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Editor’s Preface

The Undergraduate Anthropology Society is proud to present the third edition of In Situ: Journal of Undergraduate Anthropology at the University of Pennsylvania. The collection of essays and photography included in this issue engage in creative ways of understanding and portraying the world and effectively exercise the anthropological imagination.

Each essay was nominated by faculty mentors from a diverse range of Anthropology courses and were chosen based on originality, clarity, and excellence. The photographs represent a sampling of undergraduate photography from both field work and travel to be showcased at a photography exhibition at the first annual Anthrofest on February 4, 2011 at the University Museum.

We would like to thank faculty who nominated student papers for inclusion in this volume. We would also like to thank Dr. Adriana Petryna, the undergraduate Chair of Anthropology, for her support and guidance, as well as Charlene Kwon, the Undergraduate Coordinator.

If you would like to submit to In Situ's Spring 2011 edition, apply to the In Situ Editorial Board, or learn more about the Undergraduate Anthropology Society and its upcoming activities, please visit the Undergraduate Program tab on the Penn Anthropology website for more information: http://www.sas.upenn.edu/anthro.

Enjoy Reading,
Lauren Kapsalakis, Editor-in-Chief
Table of Contents

Editor’s Preface .................................................. 2

Table of Contents ................................................ 3

Articles

Domestic Politics: *Food Within The Family*  
Louis Frank .................................................. 5

Handing Over The Prescription Pad:  
*Doctors as Patients*  
Monica Pfister .................................................. 13

Sobremesa:  
*An Analysis of Food & Culture In Hispanic Communities*  
Darien Perez .................................................. 23

Attitudes and Intentions Associated with Breastfeeding in College Students  
*A survey of attitudes and intentions towards breastfeeding in undergraduate students at the University of Pennsylvania*  
Vidushi Bajoria .................................................. 31

Burning Man 2010:  
*A photographic retrospective of independent ethnographic research under Professor Brian Spooner in Black Rock Desert, Nevada*  
Molly Hude .................................................. 39

Two of our African American neighbors in Puerto Rican North Philadelphia

Fernando Montero

Tiana and her fiancee Jamal are two African American residents of Puerto Rican North Philadelphia. At the time of this photograph, Brandie, pictured in her living room, was giving us details about an illegal search and seizure conducted in her house by the Philadelphia Police Department. Brandie’s house is owned by her incarcerated Puerto Rican ex-husband and is facing imminent foreclosure. Jamal was incarcerated in April and is still in prison awaiting his trial. Brandie, who had been unemployed in Philadelphia for several years, recently moved to Allentown and is working full time at two jobs.
Food has always played an important and complex role in my life. As the child of two culturally and ideologically dissonant parents, I considered food to serve as more than just sustenance. Meals and snacks alike were often laced with the cultural tension that my parents themselves were negotiating. I paid no attention to my parents’ roots, choosing to remove myself from any discussion of religion, nationality, or class. As a child with no strong foundation on which to construct an identity, I turned to food. I developed certain associations—some bad, some good—with certain foods, but never stopped to consider the cultural, emotional, and domestic implications of my actions in forming a food-based identity, and the ways in which my parents tried to convey their own cultural history and values through the food that they served me. Was my mother trying to bring me closer to her own mother when she prepared Grandma’s special dish? On the nights that my father cooked instead of my mother, was he trying to tell me something about his identity and cultural origins?

In researching and writing this essay, I hoped to learn about those things that I had so often overlooked in my youth, and try and reconcile the ways in which food can link a family through generations—and just as easily tear it apart. I will be evaluating and discussing the processes by which culture and identity are transmitted across generations through food within both the nuclear and extended family.

Methods

In order to obtain a complete illustration of food habits across generations, I interviewed five family members from one family and four from another: a grandmother, a mother, a father, and two children. Both families resembled my own: in the first, MA (age sixty), a Jewish man of Russo-Polish descent from Great Neck, Long Island, New York married EA (age fifty-one), a New England WASP born and raised in Brookline, Massachusetts, and daughter of AB, a Caucasian woman originally from New Orleans. MA and EA have four children, two of whom I interviewed, CA (male) and JA (female), ages twenty-three and twenty-seven, respectively.

The other family embodied the same cultural intersection that I wanted to explore: BT (age fifty), an Italian-American from New Jersey, married EA (age forty-eight), an Irish-American from Virginia. They have three children, two of whom I interviewed, GT (female) and MT (male), ages twenty-one and twenty-three, respectively. I also interviewed BT’s mother, HT, an Italian-American from New Jersey.

Food as Transmitting Culture across Generations

William Frank Mitchell says that food has an innate ability to “prompt emotional conversations about identity, health, [and] spirituality…” (Mitchell 2009:2) Indeed, one’s ties to food, especially culturally significant food, can be quite strong. MA echoed this sentiment as he reminisced fondly about the traditional Jewish food that he ate during his childhood. “My strongest memories are those of the Shabbat dinners that we had every Friday night,” he said. “I would come home from school every afternoon to the smell of my mother’s brisket and challah cooking in the oven…The dinners were lavish and delicious…Mom pulled out all the stops for Shabbat.” The Friday dinners were a mere prelude, however, to the Sunday brunch: “Bagels, lox, capers, onions, and a variety of cream cheese schmears…Every weekend was a chubby adolescent Jewish boy’s dream.”

Although MA was raised to appreciate the finest traditional Jewish cuisine, his disillusionment with religion at large led him to question his faith, and ultimately search elsewhere for a spouse. Enter EA, a beautiful WASP, raised on the majestic Charles River and weaned on stories of Groton and Harvard’s “old days”—a far cry from MA’s humble Jewish roots. “When I met EA, I was very much finished practicing Judaism, but I still very much identified with the idea of being Jewish…I thought that we’d be able to balance our two different cultures, but it was always a struggle.”

As MA and EA settled down in New Hampshire and began to raise a family, the presence of children only served to exacerbate the cultural tension between them. EA’s mother, AB, was a world-class chef, renowned along the East Coast for her culinary expertise and deep-South Cajun flair. EA hoped to impart onto her children the same love for Cajun cuisine that her mother had taught her, while MA struggled to maintain his already tenuous connection with his Jewish roots. “MA was constantly working, so I did most of the cooking,” said EA. “I cooked things for the kids that my mother had made me when I was a child: skillet cornbread, gumbo, jambalaya…These were some of my mother’s and my favorites when I was growing up.” As EA continued to indoctrinate the children with her Cajun cuisine, MA could only watch idly, as he was relegated to the role of breadwinner, not bread-baker. “She was completely oblivious to the fact that I wanted the kids to have at least some sort of traditional Jewish experience…so that they could identify at least a little with their father’s roots,” said MA. Marjorie DeVault suggests that “paid employment brings power and influence within the family.” (DeVault, 2008, p. 243) However, it seemed that within the family, EA held most of the cultural power, as the importance of food and her constant presence in the kitchen afforded her most of the power in transmitting her own culture.

Dr. Kyung Rhee emphasizes the importance of parenting style in the food habits of children: “Parents play an important role in the growth, development, and socialization of children…parents influence the development of eating and activity behaviors through the use of specific feeding techniques…” (Rhee 2008, 13) MA retired soon after CA, the youngest child, was born, and he began to use his own son as a way to transmit the Jewish cultural identity that had been repressed for so long, and influence CA’s cultural development, as Rhee suggests. “I saw it as an opportunity for at least one of my children to understand and appreciate my culture,” he said. As EA went back to work, MA stayed home with CA, feeding him the same kinds of food on which he was raised. His son appreciated the attention and the meals. “I loved eating with my dad when I was little,” said CA. “Those are the best memories that I have of my childhood…In second grade I used to tell kids that lox was my favorite food, and they asked me why I would eat a security device.”

As CA grew, he became the only one of EA and MA’s children to identify with his Jewish heritage. “I started to seek out as much information as I could about the religion and the culture…In high school I joined the Jewish society, even though I wasn’t even close to practicing.” Today, CA possesses a certain sense of Jewish pride that is shared by none of his siblings. “My brother and sisters call me ‘Dad’s Social Experiment.’ I guess it worked.” Indeed, MA’s efforts to socialize CA into the Jewish identity that he had been forced to repress was quite successful; and it all began with the simple act of serving him traditional Jewish food.

CT and BT’s experience proved to be quite different from that of MA and EA. The two met at Radford University in Virginia, where BT was one year ahead of CT. As soon as she met him, CT was enamored with BT. “There was something about him…His charm, the way he talked, the way he handled himself…I’d never met anyone like him before,” she said. Growing up sheltered in a humble rural section of Virginia, someone like BT was a cultural anomaly. When she met BT’s mother, HT, soon thereafter, she experienced quite a culture shock.

HT embodied the Italian love affair with food. “I lived for the kitchen…A lot of women that I hung around with at the time were resentful of their role in the house. I relished mine. Cooking was my greatest passion,” HT said. CT had never seen anything like it. “The things she was doing in there, the food she was
cooking...I was in awe. The odor alone was intoxicating...The food [long pause], there was nothing like it,” she said of her first encounter with HT. CT was more accustomed to the goings-on around her own home: a mother who was wont to whip together quick, simple meals and voice her disdain for the amount of effort that cooking required. “My mother hated cooking. Hated it...I think she grasped the entire time that she was in the kitchen.”

Seeing HT in action—and the way that BT reacted to her cooking—inspired CT. “I wanted it all...The big busy kitchen; the aromas; the reactions from those who were eating...Everyone adored HT.” CT’s final sentiment is telling: growing up in a home with a hostile mother and near-absentee father, there was one thing that CT’s life to that point lacked: love. As Joseph Burridge and Margo Barker observe, “The construction of food [is] a tool for pursuing the happiness of others, and ultimately their love.” (Burridge and Barker 2009, 147) For HT, food was the key that gave her access to the hearts of her family and those around her. CT wanted the same for herself.

So began CT’s transformation from an unassuming country bumpkin to grand Italian matriarch. Soon after she and BT married, she spent nearly all of her time refining her skills in the kitchen. “I wanted my children to tell their friends that I was the best cook in the world. I wanted my children’s friends to tell their parents that I was the best cook in the world. I was driven.” CT abandoned her roots, assumed a new cultural identity—adopting Italian cuisine and the Italian culture—and she followed it vigorously. All in the name of family and food.

Comfort Foods across Generations

In his study of the Kalymnian islanders of Greece, David Sutton speaks extensively on the role that food plays in linking us to the past. When a transplanted Kalymnian native tastes cheese that is indigenous to his home, he is brought back, and the food serves as a comfort, easing the pain and longing for his homeland. The same principle can be applied to comfort foods across generations within families: the consumption of a familiar food from one’s childhood can trigger positive memories and associations.

As I discussed earlier, MA spoke fondly of the food that his mother prepared for him in his youth. He especially remembered the foods that she made him as a pick-me-up. “Whenever I felt down, my mother would...”(Admittedly, MT has lived a charmed life.) “Vodka penne,” he said forcefully. “Nothing in the entire world tasted as good as my mother’s vodka penne (apologies to my wife; I think she was crazy, but I began to understand the method behind her madness as I aged,” said EA). The pies were ruined, pizza night was compromised, and the family spent the rest of the night mourning the loss of the beloved delicacy. “I remember that night vividly. I’ll never forget it,” JA said.

Fortunately, pizza night survived the hiccup, and continues to thrive today, as every Friday night in JA’s home is pizza night—with a twist. “I try to eat healthy,” she said. “Eating pizza made with white flour and full-fat cheese every week? That’s a death wish.” JA has crafted a more health-conscious pizza night for her and her husband. “I use whole wheat flour and part-skim mozzarella...Sometimes I’ll use semolina flour if I really want to indulge, but that’s if I’m feeling really crazy.” Although she has made slight alterations for health considerations, JA has kept alive the ritual that began with her maternal grandmother. Says Theodore Humphrey, “Ritual sustains tradition because we human beings create meaning and significance through ritualizing our activities and calling forth deeper responses to our celebrations of life’s events.” (Humphrey 1988, 21) JA and EA’s continued practice of the pizza night ritual in their respective adult lives has helped them to connect to that same emotional meaning that they felt as giddy children, anxiously awaiting the arrival of the ever elusive pizza night.

I observed the same practice of ritual, tradition, and memory in BT and CT’s family. Of all of HT’s cooking feats, BT seemed to remember one dish most enthusiastically. “Vodka penne,” he said forcefully. “Nothing in the entire world tasted as good as my mother’s vodka penne (apologies to my wife; I think she’d understand).” Indeed, HT’s vodka penne was a staple of the household growing up, and was a huge hit at potlucks and dinner parties alike. HT had one choice when it came time to pass on the recipe: with no slight alterations for health considerations, CT was appointed the next to hold the mantle. She has not disappointed.

For nearly twenty years, CT has been refining and re-refining her vodka penne, much to BT’s delight. “Every time she makes it, it gets better. I don’t know if it will ever be able to touch my mother’s, but CT is as close as anyone will ever come...It’s different, in a good way.” Their children have also come to cherish the dish. Said MT, “When I’m at school, I get a craving for it probably at least once a week...Eating in the dining hall after eating my mom’s cooking is one of the hardest things I’ve had to do.” (Admittedly, MT has lived a charmed life.)

Kali in the Market

Collin Schenk (’11)
Well, I guess I ask her to make it every night that I’m at home.” As far as traditions go, this one shows no signs of slowing down. “Eventually I’ll pass it onto GT,” said CT. “Hopefully her kids enjoy it as much as mine do.”

Food as a Form of Rebellion & Community

Paul Fieldhouse says, “The act of eating together indicates some degree of compatibility or acceptance…” The tension between hospitality and power is also evident.” (Humphrey 1988, 67) We can observe Fieldhouse’s idea within the nuclear family: the giver of the food (the parents) possesses the power over the recipient. However, the nuclear family is also unique, in the sense that there is a constant power struggle between parents and their children, particularly during adolescence. Within this struggle, food can be employed as a means of gaining power.

JA’s relationship with her parents began to wane around her sixteenth birthday. “What I was going through at the time wasn’t unique to my situation. It happens to everyone,” she said. “You get older, you resent your parents…I was constantly looking for ways to show them that I was a mature, independent adult.”

JA found an outlet for this desire at the dinner table. “At that point in my life, I was really getting tired of the whole sit-down dinner act, and I had no interest in eating the unhealthy food that my mom was making every night.” JA subtly found a way to act out: as her mother cooked dinner, JA would enter the kitchen and prepare her own healthy alternative (The standard: two pieces of whole wheat toast, topped with fat-free cottage cheese and olive tapenade). At dinnertime, she was neither seen nor heard, reading quietly in her room. This act of defiance had emotional implications that reverberated through the entire household. “It hurt my feelings,” said EA. “I understand that kids that age are going to act out and get resentful, but food was so important to us as a family.”

If the act of eating with others is a form of compatibility and acceptance, as Fieldhouse suggests, then JA’s actions spoke volumes about her attitude: refusing to eat with the family was a symbolic act of rejection and independence, as E.N. Anderson says, “Food is used in every society…to communicate messages.” (Anderson 2001, 6) The fact that EA infused the meals that she prepared with a great deal of cultural pride lent even more significance to JA’s actions. “When I cooked, I was always trying to channel my [deceased] mother,” said EA. “The act of cooking was one of the strongest memories that I had of her.” In this way, JA’s rejection of her mother’s food was, by extension, a rejection of her roots.

Likewise, it seemed that food was symbolic of the troubled mother-daughter relationship that existed between the two parties. Nickie Charles and Marion Kerr suggest, “Food occupies a significant place in the relationships between women and their children…and tells use a great deal about age relations within the family…” It falls to women to ensure that mealtimes are a happy occasion.” (Charles and Kerr, 1988, 85) Indeed, food represented the tension between EA and JA, and EA’s refusal to accommodate her daughter’s request signified—on some level—a failure in the act of mothering.

BT and CT had no such problem with their children. Dinner time at their house was almost always an event that the kids relished with gusto. “I’ve always loved spending time with my family, and dinners are my favorite,” said GT. “I’d be the only time where everyone came together at once…plus it didn’t hurt that my mom’s cooking was amazing.” CT adopted the Italian practice of turning dinner into a grandiose affair, inviting friends and family members into the house as often as possible. “This was something I picked up from HT,” she said. “She was always entertaining people…Growing up in a tiny house with no true dining room, I wanted that.” Humphrey says, “Food-centered events create a viable, recognizable community.” (Humphrey 1988, 53)

Indeed, for CT, dinners became a means of creating this community, both within the family and the immediate neighborhood. “Mom’s meals definitely brought us all closer together [as a family],” said MT. “I never missed a dinner at home, especially on the weekends…If people invited me to come out with them, I’d tell them to give me a call after dinner.” Says Kyung Rhee, “Positive family interactions and order in the household may create an atmosphere that allows for greater acceptance by children of particular parent behaviors.” (Rhee 2008, 27) CT’s emphasis on the positive dinner ritual, coupled with the joy that her children derived from her food, allowed her and BT to avoid the traditional teenage angst and resentment that befell so many parents.

Food and Responsibility: Feeding a Child

All parents I interviewed said that they felt some obligation to feed his or her children responsibly and healthfully. These plans were scrapped rather quickly, however, as it became apparent to each of them that feeding their children foods that held emotional significance for them was more important. “I wanted CA to be a healthy boy, but honestly, my desire for him to enjoy the same foods as me was much stronger,” said MA. As a result, CA spent most of his youth battling weight issues, just as MA had in his childhood. Regardless, MA had no regrets. “To see one of my children enjoy the same things that I did as a child, to see him identify with my roots…That’s much more important to me than him being skinny.”

HT and CT echoed MA’s sentiments. “I feel BT pretty unhealthy food as a child,” said HT. Likewise, CT gave little thought to the nutritional value of the lavish meals that she prepared for her children. “GT and MT love me…A big reason for that is the fact that I cooked them such good food as children,” she said. It seems that for the baby boomer generation, a child’s affection trumps health consciousness.

JA, a prospective mother, saw the situation differently. “I appreciate what my parents did for me, but the fact that they fed me such unhealthy food for so long really led to me resenting them,” she said. JA spent most of her childhood battling weight issues, much like her brother, and blamed her mother’s food for her plight. “I’m going to feed my kids good, wholesome food…Just because it’s good for you doesn’t mean it tastes bad…I want them go grow up to be healthy and happy.” Perhaps we can point to the generational differences in nutritional education as the root of JA’s attitude. “The things that we know now about nutrition…I had no idea when I was feeding my kids fifty years ago,” said HT. Indeed, it seems that for prospective parents today, nutrition has taken on a larger role in feeding the family than it has in the past. Only time will tell whether or not JA’s plans falter in the same way that those of her predecessors did.

Conclusion

We have seen the ways in which food can play a significant role in the process of family development and identity formation. For MA and EA, it became a remnant of the past, a means of holding onto fond memories and transmitting those memories to their children (and, ultimately, grandchildren). MA’s Jewish roots, however tenuous, were always able to survive through the food that he ate, and he passed these ideals onto his son. EA was able to channel her mother through the process of feeding her own children.

For CT, food embodied an opportunity for a cultural reinvigoration: it was the catalyst in her transformation
from her rural past to her cosmopolitan present. As she took on a new identity, she simultaneously transmitted her new cultural practices to her children, repressing her past, for better or for worse.

For the children, food was a means of consent (or dissent) with their parents’ cultural practices and ideals. CA’s love of traditional Jewish meals reinforced his deep bond with his father. His sister JA’s health consciousness created a nearly irreconcilable rift between her and her parents, and inspired her to pursue alternate means of transmitting the cultural identity that her mother imparted onto her. MT and GT’s fondness for their mother’s cooking led them to grow closer to both of their parents, and created a tightly knit nuclear family.

The food each family eats speaks volumes about the ways in which that family views itself. Each bite is packed with cultural, emotional, and domestic implications. By looking beneath the surface, I was able to uncover these implications and their roots.

Works Cited

“Brotherhood” Katie Rubin (’12)

“A Weaving Woman” Katie Rubin (’12)

“Roman Baths at Bath” Jennifer McAuley (’13)

“RIP Biggie” George Karandinos (’10)

Taken in North Philadelphia as part of a continuing ethnographic project under the supervision of Philippe Bourgois examining urban poverty, the drug trade and violence.
Handing Over The Prescription Pad: Doctors as Patients

Monica Pfister

For a suffering patient, the lab coat-clad doctor toting a stethoscope and blood pressure cuff represents the invincible. Armed with state-of-the-art technology and years of medical training, the doctor will be able to address any patient complaint, expertly battling the bacteria, viruses, or insurgent cancer cells that patients may only vaguely remember from college biology. By extension, the doctor himself must be a model of constant health; to admit that doctors might also be vulnerable to such maladies would undermine our unspoken (and somewhat irrational) trust that they possess a “superhuman” influence over disease.

However, the reality is that doctors get sick too. Although they may not fall ill as frequently as the general population (due to superior knowledge of prevention strategies or improved immune systems from constant exposure), medical knowledge is not always enough to avoid taking the intermittent sick day. Occasionally, doctors are faced with more serious health scares, such as cancer or heart disease, which thrust them into the role of patient for prolonged periods of time. This experience as a patient is not a complete role-reversal, but rather an amalgamation of the “doctor-patient” relationship: the patient never ceases to be a doctor, and as a result he encounters unique challenges in the course of treatment and recovery that the average patient would not face.

Prior experience with seriously ill patients may color how doctor-patients view their own prognoses while medical expertise may make it difficult to surrender partial agency and depend on other doctors. Lastly, the doctor’s foray into the world of the patient may affect his practice of medicine in the future, in terms of both treating and interacting with patients. The interviews I conducted with five doctors who have undergone long-term care for serious illnesses indicate that their professional experience complicates patienthood to varying degrees: in some aspects of treatment, it presents daily challenges, while in others it provides practical advantages and unexpected hope.

The overwhelming consensus among the five doctors interviewed is that upon receiving their diagnoses, their minds immediately flashed to images of seriously ill patients with similar diseases for whom they or colleagues had cared. Unlike most patients, who tend to know relatively little about the possible adverse outcomes of their diseases at the beginning of treatment, doctor-patients often immediately envision real life examples of the worst-case scenarios that their disease might influence. Even how doctors view their own odds of survival. For some, these experiences are merely misleading: CNO, a private practice physician diagnosed with Non-Hodgkin’s Lymphoma, felt somewhat ill-informed because his perceptions of the disease based on treating past patients were not up-to-date with current diagnostic information. He was able to distance himself from his own experiences and get more accurate information on possible treatment outcomes from his doctors. However, for some physicians, it can be difficult to step back from the experience of their own patients’ suffering from the same diseases with which they are newly diagnosed. LRT, who was the head of hematology and oncology at a major hospital at the time of his diagnosis, became convinced that his benign liver tumor was malignant because he had witnessed many patients suffering from malignancy and did not believe that he could be any different. Similarly, WMT, who suffered from Non-Hodgkin’s Lymphoma, was haunted by the image of a woman with the same disease who had died in his inpatient service two months before his diagnosis.

While such disease-specific anxiety is undoubtedly psychologically traumatic, there is even more harm done when doctors find themselves generalizing: the assumption of a negative outcome based on past patients with the same disease becomes the assumption of a negative outcome based on the suffering of all past patients with similar diseases. For WMT (who suffered from a very specific type of cancer), “having actively cared for patients dying of cancer brought to mind vivid images of...the inevitable melting away of body mass, disability, pain, and morbid deathbed scenes.” LRT, whose potentially cancerous liver tumor also represented only a small slice of all cancers, similarly dealt with “visual images of all [his] end-stage cancer patients going through [his] head” (emphasis added). Thus, the effect of extensive experience with seriously ill patients on doctor-patients is relatively easy to identify: memories of dying patients cause anxiety and may lead to a less positive outlook on treatment.

Nonetheless, there are certain benefits that persisting mental images of past patients provide to doctors who fall ill. Two interviewed doctors described the guidance toward a more “realistic” outlook that such memories provided. This type of outlook is not exclusively pessimistic, but instead acknowledges the potential risks and challenges of treatment while still maintaining a sense of hope. VMG, who suffered from prostate cancer, described the pragmatic mantra that he developed following his diagnosis: “There’s only so much you can do, so work with what you can do, and learn to accept what you can’t change.” LRT developed a similarly realistic attitude: having cared for enough patients to appreciate that cancer is often simply the result of bad luck, he was able to avoid the question of “What did I do to deserve this?” and the accompanying downward spiral of confusion and self-pity. A pragmatic approach also contributes to informed decision-making, which can ultimately decrease stress during treatment. For instance, LRT’s realistic point of view helped him to face the possibility that he would not survive treatment. Instead of panicking, he took preventative measures to decrease his own stress during treatment by ensuring that his family would have the most stable future possible; he asked his attorney to visit him in the hospital so that he could revise his will and he set up a trust fund for his wife and children.

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However, although a sensible outlook often contributes to peace of mind, the consensus among physicians interviewed was that the psychological trauma and fear of death inspired by past experiences with suffering patients outweighed the practical gains of a more realistic perspective.

Once a doctor-patient has received his diagnosis and determined the mindset with which he will approach treatment, he must tackle yet another challenge: settling into the patient role. The doctor who has always held a leadership role in the healthcare of others must adapt to a decreased sense of agency in his own treatment. While in most hospitals the patient is still the primary decision-maker in care, he must rely on the advice of his doctors to determine a course of treatment and must trust the skills of his doctors to execute it. Somewhat surprisingly, the majority of physicians interviewed claimed not to have had trouble depending on other doctors for care. CNO, VMG, and JBl all affirmed that they had no problem putting their healthcare in the hands of fellow doctors, JBl, who underwent treatment for prostate cancer, explained the ease with which he surrendered the role of caretaker: “I trusted my surgeon and his team implicitly. I didn’t want to interfere with their care.” In fact, VMG felt that it was easier to be a patient than the physician in charge, perhaps experiencing the “therapeutic effects of dependency” (24) described in McKinley’s and Tierney’s “When the Physician-Researcher Gets Cancer.”

Understandably, some doctors found transitioning from doctor to patient to be a greater challenge. AFE, whose heart disease with coronary artery blockage led to a heart attack on an airplane, experienced difficulty deviating from his “usual role of delivering the commands,” especially when he felt he knew better than the less experienced interns or residents responsible for aspects of his treatment. LRT encountered similar issues with the junior staff and house officers in that they were sometimes intimidated by the responsibility of treating a more established physician. As a result, some avoided him and ended up providing “spotty care.” Apart from those who experienced anxiety relating to either the authority or lack of competency of junior staff members, most doctors...
felt relatively comfortable with the shift to the doctor-patient role. Adjustment to the role-reversal is by no means the only treatment complication to which doctors are particularly vulnerable—physicians’ professional backgrounds present a myriad of additional challenges both during and after illness. Even throughout the course of demanding treatment regimens for serious illnesses, doctors often feel that they should avoid complaining about pain or side effects simply because of their medical experience. Not only do some doctors avoid complaining, but they also minimize the severity of their discomfort even when specifically asked to describe it. Because treating doctors often relies on the accuracy of patient self-evaluation, the tendency to avoid complaining can have harmful effects on treatment outcomes. Doctors may also feel especially disoriented by the lack of control of their bodies during treatment. For instance, Dr. Edward Viner in “Life at the Other End of the Endotracheal Tube” described the extent to which his loss of physical control affected his emotional control. He began to experience delusions, but he was ashamed to seek psychiatric help and began to wonder if he would ever again be mentally capable of being a practicing physician.

Doctors-patients’ extensive medical knowledge further complicates their experience of patienthood and illness. For the majority of doctors interviewed, this background helped them feel more at ease during treatment, and they ultimately considered it to be an advantage. LRT, CNO, and VMG all felt that their knowledge was helpful in terms of making informed decisions about their treatment and understanding the process of recovery. VMG felt that his being a doctor affected how doctors communicated with him; they were more upfront with him about his disease because they knew there was no need to simplify the medical jargon. Doctors also may be better equipped to manage the pain that often comes as a side-effect of treatment for serious illnesses. Physicians realize that pain is controllable, they are better acquainted with the options available for pain relief than most patients and have greater access to pain medications. Finally, medical knowledge may provide a major benefit to doctor-patients when managing the conditions in a post-operative setting. As a patient, VMG felt that surgeons focused heavily on surgery at the expense of post-operative guidance, and he was grateful to have the ability to direct his own long-term recovery. Dr. Viner also relied on his ability to self-doctor post-operatively. While on a respirator, he began to vomit and worried that he was aspirating. His medical knowledge allowed him to name the problem right away, and it gave him the confidence to continue voicing his concerns even after the nurse assured him that he could not possibly be aspirating. Dr. Viner turned out to be correct and was able to ensure that the problem was addressed.

Of course, it is important to note the potentially damaging effects of knowing too much: doctor-patients understand even what their doctors deliberately do not explain, and there is less chance of finding comfort in denial. Doctor-patients are uniquely able to interpret the subtle signs of how serious their illnesses are and must cope with the resulting psychological trauma. For instance, immediately upon regaining consciousness after his second operation, Dr. Viner knew based solely on the light fixture above him that he was being kept in the intensive care unit because he was too sick to be brought back to a private room. He also knew that he was in trouble based on the presence of the surgeon, who he knew would never be called in the middle of the night merely for routine post-operative problems. Dr. Viner’s reaction was a panic that most patients would not have had to face until later, when better recovered from surgery and able to be comforted by a doctor or other staff member. Medical knowledge can also dampen doctor-patients’ hopes for recovery. Whereas doctors generally avoid causing unnecessary alarm by putting off discussion of long-term consequences until recovery has begun, doctor-patients can envision worst-case scenarios as soon as they receive their diagnoses. While most patients would have assumed that they would eventually reach full recovery, LRT knew from the beginning that he could end up as a pulmonary cripple permanently dependent on a respirator. This feeling of knowing too much can both make it difficult for a doctor-patient to maintain a hopeful outlook and cause him to question his physician, who he may feel does not know best or is withholding information.

In light of all of the possible consequences on the treatment process described above, one must ask whether being a doctor has any overall effect on treatment outcome. Undoubtedly, doctors’ medical backgrounds shape their experiences as patients, but is there a recognizable trend of significantly different outcomes among doctor-patients? If there is, it is not easy to determine whether the outcomes of individual cases can be predicted, and may be heavily influenced by factors such as difficulty depending on other doctors or professional courtesy, the general consensus among doctors interviewed is that being a doctor has no appreciable effect on treatment outcome. JBI believes that his professional background did not ultimately affect his outcome at all, and CNO agrees, although he conceded that it did help him to navigate the medical system effectively. APF cited the aphorism “If you are a doctor, you will get all possible complications described in the book” and acknowledged that he did suffer from numerous complications after his heart surgery, but he concluded that “in general…being a doctor should make no difference in the outcome of care, compared to other patients.”

The only doctor who disagreed was LRT, who spent months on a respirator in 1972, when healthcare professionals were still learning how to operate them effectively. Exhausted and short of breath in the care of residents, he was able to call in an expert colleague who made him comfortable; of the colleague, LRT said: “I probably would have died without him.” However, LRT’s experience occurred years after technology was still relatively limited and the discrepancy in care quality among patients and doctor-patients was much higher. Today, doctors generally feel that while their profession may occasionally complicate or facilitate the treatment process, it does not affect overall outcomes. In discussing the initial shock and long-term distress of dealing with a serious illness such as cancer or heart disease, it is difficult to imagine that a doctor-patient could emerge unaffected. While the doctors interviewed generally confirmed that their experiences as patients have influenced them permanently, the effect that they cited most often is surprisingly positive. Instead of focusing on the psychological trauma associated with disease, they reported that the role reversal from doctor to patient had improved their ability to interact with and care for their own patients. In the most concrete sense, this change applies to the technical aspects of patient care, such as pain management. Having experienced serious discomfort, GVM explained that he now pays much more attention to alleviating pain and discomfort and encourages pain management as an integral part of the treatment process. He is also more aware of the need for supportive post-operative care. While the operation itself may be the focus, there remains a need for guidance to deal with questions or complications long after the surgery is completed. Having experienced ongoing suffering, doctor-patients experience a greater appreciation of the fact that medicine is meant to promote quality of life, not simply survival. After spending months on a respirator, Dr. Viner realized that doctors should not utilize invasive care and life-extending technologies simply because they exist but rather should make informed decisions, contingent on the quality of life that patients can expect as a result. As Dr. Viner explained, he realized in the process of undergoing various invasive operations and therapies that “living was not in itself paramount and that maintenance of dignity and quality of life are truly valid concerns.” This realization is by no means easy to accept, especially if the doctor-patient himself is the one whose quality of life is to be determined, but it perhaps can lead to more compassionate patient care in the future. On a less tangible level, developing the ability to share the patients’ point of view by literally experiencing patienthood improves doctors’ approaches to interpersonal interactions with patients. LRT has become more aware of the importance of this type of one-on-one interaction. Caring for very sick patients all day, it is instinctive to develop a certain amount of self-protection, but his experience as a patient helps him to catch himself when he’s
becoming too distant or “not as human as [he] should be.” On a similar note, Dr. Viner noted the necessity of paying personal attention to each individual patient. He explained that it is essential for a doctor to remember that even a patient “whom illness has reduced to an eye-wathering, lip-quivering mass of protoplasm” (3) is an individual who approaches the stress of illness with a unique personality and background. Continuing personal attention can help prevent the feeling of dehumanization that may otherwise come with the loss of physical and emotional control. Even more so than facilitating this one-on-one interaction, the most significant change that interviewed physicians reported was a renewed emphasis on giving patients hope. This response is somewhat surprising coming from a scientific community devoted to facts and figures, but there was a clear preference for preserving patients’ optimism whenever possible. In reference to often demoralizing facts and figures, doctors interviewed felt that delivery style is important—often it is better to deliver bad news more gently and exclude (at least initially) discouraging statistics. In “Journey of Hope Shared,” head and neck cancer surgeon Chris O’Brien echoed that “his doctor-to-patient role reversal had reinforced the importance of remaining optimistic and positive as a treating doctor, even when the odds, such as his, were slim.”

A major determining factor in the quality of doctor-patient interaction is successful communication, which relies heavily on the doctor’s abilities both to speak frankly about uncomfortable topics and to listen carefully to the patient. Among the doctor-patients interviewed, those who benefitted from good communication during treatment and those who suffered from the lack of communication came away with an equally lasting impression of its importance. Having returned to the doctor role, they attempt to put patients at ease through enhanced communication, and most feel that they succeed. LRT explained that having experienced the sense of confusion inherent in patienthood, he is now comfortable talking honestly with his patients about the “nitty-gritty” in hopes that they will better understand their situations. Dr. Viner, who remembers wanting to talk with his doctors about the possibility of imminent death and seeing all of his caretakers withdraw, tries to be particularly open to discussion in this arena. Patients preoccupied with fear of death may feel uncomfortable talking to friends or family and may turn to doctors for support, and Dr. Viner stressed how beneficial it is for doctors to be able to speak frankly about such a taboo topic. In terms of listening, recovered doctor-patients now understand the helpfulness of the patient role and make an effort to increase patients’ sense of agency by listening to their questions and complaints. Dr. Viner emphasized the value of listening to what patients have to say; not only does it put them at ease, but it can also prevent dangerous health problems from going unnoticed. Sometimes the medical staff does not catch everything, and even non-doctor patients often know best what it is happening to their bodies. Similarly, APF believes that his experience as a patient has taught him to listen to his patients more carefully with greater patience and humility. JBI added that it is not just important to communicate; it is also essential to avoid rushing through interactions with patients and their families.

A final aspect of interpersonal interaction that doctors felt their experiences as patients had strengthened was their ability to empathize. Doctors who have stood vulnerable in examination gowns are better able to identify with patients in the same position, a perspective that VMG referred to as “being on the other side of the johnny” (a term used for hospital gowns). As Dr. Viner explained in his autobiographical article, it is “incompatible with [physicians’] self-images as empathetic care providers” (3) to admit that they do not fully understand patients’ predicaments, but the reality is that only doctors who have suffered from serious illnesses can truly appreciate what patients experience. All five doctors interviewed revealed that their doctor-to-patient role reversals have immensely improved their abilities to empathize and to identify with the sense of helplessness with which patients struggle. LRT summed up the group’s general consensus: “I feel like I was there; I feel like I understand.” This newly developed ability to relate to patients often translates to concrete action—in addition to a more empathetic bedside manner—that may improve patients’ hospital stays. For instance, Dr. Viner benefitted from the fact that

his wife, a trained intensive care unit nurse, was allowed to stay after visiting hours because she was deemed a “good” visitor. Once he returned to health and the practice of medicine, he worked to expand visiting privileges at the hospital where he worked and was treated. In terms of research, physicians who have experienced patienthood feel that researchers should involve patients and caregivers more frequently in the development and outcome-assessment of therapies. Only those who have experienced illness understand its real life consequences outside of the laboratory.

While the interactional approaches described above are by no means a substitute for skilled hands-on care, the insights that recovered doctor-patients learn from their experiences can greatly contribute to patients’ peace of mind. One could therefore say that patients may make better doctors. But do doctors generally make better or worse patients? VMG, LRT, and JBI contended that personality is the strongest factor in determining how doctors will react to patienthood, and it therefore varies based on the individual. APF maintained a more neutral standpoint, generalizing that most doctors are good patients, but there are certainly exceptions who challenge their physician’s role. VMG and CNO both believe that the doctor-patient role reversal had reinforced the importance of remaining optimistic and positive as a treating doctor, even when the odds, such as his, were slim. Without this distance between them and their physicians.” LRT and CNO, however, feel that while doctors may not make “worse” patients, they are certainly more challenging: many either fight to do what they think is correct regardless of their treating physicians or rely heavily on denial. LRT, who has treated many fellow doctors throughout his long career, told the story of one physician who refused to acknowledge his grim prognosis and vulnerability by only minimally discussing his condition. He asked to be put on a chemotherapy regimen even though he knew he would not survive. LRT elaborated that doctor-patients are also challenging on a technical level; they ask hard questions, and they will notice immediately if the treating doctor is uncomfortable being upfront and honest. Thus, the general opinion seems to be that although it does vary based on individual personality, doctors are generally not “worse” patients, but they are understandably more challenging.

While doctors may not enter the examination room with the same level of disorientation as most patients, their familiarity with the scene does not necessarily mean that they will be comfortable switching roles. The downside of taking on the patient role with a background of medical experience is that this same knowledge, which may initially have a comforting effect, prevents doctors from entering treatment with the tabula rasa from which non-physicians benefit. They cannot consider their own prognoses in isolation because they are influenced by the diagnoses and outcomes of seriously ill patients they have treated in the past. They may also feel helpless after surrendering control over the hands-on aspect of treatment. Finally, treating physicians can never completely protect doctor-patients from knowing too much: they understand what they are told, and they can infer even what they are deliberately not told from what is happening among them. However, there is hope to be found in the predicament of the doctor-patient. Background knowledge translates to expertise in navigating the complicated healthcare system, an improved ability to communicate and make decisions with treating doctors, and an appreciation for the power of modern medicine. Perhaps most importantly, doctor-patients who return to medical practice have the unique ability to identify with patients, providing the empathy and support that they had or wish they had. Therefore, although physicians do experience various profession-related complications throughout the course of their treatment, many ultimately become better doctors as a result.

Works Cited


Pablo Barrera is a Senior majoring in Art History that is currently conducting self-directed research on Joseon Dynasty (1392-1910) vernacular architecture known as “hanok.” He has been collaborating with the Penn Museum Cultural Heritage Center and Directors of the National Trust of Korea to explore cultural heritage issues surrounding the re-appropriation of hanok as part of the National Branding Campaign of South Korea. He has conducted joint research on a library and museum survey on hanok, and has completed an anthropological/architectural survey of the hanok-village preservation zone in Gahoe-dong, Seoul, Korea as part of the University Scholars Program at Penn.

Samuel Liebeskind, a senior in Biological Basis of Behavior, took this photos while studying abroad in Sydney, Australia.
Digging At the Hilltop Site (above), Skeleton (below)
Part of research with Penn Museum’s field school at San Pietro d’Asso, Tuscany, Italy.

Jennifer McAuley (’13)

These two photographs (above, below left) depict a traditional Shembe religious celebration. The woman (below right) is at her Umemulo, a Zulu coming-of-age ceremony for women. She is wearing a sheath of cow fat on her shoulders as a symbol of respect to her ancestors, while people place South African Rand on her head as gifts.

Erica Holland (’11)
Sobremesa: An Analysis of Food & Culture In Hispanic Communities
Darien Perez

If there’s one thing I’ve always associated with my large Latin family, it is food. Gathering around a table large enough to sit twelve people, I would watch as my mother and aunts shuttled delicately prepared foods to the center of the table. However, it wasn’t the food that I remembered most vividly from these encounters. Rather, it was the sense of community that permeated the atmosphere of the entire meal. It was an anchor in the midst of a hectic twenty-first century lifestyle. It was a sense of unity and inclusion that inspired me to pursue a study of the role of food in Hispanic communities. I became interested in interviewing members of the Hispanic community to see if their experiences mirrored my own. Mary Douglas informs us that “Food…is a particularly good boundary marker, perhaps because it provides…this ability to transform the outside into the inside…food is about identity creation and maintenance” (as cited in Sutton, 2001, p. 5). Fueled by these thoughts on creation of an identity and community, I wanted to examine the importance assigned by Hispanics to meals in the household and delve further into individuals’ associations with memories of eating.

In compiling my research questions, I began to wonder whether my interviewees, who span several generations, perceived a change in the role of the meal in the household. In an era where there is an increasing emphasis on individualism in American society and a prominent shift towards more women working and the average individual working more hours overall, I wondered what effects it would all have on food inside the home. This became the secondary focus of the study. I invited my interviewees to share their thoughts on any notable changes pertaining to the meal throughout the decades, whether or not they felt that the meal has been devalued, and what factors they attribute to any perceptible changes.

Methods
In conducting the study, I chose to interview a pool of eight individuals, consisting of six women and two men. The interviewees consisted of four second-generation Hispanics and four first-generation Hispanic immigrants. It is important to note that the interview pool did not have a homogenized immigrant background. Rather, the pool consisted of four Mexican informants, two Cuban informants and two Dominican informants. For clarity in this paper, I will utilize the term ‘Hispanic’ as an all-encompassing label. The word Hispanic is “of or relating to the people, speech, or culture of Spain and Portugal; of, relating to, or being a person of Latin American descent living in the United States, especially Mexican, Cuban or Puerto Rican” (Mish, 2009). For reference here, I will briefly describe each interviewee. My Mexican interviewees consisted of four females: MH, age 25; LR, age 38; MD, age 60; and SD, age 79. My two informants from Dominican backgrounds were LS, age 42, and CMP, age 88. The final two informants were Cuban: LR, age 46, and EP, age 88.

Between all eight of the interviewees, the generational divide of the pool spans from 20 to 88 years of age. This was crucial to the development of a well-rounded perspective on changes in the role of the meal over the last few decades. My interviews were structured in a four-part manner. First, we discussed meals and an air of formality, examining table etiquette and customs, as well as the role of familiarity in structuring a meal. Secondly, we discussed memories attributed to food by individuals. Next, we tackled celebratory occasions and holidays and the resultant changes that ensued during these particular moments in the year. Finally, I broached the subject of meals and how they may have changed over time.

Food and Memory
When asking my 8 interview subjects what kinds of memories they associated with food, positive or negative, there was an overwhelming and unchallenged answer of “positive”. As EP put it, “I can’t think of anything more enjoyable than the food we had together.” Deborah Lupton, in an article about food and emotion, states that “There is a strong relationship between memory and the emotional dimension of food…food is an element of the material world which embodies and organizes our relationship with the past in socially significant ways…” (2005, p. 320). Indeed, food is a powerful and evocative medium for remembrance of the past. These past experiences, in turn, are the basis for structuring how many individuals think and act today within their own households. Lupton continues by informing her readers that preparation of a meal at a later point in life can evoke memories related to the food items consumed in the past and prompt the recall of emotions or recollections associated with that time (2005, p. 320). These experiences are something that individuals chose to share or avoid, depending on what was retained through previous encounters. Both MH and LR relayed stories to me, when prompted about memories associated with food, about watching their mothers cook in the kitchen and trying to integrate those preparation skills into their own work in the kitchen. LR told me that she still tries to imitate her mother’s tamale recipes based on the little nuances that she recalls from dinnertime when she was younger. She says, “My friends ask me why I tie the tamale three times around when I invite them to dinner. I say, “Because its how my mother did it”. I won’t change it for anything.” LR’s anecdote exemplifies David Sutton’s observations on ‘doing’ cooking. She embarked on an informal apprenticeship as a young girl and draws upon images and experiences that are stored in her memory versus a set of structured rules that were laid down or written (2001, 135). Sutton emphasizes the efficacy of memory recall in situational cooking. At least three of my other female informants mentioned in the course of the interview that their ability to cook more traditional Hispanic dishes come from recollections of how their grandparents, mothers, and aunts used to cook.

Many of my interview subjects associate memories with specific sensory experiences of consumed food items. LS recalled how she associates the smell of fresh baking bread with her mother and neighbors baking in the Dominican Republic. This sensory marker triggered a tangential recall of the relationship between her neighbors and her family on the island. CMP tells me that whenever he smells banana de la viscosa simmering on the stove, he immediately thinks of Christmas. Baulao, or codfish, is a dish eaten traditionally on Noche Buena (Christmas Eve) in many Spanish-speaking countries. Indeed, the smell becomes a reminder and marker of the holiday, even if his family is making it during some other point in the year. These observations mirror Marcel Proust’s commonly quoted anecdote about how he remembered his childhood with a simple taste of a Madeleine cookie (as cited in Sutton, 2001, p. 88). Proust’s experience emphasizes the ability of a sensory part, such as smell or taste, to evoke memories of the whole of the events surrounding these individual experiences (Lupton, 2005, p. 320).

In addition to sensory and cognitive memories, food entered the realm of memory for my subjects in the form of a structured meal pattern at home. Mary Douglas’ work, Deciphering a Meal, has been highly regarded in anthropology for its study of the basic structure of the meal. Douglas argues that a meal must recall the structure of previous meals in order to cement what metonymically constitutes a meal (1957, pg 237). Meals are a repetition of key themes that can be elaborated and expanded, but are grounded in a centralized definition of what and who makes up the meal. When inquiring about memories and food in their homes, I asked my interview subjects to recall the structure of their lunch and dinner meals, if any. This included asking about table preparation, etiquette, time, place, etc. in relation to eating a meal. Out of the eight interviewees, six indicated that the meal was connected with a specific time in the home and all interviewees said that meals took place around a table, usually in the kitchen space or a dining room space. A good example came out of my interview with EP. She stated: “We always dined in the dining room, around the table. Never in another place. And at 12:00 we had lunch and at 7:00 we had dinner. From 7 to 8. My mom would say ‘if you aren’t here, you don’t eat.’” The only exceptions to these rules seemed to be during celebratory occasions. LP told me that he recalls specifically how on Christmas and New Year’s Eve, the family was not allowed to eat before midnight. Even the change in meal times and structure during holidays and special occasions, however, followed an established pattern, according to LP. The repetitious nature of the meal during holidays develops into a symbol itself; the observation of these specially structured meals indicates the arrival of these annual holiday periods. In interviewing my subjects, it was evident that the symbiotic relationship between memory and the meal plays a large role in remembering the past in the present.

Food as a Method of Socialization
Food has a unique ability to be a definer of one’s individuality and affiliation with a specific place in society (Anderson, p. 124). The foods eaten and customs followed by individuals acquire a level of familiarity that becomes embedded in their identities. In an article entitled Identity and the Global News, Allison James asserts that
shared patterns of consumption mark a distinction between one group and another (2005, pg 374). Consumption sets up a series of boundaries between what is culturally accepted as edible or tasteful and how it is eaten, standing apart from all that can be consumed in the world. E.N. Anderson echoes this same sentiment, speaking about how food is second only to language in terms of communicative functions (2003, pg. 126). Words are of little importance at the table. Rather, more information is transmitted by observance and integration of the social transactions occurring over the table than what is said verbally. This spans a broad range of interactions. Basic table etiquette falls within this category, but also rules about who is served first, who sits next to the host, food distribution and so on. LS commented on such categories when asked about preparation and etiquette at the table: “Usually my mother or my aunt would serve the kids. If there were a lot of kids, it was expected that the kids would be relegated to a smaller table and adults would occupy the main table. Kids were expected to be polite, quiet and to talk amongst themselves.” Four of my successive interviewees spoke of similar experiences regarding social divisions between adults and children and the manners expected at the table.

Food preparation methods similarly serve as a method of socialization. Cuisine, according to Maria Elise Christie, author of Kitchenspace: Women, Fiestas and Everyday Life in Mexico, is among the most important markers of ethnicity. It is a means of asserting cultural identity and the way food is cooked imbues it with ideas of who these individuals believe they are, where these individuals live and what they believe their place is in the world (2008, p. 31). The kitchenspace is where and when the family is gathered about who was expected to cook and how, according to my interviewees. LK and LS both stated that meal preparation was the responsibility of all the family members. If you were a young girl, you were expected to watch in the kitchen and once you were old enough, you could start to help. LR elaborated: “It would start that my mother would hand me corn husks and have me dampen them. Then I would learn how to make the masa, how to prepare the pacadillo, how to fill and wrap them. It was a process built in to the system and I was almost expected to do it in your own kitchen.” As Christie puts it, “kitchenspace appears to provide a refuge for culture, allowing the reproduction and reinvention of “lo nuestro” (what is ours) or core elements of collective identity” (2008, pg 259). Kinesthetic information, the motions and actions of cooking, are thus transferred from mother to daughter, aunt to niece, cousin-to-cousin. But, beyond the understanding of practical physical mobilizations of resources, these actions must be stored as part of the collective memory of the interactive experience in order to be actualized later in life (Sutton, 2001, 127).

The other side of the equation, the consuming of the finished food products and meals, plays a further role in solidifying the socialization of an individual. People begin to be known and also to identify themselves with social standards of the foods they eat, just as they come to know what religion to follow or what language to speak (Mintz, 2003, pg 23). Individuals also assimilate what types of foods should be eaten during holidays and ceremonial occasions in contrast to everyday meals. LP recalled his grandmother’s Cuban eggnog during Christmas and how it was the one time during the year that the older children were allowed to drink some alcoholic beverages with their parents. MH said that celebratory meals were particularly distinctive because she and her siblings were raised without dessert during the rest of the year. Noche Buena (Christmas Eve) signaled a brief moment of indulgence in sweet treats. MH also related a powerful example of how Spanish food is defined by regularly structured consumption and how introduction of “foreign” foods disrupted her family’s eating patterns. She noted:

Food during special occasions was always pozole or tamales. We only had turkey once, when my Aunt wanted to imitate a Martha Stewart thanksgiving recipe. Nobody liked it. It was odd tasting and poorly cooked because it wasn’t something she was used or trained to make. We didn’t have it again, thank God! Clearly, there is a boundary between what individuals associated with the traditions of their respective Hispanic culture and what seems foreign. My interviewees all recognized that culturally defined preferences for food and methods of preparation labeled what was an inside food versus an outside food, serving as a boundary marker.

Socialized meals convey strong messages about identification with the Hispanic world. Methods of preparation labeled what was an inside food versus an outside food, serving as a boundary marker. This network sobre mesa (over the table) is large in Hispanic communities. Meals are not always centered on the nuclear family. Family extends far beyond to include aunts, uncles, cousins and other visiting or nearby relatives (Christie, 2000, pg 232). Meals and eating therefore serve as a social facilitator for the rekindling of ties, exchange of information, and a reaffirmation of belonging to a group – whether a specific family or a larger connection to the Hispanic community.

Sharing the Table with A Stranger

Just as cultures create classifications for what is food and non-food, so the world is divided into kin and non-kin (Anderson, 2005, p. 125). The dynamics of the meal, according to my interviewees, does change somewhat when the table is shared with outsiders (people who are not relatives/kin). I inquired whether or not there was a difference in the meal or mealtime structure when individuals who were outside the family partook in eating within the household. LS informed: “With family, there was a sense of being more relaxed. But there wasn’t really a huge difference – it’s very customary to invite whoever was around or on the street (neighbors) to eat. It’s very Spanish thing. We take pride in sharing food.” Clearly, folks from the Hispanic community or who shared some sort of cultural identification with these families were accepted and treated as though they belonged at the meal always. In contrast, MH and MD stated that there was never someone they didn’t know at the table. It was almost exclusively family and relatives because, they said, meals equalled sharing time with your family. Other individuals should be expected to do the same with their families.

In probing my interviewees further, I made inquiries as to what, if any, changes occurred if the person attending the meal was not a member of the Hispanic community. CMP responded that the change would not be on his family’s side, but rather an adjustment made by the visitor. EP elaborated, “We serve you what we serve our family. You are expected to at least try what we have made, because it is very important! We are offering you a piece of our home.” In this way, my interviewees indicated that in being invited to a meal in a Hispanic household, it was necessary for outsiders to detach themselves, at least temporarily, from their own identities. The food consumed
during the period of the meal is imbued symbolically with the Spanish identity. The guests who voluntarily eat this food are assigned, for the interim, the position of being in the family and being a transitory member of the Hispanic community. Likewise, my interviewees noted that there was some level of heightened awareness at the table about how foods that are typically served in a Spanish household can become “exotic” in the presence of an outsider. At least four of my interviewees mentioned during this inquiry that one of the greatest offenses an outsider can make is refusing to take food from the hosts of the meal. Refusing food is intricately tied to rejection of Hispanic cultural values and identity. CMP remarked, “You don’t make it really obvious, but deep down, you get a little irritated and upset that someone doesn’t want to accept your food and hospitality. Then again, I guess that’s just how we were raised. It’s a cultural difference”. Undeniably, this interaction between strangers and the Hispanic family exemplifies the tremendous power of food to take on valued meanings and generate subjective commentary (Sutton, 2001, pg. 6). As much as these interactions are related to the symbolic value of the food, acceptance of food can also be tied to notions of hospitality. Just as David Sutton informs that hospitality is something that must be repeatedly witnessed, in order to have a solidified social effect, hospitality is something that must equally be acknowledged by the recipient in the Hispanic community. You are encouraged to remember the generosity of your host.

Meals and Generations: Valuation or Devaluation?

The last section of my interviews with my informants focused on an opinion-based look at how the concept of the meal may have changed over time. I asked my interviewees if they felt that the role of the meal in their households had changed over their lifetime and whether they felt the meal was more or less important now than in the past. LS responded, “Meals are less important because we’ve lost traditions along the line, the planning and the large gatherings of people has diminished as people move out, leave the homeland, and so on.” LS continued on to say that she felt as though food has become more streamlined, less labor intensive and more modernized. In her opinion, the most significant contribution of food as a symbol in the Hispanic community is the idea that food, acceptance of food can also be tied to notions of hospitality. Just as David Sutton informs that hospitality is something that must be repeatedly witnessed, in order to have a solidified social effect, hospitality is something that must equally be acknowledged by the recipient in the Hispanic community. You are encouraged to remember the generosity of your host.

One of the most interesting responses I got on the value of the meal was from MH. She thought that the role of the meal as a central unifier for the family has not changed, but the consumption patterns have morphed over time. MH told me that she believed that meals are more important now than ever in the sense that it’s the overall devaluation of the meal. The most common response out of my eight interviewees was that in losing the overall devaluation of the meal. It is a time for reflection and discussion and a time to simply be immersed in the presence of the family. It is clear from my interviews that food plays a variety of roles within the Hispanic community. First and foremost, food provides the opportunity for the family to come together, to share tales of the past, and to remember the communal experiences and their cultural past. The table is the forum at which young children observe and learn from their parents the skills that will fully integrate them as members of the Hispanic community and that they will later, ideally, use on their own tables. Foodways become predictable and comprehensible as methods of socialization, facilitating the entry into an ethnic identity (Anderson, 2003, pg. 115).

But, ultimately, my interviewees have supported the notion of the meal as the symbolic placeholder and unifier of the culture. In her opinion, the Hispanic meal is a mark of social existence both within the household/family and within the greater network of Hispanic communities (Christie, 2008, pg. 252). Individuals who commit to the unwritten rules of mealtime are formally establishing the boundaries between themselves and others. The fear for today, many of my interview subjects, is a deterioration and disassociation of individuals with any particular identity. The movement of people and food in greater volumes and more quickly due to increased globalization has begun to deteriorate the ties between place, food, and group. Only in making a conscious effort to recognize the symbolic nature of food can individuals hold onto a sense of ethnic pride, no matter where they are or where they are headed. Identity is not a fixed set of memories or specific ideas, but rather a never-ending assimilation of practices and traditions that define what we believe is our own individual place on the planet.

Works Cited


Douglas, M. (2004). Food as a communal denominator, the members of the Hispanic community recognize the meal as a mark of social existence both within the household/family and within the greater network of Hispanic communities (Christie, 2008, pg. 252). Individuals who commit to the unwritten rules of mealtime are formally establishing the boundaries between themselves and others. The fear for today, many of my interview subjects, is a deterioration and disassociation of individuals with any particular identity. The movement of people and food in greater volumes and more quickly due to increased globalization has begun to deteriorate the ties between place, food, and group. Only in making a conscious effort to recognize the symbolic nature of food can individuals hold onto a sense of ethnic pride, no matter where they are or where they are headed. Identity is not a fixed set of memories or specific ideas, but rather a never-ending assimilation of practices and traditions that define what we believe is our own individual place on the planet.


Samuel Liebeskind ('11) took these photos while traveling in Cambodia, Thailand, and Fiji.

Colin Schenk, a senior in Health and Societies, captured these images while researching and working with Pratit International in Kolkata slums in West Bengal India during this past summer.
Attitudes and Intentions Associated with Breastfeeding in College Students

Vidushi Bajoria

Over the past decade, research on the long-term benefits of breastfeeding has greatly increased. Women all over the world, particularly in industrialized countries, which in the past tended to have a low prevalence of breastfeeding, are becoming more aware of the advantages of breast milk and bottle-feeding. Several researchers have turned their attention toward the myriad factors associated with women's decision to initiate and continue breastfeeding. Although the past few decades have seen a dramatic increase in breastfeeding, from 25% in 1970s to 73.9% in 2005, the optimal breastfeeding rate is still not being met (CDC). There are several medical benefits to breastfeeding, both for the child and the mother (WHO). Yet, a large number of women still continue to bottle-feed (Earle, 2002). A number of social, cultural and political factors significantly affect the initiation and duration of breastfeeding. Infant feeding decisions depend on attitudes toward breastfeeding that may be developed as early as adolescence (Martenus 2001). Therefore, from a public health perspective, it is extremely important to identify the factors responsible for breastfeeding beliefs from an early age.

The goal of this study is to describe the attitudes and intentions toward breastfeeding in a group of university students in the United States, and to determine if any demographic or behavior variables can be designated as predictors of these feelings. This study also explores whether some variable, such as student or family income, cultural differences, or exposure to breastfeeding at home, is associated with attitudes toward breastfeeding. Through a review of the medical benefits of breastfeeding, contemporary barriers that women face, and worldwide cultural trends, my paper will explore the different variables responsible for certain attitudes and intentions toward breastfeeding.

Breastfeeding conveys vast health advantages to both the child and the mother (Stuart-Macadam & Dettwyler, 1995). The most obvious advantage is the nutritive function of breast milk. Breast milk is also rich in regulatory substances that stimulate the development of the infant's own immune system. Newborn babies have antibodies circulating in their bloodstream, which they acquire from the mother; however, the immune system is not yet functional and requires long-term exposure to the environment before it becomes active. In the mean time, babies have to rely on antibodies contained in the mother's milk (Stuart-Macadam & Dettwyler, 1995). Breastfeeding also prevents the growth of antibiotic-resistant bacteria in babies.

Moreover, the benefits of breastfeeding are long-term development and health of the infant. As an example, bottle-feeding is correlated to Crohn's disease (which causes inflammation of the digestive tract) and hypersensitivity to allergens (Koletzko 1989). Early feeding practices have also been associated with coronary pathologies, disorders of immune regulation, and psychomotor development (Lucas 1998; Cunningham 1995). Some theories also link infant diseases to cow's milk (Stuart-Macadam & Dettwyler). Some theories also link infant diseases to cow's milk (Stuart-Macadam & Dettwyler). Sexualization of breasts appears to be a culturally and socially constructed western phenomenon. Furthermore, the stigma attached to public breastfeeding is societal, and not a product of individual self-consciousness. In 1997, California passed a legislation that “allows a mother to breastfeed her child in any location, public or private, except the private home or residence of another, where the mother and the child are otherwise authorized to be present” (National Conference of State Legislatures). This exception was made to clarify that breastfeeding is legal behavior, not public nudity.

Artificial feeding first appealed to women because it released them from purely reproductive roles and allowed them to delve into more productive labor areas. During World War II, societal needs pressured women to work outside the home, which further encouraged reliance on bottle-feeding (Worcester & Whatley 2004). By the late 1970s, the percentage of working mothers with infants had jumped from 32% to 52%, with two-thirds of these women working full-time (Blum 1999). Therefore, to women working and breaking away from their traditional reproductive roles, bottle-feeding was alluring because of its convenience and efficiency (Worcester & Whatley 2004). By the late 1970s, the percentage of working mothers with infants had jumped from 32% to 52%, with two-thirds of these women working full-time (Blum 1999). Therefore, to women working and breaking away from their traditional reproductive roles, bottle-feeding was alluring because of its convenience and efficiency (Worcester & Whatley 2004).

Many women first arrived in the workforce, the entry of breastfeeding in the workplace: Should they be allowed a private space for breastfeeding or should they challenge the dominantly male environment? When breastfeeding was the exception was made to clarify that breastfeeding is legal behavior, not public nudity.

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condition. Pharmaceutical companies use this as an incentive to not risk breastfeeding at all (Worcester & Whatley 2004). The mere accessibility and availability of formula food also constantly encourages women to turn to bottle-feeding. These women do not breastfeed, therefore produce less breast milk, and as a result rely even more on artificial feeding (Lattie 1998).

Cultural differences also play an important role in influencing a mother’s decision to breastfeed. Breastfeeding is a biological act, but these instinctive behaviors, techniques, and commitments are strongly determined by culture (Lattie 1998). Women in collectivist countries like India, China, and Papua New Guinea experience less difficulty breastfeeding, whereas women in individualistic countries like the USA and UK experience more dissonance. A study conducted in 2006 revealed that Indian, Pakistani, Bangladeshi, black Caribbean and black African mothers were more likely to initiate and continue breastfeeding up to 6 months, as compared to white mothers (Kelly et. al 2006).

A number of reasons exist why women in collectivist countries breastfeed. For example, the majority of the population in these countries is below the poverty line and therefore cannot afford expensive formula food or bottle milk. In countries like India and Pakistan, women are expected to maintain households, not work. Therefore they are not necessitated to find convenient methods of feeding their infant. Large support groups for women in such countries also motivate continued breastfeeding. Perhaps individualism and collectivism influence decisions of women in the US at a subconscious level.

The target population for this study consists of women between the ages of 18 and 24, i.e. undergraduate students, in an urban college campus such as that of the University of Pennsylvania. Infant feeding decisions depend on attitudes toward breastfeeding that may be developed as early as adolescence (Martens 2001). Adolescents generally have positive attitudes toward breastfeeding but are subject to misconceptions embedded in culture, which are difficult to correct in adulthood (Goudet et. al 2003). Therefore it is extremely important to target the factors responsible for breastfeeding attitudes and beliefs from an early age. Lack of information may induce negative assumptions about breastfeeding in students (Kang et. al 2005). Very little is data available on university students’ attitudes and intentions toward breastfeeding; deriving such information will be helpful in building an early intervention program for young women.

In this cross-sectional and descriptive study of attitudes and intentions toward breastfeeding, a sample of undergraduate women attending the University of Pennsylvania was recruited. Any woman was eligible to participate in the study as long as she was between the ages of 18 and 24 years old and attended the University of Pennsylvania as a student. Participation was not contingent on ethnicity, race, or socioeconomic status. Data collection of surveys and questionnaires was completed within a month. All surveys and questionnaires were administered in English, and collected via email. The e-mail clarified that participation was voluntary and all information provided would remain confidential and anonymous.

A survey and questionnaire were administered to 27 students. In addition, a total of 6 in-depth, semi-structured interviews were conducted once the surveys and questionnaires were complete. The survey and questionnaire provided basic information from which more precise questions could be developed for the interviews. I conducted the interviews, either over the phone or in person depending on which method the participant was comfortable.

The surveys were used to gain demographic and quantitative information about the participants’ (age, ethnicity, major, annual income, marital status); intentions and attitudes toward breastfeeding; and exposure toward breastfeeding, both in public and at home. Questions asked whether the participants were breastfed as a child and whether they would feed their child in the future via bottle or breast milk. In addition, the questionnaire obtained information about students’ knowledge of breastfeeding. The questionnaire consisted of 17 questions in which the participants were asked to indicate how strongly they agreed or disagreed with the statements, presented on a scale of 1 to 5.

The objective of the interviews was to collect in-depth information about attitudes, beliefs and exposure regarding breastfeeding. Because of the descriptive nature of the study, interviews were not randomized, as there was only one group of participants. Base questions were already developed, but the interview took its own course based on the data from the surveys and questionnaires.

The survey variables were calculated for descriptive statistics. Each questionnaire was scored with a total possible score ranging from 17 to 85 with the higher score representing more knowledge regarding breastfeeding. The median for the score range was 63 and was used as a division between overall negative and positive attitudes. Individual questions range from a score of 1 to 5 and therefore the median was 3. Data analysis was done using JUMP.

Statistical procedures were completed at a significance level of 5%. Pearson bivariate correlations for the overall sample was performed to investigate possible relationships between factors such as intention to breastfeed, whether the participant was breastfed as a child, and whether the mother will support breastfeeding. Finally, in order to predict breastfeeding intentions, regression analysis was conducted. Predictors were picked after an examination of the bivariate correlations. The predictors that were most highly correlated with intention to breastfeed were chosen for regression analysis.

The average age of the participants was 20.29 ± 1.65 (n=27). None of the participants were married or had any children. Less than half (40.7%) reported to be in a stable union. Average annual income of family was reported as $53,214, and 66.66% of students were currently employed. 59.25% of the sample was born outside of the U.S. with a majority (48.14%) of those people being born in India. The most popular languages spoken at home besides English were Hindi and Spanish.

About 85% of the women planned to have children. Of those that planned to have children, 73.9% intended to breastfeed their child, and 11.1% said they did not know whether they would breastfeed. Of the 15% who did not intend to breastfeed, some of the most common reasons provided were “disgust at the thought of breastfeeding,” “don’t know how to,” and “sagging breasts.” Of those who intended to breastfeed, about 39% intended to also feed their child foods other than breast milk. 77.7% reported being breastfed as children, and 13% did not know whether they had been breastfed or bottle-fed. Almost all women (92.5%) felt that their mother would support them if they decided to breastfeed. Only 25.9% had seen someone breastfeed in public, while only 1 in 3 had seen someone breastfeed at home.

An interesting result showed that annual income significantly impacted the probability of intending to breastfeed (p<.003). The relationship between the intention to breastfeed and whether the student’s mother would support breastfeeding was marginally significant (p=.038). Language spoken at home did not have any correlation with exposure to breastfeeding publicly or at home. Participants from India and Puerto Rico were more willing to breastfeeding their children as compared to those from the US and UK. There was a strong correlation between a participant’s country of origin and intention to breastfeed (r = .076). Overall, participants had significant knowledge regarding breastfeeding practices. Only 11.1% of participants felt that formula milk was better than breast milk.

Knowledge and education, especially when combined with positive attitudes and intentions, is a useful intervention strategy to teach new mothers how to best provide for their babies. Many women seem to not know the specific health benefits of breastfeeding. The majority of interviewees knew breast milk was generally healthier than formula milk, but were unsure of specific medical benefits. One student said: “breast milk provides more natural nutrients and vitamins that are missing in formula milk.” However, another student disagreed, saying: “formula milk will probably provide a balance of nutrients that may be absent in breast milk.” Of the 6 interviewees who breastfed their first child, 3 reported that being breastfed as a child was a positive experience. The majority of women seem to have gained knowledge from friends and family, whereas a few cited television shows and high school education as their source of knowledge. Others attributed knowledge to general culture and having babies at home. The students exposed to breastfeeding in public, mostly in parks, malls and doctors’ offices, and those exposed to breastfeeding at home said they were not bothered by public breastfeeding. However, a few mentioned that at first glance it seemed a little shocking and inappropriate, but they would respect the mother’s choice. A few women mentioned that they had earlier been disgusted at the thought of breastfeeding; however, as they grew older and saw television programs or read about breastfeeding, they felt more “at ease and comfortable with the idea.” This suggests the malleable attitude of women toward breastfeeding and that perhaps maturation changes perspective on motherhood.

Many participants demonstrated a positive attitude toward breastfeeding. The ideas that breastfeeding is natural and “must be done,” and women who do it are “brave and strong” were generally suggested. According to the Center of Disease Control and Prevention, approximately three out of every four infants born in the U.S. are breastfed (2004). However many of the interview participants were under the impression that American women...
generally do not breastfeed their kids. The most common reasons given by women who intended to breastfeed were health benefits, feeling close to their child, a natural process, and benefits to the mother. The most common reasons for bottle-feeding were convenience, concern with work, physical issues such as gaining weight and sagging breasts, and uncertainty about the process in general.

This study has several limitations. One major drawback was the relatively small sample size. Since only 27 women were interviewed, the data is likely highly skewed and not an accurate representation of the general attitudes, intentions and beliefs of students at the University of Pennsylvania. The recruiting of samples may have also skewed data. Since this was a small-scale research project, most of the participants recruited were friends and other acquaintances. There was also no racial variability, which is important in a university setting. Anonymity could not be maintained as the surveys and questionnaires were administered by e-mail and no codes were assigned to any of the participants.

The kind of statistical analysis conducted also imposed limits. Since mostly correlation coefficients were represented, no causal relationships were imposed. The questionnaire was not reliable because no test-retest was conducted to determine whether the data gathered was an accurate representation of the knowledge of university students. There was also no questionnaire to assess behavior in regards to breastfeeding attitudes. No regression analysis was conducted to measure predictors of breastfeeding.

Additional research regarding attitudes and intentions toward breastfeeding in college students should be conducted, as few empirical research studies in this field exist. Gender differences should also be further researched, targeting young men who have not yet had children. Previous studies have shown that male partners significantly influence whether a woman will initiate breastfeeding (Arora et. al 2000). Cross-cultural studies should also be conducted to observe cultural and social differences in the way we understand breastfeeding. Furthermore, courses and workshops to increase knowledge about breastfeeding should be introduced. Universities should encourage students to develop campus organizations facilitating child health care, and health care providers and nursing schools should target students to increase awareness about breastfeeding (Kang et. al 2005). Breastfeeding as a topic need not be presented exclusively, but can instead be included in workshops or courses dealing with women’s body image, myths surrounding women’s bodies, child health, etc.

The attitudes and intentions toward breastfeeding are the result of a complex interaction of factors such as exposure in public or at home, perceived knowledge about breastfeeding, and accessibility of information regarding breastfeeding. This study shows that at the college level, the majority of women have good knowledge regarding breastfeeding practices. Attitudes and intentions toward breastfeeding are formed independently and are not correlated to whether one was breastfed as a child. Cultural differences impact the decision to breastfeed as well. Therefore, people from collectivist countries are more likely to initiate breastfeeding as compared to those from individualist countries.

Jenna Stahl spent the past summer studying grazing and climate change pressures on local ecology in Mongolia. This photo features traditional Mongolian housing, gers, under a stormy evening sky. The study included interviewing Mongolian nomads about their opinions on the changing climate and was sponsored by PIRE Mongolia- University of Pennsylvania Departments of Environmental Studies and Biology and the National University of Mongolia.
Sienese Chalk Artist  Jennifer McAuley ('13)

Halloween in Guatemala  Melissa Gradilla ('11)

Navigating the rice patches in Sapa, Vietnam  June Elgudin ('11)

Sleep in Peace  Samuel Liebeskind ('11)
Molly Hude is an anthropology major specializing in subcultures, here showcasing her ethnographic research on the annual subcultural festival of Burning Man in the desert of Black Rock City, Nevada.
Til next time!