With her other two children, the decision was a matter of tradition. Her mother had breastfed her for one year, so she chose to breastfeed her children for one year as well. Brigida and Luz struggled with not producing enough milk throughout their breastfeeding experiences, and they both supplemented breast milk with formula. They each breastfed their babies for about six months, and they quit when they stopped producing enough milk to continue. Aurora had no difficulties while breastfeeding. She did, however, decide to quit when her baby grew teeth and the biting became too much for her to handle.

Herlinda had done some research and planned to breastfeed each of her children for at least one year with no supplementation of formula, as is recommended by the medical community. With her second child, though, she was having difficulties at home and going through a very emotionally-trying time in her life. After six months of breastfeeding, she noticed her “breast milk was coming out clear like water.” As soon as she saw it, she stopped breastfeeding entirely and began to only give him the bottle. With her other three children, Herlinda had no such difficulties while breastfeeding, but she describes how stopping breastfeeding was a struggle with her oldest child:

I breastfed him for a year and three months. But the truth is, he didn't want to give it up, and I didn't either. You see, the boy and I were very attached. He didn't want to let go of me. Sometimes he didn't want to let go because of the nursing. And my nieces helped me and said, “Aunt, put chili [on your nipple]. Put coffee so that he gives up your breast. *(laughs)* Don't give it to him anymore. He's too big.” And when I finally stopped nursing him, he finally started to walk. At a year and three months.

Not wanting to lose the maternal bond between mother and child is a commonly shared sentiment among breastfeeding mothers. Teresa describes why she breastfed her youngest son longer than the rest of her children:

Maybe because I was working at night and I felt guilty for leaving him alone. Since he was little I left him completely in daycare. Then I felt like I had to be more attached to him. I left him at six months to go back to work, and I felt guilty. “No, I have to breastfeed. When I'm not there, they give you a bottle and all that.” And with him I worked up until the last day of my pregnancy, and with the others I didn't work. And that's why I felt guiltier with him too. The poor baby who didn't give me trouble and let me keep working all that time.

For Guadalupe, while she had originally planned to breastfeed her children, she never had the opportunity to experience the maternal bond that can come from breastfeeding. Guadalupe describes her experience breastfeeding her first child, “I only

breastfed for 15 days because I was a coward and it hurt me so much. When I couldn't handle the pain, I stopped. At 15 days, when I saw blood I said, 'No more.' No more because it burned until I cried in pain. I had a bad experience." After her experience with her daughter, Guadalupe chose not to breastfeed her son. Of all of the women in this cohort, Guadalupe is the only one that believes she would have made a different infant-feeding decision if she were in Mexico. She explains how her decision about breastfeeding might have been different if she hadn't moved to the United States:

There you're very poor. Sometimes you have money to buy food for yourself but not to buy bottles or milk for the babies. Then, well, I wouldn't have had any choice but to breastfeed. But here you have all the possibilities to buy milk, buy bottles. So I did what was the easiest because I didn't want any pain. But if I wouldn't have had the possibilities I have here, even if I was bleeding, I would've had to breastfeed my baby – otherwise it would die.

When discussing her choice to give up breastfeeding after two weeks, Guadalupe places blame on others and herself for her decision:

I think there's good information out there [about breastfeeding]. What happened was that the nurses never gave it to me. And it was my fault too because if I would have – I don't know. It's just that I was very new to it, and I didn't know anything. Well, maybe it's my mom's fault too, and all the people that were around me that had experience and could have told me, "No, put the breast like this," or, "Put the nipple like that." But nobody told me, and I didn't ask either, and that's why I didn't breastfeed my daughter. The information is there. I just didn't look for it.

Guadalupe isn't alone in feeling a sense of guilt over her infant-feeding experience. When Claudia's first daughter was born, she was separated from her for the first week. When they were reunited, she was unable to get the baby to breastfeed and gave up trying after a week. Claudia explains how she felt about the experience:

Because my mom had told me and everyone else had told me throughout the pregnancy that you have to breastfeed because of all the benefits. And then when

I couldn't, it was frustrating because I felt like she was going to get sick, because they said if you don't breastfeed, you'll have a sick baby. And it would be my fault.

However, Claudia still felt a sense of guilt about her decision while breastfeeding her older children. Claudia chose to exclusively breastfeed her children, but she describes how she sometimes doubts whether she has, indeed, made the best infant-feeding decision for her children:

I feel that – I *believe* that – with formula they are better fed. I think because the milk comes more enriched and all that. I feel that if I want to feed her well, I need to be eating more nutritious, but with formula it's more certain. The nutrients are there. I'm not sure if when I feed her if it's the same because you see on the formula can that they put in all the nutrients that the baby needs for her mind and all that. Then, when I feed her, sometimes I feel like she's not eating well – like I'm missing something that she needs. Like with a little bit of guilt that today I didn't eat well enough, and she's not getting enough nutrition.

When asked why she continues to exclusively breastfeed if she feels so guilty about it, Claudia explains, “Because it's something that I think, but I don't know if it's true. Always at the doctor they tell you that ‘breast is best,’ so I stick with the breast.”

Clearly, the decision of how to feed one's baby is an extremely personal decision for many mothers. Mothers have many different motivations for making the decision to breastfeed and when making the decision to eventually stop breastfeeding. Additionally, while breastfeeding each mother's experience is very different. The experience can sometimes be very positive, but it can also be a source of frustration and, at times, feelings of failure. It is in these moments when a mother's social support network can play a key role in shaping her experience.

A number of studies have determined social support to be a crucial component of both a mother's decision to breastfeed and her breastfeeding success. A study of Mexican mothers conducted by Perez-Escamilla and colleagues (1993) determined that breastfeeding support from a close relative was consistently associated with exclusive breastfeeding. This finding parallels the findings of similar studies in the United States that have concluded that a mother's infant-feeding decisions are highly influenced by the attitudes and beliefs of people in the mother's social support networks (Humphreys, Thompson, and Miner 1998) and that mothers are more likely to breastfeed if they themselves were breastfed (Joffe and Radius 1987). Within this cohort, all nine breastfeeding mothers state that their own mother breastfed them and their siblings while growing up in Mexico. The one non-breastfeeding mother, Elena, states she does not remember if her mother breastfed or not. She reports she did not have a close relationship with her mother and that she never received any advice or support when caring for her own babies. Elena proclaims, "I learned everything on my own."

Unlike Elena, many mothers receive a variety of support and advice for how to care for their babies from a wide range of sources. The most common source of advice within this cohort came from the women's own mothers. Eight of the women received advice from their mothers about the importance of breastfeeding. Herlinda recalls how her mother convinced her to breastfeed:

She always told me – because I would tell her that I wasn't going to breastfeed my children, and she said, "How are you not going to breastfeed your children?! No, daughter, you have to breastfeed if you want the baby not to get sick and you want him to be smart." And that's what my mom said, "If you want a smart child, you have to breastfeed."

Herlinda believes that without the advice and support she received from her mother, she might not have chosen to breastfeed her children.

Often breastfeeding can be challenging both physically and emotionally, and without strong support from the members of a mother's social network, the mother may find breastfeeding too challenging to continue. Claudia describes how her mother's advice influenced her decision to continue past the pain:

If my mom wouldn't have encouraged me so much to breastfeed, well, I would've given up. Because when you get here, they only tell you in the hospital that you should try it, but they don't teach you very well about all the benefits of breastfeeding. Because when you try to do it and it hurts, you want to give up.

Seven of the women described their mother's advice as the most influential advice they received about breastfeeding, and the other two women stated that they had little to no communication with their mothers while raising babies.

Previous research confirms that a baby's maternal grandmother has among the greatest influence on a mother's breastfeeding. However, the same research finds the mother's significant other to also be highly influential when encouraging her to breastfeed (Arora et al. 2000; Humphreys, Thompson, and Miner 1998). Within this cohort, six women said they received encouragement for breastfeeding from their baby's father. The other three women described their husbands as indifferent. Brigida describes her husband's enthusiasm about breastfeeding:

He wants me to breastfeed even more because he knows the benefits and all that. He wants me to do it more, but sometimes I feel like I don't have enough... and at times when the baby has hiccups, he'll say, "Nurse him," and I'll say, "Oh, if I were you," I say, "If you were the one who could nurse, you would have him so fat from so much breast milk." (*laughs*)

Aside from enthusiasm, a mother's partner can provide valuable encouragement during difficult moments while breastfeeding. Claudia describes her husband's encouragement during her painful early weeks of breastfeeding:

With my second baby, when I started breastfeeding it was very difficult because it was my first time really breastfeeding, and it was really hard, and it hurt a lot. It was very, very, very painful, and there were times when I wanted to give up, and he supported me. He told me, "Just try a little more." He motivated me to keep going, but at the same time he told me, "If you want to stop, it's okay. I support you." He'd support me whatever I decided, but he also encouraged me to keep going.

When asked where their husbands' enthusiasm for breastfeeding came from, multiple women believed, like Flor, that it was "because his mom breastfed him, so it's something he carries with him." Women related their husbands' preference for breastfeeding to the same cultural tradition they described as being passed down through generations in Mexico. Brigida believes her husband, "learned it from his mom because his mom is also Mexican so she also breastfed him and all his siblings." The perception was often that the cultural tradition preceded any other motivating factors. However, unlike the other mothers with Mexican-born spouses, Herlinda is married to a Puerto Rican man who was born in the United States. When asked if her husband's enthusiasm for breastfeeding came from his mother, she laughed and replied, "Definitely not." She explained that he didn't see breastfeeding growing up, and he learned everything from Lamaze classes and research in books and on the internet. She also stated that his research was the reason she chose to breastfeed for a full year and not supplement with formula.

Some women described receiving advice and support from their husband's mother. This was more common if the woman's own mother was not living nearby. Also, while some women received advice from their own mothers living in Mexico, women only received advice from their mother-in-law if they saw her regularly. Furthermore, almost all of the mothers-in-law were also born and raised in Mexico, and they were all supportive of the women's decision to breastfeed their grandchildren. Some women also reported receiving breastfeeding advice from sisters, cousins, and grandmothers, but the women's mothers and husbands were consistently cited as the most important sources of advice and support. Surprisingly, very few women reported receiving advice from friends about breastfeeding. Herlinda explains, "A lot of people don't like to talk about [breastfeeding]. Some, because they didn't do it, and others, because they're like closed-minded, and others, because it makes them embarrassed."

After the family, many women reported receiving advice about breastfeeding from medical professionals. Claudia would prefer to get breastfeeding advice from family but comments, "Because I'm alone here. All my family is in Mexico, so I try to get information from WIC, the doctors, and I have to take all my questions to people like that." Women stated that they received advice about infant-feeding from the Women, Infants, and Children (WIC) program, their doctors, nurses, and sometimes lactation consultants. The consensus was that the medical professionals were in favor of their breastfeeding, but feelings were mixed as to how effective their message was. Some women, like Guadalupe who only breastfed for two weeks, felt that the doctors and nurses didn't give them enough information about how or why to breastfeed. Other

women, like Brigida, felt they were well informed about the benefits of breastfeeding and received detailed instructions on how to get the baby to latch and how to use a breast pump. Also, all of the women interacted with medical professionals who spoke Spanish or used translators, so language was not seen as a barrier to information.

Women received infant-feeding advice from a variety of sources. From the WIC program and from medical professionals, the advice was generally about the benefits of breastfeeding and how to breastfeed. From family the advice was also about why and how to breastfeed. However, the women also received a considerable amount of advice from family involving cultural beliefs about breastfeeding. The most common cultural belief these women learned from others in their social network was about the avoidance of certain foods while breastfeeding. Eight women reported being told not to consume spicy chilies while breastfeeding. Herlinda explains why:

The chili is bad because sometimes with some babies when you breastfeed and you eat a lot of chilies, they say that the baby can't digest the milk right. For example, when you squeeze the nipple, the milk comes out fast and white, right? But when you don't eat right and eat too much chili, the milk comes out clear. That milk can make the baby sick. If you eat a lot of chilies, they say that the baby will get little red bumps like an allergy all over his body, and they say it's from the chili.

Several women were also advised to avoid beans while breastfeeding for a similar reason that it could make the baby sick. These findings are akin to a study of nursing mothers in Mexico, where Santos-Torres and Vásquez-Garibay (2003) reported that at least half of the mothers avoided one or more food(s) that they considered to be harmful to milk production and/or to their baby's health. They found the most commonly avoided food to be beans, followed by chili.

While women are aware of these cultural beliefs surrounding food, they don't all take the advice to heart. Claudia describes her take on Mexican cultural beliefs surrounding food and breastfeeding:

That was the only thing I took from the American beliefs. *(laughs)* Because it worked out better for me. Because when I was in the hospital and they were going to release me, I was really craving *chicharron* [spicy pork skin]. And I said to the nurse, "I've got a diet yogurt, but I'm really craving *chicharron*, but I want to take care of myself so I should eat the yogurt. But will it hurt the baby?" And the nurse said, she was American, "No. You can eat whatever you want. You don't have to give anything up. If you see that you're eating a lot of hamburgers, and you see that she's crying, then, yes, it's hurting the baby what you're eating. But if not, you can eat whatever." So that's what I did. The Mexican beliefs influenced me a little bit, because I eat everything, but in moderation. I don't go overboard with beans. And just a little chili.

Many of the women said they tried to avoid chili and beans when they could, but no one avoided them altogether. Women also reported being told to consume certain foods in order to produce more milk. The most common recommendation was to drink *atole* (a blend of milk, sugar, and either oatmeal, cornmeal, or nuts) to produce higher quality milk. Some women prepared the *atole* themselves, while others had it prepared for them by their mother, sister, or mother-in-law. The cultural practice of drinking *atoles* to produce better breast milk has been seen in other studies of Mexican mothers (Mennella et al. 2005; Skeel and Good 1988).

While most of the advice surrounding cultural beliefs involved food, several other cultural beliefs were passed to the women by members of their social network. Teresa was told by her older sister to avoid fire while breastfeeding as it can harm the breast milk. Claudia was told by her family to avoid cold and to keep her back covered so her breast milk doesn't dry up. She explains, "It's never happened to anyone in my family

that the milk has dried up, but they recommend that you don't test it, and it's better to just cover up." This cultural practice of covering one's back and shoulders was found to be common in a study of breastfeeding Mexican mothers conducted by Skeel and Good (1988). Aurora and Brigida had both been told that if a baby sucks too hard while breastfeeding or if you remove the breast too quickly, the soft-spot on the top of their head can cave in, and they were both very conscious of this while nursing their children. This cultural belief has also been seen in previous research on Mexican mothers (Weller et al. 1993).

Undoubtedly, social support and shared advice can greatly influence a mother's experience while breastfeeding. When the support is absent, it can have a considerable effect on her experience as well. Elena reports receiving no support or advice from anyone in her family. She chose not to breastfeed any of her children and states she has no regrets about her decision, but she later advised her own daughter to breastfeed her child. Luz also reports she received no support or advice from family. She breastfed all 11 of her children, and her only regret is that she couldn't produce enough milk to breastfeed for very long or without formula supplementation. Guadalupe feels that while she did receive some advice from her mother, it wasn't good enough advice to help her continue breastfeeding beyond two weeks. She feels a sense of remorse over her infant-feeding decisions, and she blames both her social support system for not advising her better and herself for not being a braver mother. As Guadalupe's experience shows, a woman's breastfeeding experience can significantly impact the way she thinks about herself and her identity.

Breastfeeding and Identity

Breastfeeding is inarguably a very personal experience for a mother, as is infant-feeding in general. Sociologist Marjorie DeVault (1991) argues that feeding one's family, and in particular one's children, is a very profound act of caring for a mother. She argues that feeding is "women's work" and that this "gendered activity" is shaped in part by "the very strong societal prescription that mothers are responsible for their children's well-being" (p. 116). Additionally, DeVault argues that women are not only allocated the bulk of the responsibility for feeding the family but also that "feeding work has become one of the primary ways that women 'do' gender" (p. 118). A mother comes to identify herself as "womanly" through the act of feeding her children.

Luz articulates DeVault's same sentiment when she states, "Well, I suppose to feel like a woman is to breastfeed your children." She also finds breastfeeding to be a key component of motherhood and explains, "Being a mother, you know you *have to* breastfeed." Other women agreed with Luz that there exists a strong association between breastfeeding and motherhood. When describing where the desire to breastfeed comes from, Roberta explains, "For a mother, it's something that we already have inside of us naturally. It's part of being of a mother – that tenderness." Luz further elaborates on why breastfeeding is such a key component of motherhood, "Because they [the babies] are receiving the blood from your body – from your being. Breastfeeding a baby is the love you can give to the poor little thing. More than the bottle or anything else." Similar to how women report maternal bonding as one of their top motivations for breastfeeding, breast milk itself is seen as a way to transmit love to one's child.

Some mothers may transmit that same ‘love’ to the children of other mothers as well. A few women mentioned the practice of mothers sharing their breast milk with other women’s babies. Teresa describes how breastfeeding is sometimes shared within communities of mothers in Mexico, “When one mother doesn’t have milk, then they’ll look for another mother who is breastfeeding and say, ‘Can you nurse my child?’ And that’s how they’re able to help each other – one mother to another.” Luz recalls her own experience sharing her breast milk with a hungry baby whose mother was in the hospital and proudly proclaims, “I have done many miracles in my time!” Again, sharing milk is seen as sharing love. However, not all women may agree. Luz also recalls a time when her sisters-in-law made her cousin feel ashamed for breastfeeding another woman’s hungry baby. Luz explains that her cousin shouldn’t have been the one to be embarrassed because the woman was the one to blame, “She [the woman] said the baby didn’t want to nurse, but *really* she just didn’t want to feed him!”

In the story of Luz’s cousin and the woman, Luz places blame on the other woman for not breastfeeding her own child. This type of judgment over infant-feeding decisions is a common theme in the literature on breastfeeding. Elizabeth Murphy (1999) argues that a woman’s infant-feeding decisions leave her very accountable to both society and herself. A woman can be judged or can judge herself for her decision to breastfeed or to formula feed her infant. Murphy argues that regardless of the infant-feeding method they choose, “women face considerable interactional challenges as they seek to establish that they are not only good mothers but also good partners and good women” (p. 187). A mother often feels that she must defend her infant-feeding decisions to both society and

to herself. Glenda Wall (2001) makes a similar claim when she asserts that “good motherhood” is often linked to breastfeeding and that a mother’s infant-feeding behavior is often “subject to public scrutiny and moral authority” (p. 604). This good mother – bad mother dichotomy adds to the very personal nature of infant-feeding decisions.

When interviewed, Roberta seems to feel the need to justify her decision to give up breastfeeding her children after only three months. Roberta returned to work three months after the birth of her children, and, unlike other working breastfeeding mothers in this cohort, she then switched to exclusive bottle-feeding. She emphasized several times throughout the interview that breastfeeding for three months was widely accepted as the ideal length of time for breastfeeding. For example, when asked, “Did your mother breastfeed you?” she responds,

Yes, my mother breastfed all of us. I was the youngest, and they say I was still breastfeeding at three or four years – even though breast milk loses quality after so much time. The important, *important* thing for a baby, *everyone* says that it’s breastfeeding for the first three months.

Later, when asked, “Why do Mexican mothers choose to breastfeed?” she responds, “I think it’s been passed down from their family. Their grandparents, great-grandparents, their parents – that the best thing is to breastfeed for at least three months.” In both of these examples and in a two other instances during the interview, Roberta brought up specifically that three months was the suggested length of time for breastfeeding even though she was asked an unrelated question. While she never explicitly said she felt any regrets or judgment over her infant-feeding decision, it did appear that she felt the need to justify it as being the ‘right decision.’ In a sense, as described by Murphy (1999) and Wall (2001) above, she is also justifying that her decision makes her a ‘good mother.’

Even if a mother feels confident in her decision to breastfeed, she may experience breastfeeding in very different ways. A qualitative study of new mothers conducted by Schmied and Lupton (2001) uncovered that mothers may struggle with the contradictions between their own breastfeeding experience and the romanticized image of breastfeeding as an intimate and highly pleasurable experience between mother and child. Schmied and Lupton note that when women are unable to achieve this ideal, as was the case with Guadalupe, they are “susceptible to disappointment and feelings of failure and a sense that somehow they are ‘bad mothers’” (p. 246). Guadalupe expressed remorse over being a “coward” and not continuing to breastfeed by pushing through the pain.

This idea that a ‘good mother’ will sacrifice her body to pain and discomfort to feed her child is shared by other women. In Luz’s description of breastfeeding as being “the love a mother can give to her child” she also describes it as being a motherly sacrifice. She equates the sacrifice of breastfeeding to the sacrifice of natural childbirth:

It [breastfeeding] is like giving birth. If you have a baby, and you have it with a c-section, you’re not going to have the same love as if you pushed it out from where it’s supposed to come out with all the strength of your body. Because I met a woman who told me that natural birth is much more painful than a c-section. With a c-section, they just open you up and take out the baby, and that’s that. You haven’t pushed at all. And women today don’t want to push. They just want the c-section... Like I said, breastfeeding is the love you can give to your child. And these same women today say, “Oh no, I’m not going to breastfeed because it’ll ruin my body.” Well, I say, “It’s already ruined!” (*laughs*)

In this case, Luz is not only affirming her identity as a good mother through her own motherly sacrifice of breastfeeding, but she is also constructing an identity of motherhood in contrast to other mothers.

This construction of an identity in contrast to others was very common within this cohort, and it was primarily seen when the mothers compared their own infant-feeding decisions to those of mothers raised in the United States. Women generally felt that mothers raised in the United States were less interested in breastfeeding than mothers raised in Mexico. Several women noted that non-immigrant mothers preferred to take the “easy path” by giving their babies formula rather than breast milk. Teresa explains why mothers born in the United States don’t breastfeed:

Sometimes they don’t want to breastfeed even though they have enough milk. Maybe because they think it’s going to be too much work. For example, you have to nurse whenever the baby is hungry, even if you have to go out or go to a meeting or school or work. They think they can’t do it. And I even think they don’t want to do it because, well, when you nurse your breasts get full of milk and, well, they get wet. I think they are uncomfortable because they don’t want to walk around all day with a wet shirt... In Mexico, it’s different. They think it’s natural. It’s a beautiful thing. If the milk is coming out, it’s because it’s time to feed the baby.

The ‘inconvenience’ of breastfeeding was commonly cited as the reason non-immigrant mothers didn’t want to breastfeed. Women stated that mothers born in the United States preferred the faster, easier option. Brigida comments about non-immigrant women, “I think they’re used to the bottle. Something fast and that’s it. Because they don’t want to waste so much time breastfeeding.”

Women believed that non-immigrant mothers chose not to breastfeed not only because it was less convenient, but also because it would “ruin their bodies” or because they “couldn’t handle the pain.” Herlinda describes the thought process of non-immigrant mothers when deciding how to feed their babies:

The difference between a mom from Mexico and one from here is that here they’re used to getting everything easy. So when they have their baby, they think,

“Should I breastfeed? It doesn’t look good. I’ll miss out on this. I’ll miss out on that. No. The bottle is better.” Or they think, “If I breastfeed my breasts will get saggy. No. Better to use the bottle.” Moms from Mexico don’t think that way.

Mothers raised in the United States are perceived as having had an easier upbringing than mothers raised in Mexico. Luz comments, “Moms from here think they have everything. They grew up saying, ‘Mom, I want this’ and ‘Mom, I want that.’ They only think about themselves. They don’t care if the baby’s crying. They just say, ‘Take the bottle’ and that’s it.” Women raised in the United States are seen as being more self-centered and less interested in the needs of their children.

Women consistently stated that mothers raised in Mexico were more willing to sacrifice their bodies and their time to breastfeed their children than those mothers raised in the United States. Many described breastfeeding as their motherly obligation. Claudia describes the difference in how each group prioritizes breastfeeding:

For people from Mexico, breastfeeding is the first choice. First they look for a way to breastfeed, and *only* if they are unable to do it, *only* then do they consider formula. But here it’s like, if you want to breastfeed, you do it, and if you don’t, then there’s the formula right there. Here they give you the milk for free. So people think, “Why should you try so hard to breastfeed your baby? It’s painful.”

Through this differentiation, breastfeeding becomes not only a common practice of Mexican-raised mothers, but a defining feature of their group identity.

Some women viewed their affinity for breastfeeding as an example of how Mexican-raised mothers desire to be closer to their children than mothers raised in the United States. Brigida describes how Mexican-raised mothers like to keep their babies closer than non-immigrant mothers:

What I’ve seen is that the people who are born here, they don’t like for their babies to sleep with them. They always give them the bottle then put them in the

crib. And we, the Latinas, we try to be *with* the baby so that we can care for him better. That's what I say.

This desire for closeness and constant contact is seen as a key difference between mothers raised in Mexico and in the United States. Roberta elaborates:

It's very different. In Mexico, a mom never leaves her baby. In a small town there's not so much to do, but whenever she needs to go to a bigger town to do things, she'll never leave her baby with someone else. She'll take the baby. Even if sometimes she has to walk long distances, she'll take her baby. And here, sometimes I've seen some moms at my work who bring their babies to daycare, and I hear them say, "No, we got out early today, but I'm not going to the daycare to pick up my baby. What am I paying them for? No, I'll wait until it's time to pick them up, while I go do what I want."

Roberta explains that she left her own children with her mother-in-law when she went to work, but that as soon as she finished work for the day, she always rushed home to see them. She adds that she has seen a difference in this desire for closeness between Mexican mothers who grew up in Mexico and Mexican mothers raised in the United States:

My sisters-in-law, all of them, the whole family came here when they were young. Ever since they went to school here, they had a lot of little friends who were born here who had ideas from here. And they're not, like, very, very Mexican. And they tell me that my ideas about raising children are "ancient." And I say I don't care if they call my ideas "ancient." Because I have always had my children right here – close.

When asked where her "ancient" beliefs about keeping her children close came from, she replies, "That maternal love was inspired in me by the family. Through the generations."

While breastfeeding is seen as a component of the cultural identity of Mexican mothers, the mothers note a difference between first- and second-generation immigrants. It becomes the responsibility of the immigrant parents to instill in their children the cultural values they bring with them from Mexico. Claudia elaborates:

I think that we women who come here from Mexico as grown-ups, that grew up in Mexico, we have more of a culture of breastfeeding. But the women that are born here – I'm referring to with parents raised in Mexico but they were born here and raised here – they don't have the culture of breastfeeding because, well, they have other interests. It's hard to explain but – the Mexicans who were born here, they don't have, like, a strong cultural education. Because I think that the parents that come from Mexico are from poor areas. Then when they get here they work and work and work, and they don't educate their children. They send them to the school and all that, but then they grow up without any culture. They grow up with a little bit from the United States and a little bit from Mexico. Then, when it's time to have children, they don't have that cultural education, and the first they choose is whatever's easiest. The formula.

Unknowingly, Claudia sums up the body of research relating breastfeeding and acculturation. Breastfeeding is a component of Mexican women's cultural identity that is lost with migration and subsequent generations in the United States.

Teresa describes why breastfeeding is not a part of the cultural identity of women raised in the United States:

It's like they never saw breastfeeding, and they've never felt it. They haven't seen it – I think – seen their mom or their aunt nursing – or seen that little face of the baby drinking milk from his mother. I think they haven't lived that experience – never even seen it. That's why I think they don't do it.

Teresa describes breastfeeding as a shared experience among women – an experience that is not shared by women in the United States. Interestingly, as seen in the discussion of breastfeeding in Mexico versus the United States, Teresa brings up the importance of visibility. When the women don't see breastfeeding, they don't recognize it as an important component of motherhood. A woman learns what it means to breastfeed by seeing it.

The women construct their identity as 'good mothers' through their breastfeeding experience. Breastfeeding is described as central to how a woman experiences

motherhood. Additionally, the women construct their identity in contrast to other mothers. By describing other mothers as disconnected or unwilling to sacrifice for the good of their children, they further affirm their own identity as ‘good mothers.’ In addition, the women use breastfeeding as a way to affirm their group identity as Mexican mothers. Herlinda expresses the important role mothers play in maintaining breastfeeding as part of this group identity:

I think that most of all, it [breastfeeding] depends on the upbringing they give you. More than anything else. If my mom is from Mexico, and she’s here, and she’s lived here many years, and I was born here – she is going to give me the same upbringing that she had, what she saw in Mexico. But if she’s going to raise me like – let me do whatever I want – raise me like they raise children here. Well, then it won’t be passed on. Because everything that I’ve done as a mother is because my mom told me how to do it. Sometimes I said, “No, I want to give them a bottle,” but she said, “No, don’t give them a bottle. There is nothing in the world better than the breast.” She’s not here with me now, but it’s as if she were here. And I know it’s something that I *have to* teach to my children as well. Whether they’re in China, in Rome. (*laughs*) Because it’s for the good of the children, but it’s also for the good of yourself. That’s what I think.

CONCLUSIONS

Evidence from this research has only begun to show how personal and complex Mexican immigrant mothers’ infant-feeding decisions and experiences can be in the United States. A number of very intriguing findings came out of this exploratory work. First, after having lived in both the United States and Mexico, the women perceived very different motivations for breastfeeding in these two societies. Women expressed the belief that a woman’s primary motivation for breastfeeding in Mexico comes from the fact that her mother and grandmother breastfed. This is particularly intriguing because it is completely contradictory to the experience of many women who were born in the

United States. The average age of the mothers in this study is 39-years-old. Today, a 39-year-old woman who was born in the United States has only a 22 percent chance of having been breastfed by her mother – lower than any other aged woman in the nation – and a less than 50 percent chance that her grandmother breastfed (Wright 2001). Also, research suggests that this perceived cultural motivation is not as powerful a motivation for Mexican women living in the United States. Second-generation Mexican mothers have much lower breastfeeding rates than their immigrant mothers despite having been breastfed themselves (Kimbrow, Lynch, and McLanahan 2008). If the practice of breastfeeding is indeed passed from mother to daughter, why aren't the breastfed second-generation mothers breastfeeding?

It appears that primary motivations do change. Only one of the women in this study mentioned her mother's breastfeeding as a primary reason she herself chose to breastfeed. Health and maternal bonding were reported as the women's strongest motivators. Interestingly, when the women spoke about their Mexican husbands' motivations for preferring breastfeeding, again most said it was mainly because their husbands' mothers breastfed, and only the one woman with a husband born in the United States said it was primarily for health reasons. Also, the women describe mothers and husbands as being motivated by having seen (or not seen) breastfeeding growing up. No woman explicitly recognized this as a motivation for why she herself chose to breastfeed, but they believed it was a key reason why Mexican women breastfeed and women born in the United States do not. It is unknown whether breastfeeding visibility has as strong

of an influence on mothers' infant-feeding decisions as these women suggest, but it certainly raises some interesting questions for future research.

Another intriguing finding from this research was the high level of combination feeding among these mothers. Women chose to supplement breast milk with formula in spite of being well aware of the health benefits of breastfeeding. While a few women chose to supplement after returning to work, others described supplementation as necessary if you wanted to be sure your baby was getting the nutrients she needs, if you didn't want your baby to be "too clingy" from exclusive breastfeeding, or if you were out in public. Each of these reported reasons for supplementation is troubling in their own right.

First, it is very understandable that a woman would choose to supplement breast milk with formula upon returning to work. However, the fact that none of these women felt that expressing milk at work was even a remote possibility for them is disconcerting. In 2001, the 'Nursing Mothers in the Workplace Act' was passed in Illinois, requiring employers to provide reasonable accommodations and unpaid break time for nursing mothers to express breast milk at work (NCSL 2010). While some mothers had their children prior to the legislation's passage, others had children after 2001 but still felt expressing milk at work was not an option for them. This suggests the need for more support for breastfeeding mothers in the workplace. Also, more support is especially needed in the manual labor sector, where most of these women are employed. Mothers in the manual labor sector have been shown to face more challenges when combining

breastfeeding and work than mothers in service or professional occupations (Kimbro 2006).

Second, it is troubling from a public health perspective that multiple mothers felt supplementing breast milk with formula would provide their babies with better nutrition than breastfeeding alone. Certainly there is a lack of education about this issue, and these mothers seem to be receiving mixed messages. Even though her doctor and the Women, Infants, and Children (WIC) program tell her ‘breast is best,’ when a mother is provided with free formula at the hospital and free formula from WIC, she may be lead to believe that the health professionals wouldn’t be giving her the formula if it weren’t actually the best for her baby. This finding suggests that the public health community needs to work harder to clarify their message.

Third, the finding that mothers believe exclusive breastfeeding will make a baby “too clingy” suggests a need for better education from these women’s health care providers about what constitutes a healthy relationship between infant and mother. Finally, the finding that women feel formula supplementation is necessary if a mother is out in public is extremely troubling, and it says a lot about the societal pressures these women perceive in the United States. Forty-four states, including Illinois, have laws protecting a mother’s right to breastfeed her baby in any public or private location where she is otherwise authorized to be (NCSL 2010). However, today many mothers still do not feel comfortable breastfeeding in public. There is a growing movement in the United States for mothers’ right to breastfeed in public, but the movement is largely led by middle-class white mothers (Blum 1991). The women in this study did not perceive a

strong support for public breastfeeding. Additionally, the women reported rarely, if ever discussing breastfeeding with friends outside of their family. It appears there is a need for more organization within the Latina community around breastfeeding issues and rights.

Finally, one of the most intriguing findings that came out of this exploratory work was the construction of an identity through breastfeeding. Other studies have explored the idea that women construct their identity as a ‘good mother’ through breastfeeding (Wall 2001; Murphy 1999). However, this finding is particularly unique because not only are the women constructing their identity as a ‘good mother,’ they are constructing their identity in contrast to other mothers. The women consistently made generalized comparisons between mothers raised in Mexico and mothers raised in the United States. Mothers raised in the United States are described as being unwilling to sacrifice their time and their bodies for their babies. Mothers raised in the United States are described as being self-centered and uninterested in achieving the special bond between mother and baby that can only be created through breastfeeding. By identifying these common features of all non-immigrant mothers, the women construct a group identity for non-immigrant women as ‘bad mothers.’ In doing so, they are affirming their own group identity as ‘good mothers.’ Not only is the mother herself perceived as superior to other mothers for having chosen to breastfeed, but the mother’s group – Mexican immigrant mothers – is perceived as superior to other groups of mothers for the communal decision to breastfeed.

As evidenced by these findings, breastfeeding is an extremely personal experience for many mothers. It can have an effect on her identity as both a mother and a woman. It

must be emphasized that due to the personal nature of both the breastfeeding and the immigration experience, the findings of this qualitative exploration are by no means representative of all Mexican immigrant mothers. No mother's experience fully parallels the experience of another mother. The findings of this study do, however, uncover rich details of how these particular mothers interpret their own breastfeeding experiences and reveal the ways these mothers have negotiated their own infant-feeding decisions within a transcultural context.

A key limitation of this study is that there was not enough time to conduct a true ethnography – which is perhaps warranted for this type of research. A 'true ethnography' would involve a long-term research project with multiple encounters and interviews with informants. This would allow the rapport necessary to gain a full understanding of the cultural meaning these mothers associate with breastfeeding. A second limitation of this study is that the Mexican immigrant community of Chicago may not be typical of other Mexican immigrant communities in other regions of the country. Also, with a sample size of only ten mothers, the breastfeeding experience of these informants may not be typical of the experience of most Mexican immigrant mothers.

Any future research on this topic should include not only a larger sample size, but also more frequency of contact with the respondents. In addition, several of the findings from this study involved these mothers' perceptions of others' attitudes about breastfeeding. Future research should explore the accuracy of these perceptions by interviewing both Mexican immigrant fathers and second-generation Mexican American mothers.

Despite these limitations, the information gained from this study and the contributions to the body of literature and knowledge on this topic are very valuable. This qualitative exploration uncovers rich details absent from much of the quantitative research on Mexican immigrant mothers and breastfeeding. Also, given the many benefits of breastfeeding for both child and mother, this type of research can have important implications for public health policies. Furthermore, while there have been a handful of qualitative studies exploring the relationship between breastfeeding and gender identity among mothers in general, to this researcher's knowledge, this is the first study of its kind to explore this relationship within a transcultural context. However, this study has only begun to explore the intersection between immigration, breastfeeding, culture, and motherhood. Much empirical work still needs to be done to fully understand the breastfeeding experience of Mexican immigrant mothers living in the United States.

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CHAPTER II

NOTES ON ETHICAL AND METHODOLOGICAL CONCERNS

Due to the very personal nature of both the immigration and the breastfeeding experience, a number of ethical and methodological challenges and concerns presented themselves during this study. A top concern throughout the research process was avoiding psychological harm to my respondents. A mother is often subject to judgment over her infant-feeding decisions. She may feel guilt or even defensive about how she chose to feed her baby. For this reason, I was very conscious of both my verbal and non-verbal body language with each respondent so as to not make her feel under judgment or feel as if I found her to be a ‘bad mother’ for her decisions. I was also very sensitive to my respondents’ verbal and non-verbal signals and avoided questions that made them feel uncomfortable or under scrutiny. Two of the mothers were brought to tears during the interview. Coincidentally, they were the two women who did not have positive relationships with their own mothers, and they began to cry when discussing that topic. When this happened I immediately reminded them that they did not have to talk about anything that made them uncomfortable and changed the subject.

Another ethical concern during this study was the issue of translation. Translation can be a subjective process and is often open to interpretation (Temple and Young 2004). In an effort to minimize this subjectivity, I translated my interview guide from English to Spanish and then back-translated it orally with a colleague who grew up in Mexico and

came to the United States as a teenager. This helped to ensure that the Spanish translations of the questions were indeed asking what I wanted them to be asking. I also kept this subjectivity issue in mind when analyzing my data and consulted with my husband, a native Spanish speaker, throughout the translation process. Additionally, as both my husband's and my knowledge of Spanish is most similar to Peruvian Spanish, my Mexican colleague was consulted when dialectical phrases or words arose that required clarification.

One methodological concern while conducting this research was the potential impact of my personal biography on the outcomes of the study. It was very important to keep my own personal biography in mind throughout the research process. First of all, like my participants, I am a woman. In many ways, this made it easier for me to interact with my participants than if I were a man. Marjorie DeVault (1999) states that "women interviewing women bring to their interaction a tradition of 'woman talk'" (p. 67). She argues that through "woman talk," female researchers are typically better equipped than male researchers to listen to and understand the language that women use to describe their own experiences. However, though I am a woman, I am not a mother. While I can conceptualize what a mother may experience, I cannot fully understand it. Participants often asked me if I had children, and I would respond that I did not but that I wanted children someday and was excited to learn about their experiences. At times, this created a dynamic where the women were not only sharing their mothering experiences with me but were, in a sense, teaching me how to one day be a "good" mother. This teacher-student dynamic may have impacted the types of responses my interviews elicited. A

researcher who was also a fellow mother may have received different types of responses from the women in this study.

Furthermore, I am a white woman. It is difficult for me to fully relate to the Latina experience. My privileged racial/ethnic status has protected me from many of the injustices and inequalities experienced by my participants. Also, as an American citizen, I cannot fully relate to the immigrant experience. My “outsider” status may have presented a barrier to building rapport with my participants. The women may not have felt as comfortable sharing their experiences with me as they might have with a researcher who was a fellow Mexican immigrant. However, a handful of things helped me overcome the challenge of being an “outsider.” First, I am able to speak Spanish fluently with very little accent. Second, I have spent a good amount of living, working, and traveling in several Latin American countries including Mexico. Also, my husband is a Latino immigrant himself. I believe that these three personal traits afforded me some added credibility with my participants.

Finally, as mentioned within the previous chapter, a major limitation and methodological shortcoming of this study is that time did not allow for the frequency of contact necessary to build stronger relationships with respondents. Each respondent was interviewed only once, and I met the respondents for the first time on the day of their interviews. While overall the women were very open and honest about their experiences, I believe I would have built more rapport and gathered even richer data if I had had more contact with the women. When exploring such a personal topic as the intersection between immigration, breastfeeding, culture, and motherhood, considerably more time

should be devoted to rapport building. Also, as mentioned in the previous chapter, this exploratory study has only begun to scratch the surface on this topic, and there is a wealth of knowledge yet to be uncovered in future research.

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APPENDIX
INTERVIEW GUIDE

INTERVIEW GUIDE

Migration Experience

- Tell me the story of how you came to the United States.
 - How about how you arrived in Chicago?
 - Were you single or married?
 - Did you bring your kids with you?

Breastfeeding in Family and in Mexico

- Did your mother breastfeed you when you were a baby in Mexico?
- Tell me a story about what people said about breastfeeding in Mexico.
- How do your female friends in Mexico feed their babies?
- Tell me about the women in your family that breastfed.

Personal Breastfeeding Experience

- Did you consider breastfeeding your babies?
- Tell me about your experience.
 - Did you have any difficulties?
 - What do you like about breastfeeding?
 - What don't you like about breastfeeding?
 - Did you ever breastfeed your baby in public (in church, etc.)? Tell me about your experiences.
 - Did you breastfeed and bottle-feed your baby at the same time?
 - How do you feel about bottle-feeding?

Social Support for Breastfeeding

- Who gave you advice about how to feed your baby?
 - What does your partner think about breastfeeding?
 - What advice did they give you in the hospital or the clinic?
 - Whose advice influenced your decision about how to feed your baby the most?
- Tell me about how your friends in the U.S. feed their babies.
- Have you ever given anyone advice about how to feed their baby?

Breastfeeding Here and There

- Do you think that you would have made the same decisions about feeding your baby if you were in Mexico?
- Do you feel that you have the same information about how to feed your baby as you had when you were in Mexico?
- Do you think that you feel the same way about how to feed your baby as you did when you were in Mexico?

Demographic Checklist (if not answered earlier in interview)

- How long has mother been in U.S.?
- How old is mother?
- How many children does mother have? Age of children?
- Children born in U.S. or Mexico?
- Were children breastfed?
- Is mother married?
- Mother's education? Mother's occupation?