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BREASTFEEDING ADULT LEARNING EXPERIENCES: WOMEN'S STORIES

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Mount Saint Vincent University

**A thesis submitted to the Department of Education
in partial fulfilment of the requirements for the degree of
Master of Arts
(in Education)**

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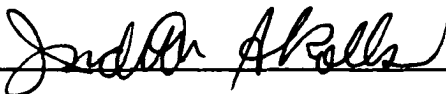


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Breastfeeding Adult Learning Experiences: Women's Stories

M. Tanya Brann-Barrett

**An abstract of the thesis presented in partial fulfilment of the requirements for the degree
of Master of Arts (in Education)**

January, 2001

Breastfeeding is a form of life sustaining work that only women can perform. It is learning and doing that exist within the lifeworld. Much of the work done by women in the homeplace and in their roles as mothers is valuable sustenance labor performed in society. Yet, like other work performed by marginalized people it is often undervalued by those who control the systems in power (Hart, 1992). The knowledge, the language and the understanding women need to help create a successful breastfeeding experience has, in some cases been buried (Dettwyler, 1995; Palmer, 1988). Despite these obstacles there are many mothers who develop methods to breastfeed their children.

After years of decline, current statistics boast an increase in the numbers of women who choose to breastfeed in Nova Scotia. While the numbers are still lower in the Cape Breton region there has been a significant increase since 1979. An increased understanding of the value of breastfeeding and the technique required to breastfeed most certainly has influenced the decision of many women to breastfeed. However, a mother's success is influenced by a myriad of factors.

For women who choose to breastfeed, learning the practice of breastfeeding can be

a significant adult learning experience. The purpose of this thesis is to explore the adult learning experiences of women living in Industrial Cape Breton, Nova Scotia. The focus is twofold. First, adult learning strategies women used to inform themselves about breastfeeding as an infant feeding choice are determined and, second, how these strategies impact the success of their breastfeeding experience is explored.

Focus group interviews were selected as the best method of data collection for this particular study. They allow for a substantial amount of data to be collected while also creating a group setting where women could share their stories with other women.

Two focus groups of four women from Industrial Cape Breton were conducted. The participants were white, middle to upper-middle income women with varying levels of post-secondary education. Based on the data generated by the women in the study, a breastfeeding adult learning model was developed. It shows the adult learning appeared to progress along a chronological continuum that began when the women first contemplated breastfeeding as an infant- feeding choice and continued often past the weaning stage. There emerged three distinct phases along this continuum: 1) the initiation phase, 2) the lived experience phase, and 3) the retrospection phase. Throughout each phase the women appear to utilize a number of learning approaches which involve knowing, feeling, doing and retrospection, enabling them to learn how to breastfeed and how to tackle the obstacles that they face throughout the process.

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CHAPTER ONE

On June 09, 1994, at 2:49 p.m. I gave birth to my first child, Robert William. By 3:00 p.m. Robert was at my breast as three student nurses and my doctor tried to help me to help him 'latch on' so I could breastfeed him. After nine months of learning what it would be like, what to expect and how to actually do it (or so I thought), I embarked on my overwhelming, (and at times frustrating and emotional) immensely rewarding experience as a breastfeeding mother. This experience lasted almost four years. I breastfed Robert William for two and one half years and Nicholas James for eighteen months, with a few months of tandem nursing in the middle. The learning continued for all those years. Upon reflection, I realize I had a successful breastfeeding experience.

Breastfeeding is a form of life sustaining work that only women can perform. It is learning and doing that exist within the lifeworld. Much of the work done by women in the homeplace and in their roles as mothers is valuable sustenance labor performed in society. Yet, like other work performed by marginalized people it is often undervalued by those who control the systems in power (Hart, 1992). As I argue throughout this chapter, the knowledge, the language and the understanding women need to help create a successful breastfeeding experience, in some cases, has been buried (Dettwyler, 1995; Palmer, 1988). Despite these obstacles there are many mothers who find ways to breastfeed their children. They have developed methods to relearn the knowledge in the face of a society that claims it believes women should breastfeed their children, but does not always provide the necessary support and acceptance. How, then, have women accomplished such a feat?

Without hearing their stories, we do not know.

For women who choose to breastfeed, learning the practice of breastfeeding can be a significant adult learning experience. I believe it is important to uncover women's adult learning stories about their breastfeeding experiences so that the narratives can be recorded, celebrated and shared among women.

Intent of the Study

Making the learning visible

The purpose of this thesis is to unearth women's adult learning stories of breastfeeding. The focus is twofold. First, I inquire about adult learning strategies women used to inform themselves about breastfeeding as an infant feeding choice and, second, I question how these strategies impact the success of their breastfeeding experience. Bringing mothers together in focus group format, I have the opportunity to listen to women from industrial Cape Breton share their breastfeeding adult learning experiences. Focus group interviews were selected as the best method of data collection for this particular study, because they allow for a substantial amount of data to be collected while also creating a group setting where women can share their stories with other women. Subsequently the focus group format simultaneously allows me to observe how women discuss their breastfeeding experiences with other women. To uncover this data, I explore numerous questions. What or who influenced their decision whether or not breastfeed? What breastfeeding learning methods did these women use? What, if any, educational

programs or adult educators were readily available to them (for example, did they have access to health and medical professionals, support programs, support people, literature, and other media)? When did they begin to implement the learning activities and what type of support or assistance did they receive during their breastfeeding learning experience? What obstacles did they face throughout their breastfeeding learning experience? I inquire about how women communicate with and learn from each other about breastfeeding. As well, I question the impact these methods of adult learning had on the success of each woman's breastfeeding experience; what learning techniques were the most helpful, what methods were less effective, and how did the various learning methods impact their own perceptions of the success of their breastfeeding experiences. Success is determined by the individual mothers and varies from woman to woman. For example, one woman may feel successful if she was able to breastfeed exclusively for the first few days another may feel unsuccessful after four months of breastfeeding.

To effectively construct the analysis for this study, I draw upon adult education, communication, and feminist literature including the work of theorists such as Mechtild Hart, Angela Miles, Cheris Kramarae, Dale Spender, Pam Carter, Linda Blum, and Patricia Dettwyler. I also refer to literature and information put forth by La Leche League International. La Leche League is an international breastfeeding volunteer support organization for women. Founded in the 1950's by seven American women, the organization promotes breastfeeding as a way of parenting. Regular monthly meetings held around the world are led by accredited league leaders who offer support, ideas and suggestions to help mothers cope with the challenges of breastfeeding. With some 40,000

members and leaders (La Leche League International, 1991), La Leche League claims to be one of the largest support group organizations in the world (Blum, 1999). The League, as it is known, has produced a substantial body of literature on the art of breastfeeding (Blum, 1999).

In this chapter I make a case for this study. I begin with an overview of the breastfeeding issue citing current trends and rates. I then discuss problems that face women who try to engage in successful breastfeeding experiences and how these obstacles can influence the breastfeeding adult learning experience. Finally, I present the argument that by listening to and collecting the adult education learning stories of breastfeeding mothers, it becomes possible to develop an adult learning model of breastfeeding learning experiences.

Breast is Best

Breast is best. This phrase is a familiar one throughout much of the breastfeeding literature (Blum, 1999; Carter, 1995; La Leche League International, 1991). Books (La Leche League International, 1991; Nova Scotia Department of Health, 1998), videos and support groups urge women to breastfeed their children and how to be successful breastfeeding mothers. Currently, studies primarily aimed at medical professionals and other experts document who is breastfeeding (Littman & Medenthorp, 1994; Keith, 1997), what motivators they are given (Gentler & Mulvey, 1999; Wright & Naylor, 1997), and whether or not they are successful according to health care standards.

Interests in breastfeeding research speak to an increased understanding of the value of breastmilk as the superior food for infants and small children. These interests followed a dramatic decrease in numbers of women who breastfed in the mid 1900's. In the early part of the twentieth century, more than 90 percent of women breastfed their children (Blum, 1995; Mac Lean, 1990). With the exception of upper class women who would engage the services of a wet nurse (a lactating woman who breastfed other women's children), the majority of women did breastfeed their own children until this point in history. While there were other times in history when artificial feeding was utilized, it became the preferred choice for mothers during the twentieth century. Mac Lean (1990) estimates that by 1963 the number of Canadian women who breastfed their babies had plummeted to between 30 and 40 percent. Here in Eastern Nova Scotia, there was no exception to this norm. In fact, the numbers lagged behind the provincial and national averages. J. Mc Cabe (personal communication, May, 2000), a nutritionist with Nova Scotia Public Health Services in Sydney, reports that in 1979 less than 20 percent of women in Cape Breton breastfed their children. These numbers refer to any women who attempted breastfeeding regardless of the duration. Clearly, in this region, formula feeding was the choice of the majority.

Current numbers boast an increase in the numbers of women who choose to breastfeed in Nova Scotia. From 51% in 1982, 63% of Nova Scotia women were breastfeeding their babies in 1994. Yet once again, the Eastern region of the province, which includes Cape Breton, was less than 41% (Nova Scotia Department of Health, 1998). As noted by J. Mc Cabe (personal communication, May, 2000), while the numbers are still lower in the Cape Breton region there has been a significant increase since 1979.

An increased understanding of the value of breastfeeding and the technique required to breastfeed most certainly has influenced the decision of many women to breastfeed.

However, a mother's success is influenced by a myriad of factors beyond her control.

Numerous problems make it difficult for women to breastfeed successfully. And these obstacles can impact negatively on women's ability to seek knowledge on how to breastfeed. In the next section, I explain how these difficulties are explicated in today's society.

Problems Impeding Women's Successful Breastfeeding Experiences

Circumstances can make it difficult for women to obtain the proper information that can help them engage in successful breastfeeding experiences. Four, in particular, stand out: 1) increased medical intervention in pregnancy, childbirth and infant care, 2) corporate interest in the infant-feeding market, 3) changing roles of women in the workforce, and 4) the western cultural perspective of the breasts as sexual objects. Here each is discussed.

Increased medical intervention

Medical intervention into women's health issues is seen to have had benefits and drawbacks. Shorter (1982) points out modern medicine significantly benefited women by reducing many of physical problems females had contended with through time including death during childbirth. He also believes it helped women form an alliance with men.

Women have begun to see other men, especially their husbands (and to a lesser extent their doctors)- instead of other women- as their main allies. Female bonding, if my argument is right, has thus been vanquished, both by improvements in health and by the companionate marriage. (Shorter, 1982, p.294)

Shorter's position is based on his assumption that:

...women's culture was a culture of 'solace', a place where the bodily misery of womanhood would find understanding. But women's culture functioned also to defend women against the malignant aggression of men" (p.292).

Shorter has documented the immense and extreme suffering women experienced as a result of myths, perceptions, and fears men and women held in regard to the female body because they did not understand the functions of the body (for example a women who was menstruating was feared because it was believed she could contaminate food and drink). He believed as modern medicine dispelled many of the myths, men no longer feared women's bodies and became women's allies.

Not everyone has such a positive regard for the intervention of modern medicine on women's health. In particular, some have written about the influence of medicine on infant feeding practices.

The bodily alienation that produces great levels of anxiety in western women is intimately connected with the dominance of the medical profession and its world view. The jurisdiction of the medical profession has expanded to include infant feeding in both developed and developing countries. It is now taken for granted that anything affecting infant health belongs in the medical domain. (Van Esterik, 1989, p. 111)

Van Esterik goes on to describe the medicalization of infant feeding as “the expropriation by health professionals of the power of the mother and other caretakers to determine the best feeding patterns of infants for maintaining maximum health” (p.112).

Palmer (1988) states there is a parallel between the decline of breastfeeding and increased involvement of the predominantly male medical profession in childbirth and infant care. Blum (1999) writes “There is ample evidence for blaming the patriarchal medical profession and, in the case of infant-feeding, their collusion with burgeoning formula industry” (p.30). She goes on, however, to point out that the argument is often made that the medical profession was also concerned with the needs of mothers and was responding accordingly.

They (women) wanted freedom from the control biology extended over their lives, including pain free, safe childbirth and birth control, and they saw medical science as an ally.

As artificial infant- feeding became safer, the bottle was similarly an emblem of modernity, progress, and enhanced autonomy for affluent in their maternal body. (Blum, 1999, p.31)

Blum notes that in many cases the medical intervention led to less control for women over their own bodies. However, working class and middle class women were probably still pleased to have a safe alternative to breastfeeding.

Medical professionals served as a source of information regarding infant feeding for centuries. However, there was a lack of real interest and knowledge in the field and the decision was primarily left to women. This began to change in the late nineteenth century as pediatrics grew as an area of medical specialization. Concurrently, medical professionals were increasing their support of formula feeding as an infant food choice. Olsson (1988) purports that the belief held by health professionals that formula feeding and breastfeeding were of equal nutritional value was one of the factors leading to the decline of breastfeeding among women.

While some medical professionals still advocated breastfeeding, the inaccurate information they provided women was detrimental to the likelihood mothers would have a successful breastfeeding experience. Unfortunately this continues today. Palmer (1988) writes:

Since “medical science” began to supervise breastfeeding it has been the custom to restrict it. When babies are only fed

at regular intervals and their time at the breast curtailed,
 then sufficient milk cannot be stimulated in most women.
 This is why the prevalence of “insufficient milk syndrome”
 follows in the wake of medical services. (p.20)

Insufficient milk is still offered as one of the main reasons a mother discontinues breastfeeding. A report of the 1994 Nova Scotia infant feeding survey (Nova Scotia Department of Health, 1998) cited ‘not enough milk’ as the second most common reason for discontinuance. Breast milk is produced, according to supply and demand. When a child is fed on demand, without supplementation, the mother’s body produces a sufficient amount of milk. Consequently, when advised and sometimes ordered to feed at regular intervals, many women have little hope of establishing a healthy milk supply. Women often experience feelings of inadequacy and perceive insufficient milk as their fault when in fact it more likely a symptom of inadequate medical advice and supervision.

Germ theory also had a negative impact on breastfeeding. Women were told to scrub their nipples before and after breastfeeding (Blum, 1999; Palmer, 1988). Subsequently, the natural secretion produced to protect the nipple was removed which lead to sore nipples and infection. Palmer (1988) mentions twentieth century text books that advised “scrubbing the nipples with surgical spirit during pregnancy to ‘harden them’ and massaging with lanolin after birth to ‘soften them’”(p.24). This kind of information was inaccurate. It caused women unnecessary pain, and it led many to abandon their breastfeeding efforts (Palmer, 1988).

Other information delivered by medical professions regarding breastfeeding was less than helpful. By advising women to restrict the amount of time they allowed the child to suck on each breast during a feeding not only affected the milk supply, but often prevented the baby from receiving the nutritious hind milk that comes in after a child receives the thirst quenching foremilk. I was unaware of the difference when I began to breastfeeding my oldest son, and it was only by talking with a La Leche League leader that I learned anything about foremilk and hindmilk. Again, many women resort to introducing artificial food supplements because their child does not appear to be growing sufficiently (Nova Scotia Department of Health, 1998) when lengthened feedings on each breast can help to remedy the problem.

When women had difficulty establishing a healthy breastfeeding relationship with their child or children, they were often encouraged to switch to formula feeding (Van Esterik, 1995; Palmer, 1988). The medical profession's respect for science and technology appears to outweighed women's knowledge about breastfeeding (Sulliman, 1995). In turn, women began to doubt their own body's ability to produce a milk product that was equal to *man-made formula* (Sulliman, 1995). Even the term, *formula*, is one associated with positivist science. Infant feeding *formula* may conjure an image of something that has been tested and proven to be accurate. Infant feeding formula is measurable and its components are scientifically determined. Carter (1995) writes: "Bottlefeeding was readily promoted as more 'scientific' and requiring expert intervention since calculations had to be made, chemicals were required for sterilization and the whole process had a more medicinal character"(p.179). Breastmilk does not fit such descriptions. It is not

known exactly how much milk a baby drinks during a feeding. It is not even known exactly what is in breastmilk. Breastmilk had not been created based on scientific knowledge and this may have contributed to the increasing concerns surrounding the value of breastmilk. Interestingly, many of the infant feeding experts (doctors and scientists) were men. Breastfeeding was a female embodied experience with which men had no actual understanding or frame of reference. Because breastfeeding was not part of the male experience it may have lacked the validation of the male experts.

Wanting to do what was best for their babies, many women chose to bottlefeed. As science continued to attempt to create the 'perfect' infant food, corporations realized they had a lucrative industry on their hands. Hence, corporate intervention in the infant feeding decision escalated.

Corporate interest in the infant feeding market

"Our current economic system does not encourage the promotion of products or systems which do not make an immediate financial profit" (Palmer, 1989). Hart (1992) supports this position when she argues: "Within the context of the world capitalist system, the quiet and invisible work of women and other subsistence producers has been considered unproductive and unprofitable"(p. 178). Breastfeeding is not marketable, artificial infant formula is. Hence, Palmer (1989) reports that in the late 1980's four billion dollars (US) worth of artificial baby milk was sold each year. Individuals from within the medical profession worked hand- in- hand with those in the infant formula industry to

create new and improved infant formula. In turn, doctors and other health professionals received monetary reimbursements when the products they created were sold. While some did so for profit, Palmer (1989) and Blum (1999) recognize that other medical professionals who supported the formula industry were responding to mothers who wanted to bottlefeed or felt they were unable to breastfeed. Because many health care professionals did not have enough valid information regarding breastfeeding and how to successfully assist mothers in their breastfeeding learning experiences, they were often unable to adequately and appropriately support the women (Blum, 1999). Similarly, a number of medical experts were still content with the value of artificial milk (Blum, 1999; Palmer, 1988). Subsequently, many of these doctors and nutritionists forged partnerships with a formula feeding industry. Van Esterik (1989) notes Caller's (1978) description of one such partnership:

One mutually beneficial relationship between pediatricians and industry developed in the 1930's at the Hospital for Sick Kids in Toronto. There, Drs. Tisdall and Drake were involved in the search for the perfect infant food to reduce infant morbidity from infections. They developed two special products, Sunwheat biscuits and Pablum. Rights to produce the biscuits were sold to Loblaw's, a prominent chain of grocery stores in Canada; those for Pablum were awarded to the Mead Johnson company in Chicago, with royalties going to support further research on child health at

the Hospital for Sick Children. (p. 118)

The positive relationship between the medical profession and the formula industry helped that industry to secure their market. Hospitals gave (and still do) free formula samples to new mothers (Blum, 1999). I recall a friend who was so excited that the nurses at the hospital gave her a case of formula and extra pills to help dry up her own milk supply. A 'how-to breastfeed' video, I received when I left the hospital was sponsored by a formula company and a free sample was included with the video. When women choose to bottlefeed the industry does not profit only from the sale of milk, they also reap financial benefits from the sale of products such as bottles, bottle warmers, artificial nipples, and pacifiers which become the necessary components of successful bottlefeeding.

The formula industry was able to gain control in a society that, through the twentieth century came to regard technological and scientific advancements as improvements on the milk that women could produce (Blum, 1999; Dettwyler, 1995; Van Esterik, 1989). And, with the support of the medical profession, the industry's success within the infant feeding market was inevitable. Breastfeeding rates continued to decline.

Changing roles of women in the workforce

While Quandt (1995) claims that the research does not support a return to work as a reason for the decline in breastfeeding among women, she does state that studies have suggested that certain conditions (such as child care and the distance between home and

work) can become factors that influence the choice not to breastfeed. Yet, a Nova Scotian study (Nova Scotia Department of Health, 1998) on infant feeding, conducted in 1994 reported that returning to work or school was named as the number one reason for discontinuing breastfeeding.

Breastfeeding was always a challenge for women who worked in environments that were unwilling to accommodate nursing mothers. It was difficult for women to cultivate breastfeeding relationships with their babies when they were away from home most of the day. Formula feeding was the ideal solution. Many women were comforted by the fact that the medical profession endorsed the product.

Whether by choice or not, many women continue to work outside the home. In the 1980's and 1990's more women than in the past are working outside of the home, including middle class women (Blum, 1999). Even though the Canadian government (as of January 1, 2001) offers approximately 1 year maternity leave at 55% of their salaries, many women cannot afford financially to take that much time off work and all provinces have not agreed to support this extended maternity leave package. As well, this leave is restricted to those women who also meet requirements to qualify for employment insurance. Essentially, they must have been working for a minimum number of hours per week within the last year. If a woman is earning minimum wage or a little more, this is not enough money to support a family. Retsinas (1987) suggests that following a return to work, lower income earners seldom have flexible work schedules, or the privacy necessary to pump breastmilk so that breastfeeding can be continued. Similarly, many companies and businesses look less than favorably upon employees who choose to interrupt their

careers in order to take extended maternity leaves. Clearly, breastfeeding can be a more difficult option for working women.

Breasts as a sexual object

In western cultures, breasts are defined by many as objects of sexual arousal. The eroticism surrounding the breasts suggests that breasts are primarily for male pleasure, not for infant feeding. Obviously such cultural attitudes may influence women's comfort level regarding breastfeeding and ultimately their decision to breastfeed. Dettwyler (1995) writes:

In some cultures, the primary function of the human breast as the physiological link between mother and child has been overshadowed, or even denied, by the force of cultural beliefs assigning a sexual role to female mammary glands. In Western cultures in particular, the image of the female breast as an erotic sexual organ has become pervasive, to the extent that some people would even deny that the breast has any function in child rearing. (p. 169)

Out of this cultural perception arises two significant barriers for women who are deciding whether or not to breastfeed. The first deals with body image. The second with acceptance.

Sulliman (1995) writes our culture is obsessed with the slender yet, full busted

female body. In recent years the trends have been toward even slimmer bodies with very small breasts, to still slimmer emaciated bodies with large, even fake breasts. Regardless of the fashion, the sizes of women's breasts are often viewed as determinants of her beauty and sexuality. It is difficult to be a woman in this society and not be impacted by such a cultural belief. Many women even opt for breast augmentation or breast reduction surgery. Dettwyler (1995) reports her students claim that it has become customary for some wealthy American families in the Southern states to give their daughters breast implants as a high school graduation gift. She writes: "As one student put it: 'Among the wealthier families, the boys get hot cars for graduation, and the girls get big breasts'"(Dettwyler, 1995, p.176). She continues: " In 1992, it was estimated that between 1.6 and 2.0 million U.S. women already had breast implants, and the demand keeps growing at the rate of 150,000 each year"(p.176).

Sulliman (1995) states, "The strong, living, giving body image of the breastfeeding mother may not fit with this youthful, slender, fragile image of the female body" (p.3). After four years of breastfeeding my two children, my breasts look different than they did before the experience. While I was nursing, my breasts were bigger, hung lower, the elasticity disappeared, and they often leaked milk in public- hardly in keeping with erotic images of the North American breast fixation. Sulliman also suggests body weight becomes an issue. While some claim breastfeeding decreases the time it takes to lose weight gained throughout pregnancy (La Leche League International, 1991), that does not reflect everyone's experience. In my case, the last few pounds stayed on until I stopped breastfeeding and my breast never looked the same as they had before I breastfed.

Instead of recognizing the beauty in breastfeeding women, North American society tends to reserve the beauty label for those who fit the kind of narrow image discussed above (Wolf, 1992).

In our culture, sex is often perceived as something that takes place in private. Because breasts are labeled sexual objects, women are usually expected to know what is appropriate disclosure and what is not. While partial exposure is accepted in certain contexts (for example a low cut evening gown at a formal evening function is acceptable, a bikini top at the office is not) exposing the entire breasts anywhere but behind closed doors is often considered inappropriate and even pornographic (Dettwyler, 1995). Carter (1995) suggests this attitude may influence how comfortable women are breastfeeding in front of others and how comfortable others feel about women breastfeeding publicly.

Breastfeeding women in North America tend to feed their children in private and if they must do it in public they often feel they must be discreet. Women have been asked to leave restaurants and shopping malls, even threatened with arrest for breastfeeding in public (Blum, 1999; Dettwyler, 1995). The chance of exposing the breast, and primarily the nipple, is too stressful for many women and they choose only to breastfeed in private—in restrooms, in changing rooms, or in their home. I recall running up a street with my crying baby so I could breastfeed him at home instead of ‘imposing’ on a store owner to find me a place in her shop. Many women must even hide in their own homes when family members do not wish to see them breastfeed.

The perception that breastfeeding is ‘private’ makes it difficult for some women to return to work and maintain a breastfeeding relationship with their children. Dettwyler

(1995) draws the conclusion that because society defines breastfeeding as a 'private' act, many work environments that strive to keep the private out of the public workplace will not encourage mothers to breastfeed their children at work or even to express milk at work. Such attitudes can be said to amount to social isolation for breastfeeding women. While it may be argued the sexual stimulation and sexual pleasure derived from the breasts for both men and women is natural in western culture, the sexual perception may be problematic for women who are breastfeeding or are considering breastfeeding. The dualistic purposes of breasts may create a sense of ambivalence and discomfort for these women. This can become another roadblock women face when trying to maintain a successful breastfeeding experience.

In this section, I identified problems that women face when they attempt to breastfeed their children. These problems, in part, can help to explain the dramatic decrease in breastfeeding trends during the twentieth century. They continue to impede the learning process of women attempting to learn how to breastfeed successfully in today's society. In the next section, I further explain the impact of these problems for mothers engaged in breastfeeding adult learning experiences.

Impact of the Problems on Women's Knowledge of How to Breastfeed: The Crux of the Problem

While the female body's production of milk is natural, breastfeeding itself is a learned activity. With fewer women breastfeeding in Western culture three possible breastfeeding learning methods are threatened: passing knowledge from woman to woman, learning by observing other women, and listening to others describe their breastfeeding experiences.

An Invisible Knowledge

In cultures where breastfeeding is still dominant, there exists among women a knowledge of breastfeeding that is innate. Donald Schon (1983), refers to this intrinsic knowing as *tacit* knowledge. When attempting to explain the knowledge it becomes difficult. Palmer (1988) refers to the research of Conton (1985) who spoke with women in Papua, New Guinea about their knowledge of breastfeeding. The women of Papua learned by observing each other, as well as through practice. They were unable to verbalize their knowledge because it had not been necessary - mothers simply knew how to breastfeed. Palmer went on to discuss a technique she learned while training to become a breastfeeding practitioner. Eager to teach the technique to breastfeeding mothers in Africa, she found they already used the technique innately. With the decline of the number of women who breastfeed in North American such innate knowledge has not had the same opportunity to be fostered and there has been fewer people to pass on the technique.

Consequently, it may be said, the tacit knowledge becomes buried or perhaps invisible.

Learning from observing

As Conton (1985) learned in New Guinea, women learn how to breastfeed by watching others. In fact, in many countries, breastfeeding is accepted as a cultural norm and not restricted to private places. Dettwyler (1995) provides Mali as an example. Mali women found it bizarre that breasts served a sexual purpose in American culture. She writes:

In Mali, where breasts have retained their primary biological function, women at home may wear no clothing above the waist, and in public contexts are able to breastfeed freely without anyone even noticing. In Mali, women breastfeed in the markets, on long treks to gather firewood, on public transportation, and even at work in offices. In Mali, wherever one sees women, one sees breastfeeding women.
(p. 172)

In such cultures, from a young age, girls are learning about breastfeeding as they watch their mothers, aunts, and even strangers. When the time comes to breastfeed their own children, they can continue to look to other women, to see how they position the baby, how they position themselves, how often they breastfeed, how much time they breastfeed on each breasts, and all the other helpful techniques that enable women to have

a successful breastfeeding relationship with their children. In our culture, that learning tool is less available to most women because fewer women breastfeed and even fewer do so publicly.

Insufficient Language to Use to Ask the Questions and Tell the Stories

Breastfeeding is a women's issue and, for most of history, it received very little attention. It was only when the male dominated medical profession asserted its control over breastfeeding that it was discussed and talked about in clinical *man* - made terms that often make it obscure to women. This is not unusual. Many phenomena that are particular to a marginalized group remain unnamed (Lewis, 1990; Kramarae, 1981; Romaine, 1999; Spender, 1990;). Spender writes (1990) writes "Trying to articulate the meaning of names which do not exist is a difficult task and yet one which feminists are constantly engaged in" (p.182-183). Women, who have not developed their intrinsic knowledge of breastfeeding, do not have other women to watch and from which to learn. Further, a language of breastfeeding that is reflective of women's experiences is not always recognized, making it difficult for women to describe their breastfeeding experiences. Many women struggle to try to describe breastfeeding because the words do not already exist to define all aspects of the experience. Other components unique to breastfeeding are beyond words as well. For example, it is difficult to articulate what it feels like when your milk *lets down*. In fact, *let- down* is a poor term to describe the sensation. It is hard to explain how a let- down can be triggered by looking at your child, hearing a baby (any baby) cry, seeing a picture of your child or simply thinking about your child. Without the

language to describe their breastfeeding experiences women often question whether or not what they feel and what they experience is right or normal. Spender confirms this: “ When one wants to describe an object or an event for which there is no name, doubt can arise as to the validity of that object or event” (1990, p.188).

Many of the words that are used to describe breastfeeding are problematic for women. Our society does not always seem comfortable with the word *breast*. I recall a conversation with a new mother. She whispered the word breast whenever she said it, so as to not offend her husband and father who were close by. She would not even attempt to say *nipple*! When breasts are talked about in public, they are usually referred to in derogatory terms such as *tits*, *boobs*, or *knockers*, anything except *breasts*. Blum (1999) writes: “When I told women friends that I was pursuing this topic (breastfeeding) they said it sounded fascinating but terrifying. But a colleague and a warm-hearted mentor said it all: ‘It sounds okay. Just don’t use the word breast’” (p.18). It can be quite a challenge for women to share an understanding of breastfeeding and to ask questions without using the word *breast*.

Sometimes the problem lies in the language used to teach women how to breastfeed. The ‘official’ terminology used to explain the breastfeeding process can be unclear, especially to first time mothers who have spent little time talking about their breasts in the past. For example, when babies breastfeed, they should ‘latch on’ to the areola, not the nipple. It is the pressure applied to the areola that pushes the milk out through the nipple. A baby that sucks on the nipple will not get any milk although it won’t take long for the mother to be in a great deal of pain caused by the improper pressure on

her nipples. Countless women suffer from cracked and infected nipples because they do not know how to help the baby 'latch on' correctly. Books and health professionals tell women to ensure the baby latches on to the *areola* not the nipple. However, I have spoken to women who were not aware that the brown skin surrounding the nipple is the areola, and they were embarrassed to admit they were unfamiliar with the term. Consequently, one friend stopped nursing because she had such great difficulty helping her baby latch on.

Even the words women use to describe their breastfeeding experience sometimes become taboo because they also possess sexual connotations. If a woman claims breastfeeding is physically pleasurable, as many do, it is sometimes assumed she means sexually. Thus she may be accused of nursing merely for her own gratification (Dettwyler, 1995). Words like *sucking*, *engorged*, and *leaking* are part of the language of breastfeeding yet, once again, they are often interpreted as sexual terms and some respondents snicker when they are used. While meaning is in people not in words, it is often argued that the people with power determine the language and in most cases those people are men (Carter, 1995; Kramarae, 1981; Spender, 1990; Thorne et.al., 1983). Consequently, women tend to work harder to define a language for a female experience such as breastfeeding. All of these factors make it more difficult for women to learn about breastfeeding or to teach others.

The decline of breastfeeding throughout the twentieth century has reversed. Few people dispute the superior quality of breastmilk. Many women want to breastfeed their children and they do try. However, it can be a struggle. Mac Sween (1999) describes one women's experience. Raquel wanted to nurse, yet she found it necessary to stop after two

weeks. “Raquel indicated that breastfeeding is a learned skill, that her husband and family were very supportive, but unless you know how to do it, support is not enough” (Mac Sween, 1999, p.26).

Learning Despite the Odds

The more obvious learning tools described above are not readily available to women and so they try to develop their own learning methods some of which work, and some of which do not. The obstacles faced by women who want to learn how to breastfeed and the impact of those problems on their breastfeeding adult learning experiences can be great. However, through the process women begin to develop their own knowledge and language as they create their own adult learning experience of breastfeeding. If uncovered, these adult learning experiences can begin to serve as the foundation for an adult education model of breastfeeding learning experiences. Hence, I argue an in-depth analysis of the breastfeeding adult learning experience has merit and can be beneficial.

Approaching the Issue Through Adult Education

Joyappa & Martin (1996) write: “One of the goals of adult education should be the democratization of society by creating contexts in which power is negotiable”(p.2). However, there are adult educators who contend this goal is becoming more difficult to reach as adult education continues to succumb to the professionalization of the discipline

and the conservatism of the systems world. Miles (1998) believes “In these times of increasing commodification, competition and globalization, the space for Adult Education to serve liberatory ends is under threat (p. 257). To me this suggests, it is increasingly important for adult education researchers to support the interests of those in society whose valuable contributions have been historically underestimated.

Women have long done the unrecognized, traditionally unpaid, and now also poorly paid, nurturing and co-operative work of individual and community reproduction. Women’s concerns and values across many diverse cultures and communities generally have been built around this life-sustaining work and responsibility. Women’s struggle for autonomy and equality is necessarily a struggle for the revaluation of their work and the life it sustains, and the generalization of responsibility and effort from women alone to the whole community. (Miles, 1998, p.254-255)

Adult education may be strengthened in its attempt to meet its liberatory goal by embracing research that looks more closely at feminist perspectives. A study that explores women’s breastfeeding adult learning experiences can enrich the feminist perspective within adult education. Hart (1992) contends the only kind of work that is truly productive “is a kind of work that is bound to a life -giving and life affirming productive process” (p. 201). Few would dispute the life-giving and life-affirming nature of breastfeeding a

child. By uncovering mother's breastfeeding learning experiences, adult education can continue to work towards the life affirming education advocated by Hart and other feminist adult educators. While adult education researchers do explore the work of women and mothers and their learning (Hart, 1992; Hart, 1997; Gouthro, 1999) there are few who specifically focus on the breastfeeding experience. Thus, an in-depth look at the adult learning adopted by women who want to engage in a successful breastfeeding experience is worthy of inquiry. Such a study can be beneficial for other women who are seeking a successful breastfeeding experience - by providing adult learning techniques and strategies, and by providing them the opportunity to hear other women's stories. Adult educators who design and deliver breastfeeding education programs can use this research to strengthen their programs to better meet the needs of women. Finally, this research will contribute to feminist adult education literature considering that the breastfeeding experience has not been a common research area in feminist adult education theory (Blum, 1999; Carter, 1995; Van Esterik, 1989). Ultimately, through increased communication and education the acceptance of breastfeeding may increase thus providing those who choose to breastfeed a more confirming learning environment. These are important opportunities for feminist adult educators and researchers. Mies (1996) suggests that a feminist researcher embarks on a project with the commitment that with the new knowledge that is created, positive social change will be implemented. An in-depth look at the breastfeeding adult learning experiences of mothers gives women a place to create a language, and to recreate a knowledge based on their own experiences that is of women, for women.

Women can empower themselves and empower each other by telling their stories in their own words.

Organization of Study

With the questions established, chapter two provides a review of other pertinent literature in order to explore perspectives central to this study. I present biomedical information to develop a clear understanding of the breastfeeding process and the nutritional value of breastfeeding. Next, I look at arguments that support a life-affirming approach to adult education. I review women and language studies focusing on the work of Kramarae, Romaine, Crawford, Spender and others. Finally, I consider breastfeeding as a feminist issue, citing the work of Carter, Blum, Van Esterik, Mies and Miles.

Chapter three focuses on research methodology. First focus groups, the means that was used to gather data for this study, are discussed. Referring to the work of Krueger, Lederman, Morgan and other researchers, a description of focus groups is given as well as reasons why this form of data collection was deemed the most appropriate for this project. With a rationale for the methodology determined, I give information regarding the specifics for this research answering questions such as; how were the individual focus groups designed, who were the participants, and how were they selected? I then explain the method of data analysis that was employed for this study.

In chapter four the data analysis is presented. Major categories and themes that emerged from the focus groups discussions are provided and in chapter five the themes are

looked at in relation to the literature presented in chapters one and two. An emerging model of the breastfeeding adult learning experience is presented, recommendations based on the study are offered, and suggestions for further study are made.

CHAPTER TWO

In chapter one, problems faced by women who want to engage in successful breastfeeding experiences were identified. The implication of those obstacles on the availability of learning methods was also suggested. Yet, the increase in the numbers of women who choose to breastfeed implies that they are developing their own learning strategies. I indicated the benefits of listening to women share their breastfeeding adult learning stories. This chapter begins to explore current literature and research that can inform this study.

I begin by providing a biomedical explanation of breastfeeding. Because this project seeks to examine an aspect of the adult learning experiences of women, I look at a feminist perspective of adult education offered by Mechtild Hart. In chapter one, I suggested that women who are learning to breastfeed do so in spite of deficiencies apparent in a recognized language of breastfeeding. To help substantiate that argument, I offer a review of communication and language studies that demonstrate the problem. As a feminist exploring an issue of relevance to many women I was eager to review the feminist literature to learn the kind of work that has been done in reference to breastfeeding. Here I present the results of that search.

The Biomedical Perspective

Experts declare breastmilk is the superior food source for infants (Gengler & Mulvey, 1999; Gartner & Black, 1997; Pipes, 1997; Wright & Naylor, 1997). While modern medicine is still unable to identify all the components of human milk, it certainly has determined enough to overwhelmingly agree that breast is best. In this section, I begin with a brief explanation of the female body's production of breastmilk followed by an examination of qualities that demonstrate why it is incomparable to other infant food choices.

The Human Lactation Process

The female body's production of milk is a natural process. Before the birth of a child and for a short time after, the mother's body produces a milk substance known as *colostrum*. High in antibodies and other nutrients, the colostrum builds a newborn's immune system and helps the baby rid its body of meconium (the tar-like substance that is in the baby's gastrointestinal tract). It contains more protein but less fat than the milk to follow (Pipes, 1997). Within seven to ten days the more mature milk 'comes in'. Human milk is produced on a supply and demand basis. It is the baby's sucking motion that triggers the milk production. La Leche League International (1991) suggests a useful analogy to help one better understand how the milk is produced and stored in the breast.

A picture of the inner structure of the breast could remind

one of branches on a tree. The top branches are deep in the breast, coming together at the trunk, leading to the nipple. Small buds represent the milk-producing cells, known as the alveoli, which select the nutrients and protective agents needed to make the milk. Droplets of milk pass through the small ducts and are stored in reservoirs just behind the nipple. (p. 358)

Between feedings, this reservoir fills up and often gives a sensation of the breast being full. However, it is 'filled' with a small portion of what the baby receives. This first portion of milk is called the *foremilk*. It quenches babies' thirst and pacifies their hunger. Then the *hindmilk* comes in. As the baby sucks, two hormones, prolactin and oxytocin are released. "Although the mechanisms are not well understood, prolactin promotes the production of milk and oxytocin contracts the cells lining the alveoli in the breast, squeezing the milk into the ducts and making it available to the infant"(Dettwyler, 1995, p. 8). The hindmilk contains the nutrients a baby needs to grow and develop. A reflex known as a 'let-down' usually signals the milk is filling the breasts. However, while some women experience a strong tingling feeling or pressured sensation others may not feel anything. This is not an indication that there is no milk in the breast. Unlike a bottle, a breast is never empty. There are times when the breast may feel 'full' or 'empty', however, because breastmilk is produced by supply and demand, as long as the baby is sucking properly, milk will be produced.

Nutritional Value of Breastmilk

The exact composition of breastmilk is unknown. Breastmilk composition varies depending on the age of the baby, the time of the day the baby feeds, whether or not it is colostrum, foremilk or hindmilk, and numerous other factors. Breastmilk is unique to each mother. It consists of more than two hundred components (Dettwyler & Fishman, 1992; Pipes, 1997) including the necessary amounts of vitamins, minerals and antibodies. While cows' milk (the milk base used in most formulas) and human milk contain similar nutrients, the make up differs to suit the different species. For example, the protein content in cows' milk is much higher than in human milk, and can be more difficult for a baby to digest.

Some mothers fear the composition of their breastmilk may not meet all their baby's needs. For instance, it is periodically suggested that breastmilk is deficient in Vitamin D (Pipes, 1997). While some doctors still recommend vitamin D supplements, others suggest very minimal exposure to natural light (for example, a few minutes by a window) is sufficient. Another concern is that a mother who is under-nourished cannot adequately produce a quality breastmilk. Dettwyler and Fishman (1992) assure that studies have shown mothers who have far less than ideal diets still produce high quality breastmilk. Referring to Jelliffe, Jelliffe, and Kersey (1989), Dettwyler and Fishman (1992) write: "It has been argued that humankind's ability to survive droughts and ice ages, and to take advantage of different ecosystems, is related to our ability to consume

opportunistically yet produce breastmilk of relatively unvarying quantity and quality” (p.183). Obviously, it is in the best interest of the mother and the baby for the woman to maintain a healthy diet. However, if something prevents her from eating properly for a short period of time (for example, minor illness) Jelliffe, Jelliffe, and Kersey, as well Dettwyler, assure she should not fear her milk is deficient.

The antibodies produced by breastmilk act as powerful illness fighting agents. Many of the antibodies found in human milk only exist in minute quantities, if at all, in cows’ milk (Pipes, 1997). Breastfed babies do have a greater ability to fight illness because of these antibodies. The Canadian Institute of Child Health (1993) reports “Infants who are breastfed have increased immunological protection against respiratory, gastrointestinal, and other infections” (p.5). As well, they contend, “Breastfeeding is an important, preventive measure for infants with a strong family history of allergies” (p. 5). Gartner and Black (1997) report “Epidemiologic research shows that human milk and breastfeeding of infants provide advantages with regard to general health, growth, and development, while significantly decreasing risk for a large number of acute and chronic diseases” (p.1036). Pipes (1997) adds:

There is no question that breast-feeding reduces infant mortality and morbidity in developing countries. The presence of the antiinfective and antiviral factors in human milk, in addition to the potential for unsanitary bottle-feeding, makes breastfeeding important for 1 to 2 years. It has also become evident that the incidences of illness is less

in breast-fed than formula-fed infants in industrial societies.

(p.102)

While the female bodies production of milk is natural, and its nutritional value apparent, breastfeeding is a learned activity that occurs within a social and historical context, part of which has been discussed in chapter one. Women who choose to breastfeed (and many make a well- informed decision not to) learn to do so with many other factors at play.

An Adult Education Perspective

Adult education offers theories and analyses that enrich our understanding of human knowledge and how it is obtained. It is useful to contextualize breastfeeding within an adult education setting. Here, I discuss an adult education model presented by Mechtild Hart.

Life Affirming Approach to Adult Education

Hart (1992) challenges adult educators to embrace an education model that is rooted in subsistent production. Hart refers to subsistence labour as work that is life sustaining.

It therefore includes such diverse activities as pregnancy, childbirth and nursing, and work associated with making

food, clothes, or shelter for immediate private use. Apart from work oriented toward physical well-being, subsistence work also includes work oriented towards psychological and sexual well-being. (Hart, 1992, p. 95)

Society tends to hold little value for subsistence work (Hart, 1992). Miles (1998) describes a feminist social analysis of the economy in which she bases her explanation on a model designed by Hilikka Pietila. The model breaks the economy into three sectors. The largest sector is made up of the *free* economy. This consists of work traditionally done by women, such as housework and child care activities. The free economy consists of the subsistence labor in society. The *protected* economy is the next largest sector. It consists of work that is done for the good of society, such as education and health care. The smallest sector is the *fettered* economy and this is production for international trade. As Miles indicates, the fettered economy has extensive control over the entire economy. The protected economy is viewed as a cost to society instead of a valuable investment. The work done in the protected economy tends to serve the fettered economy. Finally, the free-economy might also be called the invisible economy. Not only is it often demeaned, it's true value is seldom appropriately acknowledged. Yet in reality many claim it is the backbone of the economy and the society (Hart 1992; Miles, 1998). It is also the work that is traditionally done by women and others on the margins.

Hart (1992) believes traditional attitudes of work and education are oppressive. She argues such attitudes show little interest in sustaining human life and the

environment. Commodity producing work is valued while life producing labour is ignored. Hart (1993) doubts one can find a model for educative labour within this profit producing work.

... I question whether we can find at all a model for good or educative work in an environment oriented solely towards the maximization of profit and driven by the need to employ the latest technology no matter what the environmental or social cost or risk involved; where questions regarding the usefulness of what is being produced are never asked. (p. 34)

Instead she proposes that adult education look to those who create subsistence production for a model of educative work. Motherwork can provide the necessary model.

I believe that the raising of children, if blessed by social and individual circumstances, which acknowledge the importance of nourishing new life, provides numerous parallels for an educational process which is likewise - life-oriented. If motherhood is conceptualized as a labour process, a number of dialectical relationships emerge which contradict the static, oppositional, dichotomies structured by industrial-patriarchal production. (p. 183)

The elimination of the dualistic nature of traditional society is important for feminists. Miles (1998) supports the breakdown of the dualism. She writes:

Patriarchal Western dualism historically construct the world as a series of unequal opposites such as reason/emotion, mind/body, spirit/flesh, mental/manual, society/nature, public/private, production/reproduction, individual/community. The first set of each familiar pair is associated with maleness and humanity, and the second with its undermining. Feminists can not simply claim humanity by abandoning their association with the latter set of each pair without accepting their devaluation. (p.256)

The daily tasks involved with mothering do not support the usual dualism evident in the traditional male models of work, education, and society. A mother's emotion and reason, as well as her mind and body, work together to carry out the labour of mothering, hence eliminating the dichotomy that is often used by the dominant to assert power over others.

Hart's concept of motherwork can assist adult educators whose goals are to support the creation of education that is inclusive and affirming- education that sustains life. Hart believes motherwork is the ideal example of productive life-affirming work and if education is to be viewed as a productive process in and of itself, motherwork can be the model. This study aims to develop a model of mother's breastfeeding adult learning

experience. Hart's approach to work and adult education can help to inform an analysis of women's adult learning experiences of breastfeeding by providing a body of literature that recognizes life-affirming motherwork as an educative process.

A Communication Perspective

Throughout this thesis, I have emphasized the importance of language in women's ability to learn and articulate their breastfeeding experience. Here, I review academic literature pertaining to women and language.

Kramarae (1981) suggests language studies are commonly divided into two groups; 1) studies that look at language structure (the creation of language and the naming and value assigned to meanings of symbols) and, 2) language use (people's use of speech within particular contexts). She believes however, that language structure and language use are not two completely separate entities and point out that researchers do look at how they impact each other (Kramarae, 1981, p. xviii). In my thesis, I am interested in language structure and how the structure of language has impacted women's breastfeeding adult learning experiences. Hence, I focus on language structure research. Kramarae provides a theoretical framework known as the *muted group theory* that helps to inform gender and language structure studies. Muted group theory supporters contend that language reflects a world perception.

Muted Group Theory

Kramarae offers the following explanation of the muted group theory:

The language of a particular culture does not serve all its speakers equally, for not all speakers contribute in an equal fashion to its formulation. Women (and members of other subordinate groups) are not as free or as able as men to say what they wish, when and where they wish, because the words and norms for their use has been formulated by the dominant group, men. So women can not as easily or directly articulate their experiences as men can. Women's perceptions differ from those of men because women's subordination means they experience life differently.

However, the words and norms for speaking are not generated from or fitted to women's experiences. Women are thus 'muted'. Their talk is often not considered of much value by men-who are or appear to be deaf, and blind to much of women's experiences. Words constantly ignored may eventually come to be unspoken and perhaps even unthought. (1981, p.1)

Crawford (1995) speaks to the muted group theory.

Muted group theory provides a framework for understanding why the implicit norm for speech style is the (perceived) style of white upper class men, and why even feminist-influenced theorists such as Robin Lakoff and the feminist therapists of the assertiveness training movement sometimes find themselves reading “difference” as “female deficiency”.(pp.136-137)

Others who study within the field of language and gender make similar claims. A number of these feminist researchers (Code, 1991; Crawford, 1995; Romaine, 1999) recognize the significance of Dale Spender’s contribution to gender and language research. Spender (1990) states: “Historically, women have been excluded from the production of cultural forms, and language, is after all, a cultural form- and a most important one. In fairly crude terms, this means that the language has been made by men and they have used it for their own purposes” (p.52). She goes on to write:

Both sexes have the capacity to generate meanings but women have not been in the position to have their meaning taken up and incorporated in those of society. They have not been in the public arena, they have not been the “culture”- makers with the result that any meaning which they may wish to encode, but which are different or at odds with those that have been generated by men, have been

tenuous and transitory: have been cut off from the mainstream of meanings and therefore have frequently been lost. (Spender, 1990, p. 52)

An example that demonstrates the muted group theory is the naming of sexual harassment. In one study, Wood (1992) presents the lived experiences of women who have been sexually harassed as a bases for theorizing sexual harassment. She argues that while sexual harassment has always existed it is only in the past twenty years that it has been named. "Sexual harassments' low salience to those empowered to confer name and legitimacy left it unrepresented in the language they generated" (p.352). Kramarae (1981) cites Ardener (1975) who argued that the group with the greatest social hierarchical standing has a great deal of control over the dominant communication systems in societies (p.1). Further, the muted group theory suggests that women compensate by adapting their own language through the communication mode designed by men. Consequently, when women attempt to name an experience such as sexual harassment they often discover the dominant mode of communication does not consist of language that describes the experience because it is not within the perceptions of those who have created the language (Lewis, 1990; Romaine, 1999). Code (1991) writes:

Problems of interpretation, understanding, and evaluation attend all speech acts and linguistic exchanges: most acts of communication are- more or less successfully- acts of translation. Feminists have contended that women in

patriarchal societies have to perform these acts of translation twice over: to translate both from idiolect to idiolect and from an androcentered language into a language that can achieve some connection with their experiences.

(p.58)

Kramarae offers another concrete example of this phenomenon based on stories women shared in workshops she conducted. The women shared experiences for which they had no labels. She gives one example. A woman and her husband both work outside the home, however meal preparation was usually left to the wife. When she would try to discuss it with him and encourage him to share the responsibility he used flattery to tell her she was much better at meal preparation than he. She felt he was using the flattery as a verbal strategy to keep her in her female place. However, she had no word to describe it. She had to tell the whole story each time she tried to address the problem. She wanted to be able to say "You are doing something called_____". But the word did not exist.

(p. 7-8). Lewis (1991) describes examples of experiences women have in the classroom and the difficulty they often faced when they attempt to articulate those experiences. Spender (1978) compiled a list of women's experiences that need names.

Torres (1992) writes that feminist continue to expose the relationship between language and power and gender citing work by Rich (1980), McKinnon (1987), and Wolfe (1989). Other studies including Henley and Kramarae (1990) and compilations of studies in Thorne, Kramarae, and Henley (1983), and Kramarae and Spender (1992) also point to

the power dimension of language and gender. Crawford (1995) suggests taking a social constructionist approach to studies of language and gender. Cameron (1995) addresses concerns that develop out of the 'scholarly' versus 'popular' writing on language and gender. Code (1995) argues it is necessary to determine whose voice is creating theories and knowledge and whose voices are prevented from doing so. She writes:

In feminist epistemological projects, the issue is less of doing philosophy "in a different voice"- as many feminists propose- than of discerning whose voices have been audible, and whose muffled, in the articulation of prevailing theories, of showing whose experiences count, and how epistemic authority is established and withheld. These issues are more basic than that of developing *a* different voice: they require finding the voices of the epistemology makers, the processes of theory- and knowledge- production relocating epistemic activity from the no- one's land that it has seemed to occupy, into human speaking and listening spaces where dominant conceptions of experience, knowledge, and subjectivity have systematically suppressed other contenders. (p.154-155)

Romaine (1999) writes:

If the world is constructed and given meaning through

language and language is “man-made”, then our history, philosophy, government, laws, and religion are products of a male way of perceiving and organizing the world. Because this knowledge has been transmitted for centuries, it appears “natural”, “objective”, a “master” discourse beyond question. Language thus holds the key to challenging and changing male hegemony. (p.3)

Torres contends that studies continue to emerge despite the fact that “..academics continue to dismiss feminist claims about male control of the language, maintaining that language is neutral and arbitrary...” (1992, p.285). Code claims :

At a time when theorists are familiar with the influence of Wittgenstein’s philosophy and with Foucault and postmodernism, it would be unacceptable to characterize language as a neutral and transparent medium through which experiences pass untouched on their way to becoming knowledge. (p. 58)

Feminists writing about language and gender do not suggest a complacent acceptance of the power issues surrounding language structures. Kramarae, Treichler, and Russo (1985) authored, A Feminist Dictionary. Martyna (1983) makes a case for nonsexist language. Daly (1978) urges women to reclaim the power of naming by

inventing new words and creating new meaning to existing words. Torres (1992) says the work is paying off and some sectors of societies (for examples newspapers, journals and government agencies) are developing nonsexist writing policies. Women who choose to breastfeed their children and engage in the adult learning experience may not have a language readily available to them but they are finding ways to communicate their experiences. Carter (1995) found women were surprised to be asked how they felt about their bodies in relation to breastfeeding. She suggests: "Perhaps it had not occurred to them to think about their own feelings, or perhaps they had no words in which to express themselves" (p.140). Once given the opportunity, Carter found the women in her study had a great deal to say. This study aims to create a similar opportunity for breastfeeding and former breastfeeding mothers to share and create a language to express their breastfeeding experiences.

A Feminist Perspective

Is breastfeeding a feminist issue? While it is obvious to some (Van Esterik, 1995b) that breastfeeding is indeed a feminist matter, many disregard or perhaps intentionally avoid the breastfeeding perspective. In this section, I look at the absence of a breastfeeding analysis within feminist theory, explore why this is the case, and suggest why feminist analyses are incomplete without an acceptance of breastfeeding as a component of feminist discourse. I draw upon the work of Penny Van Esterik, Pam Carter, Maria Mies,

and Angela Miles.

Breastfeeding as a Feminist Issue

Van Esterik (1995b) writes; “Although breastfeeding is recognized as a women’s issue, it is seldom framed as a feminist issue. In fact, it is most often ignored by feminists” (p.76). Gordon (1989) makes a similar comment “...human lactation has not been an area of major academic concern in recent feminist analysis” (p.10). Van Esterik (1995b) ponders the reasoning behind writers who write about women’s bodies and reproduction yet fail to broach the subject of breastfeeding. Still others, openly suggest the relationship between feminism and breastfeeding has not been heavily explored (Blum, 1999; Carter, 1995). Further, when breasts are discussed within a feminist context the research usually refers to breast surgery and the sexual objectifying of breasts without significant mention of breastfeeding (Wolf, 1992).

Even ecofeminists who celebrate the female body do not embrace breastfeeding concerns. Van Esterik (1995b) believes it makes perfect sense for them to engage in the breast-bottle debate. Bottlefeeding has ecological ramifications that harm the environment. Further, the concern over contaminated breastmilk needs to be explored from a feminist perspective (Van Esterik, 1995b). Van Esterik argues ecofeminists should battle the industries within the market system that are responsible for the contaminants found in breastmilk and advocate the rights of breastfeeding mothers to produce milk free of contaminants. Instead, the response to the problem appears to be the suggestion that women switch to safer infant formulas. Ecofeminists, for the most part, remain silent on

these issues.

It may be argued that even within feminism, the discourse where women's concerns are theorized, breastfeeding women are to a degree, without voice.

Breastfeeding Receives Little Attention

Blum (1999) writes:

Since the resurgence of the women's movement in the late 1960's, it seems that feminists have been obsessed with motherhood. Readers may wonder, as I often worried, whether there could be anything left to add. Novelists, memoirists, literary critics, and scholars across many disciplines have explored how motherhood, an activity and a relationship so immensely rewarding and enabling, could at the same time be so oppressive and disabling. (p.6)

While motherhood has been researched, studied and explored, Blum contends breastfeeding has not received similar attention by feminists. She contends it may be due to the optional element of breastfeeding. Van Esterik believes the limited role of breastfeeding in feminist discourse is a symptom of a greater issue - motherhood's place in feminist theory. There are feminists who view motherhood as the source of women's oppression (Van Esterik, 1995b). Mies (1996) mentions that post modern feminist ideology expresses a contempt for motherhood. These feminists sought to free women of

traditional mothering roles in order that they may maintain control over their own body and they may function as equal, independent members of society. The advocacy of breastfeeding may be seen as a threat to this struggle.

In the view of Gordon (1989), breastfeeding may further counter this effort by supporting a “biological determinism about women’s roles” (p. 12). She fears that the breastfeeding supports, put in place by society, (for example, extended maternity leaves) may force women to take on a more traditional role in parenting. She warns that while women may advocate breastfeeding, they should be aware of the impact on other women and the role medical professionals and other experts are taking in this infant-feeding decision making process.

Mies (1989) believes that there are feminists who argue true emancipation for women can only be achieved through self-determination. Self-determination can only occur when women have control over their bodies. In the process, she laments the female body and its reproductive capacities become the enemy. Mies contend, however: “...the problem does not lie with our anatomy but rather with the destruction of living relations and patriarchal dominance” (p.55).

Does motherhood actually stifle the feminist movement? Mies (1996) does not accept this stance.

I have never understood why feminists, particularly in the centres of ongoing modern, patriarchal capitalism, in North America and in Europe could fall for such an ideology, even propagate it in the name of women’s emancipation.

Emancipation from our origins, our real mothers, and from
 “mother earth”. (p. 14)

Perhaps when feminisms are presented from what Miles (1996) refers to as an equality-framed or assimilationist feminist framework of motherhood, it is problematic. Equality-frame feminisms seek equality for women within existing systems without recognizing the flaws that make such systems misogynists. Motherhood and mother work is not valued within the existing systems (Hart, 1992). Consequently, an equality-frame feminism may view motherhood as oppressive.

Breastfeeding is a Feminist Issue

Van Esterik (1995b) offers compelling arguments as to why breastfeeding is a feminist issue including “Breastfeeding requires structural changes in society to improve the position and condition of women” (p.77). Feminists who believe motherhood (and breastfeeding), oppress women and force them into preestablished roles, seem to accept the patriarchal meaning of *mother*. Such a view perpetuates a negative myth that raises unrealistic expectations of mothers, while concurrently devaluing her productive and reproductive labour.

On the other hand, if motherhood is analysed from an integrative feminist perspective the outcome changes. Miles (1996) refers to integrative feminism as feminism that recognizes and celebrated the uniqueness and differences among women.

The alternative value core of integrative feminisms in all

their variety is the holistic, egalitarian, life-centered rejection of dominant, androcentric, dualistic, hierarchical, profit-centered ideology and social structures. These feminisms refuse the opposition that patriarchal relations presume and structure between the personal and the political, public and private, means and ends, reason and emotion, psychological and social, knower and known, production and reproduction, individual and community, society and nature. (p. xi-xii)

From an integrative feminist perspective the existing systems are not accepted as the norm, hence the traditional meaning of mother does not hold. Integrative feminists believe patriarchal structures need to be replaced with more inclusive frameworks that value the subsistence work of women and recognizes the supports they need. With this definition, each mother can create her own meaning for mother. Mothers deserve all the pertinent information needed to make an informed infant feeding choice. If she chooses to breastfeed, she deserves all of the societal supports and acceptances necessary to embark on a successful experience. Finally, she deserves the right to define her own breastfeeding experiences in her own words and to determine her success on her own, free of precontrived definitions.

Unfortunately, when feminists fail to provide a critical analysis of the breastfeeding experience, women are denied an opportunity to reclaim breastfeeding as their own and to

create a discourse that can be named and critiqued from a feminist perspective. The personal *is* the political and a women's right to make a truly informed decision regarding infant feeding and her right to carry out her decision within a society that respects and appreciates her choice is a struggle feminist theorist can address. Optimistically, feminists like Carter (1995) and Blum (1999) are investigating breastfeeding from a feminist perspective.

Conclusion

In this chapter I reviewed the literature that is used to create a theoretical structure upon which I base this study of women's breastfeeding learning experiences. I began with an biomedical overview of breastfeeding. Having argued that breastfeeding is a learned activity, I presented adult education theory that can help inform an analysis of woman's adult learning experiences with regards to breastfeeding. Two key components of the adult education theories discussed were communication and feminism. A review of current literature and perspectives in each research area was provided.

With a theoretical foundation established, chapter three consists of an explanation of the primary research project that was conducted for this study. The method of data collection is outlined, along with a rationale as to why it was an appropriate method for this study. The method of data analysis is also presented.

CHAPTER THREE

When selecting a method of data collection and analysis, researchers must consider the questions they want answered. The purpose of this study is to explore the strategies used by women who were learning how to breastfeed. As a feminist, I instinctually gravitate toward feminist research methods and analysis. I am encouraged by the idea that researchers have a right and a responsibility to situate themselves within the research (Mies, 1996) and to recognize their own subjectivity and their experiences. I also believe that personal narrative is a rich source of data. And I believe, as do many feminist researchers (Mies, 1996; Langellier & Hall, 1989), that feminist researchers must approach research not to conduct research *on* women but *for* women. Langellier and Hall (1989) distinguish between the two research approaches.

Research *on* women “adds-on” knowledge about women to existing knowledge, uses contexts and techniques that strip women from the complex contexts of their lives, and asks research questions and evaluates research findings against male-as-norm standards.....Women in the particularity of their lives remain invisible, silent, and unchanged. Research for women, by contrast, does not simply generate new

knowledge about women for the sake of knowledge, but

conducts research with the purpose of empowering women
(p. 195).

In her postulates, Mies (1996) argues that feminist researchers must engage in research with the intent to initiate positive social change and to make a difference in the lives of those women involved in the research. With these factors in mind I chose a data collection method that would enable women to share their breastfeeding learning stories with other women. I also chose a method of analysis that would respect and allow me to present the women's' stories in their own words.

In this chapter, I outline the methodological approach used to uncover the stories of women's lived experiences of learning how to breastfeed. The means of data collection (focus groups) is described and coupled with a further explanation of why it was appropriate for this particular inquiry. Finally, I explain the specific method of data analysis .

Focus Groups

An increasing number of social scientists are using focus group interviews as a method of data collection (Morgan, 1993). Gergen and Chrisler (1999) suggest “ This method (focus groups) offers some interesting avenues for feminist psychologists because it allows for multiple viewpoints and open, egalitarian discussions” (p.437). Lederman (1990) contends the focus group interview is a valuable means of data collection for

education researchers. In this section. I explore focus groups.

Focus Groups Interviews

“ The name *focus group interview* (FGI) derives from the selection of groups which are ‘focused’ on a given topic” (Lederman, 1990). Morgan (1998a) writes: “Focus groups are group interviews. A moderator guides the interview while a small group discusses the topics that the interviewer raises. What the participants say during their discussion is the essential data in focus groups” (p.1). Krueger offers the following characteristics of FGI’s: “Focus groups typically have six characteristics or features. These characteristics relate to the ingredients of a focus group: (1) people, (2) assembled in a series of groups, (3) possess certain characteristics, and (4) provide data, (5) qualitative in nature (6) in a focused discussion” (1994, p.16).

Lederman (1990) states that focus groups can be traced back to group therapy where the assumption existed that if people with similar problems could come together, the security of being in an environment with others who could relate would encourage participants to talk about their situation with greater ease. Group interviews have been used as a research method by social scientist since the 1920's (Frey & Fontana, 1993; Morgan, 1998a). During World War Two, Robert Merton, with Paul Lazarsfeld, conducted group interviews. “Merton and Lazarsfeld contributed to the war effort, using focus groups to develop propaganda materials for the American homefront, to create training manuals for the troops, and to investigate basic social issues such as racial segregation in the armed forces” (Morgan, 1998a, p. 38). In 1956, Merton, Fiske and

Kendall compiled some of the earliest research on focus groups and laid out a some of the practices for focus group interviews that are still used today (Morgan, 1988; Lederman, 1990; Krueger, 1994). Focus groups are widely used as a marketing data analysis tool (Frey & Fontana, 1993). Frey and Fontana suggest group interviews, including focus group interviews, can also be a useful tool for researchers across the disciplines such as, sociology, anthropology, political science and history (p.21). Lederman (1990) used FGI's to collect data on educational issues and to explore the impact of communication apprehension on the behavior of people with high communication apprehension (CA) (Lederman, 1983). CA refers to the anxiety and stress experienced by individuals uncomfortable in speaking situations (Mc Croskey, 1977).

There are similarities and differences between individual and group interviews. For instance, each has a specific goal, and usually adheres to a structure based on questions and answers. Differences exist as well. The most obvious difference is that a group interview allows a number of people to be interviewed at one time. Lederman (1990) suggests that another difference is the depth of data that is obtained through group interviews: "The data generated in group interviews is usually richer and deeper than data elicited in one-on-one interview situations (p. 119). She accredits the richness of the data to the dynamic that develops among a group of people that is greater than the sum of individual members. Krueger (1994) agrees. He contends that the individual interview is unable to achieve the social dynamic that is created out of the group interaction. However, Morgan does point out that focus groups do not provide as much information about individual participants. "Focus groups sacrifice details about individuals in favor of

engaging the participants in active comparisons of their opinions and experiences” (p.33). For my study, I believe the benefit of the group interaction and the synergy that was created among a group of women sharing their breastfeeding experiences outweighed the individual details that I did not gather.

Lederman also suggests self-disclosure often becomes easier for individuals when they are with others who have experienced similar situations. For example, in her work with people with high CA, she found participants who were usually reluctant to speak in public, felt safer speaking in a group with others who experienced high CA. Krueger (1994) cites Sidney Jourard (1964) who conducted studies on self-disclosure. Jourard found that people tended to self-disclose more when they were with people with whom they were alike. Because there are few venues in which women share the specifics about their breastfeeding experiences, the focus group format may help women to feel more comfortable discussing their breastfeeding learning experiences.

Another significant difference between focus groups and the individual interview is that the focus group allows the researcher to observe participants’ interaction on the topic of study. Albrecht et.al. write: “From a communication perspective, focus group methodology has a degree of external validity based on the fact that focus groups are grounded in the ‘human tendency to discuss issues and ideas in groups’ (Sink, 1991, p.197)” (p.54). Krueger (1994) contends people may form their opinions when they have the opportunity to listen to others’ views. Lederman writes that “...focus group interviews allow researchers to observe groups in interaction with one another, thereby generating the interactive data which cannot be gathered in individual interviews” (p.120). Wilkinson

(1999) makes a similar argument. She contends focus groups are an excellent method of data analysis for feminist researchers who seek data collection methods that are relatively naturalistic and contextualized. She writes: “Focus groups tap into the ‘natural’ processes of human communication, such as arguing, joking, boasting, teasing, persuasion, challenge, and disagreement” (p.225). She goes on to state: “A focus group participant is not acting in isolation. Rather, participants are members of a social group, all of whom interact with each other. In other words, the social group is itself a social context” (p.227).

Because one of the goals of this study was to determine how women communicate with each other about their breastfeeding adult learning experiences, I felt the focus group interview would provide an opportunity to observe women interacting with each other as they shared their stories. In turn, the focus group interview allows the participants to share with others who have similar experiences and this is a key priority when conducting research with people who do not traditionally have that opportunity (Kirby & McKenna, 1989).

Participants

Focus group researchers vary slightly in their perception of how many respondents constitute a *group*. Albrecht, Johnson, and Walther (1993) and Morgan (1998b) state six to eight group members, Kirby and McKenna (1989) have suggested six to ten participants, while Frey and Fontana (1990) have said eight to ten. Market focus group interviews often have up to twelve respondents. Krueger (1994) and Morgan

(1988) both suggest there are advantages and disadvantages to small focus groups (four participants) and larger groups (twelve participants). While smaller groups enable members to offer more individual information, Krueger warns it may lead to “a smaller pool of ideas”(1994, p.17). A larger group may generate vast data, however it can be a greater challenge for a moderator to facilitate the group and may lead to fragmentation among group members. My experience facilitating learning groups and focus groups suggests the ideal number of participant is between four and seven. This number allows a small group dynamic to develop (small groups typically consist of three to seven people). I have found there is usually ample time for all members to participate, somewhat reticent group members find this number less intimidating than a larger groups and the group size is quite manageable for an experienced group facilitator- interviewer.

The research on focus groups does indicate that groups must be somewhat homogeneous (Krueger, 1993, 1994; Morgan, 1988, 1993, 1998b; Knodel, 1993; Aubel, 1994). As noted earlier, participants who share common characteristics tend to feel more comfortable sharing in a focus group. Morgan writes:

The best general advice is that participants should really have something to say about the topic and they should feel comfortable saying it to each other. Would the participant normally discuss topics in day-to-day interaction?

Participants must feel able to talk to each other and wide gaps in social background or life-style could defeat this.

Note, however, that the goal is homogeneity in background,

not in attitudes. If all the participants share virtually identical perspectives on a topic, then this can lead to flat, unproductive discussion. (1988, p.46)

Participants in this study were eight women who breastfed a child (or children) for a period of time since 1990. I chose this time frame because earlier research indicated that breastfeeding was on the rise since 1990. I did not specify a length of time women had to have breastfed in order to participate in the study. I thought the learning experience existed for women regardless of whether they breastfed for a day or a year. All participants were at least 20 years of age when they breastfed their child or children. All participants had completed high school and had some form of post-secondary education. They all resided in the Cape Breton Regional Municipality and did so when they were breastfeeding. As was indicated in chapter one, while breastfeeding rates are lower in Cape Breton than other parts of the province, the Eastern region has experienced a greater increase in breastfeeding than elsewhere in Nova Scotia. This seems to suggest that women have discovered and developed successful breastfeeding adult learning tools. I was curious to learn about some of these methods. Secondly, I chose this region because it is my community. It made sense to me to work within my own region. Practically, I could establish networks of resource people and I could utilize local facilities and avoid extensive travel. Further, my own interest and ties to the community helped me to relate to many of the experiences shared by the participants.

Participant Selection

Participants were invited to take part in this study. As a mother with young children I was able to make numerous contacts with other mothers through my children's school and preschool, as well as through friends and neighbors with small children. I approached individuals and asked if they would be interested in participating in the focus groups and many of these women directed me to others who they thought might be willing to participate. Because I live in a small community, I knew it would be difficult to bring together a group of mothers who did not know each other on any level. Morgan (with Krueger, 1993; 1998b) discusses whether participants should be strangers or not. He suggests that there are advantages and disadvantages in each situation. People who know each other may require less time building a comfortable rapport and thus allowing more time to discuss the topic. On the other hand, groups who know each other may pose challenges for the moderator. For example, friends may converse quietly with each other throughout the focus group interview, or individuals may feel uncomfortable sharing an experience in front of someone they know. Morgan claims the answer to the problem calls for an experienced moderator who is capable of dealing with the situation. He further contends that in many cases whether or not acquaintances know each other does not impact on the success of the focus group. As I began to plan the composition of the groups, I realized it was almost impossible to guarantee participants were strangers (considering, also, many grew up in the same town). As it turned out, although some of the participants did know each other, this did not appear to impede the group productivity.

The Role of the Interviewer/Moderator/Facilitator

Krueger refers to the focus group interviewer as the moderator.

...I purposely choose to describe the interviewer's role by using the term *moderator*. This term highlights a specific function of the interviewer- that of moderating or guiding the discussion. The term interviewer tends to convey a more limited impression of two-way communication between an interviewer and an interviewee. By contrast, the focus group affords the opportunity for multiple interactions not only between the interviewer and the respondent but among all participants in the group. The focus group is not a collection of simultaneous individual interviews but rather a group discussion where the conversation flows because of the nurturing of the moderator. (1994, p.100)

Krueger stresses the importance of moderators having an understanding of group communication and group dynamics. Moderators must be able to facilitate the group so that participants have an opportunity to contribute. They must be able to encourage quieter group members to respond, and they must be able to ensure over zealous members do not monopolize discussion. Moderators must maintain an appropriate energy level, and make sure the discussion stays on track. An extremely important task for moderators is effective listening (Krueger, 1998b). This includes being aware of the nonverbal cues of

participants, and as Kirby and McKenna (1989) point out, being able to allow for silences.

Respondents need time to reflect on questions and to formulate their responses.

Wilkinson (1999) addresses the issue of researcher control and power in focus groups. She states that there are a number of research participants and one researcher in focus groups, hence the participants have more influence over the interaction that occurs than in traditional one-on-one interviews. For some, this may be perceived as a disadvantage. However, feminist researchers see this as a benefit (Wilkinson, 1999) because it reduces the power of the researcher. She states:

The few feminist researchers who have used focus groups (and other kinds of group work) have similarly emphasized the shift in the balance of power-and particularly the extent to which the method enables research participants to speak in their own voice-to express their own thoughts and feelings and to determine their own agendas. (p.232)

Although she acknowledges that in some contexts, the shift in power is thought to be disadvantageous, she claims:

..this reduction in the relative power of the researcher also allows the researcher to access better, understand, and take account of the opinions and conceptual worlds of research participants, in line with the suggested principles of feminist research. (p.233)

Format

Similar to individual interviews, focus group interviews have a specific goal which is usually achieved through the asking and answering of questions. And like individual interviews, the structure of focus groups interview can vary. Knodel (1993) writes: “The general topics to be explored need to be formulated as a set of discussion guidelines that can be used by the moderator during the focus group sessions. The basic idea of the guideline is to lay out a set of issues for the group to discuss” (p.36). Knodel recommends the guideline be kept brief. In order to gather in-depth information, one should not attempt to cover too many areas. In a 90 minute focus group, Morgan (1988) recommends limiting topic areas to four or five. I decided to focus on three areas: 1) learning strategies that the participants utilized during their breastfeeding learning experience, 2) the influence of learning strategies on the success of their individual breastfeeding experience and 3) other factors that influenced the learning process. This outline covered the general areas I wanted to explore while allowing ample room to probe areas of interest that may emerge through the discussion. Within each topic area I compiled questions (see appendix A). Krueger (1994) contends that a two-hour focus group can usually cover twelve questions plus or minus four depending on the nature of the questions and the subject. I felt it was important to allow the women to tell their stories and saw the questions as discussion initiators and a guide to help me stay on track. Krueger (1998a) writes that experienced moderators may choose to work just from a topical guideline. However, I decided that the

process of developing questions would also help me to formulate in my own mind what information I wanted to gather from the participants. Krueger supports this approach. Morgan (1988) made it clear, however, the moderators must remember the questions are a guide and should not impede the discussion. During the focus groups the question schedule was a valuable tool as it served more as a check- list than a script that was closely followed. I had to ask very few questions. The participants responded to many of the questions I intended to ask before I posed them. Interestingly, the women often asked each other the same questions I intended to ask. I felt ~~this demonstrated~~ that the group participants and I were on the same track, and saw the same questions as pertinent.

Organization of the Sessions

After participants were initially contacted and asked to participate in a focus group, I told them I would contact them again with specific dates, times and locations. This was one of the greatest challenges of the focus group format that I had not anticipated. With individual interviews, it is simply a matter of two parties agreeing on a time that is mutually convenient. This becomes more difficult when four or five people have to determine a mutually convenient time. Scheduling was further complicated by the nature of the participants' family agendas. All the women were mothers with young children. As well as trying to arrange child care in some cases, many of the mothers had to work around their children's extra curricular activities such as soccer games, birthday parties, and other outings. In a few cases, mothers who had intended to participate were forced to cancel at the last minute when their children became sick. One mother brought

her two month old son with her in order to be able to nurse him throughout the session. Considering the incredibly hectic schedule of the participants, I was unsure how many women would actually attend each session. I invited six women to each focus group in the hopes that at least four would be available. Fortunately, there was only two cancellations for each session so I was able to conduct each group with four participants. As discussed earlier, this number satisfies focus group requirements of participants and seemed to work well for these groups.

Morgan (1988) writes about the important step of choosing a site to conduct the research. He points out: "The site must balance the needs of participants and the needs of the researcher: there is little use for sites that participants will not come to or where you cannot do your recording" (p.60-61). I decided to conduct the focus groups in my own home. I wanted to create a comfortable and relaxed environment. I also anticipated infants accompanying their mothers and felt my home would be a comfortable place to breastfeed and care for their babies as opposed to in a community hall or a classroom. I could easily provide coffee and juice should participants want it and I thought this would help them feel at ease. Because the focus groups were small, I felt I could provide comfortable seating for everyone in my living room. I was able to easily audio record the session and the acoustics provided an excellent recording. All participants expressed they were comfortable coming to my home. This venue may have been familiar. Women with children often meet in each other's homes for play groups and informal play dates. I believe the intimate environment contributed to the relaxed communication climate that developed throughout the sessions.

I began each session shortly after the participants arrived. Once we were all seated in a circle, we took a few minutes for small talk and introductions. I also asked everyone to complete a participant data information sheet (see appendix B) and to review their consent forms (see appendix C). I then proceeded to welcome them formally and explain the nature of the study I was conducting. I took time to reassure the participants that their breastfeeding learning stories were indeed significant. I did this because many of the women I contacted regarding participation in the focus group initially questioned whether I really thought they had an experience that would offer any valuable insights. This is not unusual. Langellier and Hall (1989) contend one of the benefits of interviews (and I would include focus groups) is that interviewees do receive reassurance that their daily experiences are very important which is in contrast to the message delivered by “social and familial cultures that devalue women’s work and experience” (p. 213).

I explained that the sessions would be audio taped and that I would be taking notes in order to best capture the essence of the discussion. I also reassured the women that confidentiality was important, and that we must all respect that what was said by anyone throughout the session must remain confidential. I assured the women that my goal was to learn about their breastfeeding learning experiences, not to judge them or to tell them what they did right or wrong. It was extremely important to clarify this point because each woman had a unique breastfeeding learning experience and I did not want any of them to feel their choices and decisions were going to be debated. I did not want anyone to feel they had to defend what they did or did not do as breastfeeding mothers. These focus groups were to be supportive and friendly environments.

I then began by asking my first question. I made sure each person had an opportunity to respond to each question. I was amazed at how eager participants were to respond to questions and to engage in dialogue with each other. In the field notes I wrote immediately after the first session I stated:

That went very well. I was so happy with the climate that was created. All the participants developed a comfortable relaxed rapport immediately. Each woman was comfortable sharing her ideas, thoughts, and opinions. They listened to each other as well. There was a strong healthy group dynamic. I did not have to probe. Everyone was eager to participate. Their nonverbal was positive throughout- they maintained eye contact with everyone in the room, not just me. I think this reflected their sense of comfort with the group setting. (Field notes, Session 1)

Although I had intended to take notes throughout the session, I wrote less than I anticipated. As well as being engaged in the discussion, I found it easier to listen to the responses and to observe both the verbal and nonverbal interaction among the participants when I simply watched and listened. I periodically paraphrased responses to ensure I understood the participants' meaning and this gave the women an opportunity to clarify their comments. At the end I summarized what I had heard and gave participants an

opportunity to clarify or add any further comments. What notes and jottings I did make served as a basis for the field notes I composed following the sessions. Kirby and McKenna (1989) recommend researchers record their own reflections immediately after a data gathering experience. This allows researchers to record their thoughts, observations, concerns and questions while the group sessions are still fresh in the mind. Once participants had left, I audio recorded my own reflections on the session. I also compiled extensive written field notes. Kirby and McKenna (1989) describe field notes: "Field notes are an on-going record of the research. These consist of the content (the information you gather) and reflections (thoughts you have about the content and about the process of researching)" (p. 55). The written and audio recorded field notes proved invaluable. During the session, I thought I would remember everything that was said verbally and nonverbally. I realized this is not the case. This became more evident after I conducted the second group. The field notes helped me to recreate each session in my mind and served as a reminder of some of the initial observations made during the sessions.

The Number of Focus Groups Conducted

Krueger (1994) advises that researchers continue conducting focus groups for a study until a level of theoretical saturation has been reached. Borrowing the term from Glaser and Strauss (1967), Krueger describes theoretical saturation: "With theoretical saturation, one samples until each category of investigation is saturated" (p. 88). Kirby and McKenna agree with the concept: "Traditional methods often rely on numbers-numbers of participants, completed surveys, data or experiences recorded. Researching

from the margins relies on saturation of information”(p. 123). Morgan (1998b) reiterates the difficulty in determining the number of groups beforehand. Because I was not comparing groups, I decided to conduct two focus groups and to determine at that point if there was a need to gather further data through additional focus groups. Once I began to transcribe the sessions I realized that I had obtained a significant amount of data and had indeed reached saturation with the two groups.

Methods of Data Organization and Analysis

In this section I explain the method used to organize and analyze the data for this study. I explain the process of transcription, organization and interpretation I adapted from a system described by Nelson (1989).

Transcription

The day following the first session, I began the transcription process. I opted to do what Krueger (1994) calls a *transcription-based analysis*. I listened to the tapes and transcribed the sessions word for word. Krueger (1998) recommends novice researchers transcribe their own focus group. He writes:

Self-transcribing improves analysis because it helps the novice moderator become intimately connected with the data. You become emersed in the comments because

you've now experienced each comment several times. By looking back over the discussion and replaying it several times, the moderator can find the threads of the discussion and determine how comments are connected, when the discussion gets off track, and how the moderator functions to maintain control. In transcribing, you are looking for notable quotes, and after listening, typing, and reading you are very familiar with the discussion. (p.99-100)

The process of transcribing the focus groups was immensely valuable. I was able to record not only the spoken words but the nonverbal vocal characteristics that provided further insight into the comments and responses. I was also able to relive the sessions by listening to them for a second time, picking up on valuable points that I had missed during the actual sessions. As I transcribed, I began to see themes emerge and I believe this helped me to make a smooth transition to the next stage when I began to explore the emergent themes by organizing the data.

Organizing the Data

With transcription completed, the analysis moved to the next phase which was *organization* or as it is often called, *coding*. Aibel writes: "Qualitative data are not neatly compartmentalized as are quantitative data. Data collectors are sometimes overwhelmed with the absence of order in the mass of data which they have collected. The **coding**

process aims to organize the data in relation to the specific objectives of the study” (p.46). With my questions in mind, I began by compiling all the responses to each individual question. This was a long process that allowed me to become even more familiar with the data. I did this by color coding the responses throughout the printed transcript, and then copying and pasting the responses together in a new computer file. I refer to this as the *organized responses file*. By this point themes were quickly emerging from the data and I sometimes found myself jumping from file to file in order to begin to record responses as well as the themes that were becoming apparent. It was very clear that data analysis was not a linear process. At each stage, other phases of analysis occurred simultaneously. I began to understand the phrase ‘inundated with data’. As I was compiling one category of responses, one or more other categories would emerge and I sometimes felt as though I could not keep up with the coding. At these times I would stop and step back from the data for a little while.

I also came to understand the term, ‘richness of data’. I was in awe with these women as I read their words. I marveled at their ability to articulate their experiences with such insight and wisdom. As I looked through the organized responses, I saw sentence after sentence of quotable quotes that I felt captured the essence of their feelings.

Thematic Analysis

Once I had organized the data into categories, the final stage of analysis was to study the themes that had emerged from the categories. However, thematic analysis did not just begin at this stage. As pointed out earlier, I saw themes emerge while the focus

groups were being conducted, again during the transcription phase, and even more so as I organized the data. Kirby and Mc Kenna (1989) point out that data collection and analysis often overlaps and while at times I felt like too much was going on at once, I realize it was the nature of the this type of research. As suggested by Kirby and McKenna (1989), I constantly reflected on the data and the process while doing the research. Hence, I was more aware of themes and ideas that were emerging. Therefore, when the time came to present the themes on paper, they were evident. I knew they had not been manipulated to 'fit' but that they were accurate reflections of what emerged from the data . For example, a visible theme was that the women had intense feelings about the role hospital nurses played in their breastfeeding learning experience. Each participant discussed their experience with the nurses, and both groups engaged in extensive dialogue about the nurses' role.

Once a theme was determined I recorded it in a new file. I presented the theme in the participants own words directly from the original transcript. I then described the theme and finally interpreted it in relation to the literature. In the next chapter, I present the themes.

CHAPTER FOUR

In this chapter, the themes that emerged from the data are presented.

Themes are clustered around three categories; 1) The initiation phase, 2) the lived experience, and 3) the reflection. The first group of themes focus on the beginning of the breastfeeding learning experience, starting with the decision to breastfeed and moving to the learning resources that were utilized and to what benefit. The second category concentrates on the practical breastfeeding experiences, reporting on the issues and obstacles the women encountered throughout their breastfeeding experiences. The final area of themes are retrospective- a report of the reflections the women shared regarding the significance of their breastfeeding learning experiences- their accomplishments, their regrets and their changing roles from breastfeeding learner to breastfeeding teacher. Each theme is presented in a summary statement and then the women's own words are used to describe the theme. In order to respect the privacy of the participants, quotes are identified by the participants initials instead of full names. Also, names within the quotes have been altered to protect the identity of participants and those they mention in their comments.

The Initiation Phase

Making the Decision

The decision to breastfeed was made by most of the women in these groups either during pregnancy or before pregnancy. For the most part, they felt they would try and if they were comfortable, and if the baby was able to breastfeed they would do it. Others

were more adamant that they would make it work, whatever the cost. In most cases, they were influenced by other people, for example, female doctors and colleagues but mostly by friends or family members who were breastfeeding mothers or supporters. They were also influenced by books, and videos.

I decided before I was pregnant. I always thought I'd like to try it. I lived and worked at a community living centre and the lady there had 8 kids and she breastfed...five were her own, three were adopted. The youngest was three or four and I was there when he was born and I sort of just admired how she had breastfed all her kids and she enjoyed it and they were thriving and they looked so healthy and she glowed. I thought "I think I'll try it". It looks like a great thing...it looks like she enjoys it and he enjoys it. (C.S.)

"For me it was definitely before. Before I got pregnant...I loved kids ever since I was a child and my aunt and uncle had kids which I babysat quite often and they were breastfed and I always admired my aunt so much" (K.B.W.).

Another woman worked in a family resource centre and was continually exposed to the benefits of breastfeeding. That influenced her decision.

I decided before, and I think for me it was 'I'm going to do it for the baby.' Where I work we have prenatal classes and

things like that and the information is there. It's best for the baby and so you know it's what you're going to do. At first I thought, well, I'll do it for the baby and see how it goes and then we got along great. (L.B.)

Some women made the decision reluctantly, not overly comfortable with the idea of breastfeeding, yet willing to try because they knew it was best for their babies. Their decisions were influenced by pro-breastfeeding doctors.

My doctor was very adamant... there was no doubt. She said of course, you're going to breastfeed. It was like 'ok' (surprised laugh). I remember I went back to work that morning and I thought "O My God! What does she expect?" I was so upset about it. She gave me this dilemma. (D.J.R.)

Another participant adds: "That's like my doctor, she said 'So, you're going to breastfeed', and I said (tentatively)'Ok.'

One woman's had an experience that was different from the others. She always knew she would breastfeed, even as a child. Curiously, she did not see anyone breastfeed as she was growing up and her mother did not breastfeed her or her siblings. She seemed somewhat perplexed by the adamancy she felt. "I don't know whoever told me that (breastfeeding is how you feed a baby) or where I learned, because my mother didn't

breastfeed me. I just knew that's how you fed a baby...I never had a decision" (K.W.).

Learning Tools

Most of these women tapped into a variety of learning resources as they embarked on their breastfeeding learning experience and began to utilize these tools during their pregnancies. The learning tools used by women during the initial phase included; 1) mentors, 2) books and videos, 3) and television and the Internet. Here, each learning tool is presented and its value to the women is described.

Mentors

Having a mentor to provide information and support was deemed a crucial learning tool. As one woman put it: "I think the biggest thing is having that person to support you"(L.B.).

During the pregnancy, the mentors were people who the women could talk to about their concerns, their questions and their fears. The mentors could share their personal experiences. If the mentors were still breastfeeding their own children, the women could watch and learn techniques from observations. They could also see the pleasure breastfeeding gave the mother and the child.

I had a close girlfriend who was nursing her son at the time I was pregnant. She was nursing her son when I was pregnant. I just admired her so much because she was a single mom and she cared so much for her son and she was just doing everything she could for him and I learned a lot

from her and I took a lot of advise from her and anything she said it was “Yeah!”. (K.B.W.)

I had a friend..well the second time around. The first time around I didn't have the support and that's probably why ..one of the reasons I wasn't successful the first time. The second time though I had a friend who was in the breastfeeding support group so she was good support to call upon..knowledgeable.... breastfed her children... a good role model. (J.C.)

Books and Videos

While books and videos were helpful during the pregnancy they were limiting as well. Books and videos gave information regarding the benefits of breastfeeding as well as techniques to be used when breastfeeding. Books and videos also gave women an idea what to expect and how to troubleshoot potential problems. Yet the feelings of these women were that the books could not teach the art of breastfeeding. A book or video did not always speak to the individual situations faced by the women. As one woman says in reference to books as a resource compared to actually breastfeeding: “But really it's like theory and practice, two different things” (J.C.).

“I didn't stop reading, from the time I got pregnant. I think I bought every book or borrowed every book I could find. I tried to get knowledge that way” (K.B.W.).

Books were helpful because I thought if I familiarize myself with the book then I'll know where to look, but I found the video helpful because I actually saw it happening. In the books you see the hand drawn pictures, that doesn't really do it justice...I think I mostly learned from the books and videos. I read everything I could get my hands on. I read books this thick hoping I could learn one little new thing that I hadn't read before. (K.W.)

One woman referred to one book that she found particularly useful.

A book I wish I had ahead of time was a book the by the Nova Scotia Department Of Health....That was very helpful but it was too late for me. I wish I had it ahead of time.....before the baby was born when I had time to read it. There were trouble shooting problems in it and that was the best. I'd say "Yes! That's me..I have that problem." And then it gave a list of solutions. That was good. (J.C.)

Television, and the Internet

While only one woman mentioned using the Internet as a resource, a number of the women watched the baby show on The Life Channel in the hopes of learning about breastfeeding. "I watched the baby show on tv too, to see who was going to breastfeed

and a lot of them didn't and I thought 'ah well, I'm still going to try it'" (C.S.).

The Lived Experience

Once these mothers held their babies for the first time and put them to their breasts, the learning shifted. While outside learning sources were still important, personal experience became an tremendously important learning tool. Other tools included; 1) mentors, and 2) nurses. At the same time, the mothers began to encounter other factors that had an impact on their learning. These factors were 1) learning through talking, 2) learning by seeing, and 3) the changing perception of 'breasts'. These themes are discussed here.

The Learning Tools

Mentors

As mothers, these women needed a support person who could show them what to do, provide them with options, and who could be available almost any time, especially when things became difficult. The mentor also needed to provide emotional encouragement and strength. In one instance the mentor was the women's female doctor.

I think my doctor was really supportive..fabulously..it was,

'Whatever you need..if you need to see me, call me or come

in and see me. I will make the time'. (D.J.R.)

In reference to her doctor again, this participant says:

Ann was such a wonderful support. I had to do it for me
and for my daughter but I had to do it for her too! She
made you want to succeed. (D.J.R.)

For most of the women the mentor was a friend or family member who had
breastfeed. The mentor often helped at crucial points in the learning and helped to keep
the new breastfeeding mother from giving up.

With my son I must have been up three nights right around the
clock trying to get him latched on, trying every position possible
and coming on the morning I was like "I can't to this" I'd call my
friend and she'd say, "You can do it, just keep trying, he'll get
latched on" then she'd say ' My daughter was two weeks almost
three weeks'. And I'd say, "I can't go through this for three weeks
but I'll keep trying". (B.K.)

"She (a supportive friend) actually helped me do this and knew exactly what she
was doing and it made such a difference. If I didn't have her coming up to the hospital
when I had my daughter... one day, I was a wreck...a wreck. And if it wasn't for her I

would have quit!”(L.B.).

The mentors also provided reassurance as the following demonstrates:

“If I was having a problem or I had to find out if this was normal she’d always put my mind at rest” (B.K.).

Nurses

The women were often dissatisfied with the support they received from the hospital nursing staffs. After giving birth, the nurses are often the first people the new mothers look to for help. Unfortunately, their advice is often inconsistent and sometimes inaccurate. Most of the women found the neo-natal nurses much more helpful than the nursery floor nurses. Comments like the following were typical.

I found with my daughter the nurses were not helpful unless you were in the neo natal- then they were wonderful. They were all wonderful there, all trying to help but you go down the hallway..look out! (B.K.)

Although one participant felt positive about her experiences with the nurses, (in particular the neo-natal nurses) the others had less than positive experiences. While most found the nurses friendly (although not in all cases) the main problem was the inconsistency in the advice given from nurse to nurse and the nurses apparent lack of accurate information regarding breastfeeding. The frustration that the women experienced with the nursery floor nurses is evident in the following quotations.

“I had one (nurse) that left me bawling, sitting on my bed, telling me ‘You may as well give that up..it’s not working..you’re starving that baby. Oh they really make me feel inadequate” (D.J.R.).

I found it was confusing, conflicting information from nurse to nurse. Help with technique was just what you needed at that point...help with this and that. The thing about letting them have another nipple..some said it was ok to let them drink water, and have a nipple and some said don’t and I just found from one person to another there wasn’t continuity...all I wanted to do was the right thing so I was there thinking ‘Oh..what’s the right thing to do?’ (J.C.)

Others had similar experiences.

I was having trouble nursing and I would hear something different from each nurse that came in and that made it difficult for me. One would come in and say I was doing this wrong but this would be what the other nurse asked me to try. It was constant confusion...they tried. It wasn’t that they weren’t sincere in what they were trying to do because they wanted me to succeed but it was just mixed opinions and very confusing at a time that I was so vulnerable. So I found it hard. (K.B.W.)

The nurses were great they were all really wonderful but I got the same thing, the different shift nurses. I even have it on video, I have the very first time I breastfed on video in the labour room and a nurse helping me get the latch and she says 'put your finger down so she can breathe' and then the next nurse I have on video, she says, "You don't have to put your hand there, she'll come off if she can't breathe", then my husband missed one of them so he's coming in saying , "put your hand there" but the last nurse said I didn't have to. (C.S.)

Along with inconsistencies, the women felt the nurses were unable to present all the options needed to make an informed decision regarding the best way to breastfeed.

She (the new born) was very hungry her first night and she was born at 5:00 p.m. and I didn't have a lot of colostrum and I was very small. I had her on my breast constantly, she was crying and crying and crying..from about 11:00 p.m. I put her on the breast and was trying to feed her and she was fussy and crying and crying. At 12:30 a.m. I called the nurse to see if there was anything I could do and she said no just keep trying and put her back on the breast. I think I had her on the breast for 3 or 4 hours back and forth, back and forth. I didn't know. She cried till about 2:00 before she finally

fell asleep. She was exhausted. So I still get emotional about the fact that my child was hungry the first night she was alive. And the next nurse in the day, said 'Dear, you can just supplement with an ounce of similac in a cup. It won't hurt her.' And I gave her the ounce of Similac and she slept for 7 hours. My heart broke, I do want to breastfeed but I don't want to starve my child if I can't. I didn't know if I could at that time. I still get agonized over that. And I had just given birth and I walked her for 3 or 4 hours.....The nurse never even mentioned supplementing with a bit of similac. I'm all for breastfeeding! But don't let me starve my child. I know she had the best intentions but I didn't know it was an option! Until the next nurse said you can give her a bit of similac. I was blowing smoke out my ears I was that mad! Her first night in the world she was hungry. I still..(Visibly upset)..look at me..ah, it's terrible. The nurses were great but that was my bad experience. (C.S.)

“And you know if they (the nurses) haven't breastfed then its just repeating the book to you. I know there was one nurse, I had bruises on my breast from her trying to help me and I would see her coming and it was like, 'NO!'" (B.K.).

Other Influencing Factors

Learning Through Talking

Being able to talk about breastfeeding was very important for the women in this study. While two women felt comfortable discussing it with anyone, the others wanted to talk only to other woman who had breastfed. In particular, they were not eager to talk about breastfeeding with men.

I had a co-worker at my desk one day...I almost fell off my chair...ask me if I was breastfeeding..a male..oh yeah! A female wouldn't have bothered me half as much..but a male I hardly know? I almost slid off my chair and crawled under the counter...oohh! I hardly know you and I'm not discussing my breasts with you! I mean I was upset..I was really upset about it.. I couldn't believe it..I felt...aghhh! (D.J.R.)

"I remember a co-worker (a male) asking me if the shirt I was wearing if that was what it was for (breastfeeding) and that embarrassed me..I thought..I don't want to go there with you!"(B.K.). In both cases the male co-worker worked in a different capacity than the women and they were not well- acquainted with the men.

I don't even think I would bring it up with men. It wasn't something I thought they could relate to. I shared with my husband and a little bit with my dad. It was easier not to bring it up. I didn't know how some people would respond or would they be

comfortable..... I was cautious. It was not something you would share with everybody. I was always curious if people were breastfeeding because it's easy to talk to someone who has. (C.S.)

"I was definitely more comfortable talking with women. I don't think there were any men that I would talk to about it..maybe the odd one..but mostly women" (L.B.).

One woman suggested why she preferred to talk to women.

I didn't talk so much with men. I think I'd have to be the first to say that's just because I didn't know of any men who's wives were breastfeeding. Just the fact that they were men. To bring up the subject you'd usually bring it up because you wanted to share experiences or wanted someone to pass on their knowledge to you and basically sometimes you don't feel like you could get that from a man unless his wife or someone close to him was breastfeeding. (K.B.W.)

One woman said she was eager to find someone to talk to, but proceeded cautiously before she would bring it up with people.

I didn't mind talking about it before I had the baby with people who seemed receptive to it and I would sort of try it out and see what they said. And too, seeing people with babies and wondering if I should ask them if they breastfed,

wondering is that too personal because you want to ask
when you're pregnant. (C.S.)

Some of the women felt it was not acceptable to talk about breastfeeding with other breastfeeding mothers when they were in their workplace because male and female co-workers would become extremely uncomfortable and even offended. "There were even *women* in our office that were offended..run screaming even, if two of us would start to talk about it" (D.J.R.).

The focus group participants discussed the words used when talking about breastfeeding and how it seemed more acceptable to call breasts everything but breasts. As one woman said, with a note of sarcasm and humor: "A mother shouldn't say breast!"(D.M.).

Learning by Seeing

All of the women involved in the focus groups felt it was extremely helpful to see other women breastfeeding. By watching other women they learned methods and techniques they may not have known. Also by seeing other women breastfeed they felt validated and they did not feel like they were alone in their choice to breastfeed.

In reference to the value of being able to see other mothers breastfeed one woman commented, "I think that's the biggest thing..you see it!" (L.B.). Another woman adds: "Everybody wants to be a great mom so when you see a great mom breastfeeding you want to try" (D.M.).

The mothers lament that they can not look to popular media to see women breastfeed. Two women had the following interaction

Maybe someday you will see someone breastfeeding on a sitcom..you never know..you may start to see people breastfeeding. (K.W.)

TLC (The Life Channel) has the baby stories, do you *ever* see a women breastfeeding? (B.K.)

You see them afterward at the party with the father giving the baby the bottle. A lot of the mothers will say, 'I'm nursing' but you never actually see them do it...My God! If they can show the child being born why can they not show a breast? (K.W.)

The Changing Perception of 'Breasts'

While breastfeeding, the women claimed the primary purpose of their breasts was nourishment for the babies. For some women, this was a definite perceptual change. For others, their breasts finally had a purpose. The following dialogue demonstrate the new purpose of the breasts.

They were mine before!! (D.J.R.)

Now they belong to somebody else (the baby). (B.K.)

Now they had a job to do. (J.C.)

When they were breastfeeding, the sexuality of the breast was almost non-existent.

Oh I was so flat chested it wasn't funny, before I had my daughter. Then it was "Whoa! What are these things?!" My husband liked them quite a bit before she was born. But after she was born, that was it. There were for food, they were for her. I don't think he even wanted to... It wasn't that he was turned off of me, he thought that I was very beautiful but we were raising her right now and that was what was important and it wasn't a sexual thing for us. They (breasts) were food. They still are. (C.S.)

Another expressed sentiment was annoyance, when others, including partners, saw the breasts for sexual purposes. "The breasts were for breastfeeding only. It was frustrating to have them seen for any other use" (L.B.).

Some of the women were eager to breastfeed because they felt their breasts finally had significant purpose. "I think for me it wasn't a transition..but it was for my husband. For me, it was 'Okay, now it's time to use you puppies'. I slid right into that kind of mode. It was tough to switch back" (K.B.W.).

The woman did feel aware of the change in the size of their breast. Some were uncomfortable with the larger breasts they developed when they were breastfeeding, especially when other people made comments. While the following experience was being recounted the woman telling the story actually crossed her arms over her breasts as if it was uncomfortable just thinking or talking about it.

The strangest feeling is when you're getting bigger and they're (other people) going "Oh the hooters on you!" I have uncles and their joking. Their not being mean about it because I was so flat chested before and now... My God, they just couldn't believe it. I couldn't believe it. I didn't like them (referring to her breasts) at all but I loved what they were for. But when someone would say they were big I'd want to hide them. I was and still am very self conscious about what I wear. I didn't want to wear anything too tight. I feel like everybody is just going to look at my breasts but I feel like I'm not used to it. (C.S.)

"I was big chested anyway and I got even bigger especially the first week I was nursing..I was huge. I always felt self-conscious about my breasts anyway but I just felt it added to that" (K.W.).

Obstacles and Challenges

The women encountered many obstacles throughout their breastfeeding experiences. Learning to overcome, or cope with, the difficulties takes a tremendous effort on the part of the breastfeeding mother. One woman summed it up when she reflected on the many barriers faced by women.

Listening to the stories it's amazing that women breastfeed..it's no wonder people use a bottle. Everything you said (to the other group members) I'm thinking "oh yes, the pain, oh yes the latching on!" It's *hard*..it's hard work, it's painful. If someone was standing here in the corner listening wouldn't they want to avoid all that? (J.C.)

Physical Obstacles

One physical obstacle faced by breastfeeding mothers is flat or inverted nipples, which make it difficult or impossible for a baby to latch on. Other problems include breast infections, cracked nipples, low milk supply, and engorged breasts. These problems emerge immediately following the birthing process, regardless whether a women delivers her baby vaginally or by cesarean section. At this point exhaustion is also a factor. One woman who had inverted nipples said:

I had enough milk to feed every kid. I can still remember my second day in the hospital. I filled up two of those mudella bottle in four minutes. The nurses couldn't get over how much milk I had to give but I was so engorged that my

back would give out on me during the day because they were so heavy. I couldn't sleep at night, I cried myself to sleep at night. I was so big and I was so much in pain.....He was on a plastic nipple attached to my breast. I never even knew what a real nipple looked like, and as much as I tried to draw out my nipples when I was pregnant it didn't work. I worked all through the pregnancy to no avail. It was difficult. (K.B.W.)

Another woman remembers:

I have flat nipples..I have *nothing* for either one of them to latch on to. I ended up with mastitis from the correction of that both times (with both children) but at least the second time I knew what was coming...I've had those fears.. "Oh my God do I have enough milk? I've run out of milk, I'm going to starve them.." I've been all through that and you know what...it didn't happen. I had mastitis and I had to take my antibiotic and I nursed through pain and I had that fear of no milk and I didn't starve either one of them. My daughter doesn't give a hoot if she ever eats and as a baby she was even more so. So we were really the worst match of mother and child that you could get..nothing to latch on

to and baby who didn't want to eat. I travelled with the stupid electronic case of breast milk for three weeks before she could latch on. (D.J.R.)

One women faced different physical challenges. "Physically I was not in very good shape..I had twins.. I had an emergency C-section so I wasn't able to nurse until three days after they were born..so that was bad." This woman was air lifted to Halifax to have her physical condition attended to, yet she persevered and is still breastfeeding her now two and a half year old twins.

Psychological Obstacles

In addition to physical obstacles, these women also dealt with the fact they had little or no support from other people. In some instance, these mothers had to deal with family members, friends and others who did not see the benefits of breastfeeding. This undermined their confidence as new mothers trying to breastfeed.

If people didn't do it (breastfeed) they weren't helpful.

Some older people would blame every little thing that would be wrong with the baby on breastfeeding. If the baby was cranky or fussy or pooped twice and I had to change his bum twice in a row, they'd say: "Oh, that's the breastfeeding doing that to him...that's a sin". (L.B.)

She later added: “And if you don’t have support there you just have ‘Go get some formula, why are you doing this?’ Their attitude is ‘You did this to yourself, it’s a decision you made!’” (L.B.).

While some women had to cope with the negative comments others were coping with a lack of any kind of support.

My first two weeks were hard. I had cracked nipples. I was cracked and bruised. I nearly went bolistic. Then she (the baby) had her growth spurt after two weeks, and she cried and cried. I called the breastfeeding hotline..no answer. I had four numbers. I had a child answer at one number and no answer at the rest. There’s a group that meets every month, I went there. She (her child) was five weeks old and I was going to go every month. I went and it was a blizzard, it was freezing out. And another mother and I stood there with those car seats outside the door and nobody showed up. The doors were locked. I didn’t know what to do. I couldn’t get help if I searched for it. By five weeks, I had established my milk, I wasn’t stopping but at that two week point, where I almost quit. When I was cracked and bleeding, I was in tears dialling these numbers and nobody was there. I don’t know why I kept doing it, I almost quit. (C.S.)

Social Obstacles

While breastfeeding mothers work to overcome physical and emotional barriers, there are social barriers to face. Breastfeeding in public was one such issue. Some women avoided breastfeeding in public and would go instead to private areas. Others decided if their babies were hungry, they were going to feed them whenever and wherever. Some of the mothers found it a little unnerving doing this, but they felt their babies' needs came first. Some said this is a little easier with the second child, and it becomes easier when family is supportive. They said that breastfeeding in front of other women is not as difficult. "Feeding my son in front of a woman doesn't bother me although if it's a man..I am very uncomfortable with it unless it's my husband. I'd be afraid they'd be thinking other things so that's why I couldn't do it"(B.K.).

Another woman, who returned to work when her son was still very young, had to make the decision to breastfeed her son in public when her son refused to take a bottle.

I can't go to work and have him home not eating..the only other option..I had to take him with me. So I did that and it was at the university and I was meeting students individually and if he had to eat when there was a student there, I had to do it..it was a hard thing to do. God Bless the students... they were fantastic. (J.C.)

In some instances, others were not as accepting of a mother breastfeeding in public.

And some people made me feel uncomfortable about it even though I was starting to feel a little bit comfortable, not comfortable in the sense of confident nursing but comfortable in the sense of not caring who was around when I was trying to nurse. My mother's neighbour, who I have known since I was 5 years old, would come over to see the baby but once I was nursing, she would leave or if she knew I was about to nurse she would leave and that made me feel uncomfortable. Then my step father's mother who was like a grandmother to me my whole life would say "Oh you're not going to pop that (breasts) thing out" and I would be mortified. (K.B.W.)

Family members were often uncomfortable being present when the mothers breastfed. In time, however, the women believed their family members overcame the awkwardness.

Nursing twins you can't cover yourself up. My brother is really a shy guy. When I was pregnant he came in the room one day and wouldn't even look at me and said "Are you

going to be breastfeeding a lot?” and I said “Yeah, I might but I won’t do it in the same room as the tv if that’s what you’re worried about and he went “oh..ok”. That was his big thing -so long as he didn’t have to clear out from the tv. Then once..I think the girls were about 6 months old, I was nursing them simultaneously and he (her brother) had to go to work and he came over and kissed them both on the top of the head while they were nursing and I just thought “Okay, halleluiaah, he’s over it!” (K.W.)

Another woman said: “It takes time. Even my dad would walk right out of the room if I was breastfeeding, but now he doesn’t move. Because I can be discreet” (C.S.). It’s easier to breastfeed in public if your partner supports you. One exchange demonstrates this point.

I wouldn’t do it with my first baby..I do it now. I’ll breastfeed in McDonald’s or wherever. (L.B.)

I did it the first time, I was surprised. I used a blanket over my shoulder.(C.S.)

I didn’t have enough support to do that. (L.B.)

However, again, in time even partners can become more comfortable with their wives breastfeeding in public.

There weren't a lot of people in the group we hung around with who breastfed. My husband was great, but he wanted to put me in a closet. If there were other friends around, he wouldn't be comfortable with me breastfeeding with other men around. This time ..it's different with the second one, it's like..who cares! But the first time we were nervous, I was nervous too because I really wasn't sure what I was doing . (L.B.)

In reference to all the difficulties women encounter when they breastfeed, one mother noted: "It's hard to overcome those physical things and the mental barriers. The mental barriers and the physical barriers are difficult and there are no two ways about it. I was thinking for something so natural as a species, how can this be so difficult (J.C.).

Few Breastfeeding Mothers to Share Their Knowledge

One of the greatest challenges faced by these women was not having mothers and grandmothers to teach them how to breastfeed. They felt the knowledge was lost because their mothers, and aunts, and other family members had not breastfed.

The following dialogue deals with this issue.

I think things have been lost. When I was reading the books,

it felt as if I shouldn't need to be reading the books. I need to read the book because it (knowledge of breastfeeding) has been lost from generation to generation. I was thinking as a species, why would we need to read how to do something that was supposed to be natural. (J.C.)

I remember being angry that my mother couldn't help me. I couldn't call her and say mom what do I do now because she had no idea..and she was a nurse! (K.W.)

We don't have a generation before us that breastfed. It will be interesting to talk to your children because they have you, they have an aunt. In the past, you would have several generations in one home and you would have those ideas, techniques, visual..I mean you wouldn't need a video..you would see it there. (J.C.)

The women expressed their regret that their own mothers had not breastfed.

Yeah! I think when I was born, my generation or before, their mothers didn't breastfeed them because doctors told them that formula was the way to go..so all these women and all these children never saw it..it was never talked

about, it was never there, so then when they finally realized that formula isn't the best thing and they want us to go back to nursing we have no one..no previous experience with it to draw on and that's a real loss. (D.J.R.)

"You don't use it, you lose it. You don't use that knowledge and it gets lost through the generations" (J.C.).

"My *grandmother* didn't even nurse! My mother didn't nurse her children and my mother's mother didn't nurse her children so I had no one" (D.J.R.).

"I wish our parents breastfed, so few of us were" (D.M.).

Learning How and When to Wean

A part of the breastfeeding learning experience that is sometimes overlooked is learning how to wean. Mothers often struggle to determine when is the right time to stop. For some mothers, the obstacles are just too great and they have to make a decision to stop early in the breastfeeding experience. The women with older babies often struggle with the decision to wean their children. Weaning is often accompanied by feelings of guilt and loss.

One woman had tried to breastfeed for two or three weeks amidst tremendous physical difficulties. She finally had to make the decision that breastfeeding was not the best thing for her and her baby. She then struggled to convince herself that she was still a good mother.

When I finally made the decision that I couldn't nurse anymore I didn't have the support that I needed. And to convince myself "I'm a good mom", I think *that* was hard for me. Especially with the first because you're so vulnerable with your first to other people's opinions and other people's judgements. (K.B.W.)

I feed her (my daughter) now with formula because I'm back to work, so I'm slowly weaning her. And to walk thru Wal-Mart with a box of formula, I felt horrible, isn't that bad? I felt like everybody was looking at me, saying 'She's not breastfeeding'. I feel horrible. I have to slowly wean her and it's so hard. I feed her at night, I can't stop. But I walked through Wal-Mart with that formula and I felt horrible... And if it was possible for me to breastfeed and work I would. But I tried and it's just not possible. I tried pumping at work and a couple of times I had to drop the pump to go do something, it's very stressful. (C.S.)

"It's almost like you feel you have to say 'Well, I'm going back to work...' and explain it (why you are weaning) to strangers (L.B.).

Another woman remember similar experiences:

It's so funny you bring that up walking thru Wal Mart with the formula. I felt it too, because I didn't nurse my son long and I had to go buy formula and it was a really tough decision to make. I wanted to explain to everybody why I wasn't breastfeeding. And if they gave me a funny look, I thought "Ok..you're going to stand here for ten minutes and I'm going to tell you exactly every problem I had". Because it's almost like you know somebody is going to judge you.

(K.B.W.)

In the beginning, the women felt they would be judged negatively if they did not breastfeed their new babies. Others felt the negative judgement when they nursed their older babies. People are not always as supportive of a mother breastfeeding an older baby or a toddler as they were of a mother nursing an infant. "I found there were external people saying "I think it's about time you stopped. I think as they (the babies) become older, people become more uncomfortable with it and you begin hearing those things externally"(J.C.).

Weaning leaves a mother with feeling of guilt, doubt, and loss. One woman's children gradually weaned themselves. However, she still felt unsure when her son stopped nursing. " It is stressful. I thought, 'Am I letting him down?' (D.J.R.). Another expresses her emotions: "I feel guilt but I also feel this loss. I'm grieving. If I think that I'm never going to put my baby to my breast again..I can't think about it" (C.S.). Still another

comments: “I cried for a month afterwards” (D.M.).

Reflections

Reflecting upon their breastfeeding experiences the women recognize how much they have learned. They reflect on 1) their personal experience as a learning tool, 2) the desire help other breastfeeding mothers, 3) their success as breastfeeding mothers, and the significance of the breastfeeding learning experience. Finally, they reflect upon the significance of their participation in these focus groups. In this segment these reflections are presented.

Personal Experience as a Learning Tool

In retrospect, these women recognize that they learned the most through the actual practice of breastfeeding. “It’s the doing it that makes the difference. You then have the knowledge. You can read, but it’s not the same till you do it” (L.B.). Another woman referred to it in this way: “It’s on- the- job training. You have to figure out what’s best for you”(K.W.)

Another appeared to sum up the feelings of her group when she said:

They can give you the books to read but you can’t prepare yourself for it. You learn once you put your child to your breast. All that I read and looked up, I did learn a lot but I

don't think it had much to do with my real learning experience. It's not universal. It's not something you can give a manual to everybody and it's the same. (C.S.)

The personal experience of breastfeeding seemed to give these women more confidence in their ability to breastfeed and their ability to stand up to opposing views and ideas. "Now I have the knowledge. I know in my head. Yes you can give me your opinions (in reference to others) but this is what I'm doing and I am stronger for that"(L.B.). Another woman tells a similar story.

The second time you know more what you are doing. I didn't have a good experience with my first, it didn't last long. The second child was like starting out again but I had determination in that I was not going to give up and I wasn't going to listen to everything and I was going to decide what was right myself and stick to it.... Yes, I was more determined to make it work. I decided to listen to the baby and not everybody else. (J.C.)

Mothers with only one child have also learned lessons from their first breastfeeding experience that they intend to use when they have another child. "I feel that next time I will be more confident to be more pro-active in nursing"(K.B.W.).

Learning to Teach Others

Having had to work through many obstacles to breastfeeding, the women are eager to support and help other women who intend to breastfeed. Based on their own experiences, they believe a good breastfeeding teacher has to be a good listener, has to be available when things get rough, and has to provide positive encouragement. They struggle, though, when it comes to determining the line between being supportive and being pushy. While they recognized a good support person has to try to convince a new mother to persevere when she feels like giving up, they know, that in some cases, there is a point when a mother may need the reassurance that it is all right to stop. No one seemed sure where this point lies. "I find after going through it and having the experience, I want to share it with other women, the problems I had and the solutions I found for them, because maybe it will help them" (J.C.).

Members of one group discussed ways to support other women.

I think it's important to be a listener, too. To ask questions so it's almost like they are talking themselves through what they really want to do. (K.B.W.)

They don't really want your advice they want to go through the emotions of the whole thing. (L.B.)

The women believe a breastfeeding support person has to have breastfeeding experiences of their own.

You have to have a lot of faith in that person (the support

person). To know you're getting sound advice. You can have support but if they don't understand how to nurse themselves as soon as the first problem comes up they're willing to let *you* give up. If you're going to be a real support you have to be there saying 'No, keep going, you can do this!' (D.J.R.)

Another mother expresses a different perspective.

I learned a few lessons, though. Try not to be too pushy. I had a girlfriend who was breastfeeding and I really wanted to be there to convince her how great it was for her and her child. And I really sort of swayed her towards wanting to nurse. And I was so happy when she decided to nurse. Then she decided to stop after two months. And not because she had any problem but because she felt like it. After two months there were things she wanted to enjoy and she felt that breastfeeding was holding her back but instead of being supportive, I wasn't. And to think of what I went through and how nobody was there for me when I stopped, there I was doing the same thing to her (not supporting her in her decision to wean). I really feel like I should have been more supportive. (K.B.W.)

The women feel their eagerness to promote breastfeeding and to urge their friends to keep breastfeeding is due to the rewards attained once you get pass the difficult times.

It sounds like everybody hates those first two weeks of breastfeeding, not hates them, but they are so hard. Then you want to share with everybody how wonderful it ends up being if you can do it. I thought I wouldn't like nursing but I would do it for my daughter. But then the fact that I loved it, that's even more exciting for me to share with people.
(C.S.)

Successfulness

Most of these women felt they were successful in their breastfeeding learning experiences. One states: "I do feel successful, it's the best thing I've ever done, really, if I don't do anything else for the rest of my life I can say..I did that! (K.W.). Another women reiterates the sentiment: "I feel really good about my son, he's just growing so big and strong!" (B.K.).

After overcoming many difficulties one woman says:

I was very successful, ultimately. I remember Ann (her doctor) saying to me after my daughter was well established, she never said this to me in the weeks we were going through our problems, but afterwards she said 'I

never would have blamed you if you had given up'. (D.J.R.)

A Significant Learning Experience

Of their formal and informal learning experiences, the women in these focus groups all felt that breastfeeding was one of their most, if not their most significant learning experiences. One dialogue surrounding the significance of the learning experience transpired this way:

It's life-giving! Oh yes it's important! (B.K.)

I think it's one of the most important things I could *ever* do for my children. (D.J.R.)

It's was one of the hardest things I've ever done and I thought if I could do that, I could do anything! (K.W.)

The Significance of the Focus Group

The focus groups themselves became a part of the learning for these women. They appreciated the opportunity to share their stories with other women who understood. Many said they felt validated in the choices they had made as breastfeeding mothers. These women spoke about their focus group near the end of their session.

I'm just happy people are talking about it! (D.M.)

I've enjoyed it. This is the first time I talked about it. My husband knows and I've talked to my sister but I've not shared with other moms. It's been great, I was really excited coming! (C.S.)

This has been great to think about yourself. You never get to think about things that you've done or to get support from other people and it makes you feel good! (K.B.W.)

Conclusion

In this chapter, the themes that emerged as the focus group participants shared their breastfeeding learning stories were presented. Based on these themes and the literature collected regarding breastfeeding, a model of the breastfeeding adult learning experiences of these mothers emerges. Recommendations can also be made to those interested in enhancing the breastfeeding adult learning experience for women. As well new question arise. In the final chapter, the model, the recommendations and the questions are presented.

CHAPTER FIVE

In this chapter, the themes presented in chapter four are used as a foundation for a model describing the breastfeeding learning experiences of the women in this study. I also make recommendations based on the analysed data. Finally, suggestions for future research are presented.

Breastfeeding Learning Experiences: A Model

The data gathered, coupled with current literature, enables the design of a model of the breastfeeding learning experience of the mothers who participated in this study (see appendix D). The model follows a chronological continuum upon which the breastfeeding learning occurs. The learning occurs in three phases labelled as 1) the initiation phase, 2) the lived experience, and 3) the retrospection phase. Throughout each phase the women seemed to utilize a number of learning approaches which involve knowing, feeling, doing and retrospection. The learning tools they use help them to learn how to breastfeed and cope with obstacles. First, I define the learning approaches. Next, I explain the breastfeeding learning model and discuss the learning that occurs at each phase, focusing on the tools that are utilized and other factors that influence the learning experience.

Learning Domains

The breastfeeding model developed from this study reflects a holistic approach to learning. It is recognized that individuals learn in many different ways. Griffin (1988) suggests learning can occur on a multitude of levels in order to produce knowledge. The four approaches to learning that seemed to be utilized by women in this study can be categorized as learning that occurred through knowing, feeling, doing and retrospection. These terms are similar to those adopted by the Communication Department at the University College of Cape Breton to describe the well established learning model they have adopted for their basic communication courses (Rolls & Brann-Barrett, 1996). Hence for this model, learning through *knowing* refers to the comprehension of particular theories, concepts and other information. Learning through *feeling* consists of how individuals feel about what they are learning, and how that knowledge impacts on their lives. It also includes being aware of how their feelings impact on how they use the new insights acquired. The *doing* domain focuses on the development of the skills needed to perform a task or act. Finally, *retrospection* is the process of reexamining a learning process with a critical focus on how a learning experience may have changed one's perspectives.

As indicated, other learning models also adhere to a multi-faceted learning philosophy such as the one explained by Rolls (1993; in press). Although these models are often used in formal learning environments such as classrooms, this study indicates that the women involved were engaging in a variety of learning approaches. It also appears that at different phases of the experience, different learning domains were emphasized.

The following sections describe the learning that occurs at each phase.

The Initiation Phase

The initiation phase is the stage where women begin to contemplate breastfeeding as an infant feeding method. The women in this study typically engaged in a fair amount of learning by obtaining information during the initiation phase in order to inform their infant feeding decision and to prepare themselves for breastfeeding. There is also an element of learning through feeling in this phase as the women talk with others and think about how they feel about breastfeeding.

The initiation phase typically begins during or before pregnancy. If it starts before pregnancy it is often because women have been exposed to other women who breastfed or because they are planning to become pregnant and have already considered feeding options. It seems that the longer a woman contemplates breastfeeding, the more adamant she is about her choice. The women who thought about it for the first time during pregnancy appeared less convinced of their ability to succeed, and whether or not they would be comfortable breastfeeding, than those who began to contemplate breastfeeding before they became pregnant. Public Health nutritionist, Jan McCabe (2000, personal communication) found similar attitudes in her work with breastfeeding promotions. She claims that in her experience, the earlier in pregnancy a woman is approached and asked to consider breastfeeding, the more likely she is to try breastfeeding. It appears conviction to breastfeed and to succeed is stronger when there is more time to prepare.

The women in this study who considered breastfeeding before pregnancy were

those who had spent time with a breastfeeding mother prior to pregnancy. One had an employer who breastfed, and another spent a great deal of time with an aunt who had breastfed. Seeing the positive experience of these other women encouraged these particular study participants to think about breastfeeding their own children. Similarly, another woman spent three years trying to become pregnant. During that time, she observed and spoke to other mothers and it was breastfeeding mothers who she decided she wanted to model. The women who made the infant feeding choice to try breastfeeding while they were pregnant were influenced by other women who promoted breastfeeding.

It is usually during the initiation phase that the women begin to establish relationships with the women who will become their primary mentor throughout the breastfeeding learning experience. While it may be someone they just met, it is often a long- time friend or family member, or a doctor with whom the women have a positive interpersonal relationship.

Reading and watching videos tend to be the next most common tools used during the initiation phase. Women express interest in learning about the benefits of breastfeeding but also about the actual technique of breastfeeding. The women indicate that videos are additionally useful because they actually show women breastfeeding. Again, this seems to suggest the importance of being able to observe the act of breastfeeding. Literature and videos appear to be prominent methods of learning. The women talked about their desire to read as much as they could about breastfeeding.

Interestingly, while women report literature and other media informed their decision, and their understanding of breastfeeding, there was very little mention of the role

of prenatal fairs, Lamaze classes, or breastfeeding support groups in the decision making process and the breastfeeding learning experience. Yet, the women claim the opportunity to see and talk to breastfeeding mothers on an informal one-on-one basis had a positive impact on their ability to make an informed decision regarding breastfeeding. Matthews, Webber, McKim, Banoub-Baddour, and Laryea (1998) make a similar claim. They write “the mother’s choice was influenced less by health care professionals than by the informal network” (p.180). This pattern may be regionally bound. The study conducted by Matthews et.al. (1998) took place in Newfoundland and Labrador while this study was conducted in industrial Cape Breton. Both areas have lower than national average incidences of breastfeeding (Matthew et. al, 1998, Nova Scotia Department of Health, 1998). A study of the perception of support groups and services may offer insight as to why these women seem to be more comfortable with informal one- on- one breastfeeding learning contexts.

This study indicated a difference between the decision to breastfeed and the decision to *try* to breastfeed. Many of the women learned as much as they could during pregnancy, and decided they would try to breastfeed. If the baby could do it, and they, as mothers, felt comfortable breastfeeding, they would continue. Only two decided unequivocally that they would breastfeed. Both indicated they did not give themselves any other options. One believed her adamant approach influenced her success. She would not give up despite the obstacles she encountered. The other woman, however, experienced physical difficulties that forced her to make the decision to stop breastfeeding. She believes she suffered immense emotional and physical stress because she had not allowed

herself the option to bottlefeed. Hence, the results suggest women approach the decision to breastfeed with varying levels of conviction and determination. While conviction is an asset, it can also lead to feelings of inadequacy if women stop breastfeeding before they originally intend.

Overall, the learning that occurs during the initiation phase prepares the women to make an infant feeding choice. It is also a time to begin to gather preliminary tools to increase the women's knowledge and understanding of the benefits of breastfeeding to the baby and the mother. At this phase the women begin to learn about the basic techniques involved with breastfeeding. This is the phase when women begin to establish a relationship with their mentor. The longer the initiation phase, the more conviction the women expressed.

Next, the second phase, the lived experience is discussed. Included in this phase is an explanation of the tools that the women in the study utilized as well as other factors that influenced the learning experience.

The Lived Experience Phase

This phase refers to the time during which a woman actually breastfeeds. It begins when a mother first puts her child to her breast. While she continues to utilize breastfeeding learning tools in order to breastfeed, other elements influence the learning process. Throughout this phase there are obstacles with which women must contend, and learning expands to include how to deal with these factors. During the lived experience phase, mothers seem to rely somewhat less on learning techniques that involve gathering

information from sources such as books and videos than during the initiation phase. At this point, the mothers seem to engage in an increasing amount of learning by doing (by actually breastfeeding), and learning that occurs through discussions that enable the mothers to think about and articulate how they feel about their breastfeeding experiences.

New breastfeeding mothers tend to seek assistance with breastfeeding techniques as soon as their babies are born. The mothers need someone who can show them exactly how to position the baby, and how to help the baby 'latch on'. The advice must be consistent, otherwise the mothers may become doubtful and unsure. They also need reassurance. A less than positive relationship with nurses can be detrimental to new mothers' confidence in their ability to breastfeed. They often feel vulnerable and inadequate when nurses are inconsistent or non-supportive. Many of the women in this study were dissatisfied with the support they received from nurses. This does not appear to be unique to this study. Carter (1995) writes: "Hospitals are clearly difficult places to establish the supportive, stress-free atmosphere which is conducive to breastfeeding" (p.165).

It may be worth investigating if shorter hospital stays for new mothers has a negative impact on the breastfeeding support received. If a mother is released from the hospital within 48 hours of giving birth (which has become common) she may not see the same nurse on more than one shift, thus making it difficult to establish a rapport that is conducive to teaching and learning the art of breastfeeding. It would be interesting to determine whether or not this and other similar factors are effecting women's breastfeeding learning experiences.

Besides nurses, women still rely on books during this phase. However, the books serve more as troubleshooting tools. It becomes increasingly difficult for mothers to find time and energy to read when caring for a newborn or infant child. They also begin to discover discrepancies between what is said in the books and their own breastfeeding experiences. The women become increasingly aware of the uniqueness of their situation and the limited relationship between theory and practice. Learning becomes increasingly experiential throughout the remainder of this phase.

Like during the initiation phase, a mentor is a valuable resource for breastfeeding mothers at this phase as well. Women need a support person who understands the art of breastfeeding. The mentors are individuals who the new mothers perceive as credible and trustworthy. Mothers in this study who had mentors, rely on their mentor for information, practical techniques, and suggestions. The mothers often ask the mentor to assist in the positioning and latching processes. The mentor will observe the baby breastfeeding and give new mothers tips while they are actually nursing. Mentors are usually breastfeeding mothers or women who have breastfed in the past. This allows for an exchange of personal experiences and stories. The mentor's credibility is evident in her ability to relate her own experiences to those of the new mom, while at the same time recognizing the uniqueness of each individual breastfeeding experience.

The mentor/ new mother relationship requires a high level of trust and comfort on the mother's part. New mothers want to feel comfortable breastfeeding in front of their mentor as well as discussing their fears and concerns with them. This may account for why mentors are often friends or family members. The women in this study had mentors with

whom they already had positive interpersonal relationships; relationships that began before or during the initiation phase. A study of gendered student responses to an experiential learning model executed in a university environment determined: “Regarding (communication) lab facilitators, males focused on operational dimensions, while women gravitated toward relational considerations” (Rolls, 1997, p.57). This is similar to the importance women placed on the interpersonal element of the mother-mentor relationship in this study. In their literature review of mentoring among re-entering women, Schwiebert et.al. (1999) also note the importance of positive interpersonal relations between mentors and mentees. They write that in marketplace mentoring, women mentors focus on psychosocial mentoring as well as career mentoring while male mentors tend to focus more on the career mentoring. They cite Gilligan (1982) when they say this difference in approach may be due to the fact that women take a more relational approach to problems-solving and decision-making.

Other influencing factors are at play through the lived experience phase. These include the opportunities to talk about the breastfeeding experience and to watch other women breastfeed. They also include changing perceptions of breasts and coping with obstacles to successful breastfeeding. These are discussed in the following segments.

Talking About the Breastfeeding Experience

During the lived experience phase, a vital element of the breastfeeding learning experience for mothers is talking about their experiences. This study suggests that as women engage in breastfeeding, they want the opportunity to talk to other people whether

it be to ask questions, to clarify information, or to share positive and negative experiences. For the most part, women expressed the desire to talk to other women who have breastfed. Some of the women claimed that talking with men, or even women who did not breastfeed, is not always as satisfying. There are women who are not comfortable discussing their breasts with men. In comparison, some men and women who have not breastfed are uncomfortable talking about breastfeeding. The women in the study seemed to indicate that this may be due in part to the sexuality of the breasts, and the fact that words such as *breasts* and *nipples* makes some people uncomfortable. Women may prefer to talk with other women with whom they share the breastfeeding experience because they understand each other. For example, if a women is explaining to another breastfeeding mother why she finds breastfeeding pleasurable she is somewhat confident that the other mother can relate to the experience. As Carter (1995) points out:

There are 'places', 'times', 'situations' when women enjoy aspects of child bearing and breast-feeding and their own and other women's bodies, although it is often difficult for them for them to find a language in which to express this. There are inherent difficulties with language and forms of representation within which to express these experiences.
(p. 149)

This is in keeping with language and gender studies discussed earlier in this thesis. Those studies suggested that women often have experiences that are difficult to express

because such events have not been named (Crawford, 1995; Kramarae, 1981; Spender, 1990). The women in this study suggest that talking about the breastfeeding learning experience not only enables mothers to gain new information, but it also provides encouragement and validation which helps to increase confidence. When breastfeeding mothers do not have someone with whom they can talk about their breastfeeding experience, they often feel they are missing an important part of the learning process. One woman indicated her stress level would not have been as high if she had someone: “I needed someone else to talk to who had breastfed..who had been doing it” (C.S.).

Again, it is interesting to look at the role of the breastfeeding support group at this phase. Only two of the women attempted to utilize the services of the breastfeeding support group. One is still a member and speaks favourably of the group. The other was unable to contact group members when she needed help, and decided not to keep trying. The focus group participant who is still active with the breastfeeding support group indicated that she believed the role of the group was to support mothers in their decision to breastfeed and help them find solutions to problems they encounter. While this approach certainly benefits some women, by providing them the continuous encouragement that they need, others may be looking for reassurance that if they are unable to continue to breastfeeding they will continue to be supported. They may need to know they are still good mothers, and any duration of breastfeeding is to be celebrated. A perception (whether it be accurate or not), that they may be ‘judged’ may cause some women to avoid a breastfeeding support group.

Another problem concerning the support group may be negative public perception.

Sydney is a small community and if someone had a less than positive experience with the support group she may share her experiences with others. Two participants in this study had heard stories from women who were dissatisfied with the support group. One of the participants, in particular, was thus discouraged from attending support group meetings.

Visual Learning Opportunities

During the lived experience phase of learning, it becomes increasingly valuable for the breastfeeding mother to observe other mothers who breastfeed. This visual learning technique proves beneficial for reasons similar to the benefits of being able to talk about breastfeeding. It provides a visual learning opportunity where the mother can see how other women breastfeed. Hence, this may give her ideas in regards to positioning and helping the baby latch on, as well as methods to breastfeed discreetly. Women suggest watching other women breastfeed is reassuring and validating.

The mothers in this study talk about feeling moved when they see other women breastfeeding, particularly, in public spaces. They often feel the desire to offer these breastfeeding mothers encouragement and support in their decision- not just the decision to breastfeed, but to breastfeed in public. Their reaction may be interpreted as an act of resistance on two fronts. One, by breastfeeding in public, women are challenging a perception of the breasts as predominantly sexual. Often, when women's breasts are gazed upon in public they are seen as part of the woman's sexual body image. They are judged for their attractiveness and sexual appeal. A number of women in this study talked about the discomfort they experienced when their breasts became larger throughout pregnancy,

and when people looked or commented about them. Yet, the same women applaud women who breastfeed in public. Perhaps, by breastfeeding in public, women are showing that breasts have more than a sexual function. They are a life-giving form of nourishment. It is difficult to watch a woman breastfeed without looking past the sexual function of the breast. Breastfeeding women who want their breasts recognized as something other than sexual objects may feel empowered by women who display the other function of the breasts in public.

Breastfeeding in public can also demonstrate another form of resistance- a resistance to the devaluing of the work of mothers.

Carter (1995) writes:

...the relegation of breastfeeding to the private sphere does not simply concern modesty and embarrassment. It also involves the placing of infant feeding in the private sphere in the sense that it has become women's own responsibility to fit it into their other unpaid and economically unvalued domestic duties. (p. 131)

At the same time Carter notes that breastfeeding is subject to public scrutiny to ensure women breastfeed properly.

She continues:

The 'working conditions' of infant feeding crucially involve a notion of breastfeeding as a private 'duty', arising from

women's natural capacities and therefore requiring no financial, or other resources. Breast-feeding developed this aspect of its place within public and private discourses as part of the alarm, in the last century and in the early part of this, about infant mortality. Breast-feeding mothers had to stay at home and do their duty in private, but feeding itself became a public issue, subject to professional surveillance.

(p.131)

The act of resistance lies in breastfeeding mothers willingness to breastfeed in the public sphere. It may be a means to refuse isolation and to bring the discussion of breastfeeding to the forefront. As long as breastfeeding mothers remain tucked away in closets, washrooms, and bedrooms it is difficult to lobby for proper supports for breastfeeding women.

Changing Perceptions of the Breast

While a mother begins to experience a changing perception of her breasts during the initiation phase (specifically as her body begins to change during pregnancy) this becomes more of a factor during the lived experience. For many women, the breasts are private and it is increasingly difficult to keep them private when breastfeeding. It is easier to learn how to breastfeed without wearing a bra or a top. When the mentor helps the breastfeeding mother, the new mother's breasts are often exposed, and the teaching and

learning involves touching and moving the breast. These women, who under normal circumstances can not imagine exposing their breasts or having someone else touching their breasts in a non-sexual way, find this type of assistance normal and very beneficial. The women themselves are sometimes surprised that they can be so comfortable.

During the lived experience phase, the women perceive their breasts primarily as nourishment for their children. In most cases, the women state they do not want to think about the sexuality of their breasts. Some of the women made it very clear they did not want their breasts touched unless it was for the purpose of breastfeeding, or learning how to breastfeed.

The women experienced an increase in the size of their breasts while breastfeeding, especially in the first few months. They accepted the size change as a natural part of the breastfeeding process, yet they felt uncomfortable or annoyed when others were looking at their breasts in a way that may be perceived as sexual, or when others commented about the size of the breast. For these women, part of the breastfeeding learning experience is accepting that the breasts serve a function as a form of nutrition for their child. They see it as life-giving, some say, a natural extension of the function of the body throughout pregnancy. Hence, when the breasts are referred to in a way that may be interpreted as sexual or objectifying, it appears to be the mother's instinctual reaction to protect the breastfeeding function of the breast. For some women, sexually objectifying the breasts may interfere with the breastfeeding relationship between the mother and the baby. The severeness of this reaction often subsides after the women stop breastfeeding, but may return when she has another child. As one woman said in reference to her breasts: "It was

frustrating to have them seen for any other use other than breastfeeding when I was breastfeeding my first child...it's the same this time with my second child. Then it just sort of went away after I stopped nursing. (L.B.).

Carter (1995) refers to the conflict that exists between *mothering* and *sexuality*. She writes: "In the context of infant feeding..she must also be a good mother as well as a lively and attractive sexual partner" (p.153). She explains further:

Reproduction and sexuality remain linked through the disciplinary discourses of femininity and heterosexuality. Good girls and women must tread carefully along the thorny path of respectable wife, accommodating (desirable) lover and responsible mother. These discursive practices are conducted through various attentions to women's bodies. I have suggested that breasts are specifically involved here as a site of both visual and tactile pleasure for men and nurturance for babies, with all the potential contradictions this brings. Breasts provide a bodily focus for the policing of women through the dichotomising discourse of the whore and the Madonna. (p.154)

Blum (1999) agrees with Carter's position. She writes: " Above all, women must keep the heterosexual body strictly separate from the maternal body, although in daily life, they continually collide" (p.129). Recognition of the conflict that appears to exist between

the *sexual* breast and the *nourishing* breast may explain why the women in this study felt uneasy when they believed their breasts were being looked at or talked about in a sexual context.

Learning to Cope with Obstacles

A challenging part of the breastfeeding learning experience during the lived experience phase is learning how to deal with the physical, psychological, and social obstacles. In chapter four the specific problems the women in this study were faced with were reported. Here, the learning techniques used to tackle these problems are explained.

Physical obstacles:

To deal with the physical problems surrounding breastfeeding, it is indicated through this study that a variety of learning tools are necessary. Often problems can be rectified by learning new ways to position the baby or ways in which to help the baby latch on. Some women refer to books to troubleshoot these problems, but they also rely on their mentor to show them how to position the baby properly, how to ensure the baby is latched on properly, and to explain the methods of dealing with cracked nipples and engorged breasts. The mentors are often able to pinpoint physical problems quickly, and to help the mothers solve the problems. In instances when the mothers face unexpected obstacles such as cesarean births, or inverted or flat nipples, the new mothers often have to do their own research to determine the best course of action. These women may combine all their

sources (books, videos, mentors, nurses, and other health professionals), and sift through sometimes inconsistent advice to determine what to do. It is sometimes trial and error on the part of the mother that teaches them how to deal with a problem. This sort of learning, often enables the mother to overcome her problem. There are instances where mothers are unable to uncover the proper information to help them with the problem and they ultimately must choose whether or not to continue breastfeeding.

Psychological and social obstacles:

The women in this study credit their mentors with helping them overcome the psychological and social obstacles faced when breastfeeding. The mentor provides encouragement and reassurance. It is essential, however, that the mentor be available when mothers are in the midst of difficulty. The women in this study appear to rely on knowing they could call their mentor any time. The mothers learned to rely on their mentors when they felt ready to give up. Through talking and listening, the mothers can often work through the feelings and take time to explore why they are feeling discouraged or frustrated. Such discussions with the mentors can serve as a forum for affective learning - a time for mothers to explore why breastfeeding conjures so many emotions and the impact the breastfeeding learning experience is having on their lives. The mentors seem to guide the mothers through these discussions by sharing their own stories and by listening attentively.

Another way the women come to deal with the obstacles, in particular social obstacles, is through personal experience. Some of the mothers said they stopped

worrying about what other people said once they had been breastfeeding for a while. They learned to trust their own instincts. The role of personal experience in the breastfeeding learning model is discussed in greater detail later in this chapter.

Interestingly many of the participants expressed their regret that their own mothers or grandmothers were unable to help them deal with some of the breastfeeding obstacles. Because their own mothers had not breastfed, they did not have a knowledge of breastfeeding to pass on to their daughters. These participants revel in the thought that their own children will benefit from the knowledge they, as women who did breastfeed, will be able to share.

Learning to Wean

The final element of the lived experience phase to be discussed is learning to wean. From this study it was determined that weaning is rarely a concern for the mothers when they begin their breastfeeding learning experience. Consequently, mothers often find themselves quite suddenly faced with the weaning process, having not learned a great deal about how and when to wean and having not prepared for the feelings they may experience. The mothers in this study suggest that when it comes to weaning, the experience is very unique for everyone. Each mother has different circumstances that influence when she must stop breastfeeding. The learning includes learning when to know the time is right and learning to trust the decision to wean. Then, the actual weaning is a learning experience. If, for example, a baby is accustomed to nursing to sleep, mothers have to readjust their baby's routine and find new ways to help the baby sleep. The

mothers also have to learn to cope with the emotions that often accompany weaning. Mothers' emotions, such as grievance, emptiness, and sadness, need to be addressed. These feelings are particularly intense when the mothers think their weaning is premature. These mothers expressed feelings of guilt. The participants perceived that others may negatively judge their decision to wean and felt a strong urge to justify their choice with family and strangers.

This seems to be one time throughout the lived experience phase when the mothers did not mention turning to their mentors. In fact, it seems the mothers tended to work through the weaning process on their own. It is often after the fact that they discuss their weaning experiences.

The Retrospection Phase

While some degree of retrospection occurs throughout each phase of the breastfeeding experience, much of it seems to take place when women are close to weaning, in the process of weaning, or have weaned their child. This is the stage when the women look back on their breastfeeding experience. One of the greatest realization that the women in this study made was that their own experience was an excellent learning tool. The more experience they gained as breastfeeding mothers, the more confident they appeared to be about the decisions they made throughout the process. The women with more than one child spoke of learning from the first time they breastfed, and making positive changes to their approach the second time. Their personal experiences also appeared to give them the confidence and the desire to support and mentor other

breastfeeding mothers. For women who stop breastfeeding before they intended, the retrospective phase seems to be extremely important. When they have the opportunity to reflect with other positive and supportive mothers, they often come to realize that the duration of their breastfeeding relationship with their child does not determine whether or not they are good parents. Some women find it difficult to come to this conclusion on their own.

The retrospective phase of this model must not be underestimated. Many adult education theorists embrace the value of critical reflection in learning. Mezirow (1990) writes: "Reflection enables us to correct distortions in our beliefs and errors in our problem solving" (p.1). Knowles (1980) suggests reflection helps adult learners to unfreeze their experiences and to use them as a source of knowledge. It has been my own experience that upon reflection personal experience coupled with theory becomes knowledge. I suggest the retrospective phase of the breastfeeding learning experience is the phase where women can come to recognize their breastfeeding knowledge.

I am not convinced, however, that retrospection occurs automatically. Sessions, such as the focus groups conducted for this research, provide a forum for mothers to engage in self-reflection of their experience. However, it has not been determined whether or not all women find a venue for this type of learning. For the women in this study, retrospection allowed them not only to recognize their knowledge, but also to consider the significance of their breastfeeding learning experiences. All the women noted it was among the most significant learning experiences of their lives. The women indicated they not only learned to breastfeed, some of the women claimed that they learned about mothering,

others learned to think about their bodies in new ways (for example as a source of food and a giver of life), still others learned how strong they were and that they were capable of more than they had ever believed. Based on the experiences of the women in this study, I suggest the retrospective phase helps women to validate their learning experience and the knowledge they created.

Recommendations

As a result of this study, preliminary recommendations can be made that may be useful to those who wish to provide support to women engaged in the breastfeeding learning experience. In this section, I outline recommendations that speak to many of the needs addressed in this study.

A Mentor Program

Mentors appeared to play a significant role in the success of the breastfeeding learning experiences of the women in this study. Those who did not have a mentor expressed their desire to have such a support person. In a community where the breastfeeding rates are still lower than the national and provincial averages, it can be difficult for women to find a mentor among their friends or family. Perhaps a volunteer program that links expectant mothers with mothers who have breastfed could be established through the Department of Health, the local Family Resource Centre, or the local breastfeeding support group. While attending a conference on breastfeeding a

number of years ago, a Public Health nutritionist talked to me about such a possibility. She referred to the creation of this type of program as *Bosom Buddies* (Mc Cabe, personal communication, October, 1996).

Women mentoring programs in areas such as business (Duff, 1999) and education (Sands et.al., 1991) are already in existence. There is substantial research in the specific area of mentoring in particular in career development and academia. Research conducted by Chao (1992), Quinlan (1999) and Schwiebert et.al (1999) are examples of such work. Many of their findings, ideas, and recommendations could be adapted to work for a breastfeeding mentoring program. Based on the research from this study a mentoring program for breastfeeding mothers may be successful if the following conditions are considered: 1) an early establishment of the relationship between mothers and mentors, 2) a substantial time commitment from the mentors, and 3) a mentoring philosophy that recognizes and respects all decisions made by the mothers. Here each is discussed.

First, the earlier in pregnancy a woman is connected with her mentor, the more time the pair has to establish a positive relationship. The mentor would not only have to possess a knowledge of the breastfeeding learning experience from her personal experience, but she would also have to have good interpersonal communication skills. This would help to establish a sense of mutual respect based on credibility and trust. The mentor should have to have the time to commit to such a relationship, in particular, just after the birth of the baby. Schwiebert et.al. (1999) state the importance of a time commitment on the part of the mentor to ensure the success of the relationship. Finally, the mentors' main goal must be to support the new mother through her breastfeeding

learning experiences, with a philosophy that any amount of time breastfeeding is considered successful. Effective mentors avoid authoritative approaches and they allow mentees to make their own decisions (Schwiebert, 1999). This is extremely important when it comes to weaning. The mentor must avoid sacrificing the mother's self esteem in order to ensure she continues to breastfeed. She must also be willing to support the new mother through weaning, if that type of support is required. At all times, the mother's sense of dignity and self-confidence must be respected.

One possible way to help prepare potential mentors would be to organize a training session that provides accurate information regarding the process of breastfeeding. Preparation should also include interpersonal communication training since this study and others (Rolls, 1997) suggest the importance women place on a positive relationship with a mentor or support person. Mentors can also be provided with an updated list of sources of breastfeeding information, including the titles of books and videos, as well as breastfeeding Internet sites. Also included would be a list of libraries and stores that carry the books and videos. These would be tools mentors could share with their partner which is an important role of mentors (Schwiebert et. al., 1999). Sessions could be held periodically to accommodate new mentors and to provide a refresher for established mentors.

To provide a forum for the retrospective phase of the breastfeeding learning experiences there can be sessions for mentors and new mothers to attend. This could be done in association with the breastfeeding support group if it is determined that both programs share a similar philosophy. In the beginning, these meetings can be held on an

'as needed' basis. However, once the program is established there may be regular sessions to accommodate the women.

While such a program calls for a strong commitment on behalf of the mentor, I am confident that there are women who would be eager to participate. The women in this study spoke of their desire to be there for other women who are breastfeeding. As well, the University College of Cape Breton has a number of cooperative based programs that include work placements for their students. One program, the Bachelor of Arts in Community Studies, requires students to do two volunteer work placements. Students interested in adult education, health education, or women's studies (just to name a few) may be willing to become involved in this sort of program. These students could help with tasks such as compiling lists of sources, arranging meetings, and assisting with the research and development of the program.

The mentor program is a huge undertaking and a great deal more preliminary study, including a needs assessment, would have to be undertaken before launching this initiative.

Education for hospital nurses

A major concern for the mothers in this study was the support they received from nurses in the hospital. The central problem was the lack of consistency in the care, advice, and the information offered to the new mothers by hospital nursing staff. This suggests that nurses need more accurate and updated information regarding the breastfeeding process, and perhaps trainer training to assist them in the role as breastfeeding teachers for

new mothers. Nurses need to know the common and uncommon obstacles faced by mothers who are learning how to breastfeed. They need to be made aware of all the options available to mothers to help them overcome feeding barriers. It is unfair to expect nurses to teach mothers how to breastfeed when they have not been given the tools or resources to do so effectively. I recognize that this is an added responsibility to nurses who are already overworked. Nurses at the Cape Breton Regional Health Complex in conjunction with other health professionals recently participated in breastfeeding in-services and training seminars (personal communication, J. McCabe, November, 2000). This is a step forward. However, some of the concerns that emerged through this study need also to be addressed in that training. As well, further study needs to be conducted to determine how to incorporate this kind of training into the nurses' training curriculum and their schedules once they are practising.

Study Limitations and Future Research Suggestions

As with any study, this research has its limitations. Further research may begin to address some of the question that were raised as a result of this study. In this section, these possibilities are presented.

Similar Studies with Different Populations

The mothers who participated in this study were white, middle to upper middle

class, with at least some degree of post secondary formal education. They each had the support of a partner during their pregnancy and following the birth of their children. Women from different backgrounds may require different kinds of support and would have different experiences to share. It may be interesting to conduct a comparative study with different segments of the population.

As well, this study was conducted in a region of the province and country that is known to have lower rate of breastfeeding mothers than other areas. Again, a comparative study with women from, Halifax or Toronto, for example, may show the region does make a difference. For example both Halifax and Toronto have well-established La Leche League groups and hospitals that focus on children and women. These factors may influence the kind of support women in these centres require.

This study represents the story of the women who participated in this research. It should not be generalized to represent all populations.

The Support Group Factor

I was intrigued throughout this study by what I perceived as the under-utilization of the local breastfeeding support group. Further studies that examine how citizens of the Cape Breton industrial area regard support groups may shed light on this finding. It could be narrowed to focus just on the breastfeeding support group, or widened to look at support groups in general. Another possibility would be to compare how women in larger, more urban centres utilize breastfeeding support groups with how they are used by women in Cape Breton.

Women's Perceptions of Their Bodies

During the focus groups, the women spoke about how they perceived their bodies during pregnancy and while breastfeeding. Interestingly, many of the women claimed that when they were pregnant they did not worry as much about body image as they did at other times in their lives. Two women made the following comments:

I was the happiest I ever was when I was pregnant and breastfeeding. There wasn't a sad day. I gained seventy pounds. (D.M.)

I gained 46 and felt great! (K.B.W.)

Western society seems to have a fixation on female body image (Wolf, 1992) and weight is a major factor in the equation. However, some of the women in this study seemed to be less intimidated by the societal image of beauty when they were pregnant and recognized the beauty of a pregnant woman. Further study to explore women's perceptions of their bodies during pregnancy and breastfeeding is a worthwhile investigation.

Breastfeeding and Popular Media

Many of the women in this study referred to television and its seemingly

unwillingness to show breastfeeding women. An interesting study might be to explore these observations a little more to determine if there is actually an unwillingness to show breastfeeding women in popular media, and if so, why.

The Private and Public Aspects of Breastfeeding

Breastfeeding has both private and public domains. Clearly, further examination of the politics surrounding issues such as breastfeeding in public, and a breastfeeding mother's right to privacy may provide much needed insight into these concerns.

Conclusion

The purpose of this study was to determine 1) what adult learning tools were used to learn how to breastfeed, and 2) the impact these tools had on their success. Based on the data generated by the women in the study, a breastfeeding adult learning model was developed. It shows the adult learning appeared to progress along a chronological continuum that began when the women first contemplated breastfeeding as an infant-feeding choice and continued often past the weaning stage. Three distinct learning phases emerged: 1) the initiation phase, 2) the lived experience phase, and 3) the retrospection phase. Throughout each phase women rely on learning tools that enable them to learn how to breastfeed and tackle obstacles they face throughout the process. As the women continue to reflect on the experience they create for themselves a new understanding, and

knowledge regarding the breastfeeding learning experience. This study begins to explore the breastfeeding learning experiences of women in Industrial Cape Breton. It is one in many possible research works that can explore the lived experiences of women while in turn recognizing the importance of the learning and working that occurs in their daily lives.

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APPENDIX A

THE LEARNING PROCESS

At what point did you first decide to breastfeed your child/children?

At what point did you begin to learn about how to breastfeed? (for example; before pregnancy, early pregnancy, mid-pregnancy, late pregnancy, when the child was born)?

Was breastfeeding a subject you were comfortable discussing with others (i.e. friends, family, partner, co-workers, neighbours)

Tell me about the methods and resources you used to learn how to breastfeed.(For example, doctors, friends, family, books, and other media)

EFFECTIVENESS OF THE LEARNING METHODS

Tell me the learning strategies (if any) that worked best for you?

Tell me the learning strategies (if any) that were not helpful?

Tell me about anything else that influenced the learning process?

Tell me if the learning process prepared you for obstacles that may make nursing difficult?

While you were breastfeeding were there people with whom you discussed your breastfeeding experience

Tell me if the learning process effected how you felt at the end of your breastfeeding experience?

How important was this learning experience?

*This schedule will serve as a flexible guide to help facilitate discussion among group members.

APPENDIX B
PARTICIPANT DATA SHEET

(please print)

FOCUS GROUP SESSION #:_____ **DATE:**_____

NAME:_____

PSEUDONYM:_____

PHONE NUMBER:_____

ADDRESS:_____

NUMBER OF CHILDREN BREASTFED:_____

DURATION AND START YEAR EACH CHILD WAS

BREASTFED:(give child's name, length of time and start year) _____

APPENDIX C

INFORMED CONSENT FORM

You are invited to participate in a study on breastfeeding. The title of the study is **Women's adult learning stories about breastfeeding: A study examining the adult learning strategies women use to learn how to breastfeed and the impact of the adult learning on women's breastfeeding experiences.**

I intend to conduct three focus groups, each consisting of five to seven women from industrial Cape Breton who breastfed their child or children (it does not matter how long you breastfed your child). I want to hear how you learned how to breastfeed (who and what helped you) and how the learning methods effected how successful you felt about your own breastfeeding experience. For women who choose to breastfeed, the learning process can become an important adult learning experience. I believe women who are hoping to breastfeed may benefit from hearing the stories of other mothers.

I am a graduate student in the Master of Arts in Education program at Mount Saint Vincent University. This study will serve as the basis of my Master of Arts thesis. I also may refer to parts of the thesis and data in academic papers submitted to conferences and journals.

I will arrange the focus groups at times and locations that are convenient for all participants. Each focus group will last approximately two hours. In order that I can accurately refer to the group discussions, the sessions will be audio taped. It is your own

choice whether or not you answer the questions and you are free to withdraw from the study at any time. **Because this study brings a group of people together to share their experiences, it is impossible to guarantee complete confidentiality. However, I will take measures to ensure all information shared is kept as confidential as possible. I ask all participants to respect the confidentiality of others in the group and you may choose a different name to be used in the documents for the study. I am the only person who will listen to the tapes and have access to them. Both tapes and transcripts will be kept in a locked cabinet.**

Please feel free to contact me at 563-1322 if you have any questions. As well, you may contact my thesis supervisor Dr. Patti Gouthro, Education Department, Mount Saint Vincent University. If you have any concerns about my conduct and wish to speak to a person who is removed from this study please contact Dr. Donovan Plumb, Education Department, Mount Saint Vincent University.

You participation in this study is voluntary. Please sign this form of consent to indicate you have read the information in this letter and are willing to be contacted for participation in this study. You will receive a copy of this consent form. Thank you for your help.

SIGNED CONSENT

I, _____, agree to participate in a focus group conducted for the study, **Women's Adult Learning Stories about Breastfeeding**. I

understand the information is confidential. Any questions I have about the study to this point have been answered.

Signature of Participant: _____

Address: _____

Phone(s) _____

Signature of Researcher: _____

Thesis Advisor: _____

Program Coordinator: _____