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Sense of Support: The Impact of Healthcare Encounters on the Breastfeeding Experiences of African American Mothers

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SENSE OF SUPPORT: THE IMPACT OF HEALTHCARE ENCOUNTERS ON THE BREASTFEEDING EXPERIENCES OF AFRICAN AMERICAN MOTHERS

by

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ABSTRACT

Although many studies have found a substantial racial disparity in infant feeding habits, the factors contributing to this unique disparity and potential solutions remain unknown. The general importance of social interactions and medical interventions in successful breastfeeding has been studied, but little research addresses the specific experiences of breastfeeding Black mothers interacting with their medical providers. This paper examines the perspectives of Black women with breastfed infants on their encounters with healthcare providers during prenatal, perinatal, and postnatal periods. Using qualitative data from 22 in-depth interviews addressing infant feeding decisions and experiences, this paper analyzes the link between healthcare interactions and the breastfeeding experience among Black women.

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INTRODUCTION

The unique benefits of breastfeeding are a point of widespread consensus within the medical community on a global scale. The general recommendation for mothers of infants is to breastfeed exclusively for the first six months of life and then continue breastfeeding while introducing solid foods to maximize short-term and long-term effects for both the mother and the child (Binns et al., 2016; Couto et al., 2020). Breastfeeding has a unique capacity to nourish, confer immunity, and socialize a child all at once resulting in a wide range of benefits including improved physical and cognitive development during infancy, reduced rates of infection during infancy, and greater bond formation between the mother and child (Couto et al., 2020). As the first source of nourishment for breastfed infants, it also has a lasting impact on the child's metabolic activity throughout their lifetime with recent studies finding that exclusive breastfeeding is associated with reduced rates of chronic diseases – including heart diseases, obesity, and even some cancers – upon adulthood; similar impacts on chronic disease occurrence has been found for mothers who breastfeed (Binns et al., 2016). However, the medical benefits associated with breastfeeding are only one factor among the many that impact the decision to breastfeed an infant. While some mothers are physically unable to breastfeed for one reason or another, others choose not to breastfeed exclusively based on a multitude of sociocultural influences. These social influences impact individuals belonging to different social categories in different ways resulting in clear disparities in breastfeeding rates between social categories.

The Racial Disparity in Breastfeeding

Like most things in society, there are social barriers blocking some women from exclusive breastfeeding. Although rates of overall breastfeeding and of exclusive breastfeeding

are lower than the national goals, some social categories tend to have significantly lower rates of breastfeeding compared to others with these patterns mirroring patterns of privilege and disadvantage. Disproportionate breastfeeding rates between racial and socioeconomic categories, as well as the intersection between these two factors, persist even despite widespread campaigns and programs to increase breastfeeding rates through both general and targeted approaches.

As for socioeconomic status, low-income families who are eligible for food assistance continue to breastfeed at lower rates and have seen significantly lower increases in the rates of sustained, exclusive breastfeeding in recent years when compared to higher-income families (Zhang et al., 2019). As for race, while White women tend to have higher breastfeeding and exclusive breastfeeding rates compared to all other racial and ethnic categories, Black women tend to have significantly lower breastfeeding rates compared to other racial categories indicating a uniquely large disparity impacting Black women (Louis-Jacques et al., 2017). Although Black families are overrepresented among low-income households, this relationship is not sufficient to explain both disparities as Black women continue to breastfeed at significantly lower rates compared to other races and ethnicities even when socioeconomic status and other confounding variables are accounted for and controlled (Forste et al., 2001). This means that the intersection of race and socioeconomic status compounds the barriers experienced by Black women impacting their ability to and choice to breastfeed their infants. The decision to breastfeed is complex relying on a variety of factors including social, cultural, economic, and medical influences as well as personal values and beliefs meaning that the disproportionately low rates of breastfeeding among Black women are not solely explained by economic factors like income and occupational environment (Oyeku, 2003).

Influences on Breastfeeding Practices

With regard to the economic factors that do influence one's breastfeeding practices, when evaluating the effect of food insecurity on how one chooses to feed their infant, racial differences are not very significant in the rationale for not breastfeeding with both Black and White women citing the need for another's assistance in feedings (Gallo et al., 2019). A simple explanation for this may be the need to return to work coupled with a cultural taboo against breastfeeding in public spaces such as the workplace. Even in workplaces where employers seemingly support breastfeeding mothers by allowing designated lactation rooms and breaks, many women still reduce the ratio of breastmilk in their infants' diet after returning to work. These technical interventions are not enough when the cultural stigma persists with breastfeeding outside the home often being associated with feelings of embarrassment and lactation breaks at work being associated with reduced efficiency (Tsai, 2014).

These sociocultural influences add to the difficulties many women face when choosing to breastfeed and provide more insight into possible reasons for the racial disparities. The social environment created by a women's friends, families, and even internet exposure brings attention to the stigmas associated with public breastfeeding, the sexualization of the human breast and thus the act of breastfeeding, and the historical connotations of breastfeeding and exploitation unique to Black women (Lutenbacher et al., 2016; Owens et al., 2018). Despite these barriers, many Black women still breastfeed their children citing their personal beliefs and attitudes as their reason for doing so. In fact, attitudes regarding the perceived benefits of breastfeeding have significant impacts on women's intentions to breastfeed and on their continuation of breastfeeding through the few several months of life (Topolyan & Xu, 2019). Similarly, attitudes about breastfeeding among Black college students are associated with their intentions to

breastfeed with more positive attitudes being associated with greater intent to breastfeed any children they may have in the future (Jefferson, 2014). In this last case, the study only describes intentions and not the actual practice of breastfeeding, and as the participants in the study gain more experiences their attitudes and intentions may in turn evolve.

Support by medical professionals is another significant factor contributing to women's desires to start or continue breastfeeding. Most women experience some kind of difficulties when breastfeeding including physical symptoms, milk supply deficiencies, or latching problems, but only about half actually feel as though medical professionals provide sufficient support when those problems arise. When such difficulties persist without support from medical professionals after delivery, the number of women who choose to stop or reduce breastfeeding increases (Gianni et al., 2019). These effects are further illustrated among low-income women who have been shown to breastfeed longer when community-based medical professionals continue to provide support in the months following delivery (Pugh et al., 2002), and they are illustrated among Black women who found continued support by healthcare professionals assisted in successful breastfeeding over extended periods of time (Petit et al., 2021). Black women's experiences with support by healthcare providers are often unhelpful as a result of dismissive, impersonal encounters and can even be detrimental as a result of racial bias and profiling as some providers reduce patients to statistics rather than addressing the real needs of the patient (Lutenbacher et al., 2016). To combat this trend, at least one recent study suggests educational and training programs targeting healthcare providers to improve recognition and mitigation of systemic racism in healthcare and individual biases that many providers may not even realize they possess; coupling improved sensitivity among providers with improved communication

with patients focusing on the individual may help make medical interventions and support more effective and in turn increase successful breastfeeding among Black women (Petit et al., 2021).

Importance of Language

People learn social norms, values, and attitudes through individual interactions with each other; as beliefs and ideals are shared by individuals a common understanding is formed allowing communities to form around common values and standards as described in symbolic interactionist theories. With global communication becoming more accessible than ever before due to the Internet, these values and beliefs can become much more widespread much quicker giving a great deal of power to the words and imagery used to give meaning to various aspects of society including people and their behaviors. The language and portrayals – or lack thereof – surrounding breastfeeding thus has a significant influence on the degree of social acceptance and stigmatization of the practice.

When describing their experiences of being able to take breaks at work in order to pump, some women described their "luck" and "privilege" for having that opportunity as such supports are not considered norms in current society (Turner & Norwood, 2014). As it stands, today's society makes it difficult to merge the imagery of a mother with that of a working woman as the ideals for each elicit diverging characteristics. The workforce is still viewed as a masculine environment that is inherently at odds with the feminine sphere of childrearing and breastfeeding resulting in a norm in which women do not expect to receive any support for breastfeeding once they return to work and may expect discouragement instead (Turner & Norwood, 2014).

Even outside the specific setting of the workforce, there is a dichotomy in the values and ideals that women are expected to strive toward. Recent campaigns advocating for increased breastfeeding have used the phrase "breast is best" creating two unintentional consequences: the

implication that formula is harmful rather than simply different and the implication that breastfeeding is not the norm and instead is an alternative to standard feeding practices (Woollard, 2018). The use of language referring to "benefits" and "harms" creates a moral polarization in which breastfeeding's depiction as be the good choice inherently forces formula to be portrayed as the bad choice regardless of the individual social, cultural, and economic environment that surrounds a family. These environmental factors create limitations on what decision one can make regarding infant feeding or if one has a choice in the matter at all putting women in vulnerable situations at greater risk for scrutiny and scorn if they are unable to successfully breastfeed according to social standards (Woollard, 2018).

While new mothers are constantly told "breast is best," social stigmas against public breastfeeding are still prevalent limiting the agency of breastfeeding mothers as time spent outside the home – including at work – is limited by their infants' feedings and their own needs to pump. For Black mothers, this stigma often persists even at home when male figures and guests are present further restricting these women as they attempt to navigate a complicated journey of feeding their child while avoiding judgment and ridicule for violating cultural standards (Owens et al., 2018; Papadopoulos, 2018). The idea that breastfeeding must be a hidden and private act is born from the hyper-sexualization of the human breasts making exposure of such in public and semi-public settings deemed lewd or indecent even when in an extremely maternal context as is the case with breastfeeding (Papadopoulos, 2018). The taboo against public nudity is in direct violation of the imagery evoked by the idea of a mother creating a conflict as the maternal act of breastfeeding requires a degree of exposure severely limiting the ability to breastfeed successfully.

Impact of Medical Encounters

A common difficulty faced by many women who initially choose to breastfeed is a lack of personalized or continued support by medical professionals. Though touted as a natural behavior, breastfeeding is not easily maintained without the support of others especially for Black women who have found a notable lack of breastfeeding role models in their communities due to ongoing stigmas and the already low rate of breastfeeding among Black mothers. Even during the prenatal period, provider encounters are associated with an expectant mother's intent to breastfeed her child; care provided by midwives is associated with an increased intent to breastfeed compared to physicians, and irregular or lack of prenatal care is associated with lower intent to breastfeed compared to any regular care provider (Balyakina et al., 2016). Successful breastfeeding support requires a sense of trust by the mother formed as she is treated as an individual with unique needs and concerns rather than just another routine case. It also requires continuity of accessible care after delivery to ensure that support is available when needed (Schmied et al., 2011). This type of personalized, continuous care tends to be more common among midwives possibly accounting for the greater intent to breastfeed among women whose prenatal provider was a midwife. Additionally, focus on mutual communication between the mother and healthcare provider has also been suggested as an essential aspect of support to ensure that the mother is humanized and heard rather than dismissed (Blixt et al., 2019). Each of these aspects is particularly important when supporting Black mothers as a long history of exploitation, deception, and racism directed toward Black patients has ultimately generated extensive distrust of the healthcare system and medical professionals in general (Papadopoulos, 2018).

Significance of Race in Obstetric Medicine

Black women face a unique situation with regard to medical encounters due to the intersection of long-standing racism and sexism in medicine and society at large. As a result, they bear a particularly high degree of vulnerability when receiving obstetric care. The nature of medical interactions integrates service transactions and social endeavors governed by social norms and prejudices. In obstetrics and gynecology, this results in a foundation based on the continuation of social norms regarding gender and sexuality with heteronormative focuses on maintaining reproductive capacity (Falu, 2019). When this intersects with race, obstetric racism manifests in which medical racism intensifies the effects of obstetric violence causing Black mothers and their children to be more vulnerable to complications as racial biases guide the perceptions and decisions of their medical providers (Davis, 2019a). This manifests in the form of neglectful care, deficient communication, and dismissive or disrespectful behavior, which in turn can result in a loss of agency among patients along with feelings of trauma and fear (Davis, 2019a; Sega et al., 2021).

Social biases and stereotypes create environments in which Black women are more likely to experience poor obstetric interactions. Hypersexualized depictions of Black women throughout society and the media increase their vulnerability in obstetrics as their bodies are objectified and distanced from traditional imagery of motherhood (Carter & Anthony, 2015; Carter et al., 2022; Falu, 2019; Owens et al., 2018). This intensifies the stigma against breastfeeding for Black mothers, increasing their perceptions of disapproval and judgement from others when not entirely private (Owens et al., 2018). Attempts to rectify the racial disparity in breastfeeding rates often tend to have an unintentional effect of reinforcing these stereotypes. Promotional campaigns often represent Black women as a single, fixed entity with race and

gender being defining characteristics which predict their behaviors and attitudes. Proposed policies accompanying such depictions focus on policing individual behaviors rather than structural barriers further threatening the agency of Black women (Carter et al., 2022). The moralized language and the disregard for structural disadvantages in these campaigns also reinforce moralized racial hierarchies in which Black women are stereotyped as bad mothers (Carter & Anthony, 2015). These biases have tangible effects on breastfeeding among Black women within medical environments as well as in public. In medicine, they are evident in narratives of formula pushing and discouragement by medical providers when breastfeeding. Healthcare staff even invoke racial stereotypes when discouraging Black patients from breastfeeding describing them as unreasonable or demanding (Davis, 2019b).

The primary purpose of this study is to examine the specific effects that healthcare encounters have on breastfeeding experiences among Black mothers. Based on the correlation between personal, mutual communication and a sense of effective support, it is hypothesized that women who received this type of supportive care will have more positive attitudes regarding their overall experiences breastfeeding and their ability to overcome difficulties compared to women who felt dismissed or disconnected in their encounters. Essentially, the hypothesis states that perceived support from healthcare providers will result in a greater sense of success in the breastfeeding journey.

METHODS

The data for this study were collected through qualitative, in-depth interviews with 22 African American mothers in the Central Florida region inquiring about infant-feeding attitudes, decisions, and experiences. All participants were breastfeeding or had previously breastfed their infant at the time of the interviews. Data were collected during prior research under the supervision of Dr. Shannon Carter as the principal investigator.

For the purposes of this study, interview excerpts involving encounters with healthcare providers will be encoded according to the provider type and the mother's general attitude about the interaction. Questions asked about healthcare providers involve pre-natal discussions about feeding preferences, delivery experiences, post-natal interactions and discussion on feedings, and overall impressions of provider attitudes toward breastfeeding as well as suggestions to reduce the breastfeeding disparity (See Appendix 1: Infant Feeding Study – Interview Guide). Attitudes toward healthcare providers will be categorized as positive, negative, neutral in which neither positive nor negative attitudes are expressed, or mixed in which both positive and negative attitudes are expressed regarding a particular type of medical provider. Encoded data will then be evaluated for common themes and any correlations.

RESULTS

Quantitative Data

Among the interviews, 5 specific categories of healthcare providers were mentioned by the mothers: OB/GYNs (obstetrician-gynecologists), pediatricians, midwives, doulas, nurses, and lactation consultants. Additional providers such as anesthesiologists were only explicitly mentioned by a couple mothers or were only referred to collectively among medical center or WIC (Women, Infants, and Children federal nutrition program) staff. These providers are compiled and evaluated within the "Other/General" category for the remainder of this study. Table 1 summarizes the attitudes expressed by each of the 22 mothers interviewed toward the 5 specific categories and additional general category of healthcare providers.

Table 1: Mothers' Attitudes Regarding Different Types of Healthcare Providers

Healthcare Provider Type	Positive	Negative	Neutral	Mixed	Total
OB/GYN	4	5	5	7	21
Pediatrician	4	2	2	4	12
Midwife	4	0	2	5	11
Doula	3	0	0	0	3
Nurse	12	0	2	8	22
Lactation Consultant	11	0	2	6	19
Other/General	2	3	1	7	13
Total	39	10	13	37	

The most frequently mentioned types of healthcare providers were nurses who were discussed by every mother in the study (N=22) and OB/GYNs who were discussed by all but one

mother (N=21). The least frequently mentioned categories were doulas who were discussed by 3 mothers followed by midwives who were discussed by 11 mothers and pediatricians who were discussed by 12 mothers. Only the doula category received entirely positive responses, and none of the mothers had exclusively negative attitudes toward the midwife, nurse, and lactation consultant categories. Only the OB/GYN and other/general categories received fewer positive responses (OB/GYN N=4; Other/General N=2) than negative responses (OB/GYN N=5; Other/General N=3). OB/GYNs are also the only provider type that received fewer positive response compared to all other attitudes. Tables 2 and 3 further present the specific contexts of midwife and lactation consultant interactions by distinguishing providers by location of encounter.

Table 2: Mothers' Attitudes Regarding Different Types of Midwives

	Positive	Negative	Neutral	Mixed	Total
Hospital	3	0	1	0	4
Private	0	0	0	4	4
Unspecified	1	0	1	1	3
Total	4	0	2	5	

Among the midwives described, all 4 mothers who interacted with hospital midwives during delivery expressed positive or neutral attitudes while all 4 mothers who interacted with private midwives during pre-natal periods and/or during their home birth expressed both positive and negative attitudes toward their midwives. Additionally, 3 mothers described interacting with a midwife without specifying the context describing the interactions positively, neutrally, and mixed respectively.

Table 3: Mothers' Attitudes Regarding Different Types of Lactation Consultants

	Positive	Negative	Neutral	Mixed	Total
Hospital	8	0	2	3	13
Private	2	0	0	0	2
WIC	0	0	1	3	4
Unspecified	0	0	1	1	2
Total	10	0	4	7	

Although a total of 19 mothers described encountering at least one lactation consultant, 2 mothers specifically described interacting with 2 different types of lactation consultants expanding the total data points listed in Table 3 to 21. Among the lactation consultants described, the majority were encountered in the hospital (N=13). Of the hospital lactation consultants, most were described positively (N=8), but a small proportion were described neutrally (N=2) or mixed (N=3). Private lactation consultants were specifically mentioned by 2 mothers and were described positively by both, while WIC lactation consultants were mentioned by 4 mothers and were described neutrally by 1 mother and mixed by 3. Additionally, 2 mothers described interacting with a lactation consultant without specifying the context describing the interactions neutrally and mixed respectively.

Figure 1 illustrates the ratios between the attitudes expressed toward each type of healthcare provider and the total number of mothers who mentioned that type of provider.

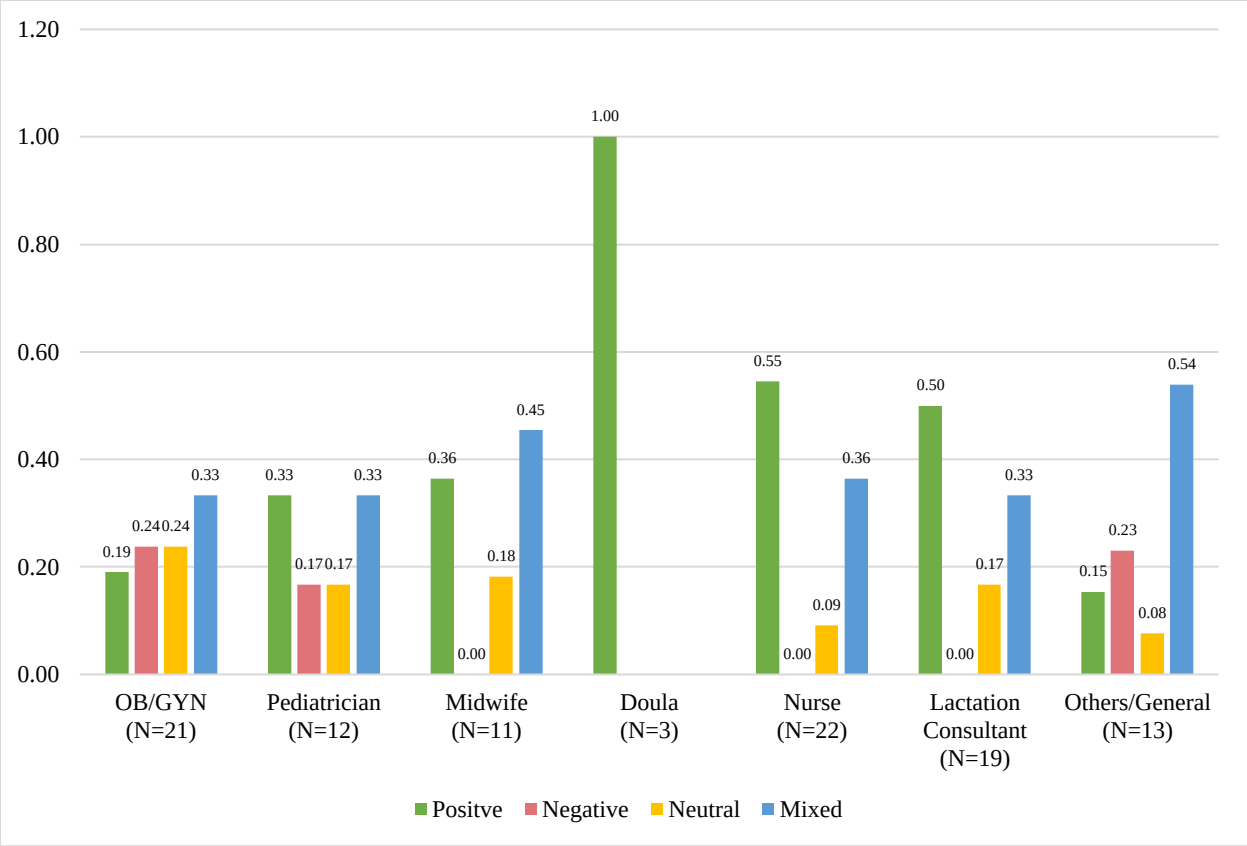

Figure 1: Ratio between mothers' attitudes toward healthcare providers and total mentions of each type of provider.

Although nurses received the most positive responses in total, doulas received the greatest ratio of positive responses with all 3 doulas being described positively. Nurses also received the most total mixed responses, but the other/general category had the greatest ratio of mixed responses with a total of 8 and ratio of 0.36 for the nurse category and a total of 7 and ratio of 0.54 for the other/general category.

Qualitative Data

Only one mother (Participant 18 – Serena) expressed entirely positive attitudes toward her healthcare providers. Serena discussed her OB/GYN and nursing team describing them as supportive and comforting. Her nursing team additionally recognized her prior experience having

already breastfed her 2 older children and made themselves available for advice without pushing unwanted advice: “They could see that I had children before, so they didn’t want to be too invasive with their suggestions.”

There were 4 mothers who did not express exclusively positive attitudes toward any of the provider categories: Participant 1 – Candy Kane, Participant 8 – Lisa, Participant 10 – Sarah, and Participant 11 – Daphne. All 4 did have at least one individual healthcare provider who they described positively at some point; however, there were either additional providers within the same category or additional experiences with the same provider that were described negatively. Candy Kane expressed overall negative attitudes toward her time at the hospital feeling frightened due to a lack of communication from hospital staff. While describing her cesarean section, Candy Kane stated:

> “They put the little blue curtain up; she asked me, she was like ‘um do you want us to tell you when we start?’ And I’m like ‘of course.’ Oh, they started, and I was like what do you mean? I’m over here freaking out thinking I’m going to feel everything.”

She also expressed negative views toward doctors in general saying, “I didn’t want to go to a doctor; I didn’t want to be a number; I wanted to be known by my name,” when explaining her desire to see a midwife instead. While she loved the personal care she received from her midwife, that experience was also not entirely positive as the midwife was not equipped to handle or even detect certain complications including the one the forced Candy Kane to go to the hospital for delivery.

Lisa also sought out midwives for that personalized care but disliked that her practice kept switching having her see different midwives limiting her ability to form good rapport. Additionally, while she loved one of her doctors and found him very supportive, she disliked the

other describing his attitude as “everything was like in-and-out like I’m the doctor and I don’t have to tell you anything” making communication very difficult and uncomfortable for Lisa.

Sarah had also chosen to use a midwife due to discontent with the hospital and OB/GYN during a prior pregnancy for pushing formula despite her plans to breastfeed and failing to explain why some procedures were performed. However, her midwife, while generally helpful, missed the birth leaving Sarah to deliver at home with only her family’s assistance. Sarah also disliked one pediatrician for pushing formula and repeatedly belittling her parenting decisions. She described her encounters with this physician in the following:

> “It’s just an assumption that we should have formula. He thought it was crazy that I gave birth at home. He thought it was crazy that I refused the vitamin K, and the ointment drops. Um he said, ‘let this go on record that this could be harming your baby.’ We haven’t done immunizations yet with my daughter, so everything has just been ‘You’re crazy, crazy, crazy for that.’”

Daphne was uncomfortable with the attitudes and demeanors of some of her doctors describing one OB/GYN as being “very cold” in his interactions. She also disliked the attitude of the lactation consultant she saw in the hospital though she loved a different lactation consultant who she began seeing later. When comparing the two, Daphne described the hospital lactation consultant as being less caring stating:

> “I am thinking you work in a hospital. This is what you do all day long with moms all day. Why is it that you gave me so little?”

While all 4 of these women had at least one individual healthcare provider who they found at least somewhat supportive, there were either additional providers within the same category or additional experiences with the same provider which were lacking.

Examples of negative attitudes toward healthcare providers generally involved a lack of support in some way. This includes the inability to provide effective support such as midwives being ill-equipped to handle significant complications as well as the failure to provide feasible, expected support. In the latter case, individual healthcare providers or the medical centers in general exhibited disregard for the needs and autonomy of their patients. For Michelle (Participant 14), this escalated to a point of feeling dehumanized. Although she had positive attitudes regarding the individual providers during her labor, when describing the overall hospital experience, she stated, **"**I felt like a guinea pig, and I was violated and giving birth is like a violation of every part of my body." Following the birth of her child, Michelle had additional issues with a pediatrician failing to adequately communicate with her. The pediatrician would speak Spanish to the baby's father, but Michelle was unable to understand explaining, "umm hello I don't speak another language, so when you speak about my child, you need to speak to his mother." As presented earlier, Candy Kane (Participant 1) and Sarah (Participant 10) endured similar experiences with Candy Kane feeling as though the standard healthcare system reduces her to a number while also feeling frustrated by a lack of effective communication and with Sarah describing how her child's pediatrician would belittle her and ridicule her decisions. Mandy (Participant 19) described a sense of losing autonomy and control over the medical decisions for herself and her child due to dismissive attitudes of providers:

> "I didn't feel like I had much say, like, 'this is what we do,' 'this is procedure,' 'this is what we have to do,' 'this happened,' 'it was necessary we did it.'"
>
> "When I say 'I want to go wherever my child goes in the hospital,' and you purposefully try to come in at 2 o-clock in the morning and take my child out of my room, I have a problem with that."

Examples of positive attitudes toward healthcare providers generally involved perceived sincerity, support, and personalized care. April (Participant 17) had difficult experiences in the hospital spending weeks on bedrest prior to delivery and weeks after as her child was placed in the NICU, but despite this, she generally described her interactions with providers in the hospital positively. She explained that even though she was being poked and prodded day and night, "everybody – you know – was very friendly and tried to keep me informed about everything," relieving some uncertainties and discomfort. As she was struggling with lactating, her healthcare team explained exactly what was happening to help alleviate April's feelings of failure:

> "She would call and tell me it is Ok, the baby is not there, and he's born early anyway, and your body wasn't really ready for breast feeding, and you had a C-section at that, so you didn't even go through the whole labor process, so and I was like I know, and they had the breast-feeding consultant come and tell me the same thing. So, they were really good about making sure that I knew that it wasn't my fault that I wasn't making milk, but it's just my body."

Kim (Participant 13) explained how the overall attitudes of her nursing team helped her even as she was exhausted:

> "The team of women just was really, extremely, extremely bubbly and just on 10 and wow. They were like so funny because they were my team at 6 in the morning. And they were like 'Helloooo' and blah blah blah. But, you know, it cheers you up. So – you know – at first, I'm like 'Oh my God, I'm trying to sleep why are you so bubbly?' but then it's like ok, you know, it cheers everything up. And it was sincere."

Particular interactions with providers resulted perceptions among some mothers of biased care. As described above Sarah (Participant 10) was belittled by her child's pediatrician who

described her choice to breastfeed as "crazy." She further described how she did not feel like this physician even considered breastfeeding to be an option as "he just defaulted to just talking about formula feeding the whole time." She also described a similar experience with her OB/GYN during pre-natal stages: "you can tell the formula pushed. Even when you talk to your OB/GYN about post pregnancy things, and they mentioned formula feeding like it's a common thing; it's your only option." Arianna (Participant 2) believed this assumption experienced by Sarah is unique to Black mothers. Arianna explained her suspicion of a racial bias in care:

> "Having spoken to a couple of Black women who are pregnant now, their doctors don't approach the topic of breastfeeding; they are the ones that have to bring it up versus White women I've talked to where their doctors ask them 'Well how do you intend on feeding?' It's almost an assumption that because you're Black, you are going to formula feed.

DISCUSSION

When describing their specific experiences with healthcare providers, participants often alluded to their perception of support. Positive attitudes were directed toward providers who were perceived as supportive and compassionate in their care, while negative attitudes were directed toward providers who were perceived as dismissive and distanced. These trends suggest that the lower rates of positive attitudes directed toward physicians and hospital systems, in general, can be partially attributed to a predominantly mechanical view on medicine. That is to say, the participants noticed a difference in demeanor and respect between medical providers perceiving the mechanized view of the body as being cold and dismissive of their unique needs. Several participants explicitly cited their desire to be seen as a human with personal needs when describing their dissatisfaction with physicians or hospitals. Likewise, the higher rates of positive attitudes directed toward nurses, doulas, and private lactation consultants appear to be related to increased patient contact times permitting the establishment of relationships between providers and patients and a sense of more personalized support. Additionally, the high rate of positive attitudes toward hospital midwives and hospital lactation consultants appears to be related to the more personalized care inherent to their work. Many narratives describing these midwives were centered on the personal touch they added in contrast to traditional OB/GYNs, and many narratives describing these lactation consultants centered around working to figure out the unique challenges each mother-child pair initially faced while nursing. The narratives regarding private midwives all involved mixed attitudes primarily due to the limitations in the care that they could provide forcing participants to seek additional care elsewhere despite otherwise positive experiences. However, in one case, Janet (Participant 7) described her midwife pressuring her to

ignore her own preferences regarding her home birth illustrating that this sense of pressure and loss of agency is not universally tied to traditional hospital settings even though it may be less common in holistic care.

The combination of these results suggests a relationship between communication and the impact of interactions on participants. Specifically, both nonverbal and verbal aspects of communication are linked to the feelings expressed regarding particular interactions with healthcare workers. Feelings of being dismissed, looked down upon, ignored, or reduced as a result of the demeanor, tone, or words of healthcare providers are tied to negative views of those providers. Some mothers went on to generalize these views over the entire provider category such as when participants avoided physicians and hospitals in general because they were worried about being reduced to a number. Other participants' testimonies show that this is not a universal experience with physicians, but it is frequent enough for the generalization to form for some. In contrast, the belief that one's healthcare providers are genuinely interested in their patients as individuals is tied to positive views of those providers especially when mothers perceive individualized care and support. Perceived knowledge is another aspect impacting the mothers' opinions on healthcare providers. However, the overall attitudes about providers were more strongly linked to the impressions of providers' own attitudes than to their bank of knowledge. Specific examples of this include participants expressing positive attitudes overall regarding midwives with the caveat that they do not have the training to handle complicated cases as well as expressing negative attitudes overall toward some physicians despite stating that those doctors made appropriate decisions and knew what they were doing. This suggests that quality healthcare goes beyond simply having scientific and technical knowledge and providing pure medical

advice. Instead, the patients' perceptions of their providers' intentions and motivations bear weight on whether or not they felt as though they received adequate care and support.

With regards to the disparity in breastfeeding rates, multiple participants brought up formula pushing by their medical providers with Arianna (Participant 2) believing this to be an experience unique to Black women thus perpetuating the disparity as a result of racial biases. Furthermore, the dismissive, degradative care experienced by several participants reflects prior narratives of obstetric racism (Davis, 2019a; Davis, 2019b; Falu, 2019). Despite this, greater feelings of being supported coincided with greater resiliency in the breastfeeding journey when problems or concerns arose. Support throughout the journey built confidence among the mothers helping them to push past the problems and alleviate concerns. While all of the mothers in this study generally held positive views toward breastfeeding, some faced more challenges and found less support overall or fewer sources of support adding additionally difficulties in continuing breastfeeding. Thus, positive interaction effectively had a positive influence on breastfeeding insofar as maintaining a positive morale among participants. Although the disparity has complex sources drawing from various social, cultural, and economic factors, the results of this study suggest a possible avenue for increasing rates of breastfeeding among Black women specifically through the actions of healthcare providers. Improving interactions between patients and providers – particularly focusing on personability and individualizing care – can increase the sense of support experienced by patients and in turn, increase trust in providers as well as confidence in oneself while on their breastfeeding journey. This is particularly important when caring for Black mothers in order to counteract prior experiences of obstetric racism – or medical racism more generally – and the inflated stigma against breastfeeding resulting from racial stereotypes.

Confirming this route for improvement would require additional studies focusing specifically on the direct impact of provider language and demeanor on infant feeding choices, as well as studies focusing on sociocultural training for providers to educate them on ways to communicate and present themselves in a manner that patients find welcoming and genuine with attention to mitigating racial biases. In the case of the former, such studies would confirm the importance of perceived attitudes and biases on patient experiences, challenges, and parental decision-making. In the case of the latter, additional studies would help to establish changes in training curriculum to teach patient-provider interactions more effectively to new generations of healthcare providers improving the connections formed and thus the outcomes of those interactions while also reducing the impact of racial stereotypes on medical decisions and thus healthcare outcomes. Improving interactions as a whole could have further, more widespread impacts in healthcare by potentially improving patient experiences altogether in all sectors of medicine.

APPENDIX 1: INFANT FEEDING STUDY – INTERVIEW GUIDE

First I want to verify that I have given you a copy of the Informed Consent form.

- You agree to the interview?
- I want to remind you that you do not have to answer any questions you don't want to, and you can end the interview at any time. Ok?

Introduction

We are interested in infant feeding. To start, what are you feeding your baby?

- Is that exclusive, or are you feeding him/her anything else?

Have you always fed him/her _(breast milk/ formula / etc.)__?

If formula, what kind? Why that kind? Did you ever try any other kinds?

Decisions About Feeding

I'd like to talk a little bit about how you came to the decision to feed your baby _(breast milk/ formula / etc.)_.

When did you first start thinking about what to feed your baby?

Let's talk more about that. What made you decide to feed him/her _(breast milk/ formula / etc.)__?

- Did you talk to anybody about what you would feed him/her?
  - What did s/he say?
  - How did you feel about what they had to say?
- We know that people like giving pregnant women lots of advice about pregnancy and caring for children. Did anyone give you advice about what to feed him/her while you were pregnant?
  - What did they say?
  - How did you feel about what they had to say?
- Did you read any books or websites or anything like that to help you decide what to feed him/her?
  - What did they say?
  - How did you feel about what they had to say?
- Did any of your healthcare providers talk to you about what to feed your baby? Like your OB or midwife, any nurses, or anybody like that?
  - What did they say?
  - How did you feel about what they had to say?
- Did you take a class to help you prepare to give birth? (If yes,) Did they talk about what to feed your baby at all in the class?
  - What did they say?

- How did you feel about what they had to say?

- Did you ever meet with a lactation counselor when you were deciding what to feed your baby?
    - What did they say?
    - How did you feel about what they had to say?
- Did any of these interactions change your ideas about what to feed your baby?

After you made the initial decision to feed your baby __(breast milk/ formula/ etc.)__ , did you have to do anything to prepare for feeding? Like, were there any supplies or anything that you bought?

- Did you seek out more information at that point, or did anyone talk to you about feeding your baby after you made the decision? What were those conversations like?

Feeding Experiences in the Hospital or Birth Center

I'd like to talk now about your experiences feeding your baby. First, can you tell me a little bit about your birth experience?

- Was it a vaginal birth or a cesarean?
- Who was there when your baby was born?
- How did you feel about your healthcare providers throughout your labor and birth?
- From the time you went to the hospital to give birth, did anyone ask you how you were planning to feed your baby or talk to you about feeding your baby at that point?
- Did they (healthcare providers) do anything to prepare for feeding your baby while you were in labor?

So tell me what happened when your baby was first born.

- Did you hold the baby, or did the baby go somewhere else?

When was the first time your baby was fed?

- Tell me more about that. Who was the first person to feed your baby?
- (If participant) Did anybody help you?
- Did anybody give you any kind of information or advice about feeding your baby at that point?
- How did you know what to do to feed your baby?

What was your experience like while you were in the hospital, with regard to feeding your baby?

- Did you feed your baby every time, or did somebody else feed her/him?
    - What was that like for you?

What about the healthcare providers who helped you with feeding your baby.

- What was your relationship like?

- Did you feel comfortable asking questions?
- Did you feel like they were friendly? Like they were there to help?
- What were their characteristics, were they women or men? What was their race or ethnicity?

Did you receive any formula from anyone when you were pregnant or when you gave birth? For example, from your OB or pediatrician? Did you receive any in the mail? How did you feel about that?

Feeding Experiences at Home

Let's talk about your experiences feeding your baby after you came home from the hospital. What was feeding like once you got home?

- Did anybody help you? Give you any kind of information or advice about feeding your baby after you got home?

Have you had any contact with any healthcare professionals since you've returned home from the hospital? Pediatrician? OB? Nurse? Lactation professional?

- Have they spoken with you at all about feeding your baby?
- What were these interactions like?

Perceptions of Breastfeeding

Now I'd like to talk a little bit about different ways to feed babies. So let's start with breastfeeding.

What do you think about breastfeeding overall?

What do you think about mothers who breastfeed?

What do you think are some advantages of breastfeeding?

What do you think are some disadvantages of breastfeeding?

What do you think your healthcare providers think about breastfeeding?

- Do you feel like they encouraged you to breastfeed?
- Do you feel like they provided you with adequate support for breastfeeding?
- Do you think there is anything else they could have done to encourage you to breastfeed or to support you in breastfeeding?

In Florida and the United States as a whole, research shows that African American mothers are less likely to breastfeed than white or Hispanic mothers. Why do you think this is?

- If it were your job to increase breastfeeding among African American mothers, what would you do?
- Are there any kind of public policies that you think would increase breastfeeding among African Americans, or hospital practices?

Perceptions of Formula Feeding

Let's talk now about formula feeding.

What do you think about formula feeding overall?

What do you think about mothers who formula feed?

What do you think are some advantages of formula feeding?

What do you think are some disadvantages of formula feeding?

What do you think your healthcare providers think about formula feeding?

- Do you feel like they encouraged you to formula feed?

Did any of your healthcare providers ever give you any formula?

Demographic Information

Next I just have some demographic questions.

How old are you?

Were you born in the United States?

- Were your parents born in the United States?

Are you originally from the Orlando/Central Florida region?

What is your relationship to the father of your child?

- Are you married, living together, divorced, never been married?

Are you currently in a relationship? Married, dating?

What is the highest level of education that you have completed?

- Less than high school diploma, high school diploma, some college but no degree, Associate's degree, Bachelor's degree, Master's degree, Doctorate degree
- If degree, what field is your degree in? Where is it from?

What about the father of your child? What is the highest level of education that he has completed?

- Less than high school diploma, high school diploma, some college but no degree, Associate's degree, Bachelor's degree, Master's degree, Doctorate degree
- If degree, what field is his degree in? Where is it from?

Are you currently employed? What kind of work do you do? How long have you been doing that?

Throughout your pregnancy and early postpartum, did you have health insurance? (If yes) was it private insurance, Medicaid or something else?

What is your yearly household income?

- (If no response) can you tell me a range? Is it less than $25,000, around $50,000, $100,000, $200,000?

That concludes my questions. Is there anything you would like to add, or anything that you think is important about infant feeding that we didn't cover?

Interview Number: _____

Fictitious Name: _____

Health Care Provider Verification

Where did you give birth at?

- Orlando Regional Medical Center – 1414 Kuhl Ave., Orlando
- Winnie Palmer Hospital for Women and Babies – 83 West Miller St., Orlando
- Florida Hospital – Main Campus – 601 East Rollins St., Orlando
- Florida Hospital – East Orlando – 7727 Lake Underhill Road, Orlando
- Florida Hospital – Altamonte – 601 E. Altamonte Dr., Altamonte Springs
- Winter Park Memorial Hospital – 200 N. Lakemont Ave., Winter Park
- Florida Hospital – Celebration Health – 400 Celebration Place, Celebration
- Central Florida Regional Hospital – 1401 West Seminole Blvd., Sanford
- Health Central Hospital – 10000 West Colonial Drive, Ocoee
- Heart 2 Heart Birth Center – Lexington Green Ln., Sanford
- The Birth Place – 1130 East Plant St., Winter Garden
- Inspiration Family Birth Center – 434 Grove Ave., Winter Park
- Other: _____

What is the name of your obstetrician or midwife? _____

What is the name of their practice?_____

What city is that in?_____

What is the name of your pediatrician? _____

What is the name of their practice?_____

What city is that in?_____

Did you see any lactation counselors or anyone like that? If so, what is their name? _____

_____

What is the name of their practice? _____

What city is it in?_____

Were there any other healthcare providers, organizations, or anything like that that influenced your feeding practices? LaLeche, or baby group or anything?_____

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