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# A Community of Isolation: An Ethnographic Examination of Mothering in Poverty and Its Impact on Food Security in Pinellas County, Florida

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A Community of Isolation:  
An Ethnographic Examination of Mothering in Poverty  
and Its Impact on Food Security in Pinellas County, Florida

by

Amanda Marie Terry

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
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## **DEDICATION**

I dedicate this dissertation first and foremost to the mothers who so generously gave up their time and energy to speak with me. I thank them for allowing me into their homes and their lives.

Thanks to my family and friends who have provided unconditional support, encouragement, love and patience. To my amazing parents, Ken and Diane Terry, thank you for asking me every day what you could do to help. I appreciate the words of encouragement, loads of laundry, babysitting and the hundreds of other ways you invested in me and in this project. Thank you also to my siblings for never asking me why it took so long to finish.

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## **ABSTRACT**

The objective of this dissertation is to document the lived experience of mothering in poverty and the unique challenges the role of mother presents to maintaining food security. Millions of households in the United States are struggling to put food on the table, a problem made worse by the current economic recession and high food prices. Among them, households with children and specifically, single mothers, report the highest prevalence of food insecurity. While Federal food assistance programs are available to help alleviate this issue, the continued problem of hunger is a very real and pervasive concern for millions of American families.

While there is a robust and comprehensive scholarly body of work focused on food security and nutrition, this study fills an important gap in the literature. By describing the unique social and cultural circumstances that accompany the transition to motherhood in a low-income setting, I connect the lived experienced of mothering with vulnerability to food insecurity. This is framed within the underlying assumption that the related experiences of expectant mothering and caring for an infant impart different risk factors for food insecurity.

This study used a mixed methods approach to examine its objectives. These include semi-structured ethnographic interviews, participant observation, surveys and questionnaires and foodscape analysis. The mixed method design allowed for a holistic examination of the lived experience of mothers through narrative analysis, the visual representation of their foodscape through community mapping, and the triangulation of findings through administered surveys and questionnaires.

The primary findings of this dissertation include identification of social, cultural and geographic patterns of maternal isolation among low-income women and their impact on food security. Results of this study indicate that the unique demands of mothering in a low-income setting present challenges to maintaining food security. Gaps in services provided to low-income mothers to address food insecurity were identified to include improving the social connectedness of expectant and new mothers.

This study is intended to reach a wide target audience including students, practitioners, anthropological colleagues and policymakers. In an effort to translate the findings of this study into practical recommendations for action, the author calls for more research into the issue of maternal isolation and for policy initiatives to recognize the unique role mothering plays in contributing to household food security status.

## **CHAPTER 1: INTRODUCTION**

### **Objective of the Dissertation**

The aim of this dissertation is to explore the factors impacting the food security of low-income mothers in Pinellas County within the specific context of their mothering role. An underlying assumption of this project is that the demands of mothering, particularly in a low-income setting, create unique barriers to maintaining food security not currently addressed in the literature or in public policy. By identifying current gaps in the topical literature, this study will contribute to the scholarly body of work on food security, providing important insights into the unique challenges presented by the transition to motherhood for women living in poverty. This dissertation seeks not only to contribute to the academic literature, but to translate its findings into practical recommendations for mitigating the barriers to food security identified within the participant sample.

### **Rationale/Justification for this Study**

In 2008, global food prices reached record highs resulting in a sharp increase in rates of food insecurity worldwide (Himmelgreen and Daza 2009). Coinciding with this disaster, the 2008 financial crisis erupted, followed by the worst economic recession since the Great Depression. In the United States (U.S.), thousands of previously middle-income households were plunged into poverty (Swagel 2009). Those families already struggling to find employment, procure adequate housing and put food on the table prior to 2008 were decidedly worse off after the recession hit. One adverse outcome associated with these syndemic crises, was the increased prevalence of household food insecurity in the U.S. which jumped from approximately 10% in

2007 to just over 14% in 2008 (United States Department of Agriculture (USDA) 2014). The most recent estimates indicate 14.3% of U.S. households (or 17.5 million) in 2013 experienced food insecurity at some point that year (USDA 2014). While the recession is beginning to wane, the prevalence of food insecurity has essentially remained unchanged.

Of those households reporting food insecurity, only 62% currently participate in one or more of the available Federal food and nutrition assistance programs (Supplemental Nutrition Assistance Program (SNAP); Special Supplemental Nutrition Program for Women, Infants, Children (WIC); and National School Lunch Program (Nord, Coleman-Jensen and Gregory 2014). This translates to just over 6.5 million households reporting food insecurity who do not currently receive government assistance to supplement their food supply. According to national data, about 57% of families struggling with hunger and food insecurity have incomes above the federal poverty level which disqualifies them from receiving Federal food assistance (Nord, Coleman-Jensen and Gregory 2014). This need gap points to a number of complex and interrelated socioeconomic issues plaguing the U.S. to include high rates of underemployment (e.g., increased number of part-time job offerings), a lack of affordable housing, Federal minimum wages far below the current cost of living (COL) index, and a federal poverty threshold (\$23,624 for a family of four in 2013) (USDA 2014) that does not capture the full extent of households living at below the level of subsistence.

More than one-third of households reporting food insecurity in 2013 were headed by a single woman (USDA 2014). Additionally, African American families reported food insecurity at twice the rate of White, non-Hispanic households (USDA 2014). These data are relevant to this dissertation as they reflect not only the participant sample chosen for this study, low-income mothers, but also point to racial disparities in vulnerability to food insecurity.

This study seeks to move beyond the food security data to produce an account of the lived experience of low-income mothers and the daily challenges they face in maintaining food security. While the anthropological body of work on food security is robust, I have yet to find another study suggesting that the practice and demands of mothering may uniquely impact food security outside of socioeconomic and built environmental risk factors. This study therefore fills an important gap in the literature with implications for re-framing approaches to mitigate food insecurity among low-income mothers and their families.

### **Structure of the Dissertation**

In Chapter two, I present the research setting for this dissertation. Set in Pinellas County, Florida, this chapter frames the ‘field’ within the larger macro level land use and development trends of urban renewal and tourism. As one of the top tourist destinations in Florida, Pinellas has historically focused its tax dollars and attention on those commodities both attractive to tourists and inaccessible to low-income residents. Located within a southern Confederate state, the Jim Crow era of segregation has left an indelible mark on the economic and social mobility of Pinellas County’s African American population. Residential displacement of low-income residents in favor of development projects enticing to tourists and the urban middle-class have pushed low-income residents to the urban fringe. Paired with overburdened infrastructure and inadequate public transportation, Pinellas County residents living in poverty with no access to a vehicle are particularly vulnerable to poor health and food insecurity. These topics will be examined in this chapter in relation to this dissertation’s participant sample, low-income mothers.

In Chapter three, I review the literature on the relevant topics for this dissertation. First, I present an overview of the conceptualization of food security to include its definition(s) and

scope. I focus on the post-World War II (WWII) paradigm shifts in its operationalization that have helped to define the factors that determine who is food secure and who is not. Next, I review the development of the food security measure in the U.S., touching on public awareness of the issue of hunger in the land of plenty and the call to measure its prevalence and take action against it. I will examine the United States Department of Agriculture's (USDA) decision to remove 'hunger' from the categorical definition of food insecurity and explore its implications for public policy. Of particular interest to this study is the lived experience of mothering in poverty in the U.S. This chapter will therefore describe the predominant mothering ideology in the U.S., known as 'intensive mothering' focusing on its role in the normative construction of mothering practices and standards. I will end the chapter by exploring the intersection of food security and mothering within the riskscape of poverty.

Chapter four situates the dissertation within the theoretical framework of the political economy of health. Using this approach, I couch the issue of food security within the larger capitalist economic structure of the U.S. I argue that the U.S. political economic model maintains socioeconomic class disparities, contributing to the pervasive and persistent condition of household poverty. Relative concepts including power and agency as well as hegemony, are presented to frame the discussion of the role of mothering within the current social class structure in the U.S.

Chapter five provides an overview of the methods used in this dissertation to examine the three central research questions:

1. How does the experience of mothering influence the food security of low-income mothers in Pinellas County?
2. How do space and place impact low-income mothers' perceptions of their 'foodscape'?
3. How do racism and discrimination (both perceived and structural) affect the food security and nutritional health of low-income mothers in Pinellas County?

As a mixed methods study, this dissertation employs a variety of data collection techniques including semi-structured ethnographic interviews, surveys and questionnaires, foodscape visualization, windshield ethnography, and participant observation. Recruitment for and conduct of the interviews occurred over a 15 month period from November, 2011- February, 2013 with a total of 31 interviews completed. Each interview was transcribed verbatim between March, 2012 and December, 2013. Over 200 hours of participant observation were logged throughout the data collection period in Women Infants and Children (WIC) offices throughout the county, community health clinics and in my own prenatal care setting which served majority Medicaid patients. Windshield ethnography was used to document all food resources within the two zip code areas chosen for foodscape visualization and analysis. The rationale, objective and implementation of each method will be described in detail in this chapter.

Chapter six presents the results of data collected through the mixed methods described in chapter five. Given the variety of methods employed in this study, this chapter is structured to provide a separate overview of the findings from each data collection technique (semi-structured interviews, surveys/questionnaires, participant observation and foodscape analysis). I use descriptive statistics tallied from responses to the participant interviews to provide a snapshot summary of the interview findings, followed by narrative analysis. Survey and questionnaire results for this participant sample are compared with larger trends in the general population and Tampa Bay Region (for example, the household food security status of participants are compared with prevalence rates within the Tampa Bay region and Pinellas County). The foodscape analysis is presented as a visual representation of the community food environment and framed again, within the participant narrative. A final summary of the primary findings of each method

is presented separately. The chapter is concluded by triangulating the highlights from each method into the primary findings to be examined in detail in chapter seven.

Chapter seven examines the results presented in chapter six using two central themes, Maternal Isolation and Missed Opportunities, to structure the discussion. Framed within the context of the original research questions, this chapter provides a visual modeling of the macro and micro level social, cultural and geographic patterns of maternal isolation identified as findings in this dissertation. The discussion of results will couch this study's findings within the current scholarly body of work on food security and mothering as well as the overarching political economic framework discussed in chapter four. The theme of Missed Opportunities will be used to identify current gaps in research, services and policy impacting the food security of low-income women. This will support the argument for translating the findings of this study into practical recommendations to mitigate the risk of food insecurity among low-income mothers.

Chapter eight presents recommendations for improving the household food security of low-income women, based on the findings of this dissertation. I suggest that changes should occur at the macro, community and micro level to include public policies related to low-income households such as living wages, affordable housing and subsidized childcare. I also argue for engaging already-available local resources such as neighborhood corner stores to carry more produce and for local Healthy Start and WIC branches to focus attention on building more social connectedness among low-income, single mothers.

### ***The Reflexive Turn: A Note on Personal Reflections in the Dissertation***

Throughout the 15 month data collection period for this study I was privileged to experience my first pregnancy and the birth of my daughter. With this project's focus on the

unique experience of mothering and its impact on food security, the participant observation component of this study was deeply personal. As a result, I included my personal journal entries from my prenatal and new mother experiences as part of my participant observation field notes. The personal reflections provided at the end of each relevant chapter therefore summarize my own thoughts and recollections on the topical focus, presenting my own personal subjective experiences. In the postmodern tradition, this reflection on my own biases, cultural and ideological background, particularly within the politically-charged arena of mothering practices, serves to situate the ethnographic analysis. As Scholte states in his essay, *Toward a Reflexive and Critical Anthropology*, “The comparative understanding of others contributes to self-awareness; self-understanding in turn, allows for self-reflection and (partial) self-emancipation; the emancipatory interest, finally, makes the understanding of others possible.” (1999: 431) Thus, these self-reflections are presented as a critical component to my final ethnographic analysis, conclusions and recommendations.

## CHAPTER 2: THE RESEARCH SETTING

*“The tourist gaze is the gaze that consumes; the experience of the tourist is one that is mediated and dictated by capitalism”*

----*Rachel Esner*

### Introduction

Located on the Central West coast of Florida bordered by Tampa Bay to the east, the Gulf of Mexico to the west and Hillsborough and Pasco Counties to the north, Pinellas County was once a sparsely populated peninsula of wetlands and jungle until the late 1800's (Covington 1957). Around the turn of the century, coinciding with the arrival of the Orange Belt Railroad in 1887, Pinellas began selling itself as a tourist destination attracting visitors to its warm climate and gulf coast beaches (Covington 1957). The county remains dependent upon tourism today as its largest employment sector (56.4% of the county's labor force) (Pinellas County Planning Department 2008; Florida Department of Labor 2013) catering to over five million visitors annually.



Boasting almost six hundred miles of coastline and thirty-five miles of white sand beaches, Pinellas is the most densely populated county in the state with just under one million residents ([www.pinellascounty.org](http://www.pinellascounty.org) accessed 11/3/14). It is also the first county in Florida to reach 'build-out' meaning less than

Figure 2.1: Pinellas County ; Source: <http://fcit.usf.edu/florida/maps/pages/8600/f8612/f8612.htm>

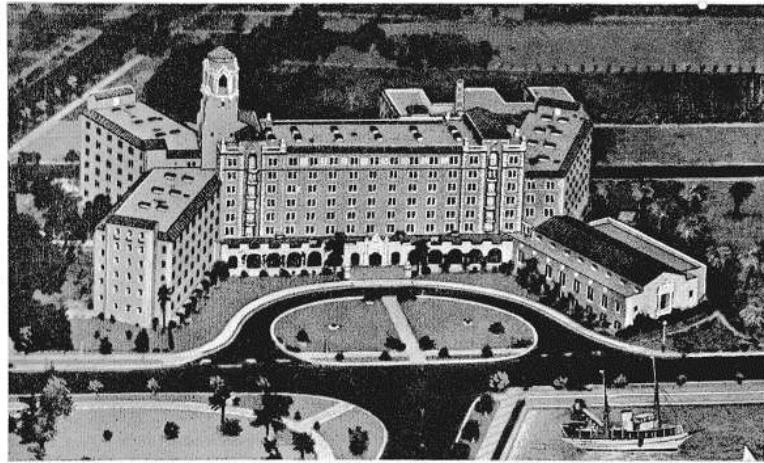
five percent of land designated for housing remains undeveloped (Pinellas County Planning Department 2005). Connecting its two largest metropolitan areas to the rest of the state by just three bridges, modern day Pinellas County is a tangle of urban/suburban sprawl.

The large-scale development of Pinellas began in earnest in the 1920s during the Florida Land boom which created Florida's first real estate bubble (Vanderblue 1927). The cities of St. Petersburg and Clearwater, the largest urban centers in the county and currently home to a combined total of 45% of the county population (U.S. Census Bureau 2013), became globally popular as luxury resort towns during the boom years. Land speculators bought up huge swaths of land and built waterfront hotels, parks and clubs (see figure 2.2) (Frazer and Guthrie 1995) throughout these urban centers with much of the original architecture still preserved today. The county continued to attract tourists in large numbers until the lean years of the Great Depression and WWII. Post-war 1950s Pinellas County saw a revitalized tourist market with servicemen and women who had trained there during the war returning with their families (Pinellas County Planning Department 2008). This period also garnered record population growth (Pinellas County Planning Department 2008) and from the 1950s through the 1970s Pinellas earned its reputation as a retirement haven with over 70% of its population over the age of 60 (Pinellas County Planning Department 2008). While the county experienced record population growth, its urban centers underwent simultaneous deterioration as ‘white flight’ to suburbia was followed by industry (and skilled labor jobs) (Nolan 1984) contributing to the decline of once-thriving central business districts like that of St. Petersburg's Central Avenue pictured in its heyday in figure 2.3.

Immortalized as “God’s Waiting Room” in the 1985 film *Cocoon* Pinellas County’s social history is defined by socioeconomic disparities. Historically, large estates and high-rises catering to tourists have lined the beachfront and tourist hotspots while suburban residential

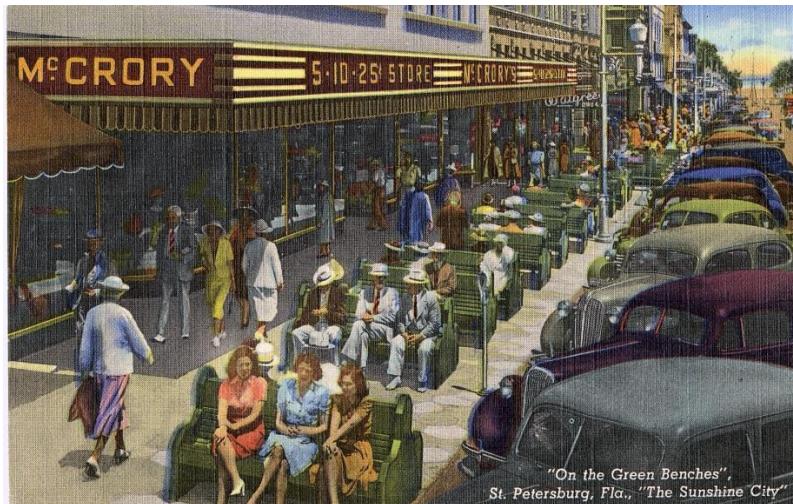
developments catering to middle-class retirees have filled the county's interior. Until recently, the urban centers consisted of aging infrastructure, dilapidated structures and poor, mostly African American residents (Pinellas County Planning Department 2008). Not until the last couple of decades has Pinellas begun to grow a larger, more diverse residential population in its urban centers that includes young professionals and students, shaking off its earlier moniker and gaining global fame as a hip destination once again (Boatwright 2014).

In this chapter I will contextualize the research setting for this dissertation by first discussing the development trends of urban renewal as well as the process of gentrification and urban sprawl which have created concentrations of urban poverty and 'boundless' cities throughout the United States. Next, I will couch Pinellas County within these land use trends touching on the role the tourist economy has played in urban investment and its impact on low-income residents throughout the county. Thirdly, I will address the racial history of Pinellas County concentrating specifically on urban renewal's impact on historic African American communities in St. Petersburg. Finally, I will provide a 'health climate report' to include a snapshot of the demographic, socioeconomic and health factors impacting Pinellas County residents and their household food security. These data illustrate the association between the county's land use and development plans, its history of racial segregation and resultant impacts on the health of its residents. I will end the chapter with a reflection of my own experience conducting fieldwork at home as a resident of Pinellas County. It is important to note that the objective of this chapter is to provide a macro level overview of the political economic factors affecting the social and built environment(s) of the county and thereby those of the mothers who participated in this study. Their impact specifically on the food security of low-income mothers in Pinellas will be addressed in detail in chapter six, Results and chapter seven, Discussion.



Vinoy Park Hotel-St. Petersburg, Fla.

**Figure 2.2: Vinoy Park Hotel 1925.** This resort, located on the bay front in downtown St. Petersburg was completed in 1925 by Aymer Vinoy Laughner. After a long period of dereliction including 18 years of sitting vacant, the Vinoy was restored and reopened in 1992 as the Vinoy Renaissance St. Petersburg Resort & Golf Club. It now serves as one of the crowning jewels of St. Petersburg's revitalized downtown.  
© State Archives of Florida, *Florida Memory*, <http://floridamemory.com/items/show/148327>



**Figure 2.3: “On the Green Benches”.** This is a vintage postcard of downtown Central Avenue during the 1940s. The green benches, painted their iconic color due to a 1916 citywide ordinance, were considered a major tourist attraction and numbered more than seven thousand throughout the downtown at one point. The text on the back of the postcard states, “*The Green Benches, St. Petersburg’s own, are known all over the country. Here on the benches tourists from all parts of the globe congregate and many, many wonderful hours are spent by the visitors. On the Green Benches daily throughout the winter season, on pleasant days, you will find an acquaintance or friend and may while away many pleasant moments, with memories of the past.*” © State Archives of Florida, *Florida Memory*, <http://floridamemory.com/items/show/161761>

## The U.S. Urban Renewal Movement: A Brief History

The U.S. urban renewal movement began as early as the 1930s (Gotham 2002). By the 1950s most major cities throughout the United States started to see a decline in their central

business districts (CBD) – downtown corridors that had once served as hubs of industry and commercial development (Gotham 2000). The resultant urban centers, characterized by majority poor and African-American residents, were regarded as undesirable within the prevailing political climate (Sloane 2006). Strong rhetoric was used to classify these communities as ‘diseased’ or more formally as ‘blighted’ as demonstrated by the 1954 United Auto Worker’s statement, “The spread of blight will be just as fatal to the city as the spread of cancer is to the individual and the treatment must be just as thorough.” (Lopez 2009: 1605) The perceived threat of urban blight led to the passing of the Federal Housing Act (FHA) of 1949 which created a federal urban renewal program. This program helped to provide legal standing to local governments to redevelop urban centers for ‘public benefit’ (Lopez 2009). This policy of urban redevelopment (also known as urban renewal) is active today and is currently defined under the Florida 2011 State Statute 163.340 as,

“undertakings, activities, or projects of a county, municipality, or community redevelopment agency in a community redevelopment area for the elimination and prevention of the development or spread of slums and blight, or for the reduction or prevention of crime, or for the provision of affordable housing, whether for rent or for sale, to residents of low or moderate income, including the elderly, and may include slum clearance and redevelopment in a community redevelopment area or rehabilitation and revitalization of coastal resort and tourist areas that are deteriorating and economically distressed, or rehabilitation or conservation in a community redevelopment area, or any combination or part thereof, in accordance with a community redevelopment plan and may include the preparation of such a plan.”

In other words, urban redevelopment works by designating undesirable urban areas as ‘blighted’ to pave the way for public acquisition of those lands and their sale to private developers (Lopez 2009; Gotham 2002). While the term ‘blight’ has historically been defined subjectively to suit the needs of the project at hand, Florida’s 2011 Statute 163.340 goes on to define a ‘blighted area’ as,

“an area in which there are a substantial number of deteriorated, or deteriorating structures, in which conditions, as indicated by government-maintained statistics or other studies, are leading to economic distress or endanger life or property, and in which two or more of the following factors are present:

- (a) Predominance of defective or inadequate street layout, parking facilities, roadways, bridges, or public transportation facilities;
- (b) Aggregate assessed values of real property in the area for ad valorem tax purposes have failed to show any appreciable increase over the 5 years prior to the finding of such conditions;
- (c) Faulty lot layout in relation to size, adequacy, accessibility, or usefulness;
- (d) Unsanitary or unsafe conditions;
- (e) Deterioration of site or other improvements;
- (f) Inadequate and outdated building density patterns;
- (g) Falling lease rates per square foot of office, commercial, or industrial space compared to the remainder of the county or municipality;
- (h) Tax or special assessment delinquency exceeding the fair value of the land;
- (i) Residential and commercial vacancy rates higher in the area than in the remainder of the county or municipality;
- (j) Incidence of crime in the area higher than in the remainder of the county or municipality;
- (k) Fire and emergency medical service calls to the area proportionately higher than in the remainder of the county or municipality;
- (l) A greater number of violations of the Florida Building Code in the area than the number of violations recorded in the remainder of the county or municipality;
- (m) Diversity of ownership or defective or unusual conditions of title which prevent the free alienability of land within the deteriorated or hazardous area; or
- (n) Governmentally owned property with adverse environmental conditions caused by a public or private entity.

However, the term “blighted area” also means any area in which at least one of the factors identified in paragraphs (a) through (n) are present and all taxing authorities subject to s. [163.387\(2\)\(a\)](#) agree, either by inter local agreement or agreements with the agency or by resolution, that the area is blighted. Such agreement or resolution shall only determine that the area is blighted. For purposes of qualifying for the tax credits authorized in chapter 220, “blighted area” means an area as defined in this subsection.”

The definition of ‘blighted area’ presented above is large enough in scope and ambiguous enough to apply to a large number of areas throughout the county, yet it has been applied disproportionately to Pinellas’ historically black communities. The power of eminent domain granted by the FHA in 1949 gives local governing bodies the right to assemble private property defined as blighted and sell it for reuse (FHA 1949). Thus, governing bodies effectively have

the power to trump the rights of private home and business owners in favor of more profitable uses for their lands. Though FHA regulation states that eminent domain must only be used to benefit projects for the public good (FHA 1949), the ‘public’ that typically stands to benefit most from urban renewal projects is the one with the most economic and social capital (Sloane 2006).

The majority of successful urban renewal efforts rely on public-private partnerships wherein private developers provide the capital investment needed while it [the government] acquires the land (Gotham 2002; Squires 2002). Gotham termed these partnerships ‘privatism’ in his paper chronicling the history of these arrangements where he states, “As an ideology and political strategy, privatism has been the mechanism through which public policy and planning has traditionally reinforced social inequalities by dispensing public resources unequally.” (Gotham 2000; Squires 1994) Given that the overarching U.S. political economic structure imposes and sustains social class inequities to be discussed in detail in chapter four, the idea that privatism targets those communities with little political, economic, social or symbolic power is certainly not surprising. Moreover, since the implementation of urban renewal projects typically requires the displacement of residents (e.g., of 400,000 residential units demolished in urban renewal areas as of 1967, only 10,760 low-rent public housing units were built to replace them) (Weiss 1985), there is a large body of work linking urban renewal with the erosion of identity and cohesion in historic African American communities (Beideman 2007; Garnett 2006; Greenbaum 2008).

### **New Urbanization and Gentrification: The Consequences of Urban Renewal**

The parallel trend of ‘new urbanization’ occurs as a natural outcome of urban renewal efforts. Defined in simple terms as the reverse of the suburbanization movement that changed

American cityscapes between the 1930s and the 1980s, this trend attracts middle and upper class professionals to previously ‘blighted’ urban areas (Brueckner and Rosenthal 2009; Papachristos et al. 2011). One way to explain this trend is through production-side theory which states that while manufacturing and industries requiring both a large footprint and unskilled labor remain in the suburbs, new job opportunities attracting educated, high-skilled workers are increasingly located in cities (Smith 1987; Bridge 2001). This in turn spurs the gentrification of historically black and low-income neighborhoods. Defined as “the process of renewal and rebuilding accompanying the influx of middle-class or affluent people into deteriorating areas that often displaces poorer residents” (Atkinson and Bridge 2005: 26) gentrification is a complex phenomenon that cannot be fully examined through a solely neo-Marxian production-side framework. A more nuanced view of urban gentrification takes into account the social and cultural capital gained from an urban lifestyle and the potential that this new urban class is actually a new middle class “and the gentrified neighborhood the spatial manifestation of the new middle-class habitus.” (Bridge 2001: 204)

Bourdieu’s concept of habitus to be discussed in detail in chapter four is relevant to this discussion to illustrate the ways in which gentrification contributes to social inequities. Briefly, habitus defines “a sense of one's place and a sense of the place of others.” (Bourdieu 1989:19) Or put another way, habitus is essentially the way in which the culture of a particular social group is embodied (internalized) in the individual (Bourdieu 1990). If we consider gentrifiers as a new urban middle class with their own habitus, we must consider how the emergence of this class impacts class relations in what were once predominately low-income neighborhoods (Bridge 2008). As an expression of their habitus, “The hitherto devalorized inner city, becomes the symbol of vitality, accessibility and being at the heart of things.” (Ley 1996: 297) As the

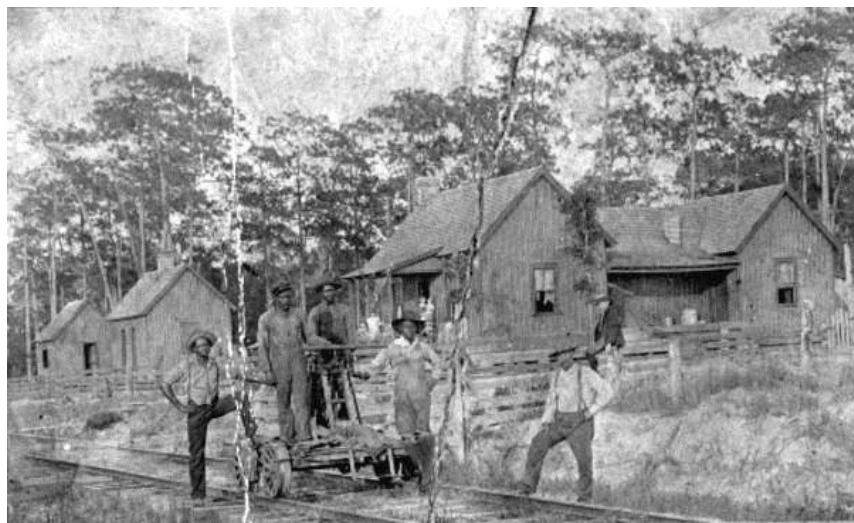
gentrified class move into a neighborhood, bringing with it political and economic capital as well as its products, values and tastes, the spatial and built environment begin to reflect its class preferences more and those of its low-income neighbors less (Ley 1996). As these neighborhoods develop to reflect the new urban middle class habitus, they attract gentrifiers in greater numbers, driving up rent and the cost of living and eventually displacing original residents. Thus, the built environment is molded to reflect the preferences of this new urban middle class, the end result being the displacement of the urban poor into ever growing pockets of poverty on the urban fringe.

### **The Tourist's Gaze: Racial Segregation in Pinellas County**

Before describing how Pinellas County has fared in the context of the land use trends presented thus far, it is important to first provide some background on the history of race relations and historical black communities in the county. After providing a brief overview of the racial history of the county as a whole, I will concentrate specifically on St. Petersburg since all 20 African American participants in this study were St. Petersburg residents and the city is home to 59% of Pinellas County's total African American population (U.S. Census Bureau 2013).

Pinellas County's African American history began alongside its origins as a tourist destination when the owner of the Orange Belt Railroad, Patrick Demens, hired one hundred black laborers to complete the tracks in 1888 (See figure 2.4) (The Olive B. McLin Community History Project 1999). By 1910, African Americans made up 26% of the total county population (The Olive B. McLin Community History Project 1999). This large black population was summarily invisible within the tourist literature and advertisements of the time (The Olive B. McLin Community History Project 1999). Working primarily in the construction and service industries the African American community was vital to the success of Pinellas County and St.

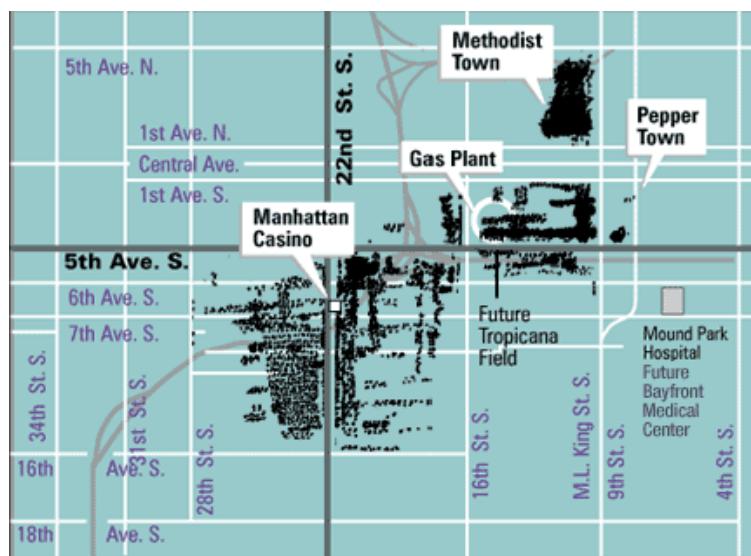
Petersburg in particular as thriving tourist destinations. But as a southern state, Florida adhered to Jim Crow laws which mandated racial segregation in all public facilities in Southern states of the former Confederacy, with a ‘separate but equal’ status for African Americans. Though these laws were overruled by the Civil Rights Act of 1964 and the Voting Rights Act of 1965, in Pinellas County segregation remained effective until the early 1970s across a number of public institutions including schools and public spaces, keeping its vibrant African American communities largely invisible to the tourists’ gaze (Phillips 1994).



**Figure 2.4: African American Laborers for the Orange Belt Railway circa 1888.** © State Archives of Florida, *Florida Memory*, <http://floridamemory.com/items/show/7856>

Thus, African Americans in Pinellas County have been historically and systematically denied the right to access the facilities they toiled to build and maintain. For example, they were never allowed to sit on the famed green benches of St. Petersburg illustrated in figure 2.3 which were largely removed from downtown by the 1960s, before the Jim Crow laws were abolished (Paulson and St. Julien 1985). Nor were they historically allowed to visit the city or gulf coast beaches, relegated instead to one small, mostly hidden beach on Tampa Bay located near the current St. Pete/Clearwater International Airport (Ponder 1998). Despite the denial of their civil

liberties (or perhaps as a direct result thereof), thriving black communities were established throughout Pinellas County with the majority located in St. Petersburg including the settlements of Gas Plant, Pepper Town, Methodist Town and along 22<sup>nd</sup> Street South (Phillips 1994; St. Petersburg Times 2002). Figure 2.5 below is from the 1951 city directory, the last year the city directory designated black residents. Each dot represents an African American individual listed in the city directory. It is a clear representation of St. Petersburg under Jim Crow segregation with all black residents confined to those communities shown.



**Figure 2.5: Black residential segregation in 1951 St. Petersburg, FL**

Source: <http://www.sptimes.com/2002/webspecials02/deuces/map.shtml> Accessed: 9/5/2014

These historically black neighborhoods existed through the civil rights era of the 1960s and 70s but began their decline in the 1980s - a decade after desegregation and coinciding with the advent of the crack-cocaine epidemic that hit black, urban, poor neighborhoods especially hard throughout the U.S. (Phillips 1994). The 1980s was also the decade when St. Petersburg began to focus seriously on urban renewal with an eye towards luring tourists back to the city. As an indicator of the city's historic valuation of these black communities, the Gas Plant, Methodist Town and Pepper Town neighborhoods no longer exist today having fallen prey to urban renewal, a historical lack of interest or investment in the communities' needs, the violence and

social disintegration of the 1980s and a focus on bringing wealthy, white tourists to the city. The 22<sup>nd</sup> Street neighborhood is but a shadow of what it once represented. As described by Phillips in her Ethno history of African Americans in St. Petersburg,

“St. Petersburg is portrayed as a monolithic white American community in its Chamber of Commerce’s glossy brochure. Pictures of well-tanned prosperous looking white Americans combined with photos of the …city’s signature building, and aerial shots of the sea coast invite snow bound residents and businesses of the North to come, live in, and enjoy this beautiful tropical waterfront community on the west coast of Florida.” (1994: 2)

St. Petersburg’s racial history may thus be summed up. Since its inception, African Americans have played a vital role in the success of the tourist trade on which the city (and Pinellas County) summarily rely yet it has systematically devalued the black community’s contribution by perpetuating its invisibility. This racial history is particularly relevant to this dissertation as it represents the social climate in which the mothers who participated were raised and are raising their own children.

### **Pinellas County: Contextualizing the ‘Field’ within U.S. Land Use Trends**

#### ***Urban Renewal***

In the 1970s the urban centers of Pinellas County began to focus on development projects that would attract tourists back to its cities. The expansion of interstate 275 into downtown St. Petersburg was meant to serve this purpose and “sliced through the area separating the Gas Plant neighborhood (see figure 2.5) from today’s Dome Industrial Park area and 22<sup>nd</sup> Street South commercial hubs, contributing to the decline of each.” (Community Redevelopment Plan 2007: 4) The city’s next large-scale public-private development venture, a baseball stadium, was built in 1987 to attract a major league market to the area. Located again in the Gas Plant district of St. Petersburg, Tropicana Field (originally called the Thunder Dome) was built by first designating what was left of Gas Plant as ‘blighted’ and using eminent domain to raze the community to

include hundreds of residential homes and locally owned businesses (Phillips 1994).



**Figure 2.6: Tropicana Field Stadium and Parking Lot, 2015.** Site of former Gas Plant neighborhood (see figure 2.5) Source: Photo taken by PI 2/2015.

Though this project was billed as benefitting the public good to justify the use of eminent domain, the stadium sat empty for ten years until 1998 when the Tampa Bay Devil Rays hosted their opening season. The displacement of residents to make way for the stadium resulted in the loss of an historic black community. Figure 2.6 above showcases the vast parking lot adjacent to



**Figure 2.7: Vacant historic building in Midtown.** Located next to the I-275 Overpass that cut through this section of St. Petersburg.  
Source: PI photo taken 12/2014

this historic neighborhood that followed the construction of I-275 and Tropicana Field.

the stadium that once made up the Gas Plant community. The lack of social cohesion in this once thriving urban district continues to plague this area of St. Petersburg, what is now known as 'Midtown'. Figure 2.7 is an example of the degradation of

In the last decade the county has worked to right some of its past wrongs with regards to disproportionately targeting poor, black communities for urban redevelopment and subsequent displacement. For example within the Midtown district, the city of St. Petersburg recently purchased and restored the historic Manhattan Casino (re-opened in 2013) located on what was once considered one of the most thriving African American main streets in the country. The Manhattan Casino was located in the heart of the African American downtown in St. Petersburg, the section of town referred to as ‘The Deuces’ since most businesses were located on 22<sup>nd</sup> Street South. The Casino hosted some of the biggest names in jazz including Louis Armstrong, James Brown, Duke Ellington, Count Basie, and more (Phillips 1994).



**Figure 2.8: Restored Manhattan Casino**  
Source: PI photo taken 12/2014

Pictured to the left in figure 2.8, it has now re-opened with an upscale restaurant occupying the lower level called *Sylvia's Soul Food*, an off-shoot of the famed Brooklyn, N.Y. establishment, and an event space in the restored upper level casino ballroom. It is a symbol that the urban revitalization of Pinellas County, specifically St. Petersburg, has begun to make its way past the glittering tourist destinations along the waterfront and focus on the needs of residents. Despite this recent attention, the Manhattan Casino remains the only business on this historic block with vacant lots occupying the area across the street where

businesses once thrived. In the background of this photo, interstate 275 figures prominently, illustrating how the interstate cut directly through this community when it was built. In her book chronicling the history of “The Deuces” Rosalie Peck writes,

“Life was the soul of this once-great street...like downtown Central Avenue, the place to meet and greet...But then one day the interstate came...Wiped out our history...changed everything...But remember the name 22<sup>nd</sup> Street, for like the Phoenix, one day it too may rise...It will never be the same, but before our very eyes, it may breathe life again. It may survive and surprise...Like an oak with a tap root it may refuse to die...22<sup>nd</sup> Street might still rise up to defy; and take its rightful place once more...Serving good people of St. Petersburg once more; under God’s clear-blue spacious sky.” (Peck and Wilson 2006: 96)

Indeed, a number of community efforts are underway in “The Deuces” including a monthly spoken word event in the historic Royal Theatre pictured in figure 2.9 below, top right, a monthly farmer’s market on 22<sup>nd</sup> Street South pictured below, bottom center and several new privately owned businesses and restaurants that have recently opened including the Creole Café pictured below, top left.

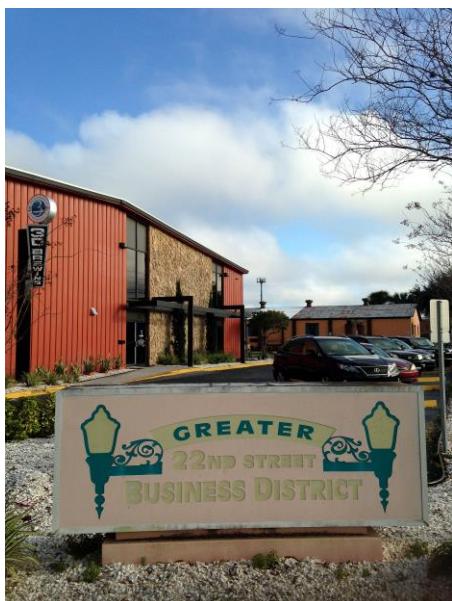


Figure 2.9: “The Deuces” Revitalization Projects. Source: PI photo taken 2/2015

Yet, city plans remain on the books for more residential displacement to come in Midtown where an industrial park complex (the DOME industrial park) and arts district is currently being developed (Pinellas County Planning Department 2008). Located 6 blocks north of the



**Figure 2.10: The Dome Industrial Park Arts District.** Starting from the left is an historic train station now converted into the Morean Center for the Arts. To the right is the Dome Industrial Park marker. Source: PI photo taken 2/2015



Manhattan Casino, figure 2.10 shows a converted historic train station now housing the Morean Center for the Arts. In the right hand side of the image is the Dome Industrial Park monument demarcating this area as a focus for urban renewal efforts. On the same block is 3 Daughters' microbrewery pictured in figure 2.11 that shares a parking lot with a converted warehouse now home to the 5 Deuces: Art Gallery. Directly across the street from the brewery is a warehouse that hosts a monthly vintage market. Thus, the

**Figure 2.11: 3 Daughters' Microbrewery.** success of businesses like these have brought attention and Source: PI photo taken 2/2015

development to this previously neglected area of St. Petersburg. However, their success threatens more residential displacement, proving there is more to be done to preserve and restore the important historical legacy of Pinellas County's African American communities.

### ***Gentrification***

In addition to large-scale development projects conceptualized to entice tourists, Pinellas County communities have invested in local arts and small businesses creating financial incentives for local residents to open retail and gallery spaces throughout their urban centers (Pinellas County Community Cultural Plan 2005). These subsidies have helped to shape downtown St. Petersburg into an eclectic mix of art studios, gallery spaces, boutiques and craft breweries. Figure 2.12 below showcases two examples of these subsidies at work. The image on the left is the Green Bench brewery opened in 2011 which pays homage to the city's historic green benches. The Florida CraftArt gallery is one of dozens of art galleries lining the newly revitalized Central Avenue.



**Figure 2.12: St. Petersburg local craft and art businesses.** Source: PI photo taken 11/2014.

The city's urban renewal efforts over the past decade have thus created a city attractive to tourists and the urban middle class alike. Listed by the New York Times as one of the top fifty-two places to go in 2014 ([www.nytimes.com](http://www.nytimes.com)), the city has recently experienced an influx of middle and upper class residents relocating to the area. In response to this growth, the cost of living (COL) has risen substantially so that it now mirrors that of larger Southern cities like Atlanta, GA and Raleigh, NC (st.pete.org). The historic urban neighborhoods adjacent to downtown previously regarded as blighted are being bought up and revitalized by these new residents. Thus, St. Petersburg is a rapidly gentrifying city as a natural outcome of the positive community investment in recent years.

### *Urban Sprawl*

Between 2000 and 2010 the permanent resident population of the State of Florida increased by 17.6% with approximately 1,000 people moving to the state each day (<http://www.stateofflorida.com>). As the most densely populated county in the state, Pinellas reached build-out (as defined earlier) in 2005 making it essentially a 'boundless city' due to the urban/suburban sprawl that stretches the entirety of its land mass. With the exception of the coast and the city centers of St. Petersburg and Clearwater as well as some of the other historic waterfront communities that dot the peninsula, the majority of Pinellas County is a congested mix of residential neighborhoods and shopping/business plazas with only three bridges and its northern border connecting it to the rest of the state.

Due to the trend of suburbanization discussed earlier, large single-family lots and infrastructure built to accommodate cars rather than public transportation have become the status quo for most middle class Americans. In Pinellas County, decades of increasing population growth combined with new residents' middle-class suburban expectations have created huge

infrastructure demands that continue to challenge city planners. Table 2.1 illustrates the population growth of Pinellas County over the years 1920-2000. In eighty years, Pinellas County has grown by approximately 900,000 residents, increasing by 400,000 between 1970 and 2000 alone. Reflecting the current lack of undeveloped land available in the county, the percentage of the population classified as rural in 2000 was .1% with the most significant shifts in rural to urban residency occurring from 1920 to 1930 and again from 1970 to 1980.

**Table 2.1 Rural to Urban Residential Trends in Pinellas County, 1920-2000.** Source: U.S. Department of Commerce, Bureau of the Census; Bureau of Economic & Business Research, "Florida Population Studies". 34.

<b>Rural to Urban Residential Trends and Population Growth in Pinellas County, 1920-2000</b>					
<b>Year</b>	<b>Total Population</b>	<b>Urban Population</b>	<b>% of Population Classified as Urban</b>	<b>Rural Population</b>	<b>% of Population Classified as Rural</b>
<b>1920</b>	28,265	14,237	50.4%	14,028	49.6%
<b>1930</b>	62,149	51,446	82.8%	10,703	17.2%
<b>1940</b>	91,852	74,350	80.9%	17,502	19.1%
<b>1950</b>	159,249	137,702	86.5%	21,547	13.5%
<b>1960</b>	374,665	341,384	91.1%	33,281	8.9%
<b>1970</b>	522,329	502,277	96.2%	20,052	3.8%
<b>1980</b>	728,531	724,988	99.5%	3,543	.5%
<b>1990</b>	851,659	848,230	99.6%	3,249	.4%
<b>2000</b>	921,495	920,531	99.9%	964	.1%

The residential trends illustrated in Table 2.1 have created inevitable urban sprawl and unmet infrastructure needs throughout the county. An inefficient metro bus system is currently the only means of public transportation connecting the county, creating exceptional challenges for low-income residents with no access to a vehicle. As of 2009 Florida's per capita pedestrian crash fatality rate was 85% above the national average with Pinellas County's rate comparable to that of the state's making it not only a challenging place to live without a car but also a dangerous one (<https://www.pinellascounty.org>).

The residential and development/land use trends described in this chapter have created segregated pockets of poverty in Pinellas County. Due to unwieldy urban planning, a lack of access to transportation and safe pedestrian and/or biking pathways, residents living in these communities experience significant mobility challenges. While there are improvements planned, the exponential population growth illustrated in Table 2.1 makes keeping up with needed infrastructure improvements increasingly difficult. In the context of this study, this is an important issue as it affects the majority of participants, 84% of whom do not have access to a vehicle and live in low-income pockets within the congested sprawl of Pinellas County. These areas have few, if any, sidewalks or amenities that may be reached without having to cross multiple lanes of traffic on main county thoroughfares exposing them to the dangers of traffic and heat exhaustion in the summer season.

### **Pinellas County: The Health Climate**

#### ***General Population: Demographics/Socioeconomic Data***

To be discussed in detail in chapter four, the built and policy environments of a community significantly impact its social landscape to include employment opportunities, income level, racial/ethnic/cultural diversity, community cohesion and identity. The data presented in this section of the chapter provide a brief overview of the social landscape of Pinellas County including overall population demographics compared with that of the U.S. general population and the State of Florida followed by data illustrating the persistence of socioeconomic racial/ethnic disparities in Pinellas County.

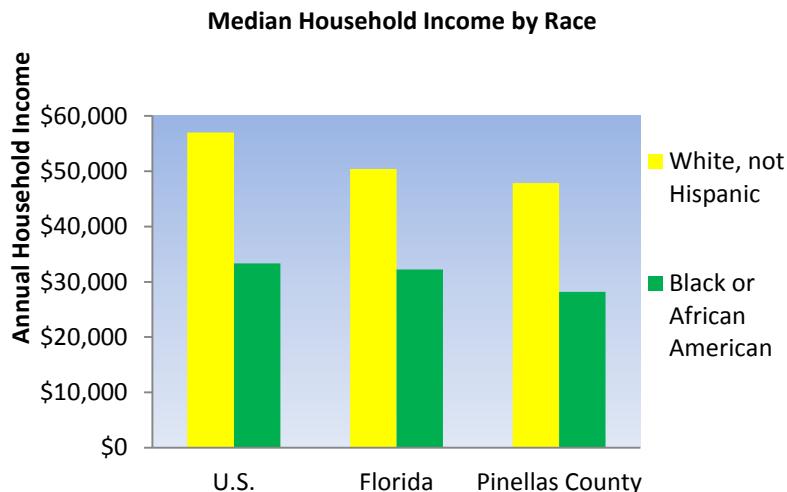
**Table 2.2: 2013 Total Population by Race/Ethnicity.** Source: <http://quickfacts.census.gov/> Accessed 8.21.2014

**Estimated 2013 Total Population by Race/Ethnicity**

Race/Ethnicity	% Population (U.S.)	% Population (Florida)	%Population (Pinellas)
White Alone (Not Hispanic)	62.5%	56.4%	75.8%
Black Alone	13.2%	16.7%	10.8%
Amer. Indian Alone	1.2%	0.5%	0.4%
Asian Alone	5.3%	2.7%	3.3%
Pacific Islander Alone	0.2%	0.1%	0.1%
Two or More Races	2.4%	1.9%	2.0%
Hispanic Origin (Any Race)	17.1%	23.6%	8.6%

While the population of Florida is more racially and ethnically diverse than that of the U.S. general population as indicated in Table 2.2, Pinellas County remains predominately White, non-Hispanic (75.8%) compared with the rest of the state (56.4%) and the U.S. general

population (62.5%) (U.S. Census



**Figure 2.13: Median Household Income by Race**  
Source: 2012 American Community Survey 1-Year

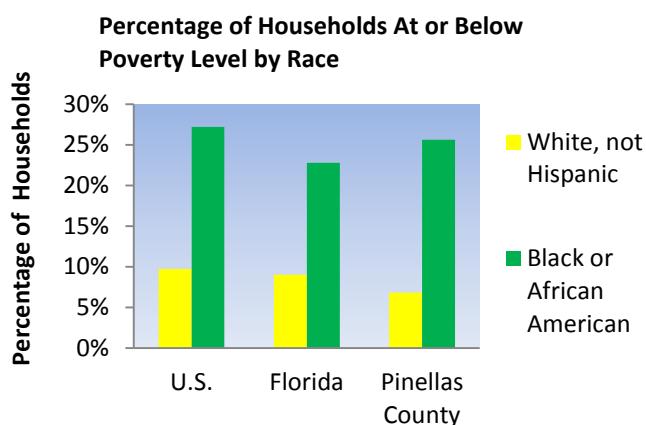
Bureau 2013). This is important

as we consider the social landscape of the field setting and its relation to this study's participant population. As a tourist destination and part of a southern Confederate state, Pinellas County has historically remained residentially segregated

as discussed earlier. We continue to see the lingering effects of institutionalized racism and enforced segregation in a number of key demographics such as income, educational attainment

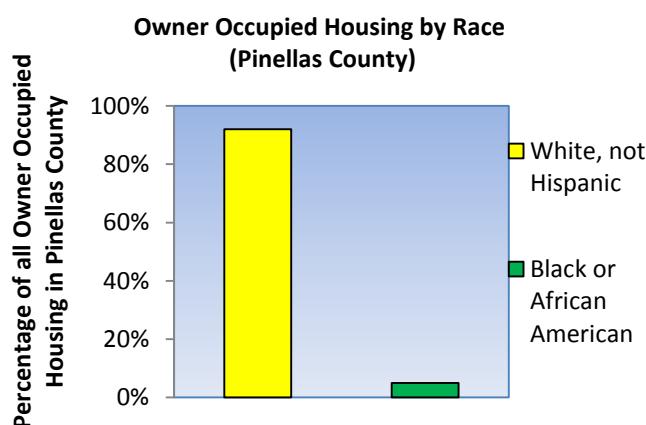
and employment (U.S. Census Bureau), represented by figures 2.13-2.15.

According to the data presented in figure 2.13, the median income for African American households in Pinellas County was \$28,160 compared with the median income for White households, \$47,872 (U.S. Census Bureau). While African Americans as a group make up the smallest portion of the overall county population (11%), they experience household poverty at a



**Figure 2.14: Percentage of Households At or Below Poverty Level by Race.** Source: 2012 American Community Survey 1-Year Estimate, U.S. Census

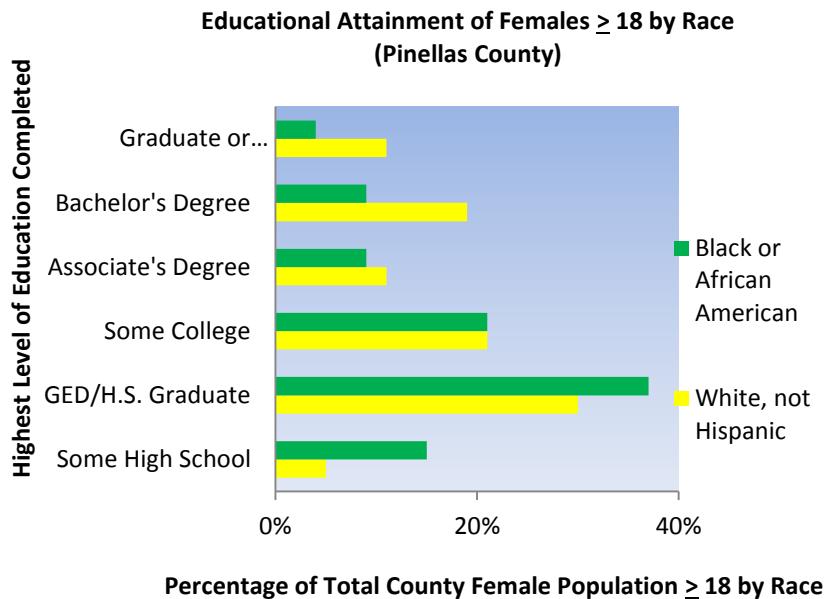
rate of four to one when compared with White households (U.S. Census Bureau) as shown in figure 2.14. Figure 2.15 at the bottom of this page reveals that of all owner-occupied housing in Pinellas County, only 5% are owned by African Americans compared with 92% owned by



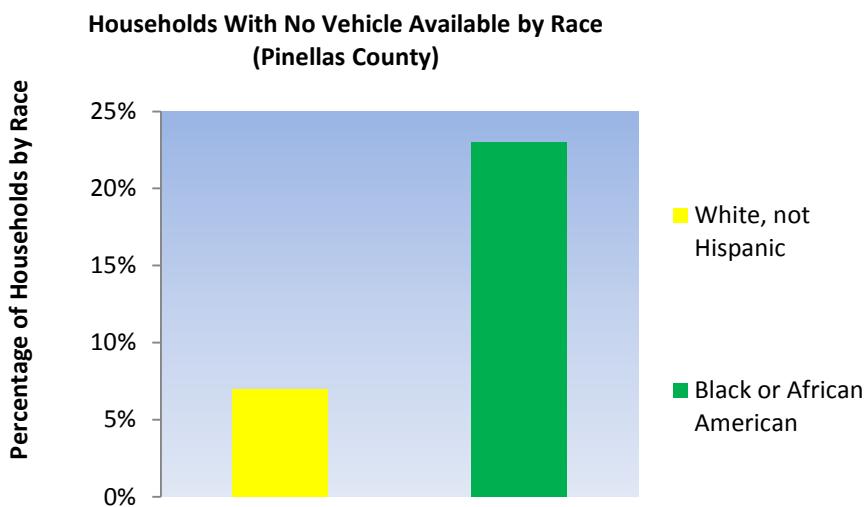
**Figure 2.15: Owner Occupied Housing by Race (Pinellas County).** Source: 2012 American Community Survey 1-Year Estimate, U.S. Census

Whites (U.S. Census Bureau). For each additional key factor associated with poverty presented on the next page (educational attainment, receipt of government assistance and ownership of a vehicle) African Americans are disproportionately represented in Pinellas County (U.S. Census Bureau). Figure 2.16 shows that African American women in Pinellas are less likely to have graduated from high school than their White counterparts. The same figure shows that

for the majority of African American women, high school represents the highest level of educational attainment. While both groups are equally likely to have completed some college,



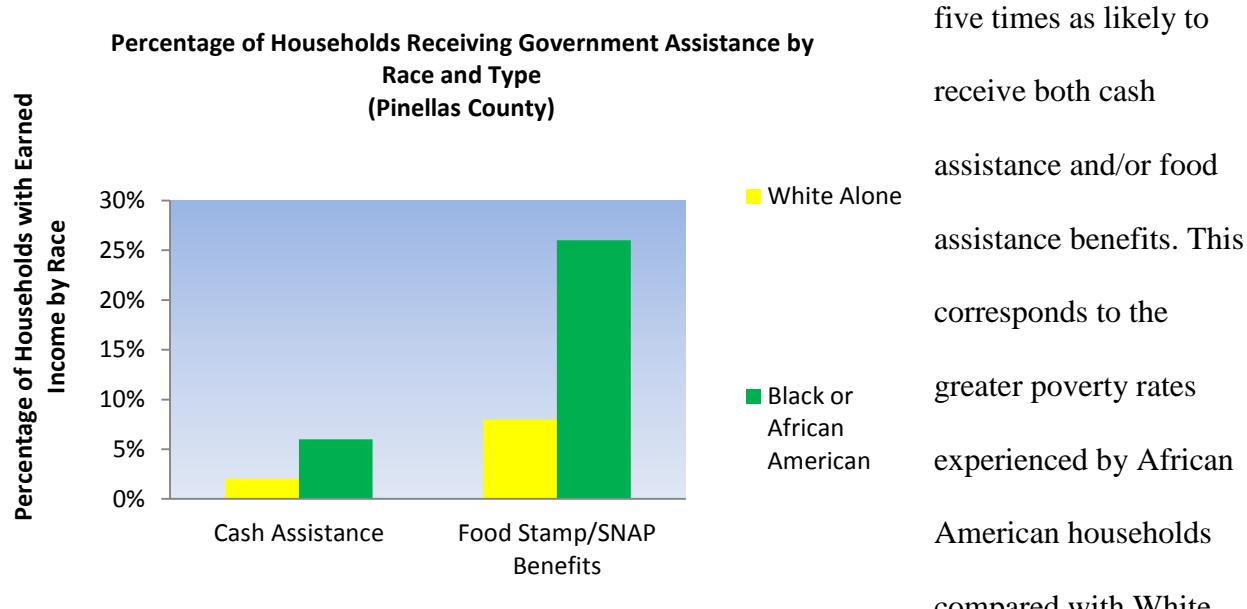
**Figure 2.16: Educational Attainment by Race (Pinellas County).**  
Source: 2013 American Community Survey 1-Year Estimate, U.S. Census



**Figure 2.17: Households with No Vehicle by Race (Pinellas County).**  
Source: 2013 American Community Survey 1-Year Estimate, U.S. Census

White females in Pinellas County are twice as likely to hold an Associate's degree or higher. Given that annual median earning estimates for individuals with a high school degree are \$21,569 compared with \$42,783 for those with a Bachelor's degree (U.S. Bureau of Labor Statistics), this represents a significant loss of lifetime earning potential for this study's have a high school degree or less as their highest level of educational attainment. Similarly, figure 2.17 indicates that African American households are

four times less likely than White households to have access to a vehicle. As discussed earlier, Pinellas County is a uniquely difficult region to navigate via public transportation with very few of the low-income communities in which the participants in this study live either walkable or pedestrian friendly (discussed in chapter six). Finally, figure 2.18 defines household utilization of government assistance by race and type with African American households



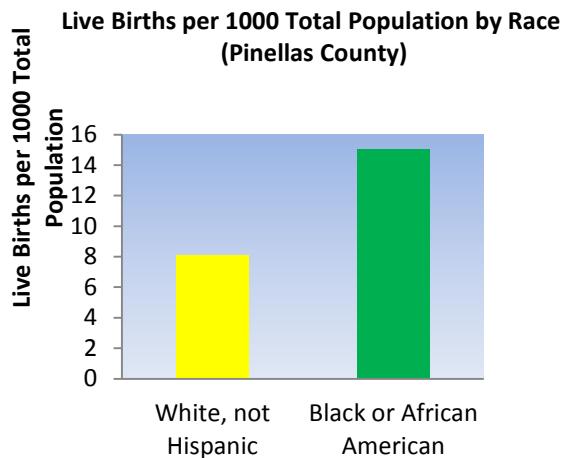
**Figure 2.18: Households Receiving Government Assistance by Race and Type (Pinellas County).** Source: 2013 American Community Survey 1-Year Estimate, U.S. Census

five times as likely to receive both cash assistance and/or food assistance benefits. This corresponds to the greater poverty rates experienced by African American households compared with White, non-Hispanic households.

These socioeconomic disparities have a very real impact on the health of Pinellas County's African American families. It is within this social landscape of persistent racial disparities in economic mobility that Pinellas County mothers are raising their children. These data are presented to demonstrate the significant additional daily burdens faced by African American mothers in Pinellas County compared with their White counterparts in providing for their families. The next section of county data focuses specifically on Pinellas County mothers.

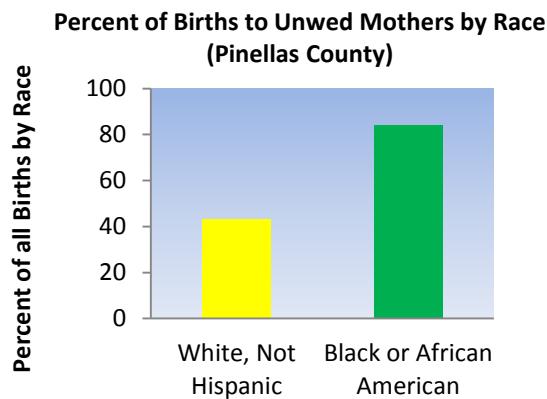
## *Pinellas County Mothers: Demographics/Socioeconomic Data*

The data presented in this section provide a snapshot of the socioeconomic and health characteristics of mothers in Pinellas County. Beginning with the county's live birth rates per 1,000 women ages 14-44 represented in figure 2.19 we find that the 3- year rolling birth rate for



**Figure 2.19: Live Births by Race (Pinellas County)**

Source: [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/2014



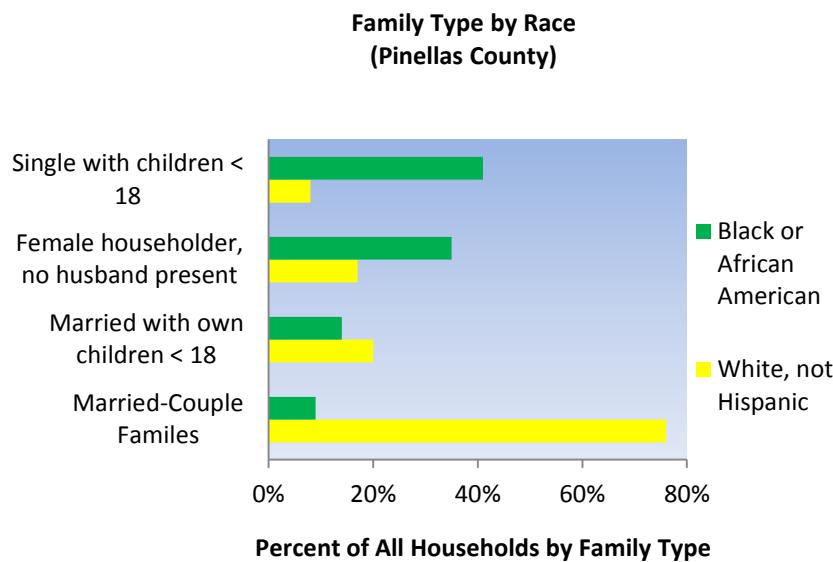
**Figure 2.20: Percent of Births to Unwed Mothers by Race (Pinellas County).** Source [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/201

families in the county, 80% are White compared with 7% African American. Interestingly, according to figure 2.22, for White residents, marriage does not appear to protect against poverty with White married-couples and White single female householders experiencing

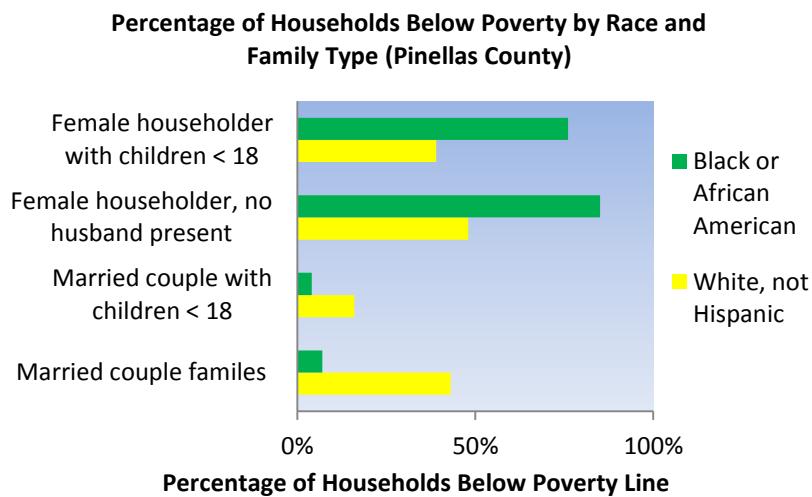
2011-2013 for African Americans was close to double the birth rate for Whites. Further analyzing the relationship between percent of total births by race and the percent of the population in the 14-44 year old age group in Pinellas, African American mothers made up approximately 13% of the total population in this age group but were responsible for 17% of all births in the county from 2011-2013.

Looking at births by family type in figures 2.20 and 2.21, we find that of all Pinellas County births to African American women in 2013, 80% were to single (unwed) mothers compared with 43% to

White, non-Hispanic single (unwed) mothers. Similarly, of all married-couple



**Figure 2.21: Percent of All Households by Race and Family Type (Pinellas County)** Source: 2013 American Community Survey, U.S. Census Bureau



**Figure 2.22: Percent of Households Below Poverty by Race and Family Type (Pinellas County)** Source: 2013 American Community Survey, U.S. Census Bureau

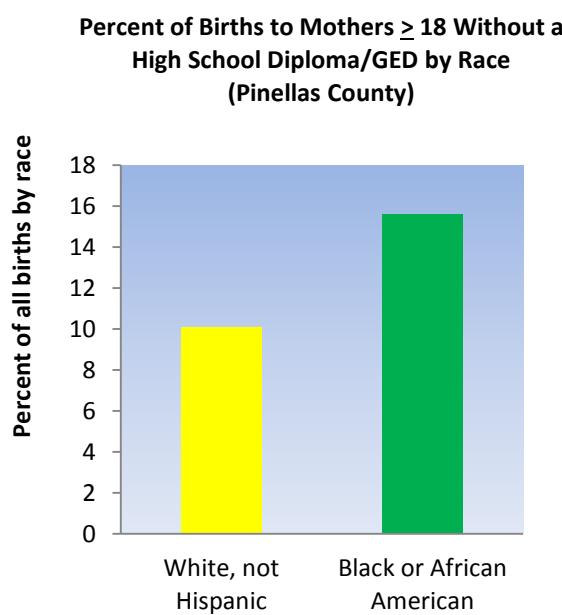
(see figure 2.23 on next page) of which 16% are African American compared with 10% White.

The literature indicates that for women, income level is associated with risk for obesity with a correlation found between poverty and obesity (Himmelgreen 2013, Dinour, Bergen and Yeh

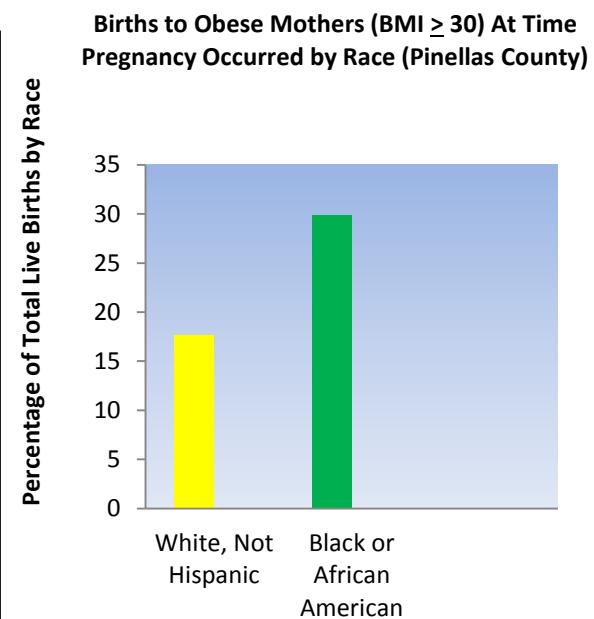
approximately equal rates of poverty. This is an important point if we consider the stigma still attached to unwed mothers and the generally accepted notion that marriage by default imparts financial and emotional stability.

For all other key indicators associated with poverty and mothering, African American women are disproportionately represented within the Pinellas County data. These include the percent of births to mothers greater than or equal to eighteen without a high school diploma or GED

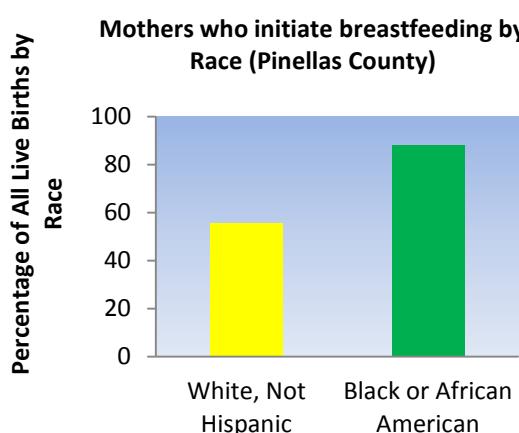
2007). Since African American women in Pinellas County experience higher rates of poverty than their White counterparts, it follows that they would also have higher rates of obesity as indicated in figure 2.24. Despite these data associated with negative impacts on African American mothers, there are also positive trends associated with breastfeeding initiation and smoking during pregnancy. Figures 2.25-2.26 included on the following page clearly indicate that African American mothers in Pinellas County are twice as likely as their White counterparts to initiate breastfeeding and 50% less likely to smoke during pregnancy. These data help to counter the negative stereotypes associated with poor, African American mothers.



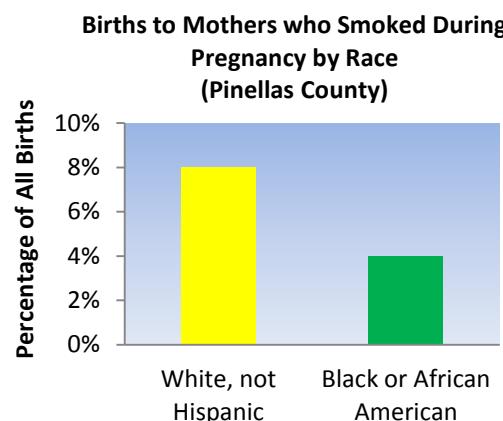
**Figure 2.23: Percent of Births to Non-High School Grads by Race (Pinellas County).**  
Source [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/2014



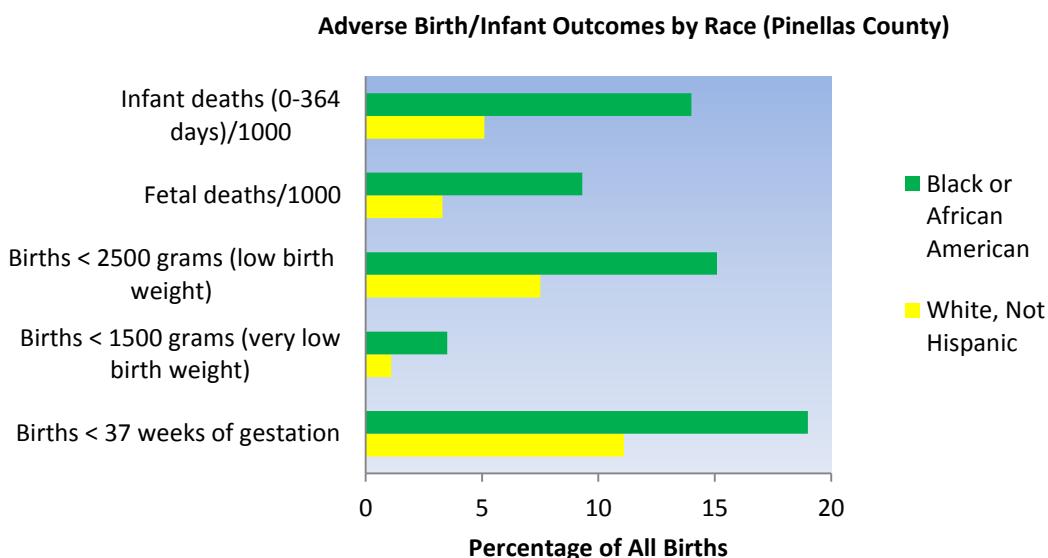
**Figure 2.24: Percent of Births to Obese Mothers At Time Pregnancy Occurred by Race Pinellas County.** Source [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/2014



**Figure 2.25: Percent of Mothers who Initiate Breastfeeding by Race (Pinellas County).**  
Source [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/2014



**Figure 2.26: Births to Mothers who Smoked During Pregnancy by Race (Pinellas County).**  
Source [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/2014



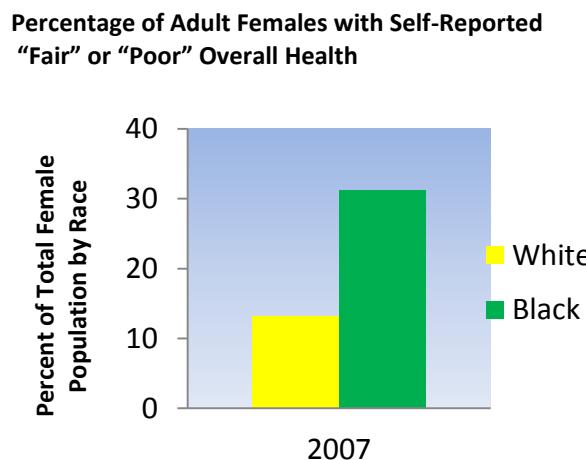
**Figure 2.27: Adverse Birth/Infant Outcomes by Race (Pinellas County).** Source [www.FloridaCharts.com](http://www.FloridaCharts.com) Accessed 6/25/2014

Finally, figure 2.27 illustrates that African American infants in Pinellas County are approximately twice as likely than their White counterparts to be born underweight for gestational age (<2500 grams), pre-term (< 37 gestational weeks) and to die in utero or within the first year of life. These adverse outcomes persist even when controlling for income

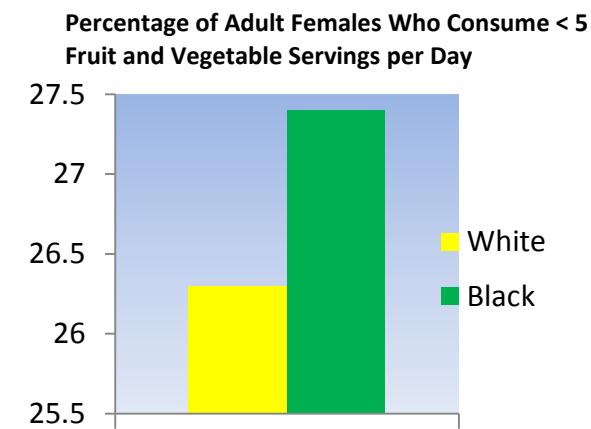
indicating that other factors, such as chronic stress related to persistent racial discrimination and neighborhood violence, disproportionate toxic environmental exposures in majority African American neighborhoods and a lack of access to healthful amenities such as parks, sidewalks, grocery stores and good schools, may also be to blame for the poor outcomes illustrated in figure 2.27.

### ***Pinellas County Women: Overall Community Health Indicators***

Lastly, the figures presented in this section provide an overview of the general health of adult women in Pinellas County. Mothering is both physically and psychologically demanding work. Thus, the ability to care adequately for ones' children may be significantly affected by an individual's health status. Beyond carrying and delivering a healthy child, a mother's body and state of health may either hinder or help in the day-to-day tasks of raising a family. For example, not getting enough rest or adequate nutrition may result in lethargy and a lack focus making it difficult to maintain the motivation to seek out and prepare healthful meals for the family (Attree 2005, Chase-Landsdale et al. 1994). The data presented on the following pages therefore illustrate Pinellas County women's general state of health.



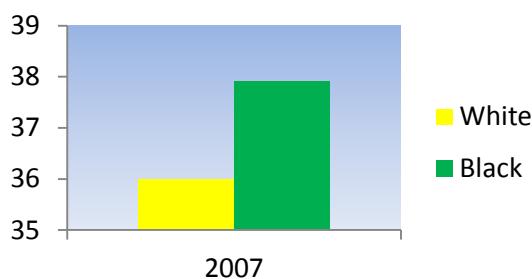
**Figure 2.28: Percent of Adult Females with Self-Reported "Fair" or "Poor" Overall Health by Race (Pinellas County).** Source: [www.floridacharts.com](http://www.floridacharts.com)



**Figure 2.29: Percent of Adult Females Who Consume < 5 Fruits and Vegetables per Day by Race (Pinellas County).** Source: [www.floridacharts.com](http://www.floridacharts.com)

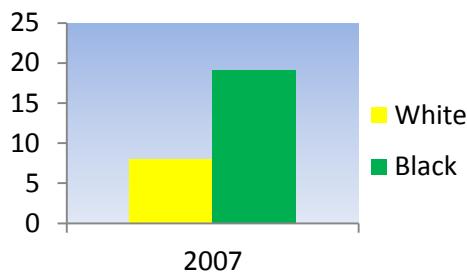
Figures 2.28 and 2.29 provided on the previous page indicate that in Pinellas County, African American women are twice as likely to self-report their overall health as “fair” or “poor” and to eat fewer than the recommended daily amount of fruits and vegetables than their White counterparts. Similarly, and corroborating the rest of the data presented in this chapter thus far, African American women in Pinellas County are more likely than their White counterparts to experience adverse health conditions such as overweight, obesity, diabetes and hypertension as illustrated in figures 2.30-2.33 (Florida Charts 2007). This is important as we consider the interconceptional health of mothers and its impact on the long-term health of the baby.

**Percentage of Adult Females Who Are Overweight: Pinellas County**



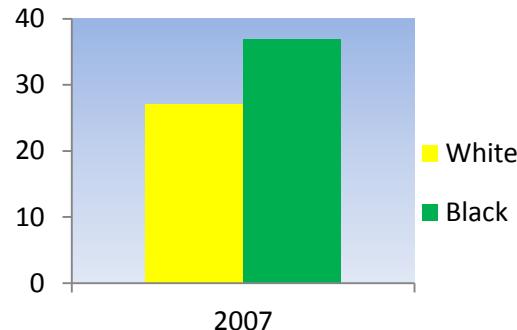
**Figure 2.30: Percent of Adult Females Who Are Overweight by Race (Pinellas County).**

**Percentage of Adult Females Diagnosed with Diabetes: Pinellas County**



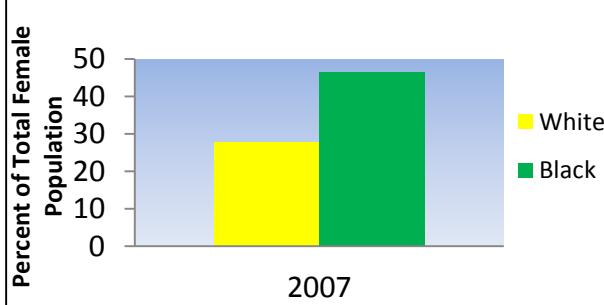
**Figure 2.32: Percent of Adult Females Diagnosed with Diabetes (Pinellas County).**

**Percent of Adult Females Who Are Obese: Pinellas County**



**Figure 2.31: Percent of Adult Females Who Are Obese (Pinellas County).**

**Percent of Adult Females Diagnosed with Hypertension: Pinellas County**



**Figure 2.33: Percent of Adult Females Diagnosed with Diabetes (Pinellas County).**

## **Conclusion**

The information provided in this chapter serves as an orientation to the field site in which this study was conducted. As a densely populated county with continued exponential population growth and a large contingent of annual visitors, Pinellas County has exploded in recent years in terms of attractions and urban development. As a natural outcome of the county's focus on urban renewal and tourism, particularly in St. Petersburg, its urban centers have become increasingly gentrified. With the cost of living rising in once 'blighted' neighborhoods, the low-income population is being pushed to the urban fringe where a lack of transportation and infrastructure present significant barriers to healthy living, including the ability to put healthful meals on the table.

The repercussions of the historical mistreatment of African American residents are still being felt as indicated in the data provided in this chapter. The disproportionate burden of poverty, morbidity and mortality within the African American community is a direct reflection of the macro-level structural violence inflicted upon Black Americans. Coined by liberation theologian, Johan Galtung in the 1960s and more recently popularized by Paul Farmer, the term structural violence is used in this context to reflect the institutionalized racism still at work today. Despite this, in recent years the county has made efforts to preserve the important cultural heritage of its African American community and to encourage greater racial, ethnic and cultural diversity.

## **Reflection – Notes from the Gentrified Middle-Class**

As a St. Petersburg resident, the field site is also my home, which presented both advantages and challenges in the conduct of my work. My familiarity (both geographic and social) with the area allowed for immediate orientation to participants' descriptions of their neighborhoods and surrounding areas, preferred shopping locations, and so forth. As a local I

was also able to build on relationships previously established with the organizations assisting in recruitment making my entrée into the ‘field’ a smooth transition. I had the distinct advantage (or disadvantage depending on your outlook) of being able to maintain the normalcy of my life (albeit busier than usual) throughout my fieldwork. As a full-time working mother, continuing to financially support my family while completing my fieldwork was a necessity and I am grateful I was provided the opportunity to complete this work outside of business hours and throughout my maternity leave.

The majority of the challenges I faced in conducting my fieldwork at home were emotional and ideological. As previously indicated, this dissertation became an intensely personal experience for me as I learned of my pregnancy within the first few weeks of beginning my data collection. As a result, witnessing participants’ struggles to support their families, feed their children and provide basic necessities was particularly difficult. As a new mom, this experience of moving between my middle-class life where I can easily meet the needs of my family and the lives of my participants’ was disorienting. I was keenly aware during those interactions that within the sociodemographic data and health statistics presented earlier, I represent the White, educated, married, middle-class majority with a healthy, planned pregnancy and optimal birth outcome. While my participants worried about running out of food each month, I worried about whether or not the chicken I bought was fed antibiotics or the apples I purchased were sprayed with pesticides. These differential perceptions of risk constitute the embodiment of the difference in socioeconomic status between my participants and me. Yet, as I will discuss in later reflections, the visibility of my pregnancy and the presence of my infant daughter during later interviews provided the opportunity to relate on a very real and basic level,

as a mom, with the women in this study. This allowed for what I believe were more genuine and open conversations than would have occurred otherwise.

In addition to the disorientation of moving between my participants' home lives and my own is the somewhat discomforting fact that I am also a homeowner in a rapidly gentrifying neighborhood adjacent to downtown St. Petersburg. The historical background and land use trends of Pinellas County presented in this chapter have made me more keenly aware of 1) the hypocrisy of being outraged by the social inequities resulting from urban renewal discussed in this chapter and 2) the fact that I personally represent the 'new urban gentrifying class' in all of its trappings. I have chosen to make my home in St. Petersburg precisely because of its attention to new urban revitalization and all it has to offer. Living in a neighborhood that until ten years ago was majority low-income and African American, I cannot help but reflect on the increasing lack of racial diversity now represented there and the fact that my family and I are contributing factors to its cultural homogenization. Though I have yet to resolve these conflicts in my conscience, I do believe that my critical awareness and self-reflexivity on the issue serve an important purpose. For example, as an active member of my neighborhood association, I am able to influence local community development plans and policies to ensure that our neighborhood continues to offer housing options to low-income residents. In light of this research, I hope to be able to contribute further to ensuring that what is left of the socioeconomic and cultural diversity I so valued when I first moved to the neighborhood remains.

## CHAPTER 3: LITERATURE REVIEW

*“Starvation is the characteristic of some people not having enough food to eat. It is not the characteristic of there **not being** enough food to eat.”*

---Amartya Sen

### Introduction

The concept of food security has been evolving for centuries since at least 1798 with Thomas Malthus' *An Essay on the Principle of Population as it affects the Future Improvement of Society* in which he predicted food production would not meet the future demands of a rapidly growing global population (Malthus 1798). In this chapter I will first review the history of the definition and scope of food security, focusing on the post-WWII period as the historical framework pertinent to this dissertation. Given that there have been over two hundred working definitions of food security described in the literature (Maxwell and Smith 1992), this chapter will examine only those that have gained the widest acceptance and best highlight paradigm shifts on the topic. Next, I will describe the evolution of food security measurement in the U.S. highlighting the controversial decision in 2006 to remove ‘hunger’ as a component of household food security status (Himmelgreen and Daza 2010, USDA 2005). Thirdly, this study’s focus on the food security of low-income mothers in Pinellas County necessitates an examination of the prevailing ‘intensive mothering’ paradigm espoused in the U.S. as the standard to which all mothers are held (Abrams and Curran 2009, Barlow 2004). This discussion will provide the framework for exploring the complexities and intersections between the experience of mothering in a low-income setting (couched within the intensive mothering paradigm) and the barriers it

creates to maintaining food security. Finally, using a riskscape framework, this chapter will end with a discussion of the related concepts of vulnerability, hunger and malnutrition.

In this context, I employ the following concept of vulnerability,

“Exposure to contingencies and stress and difficulty in coping with them. Vulnerability thus has two sides: an external side of risks, shocks and stress to which an individual or household is subject: and an internal side which is defenselessness, meaning a lack of means to cope without damaging loss.”  
(Chambers 1989:1)

This definition of vulnerability allows for a nuanced examination of both the external (macro-level) structural framework influencing risk to household food insecurity and the internal (intra-household) ability to respond and cope with those risks. What is important to capture is the dynamic interaction between both the internal and external factors that define a household’s vulnerability to food insecurity. With the objective of defining the intersection between mothering in poverty (macro-level political economic structure) and its impact on household food security (micro-level), relating the dynamic interaction between internal and external vulnerability is the primary purpose of this project.

Just as vulnerability is a difficult concept to define, so too is the concept of hunger. While hunger is a familiar physiological experience for most people, it is also a complex social problem. Definitions of hunger tend to focus either on the physiological or socioeconomic aspects of the concept (Himmelgreen and Daza 2010; Holben 2006). Here, I use the general definition of hunger proposed by the Task Force on Food Assistance in the 1980’s as “the inability, even occasionally, to obtain adequate food and nourishment.” This conceptualization of hunger allows it to be framed as a social problem rather than merely a physiological symptom. Finally, malnutrition is defined as any nutritional imbalance (Dorland 2011), encompassing

under and over-nutrition to account for the paradox of obesity and malnutrition. Here, obesity is defined as a condition in which the body has excess fat (Mayo Clinic 2014).

## **Food Security**

Just after the end of World War II, the 1948 United Nations (UN) Universal Declaration of Human Rights stated,

*“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” (UN 1948: Article 25)*

This rights-based approach to food security was the first time food was presented as a human right on the global stage with buy-in from a diverse contingent of nations. Countries signing the declaration essentially agreed that states have a moral (if not political, economic and/or legal) imperative to guarantee that right to their citizens (Maxwell and Smith 1992). In terms of food security research, this declaration provided the support to think conceptually about the determinants of food security, the right to food and its implications for the health and well-being of populations (Maxwell and Frankenberger 1992). The subsequent evolution of the definition and scope of food security has allowed us to push beyond the rhetoric of the right to food and accomplish the task of operationalizing what it means to be food secure. While defining food security has proven a complicated task, the process has helped to shape a holistic understanding of the essential elements required for maintaining a food secure status.

### ***Neoliberalism and Structural Adjustment***

A discussion of food security would not be complete without first providing a brief overview of neoliberalism, structural adjustment programs (SAPs) and the role these concepts have played in contributing to the famines that drove a renewed focus on food security beginning

in the 1970s (Sen 1999; Riddell 1992; De Waal 1997). Neoliberalism is generally regarded as a set of market-based, liberal economic policies. Essentially, it argues that the ‘free market’, a market economy based on supply and demand with little to no government control, creates a better engine for economic growth than government intervention (Sen 1999; Healy and Link 2012). The central neoliberal economic principle, that “human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (Harvey 2006:2), has become the predominant global economic paradigm (Healy and Link 2012; Sen 1999).

Yet, neoliberalism is more complex than a set of economic principles. It encompasses social values, ideologies, practices and discourse that may be thought of more broadly as a “cultural field” as suggested by Henry Giroux (2005). The root of neoliberal thought is tied to a value system based on the “ideals of human dignity and individual freedom as fundamental, as the central values of civilization.” (Harvey 2005: 11) By aligning its economic principles to overarching ideals like freedom and human dignity, neoliberalism has successfully branded itself as the “right” way to conduct business in countries that value these tenets of democracy. Rooted in the post WWII period of the late 1940s, neoliberalism evolved from development economics, which focused specifically on the re-structuring of low-income countries’ economic systems toward a ‘free market’ model (Escobar 1995).

After WWII, one of the ways in which the international community sought to restore and maintain global peace was to ensure economic growth and stability in low-income countries (Gilpin 1987). First stated in the Truman doctrine (1947) and reiterated in his inaugural address in 1949, the American dream, “that we should make available to peace-loving peoples the

benefits of our store of technical knowledge in order to help them realize their aspirations for a better life..." became a global dream. This is illustrated in the following UN statement:

"There is a sense in which rapid economic progress is impossible without painful adjustments. Ancient philosophies have to be scrapped; old social institutions have to disintegrate; bonds of caste, creed and race have to burst; and large numbers of persons who cannot keep up with progress have to have their expectations of a comfortable life frustrated. Very few communities are willing to pay the full price of economic progress." (UN 1951: 15)

This renewed global dream was flawed in its ethnocentrism and its implication that a Western democratic 'free market' economy should be the quid pro quo by which all other economic systems were to be judged 'under-developed' (Escobar 1995). In his work unpacking development theory as discourse, Escobar states,

"the development discourse...has created an extremely efficient apparatus for producing knowledge about, and the exercise of power over the Third World...In sum, it has successfully deployed a regime of government over the Third World, a 'space for subject peoples' that ensures certain control over it." (1995:9)

The creation of the World Bank and the International Monetary Fund (IMF) whose official goals were to reduce poverty and facilitate capitalist economic systems were created precisely to fulfill the dream of bringing 'under-developed' countries into the 'modern' Western world of unfettered free market economic capitalism (Gilpin 1987; Mohan et al. 2013; Abouharb and Cingranelli 2008). To accomplish this task, the IMF and the World Bank offered loans in the form of SAPs to countries in economic crisis beginning in the 1970s through 1999 (WHO 2014). Simply put, these loans came with conditions requiring countries to privatize much of their social welfare infrastructure in the name of 'development' with the (mostly) net effect of plunging the poor into greater poverty as social spending dried up and the cost of necessities like food and housing were driven higher (Mohan et al. 2013). Although structural adjustment loans were replaced in 1999 by the Poverty Reduction Strategy Paper approach with a stated aim "to

present a coherent strategy that helps poor countries to experience faster sustainable growth and achieve a substantial reduction in poverty” (WHO accessed 10/01/2014) this approach, still steeped in neoliberal ideals of individualism and risk management, has yet to deliver the benefits promised (Mohan et al. 2013).

### ***Food Security Definitions and Scope***

It is within this political pedagogy that the concept of food security evolved, beginning with the African food crisis in the early 1970s. Precipitated by increased food prices due to SAPs, drought and subsequent inadequate food supplies the famine mobilized the global community to bring renewed focus to operationalizing food security to prevent future food crises (UN FAO 1998). The resultant work on food security during that period concentrated almost exclusively on national and global food supplies with the assumption that famine and starvation could be avoided given adequate aggregate food supply for a given geographic region or population (Sen 1981; 1999). Reflective of this supply-side perspective, the first definition of food security introduced by the United Nations’ World Food Conference of 1974 stated that food security entailed,

*“Availability at all times of adequate world food supplies of basic foodstuffs [...] to sustain a steady expansion of food consumption. [...] and to offset fluctuations in production and prices.” (United Nations 1974)*

This definition of food security clearly places the unit of measure at the national, macro-level of supply and does not reflect individual or household vulnerabilities to food insecurity in the midst of sufficient aggregate supply.

Amartya Sen’s seminal work, *Poverty and Famines* (1981) provided an important critique to this perspective on food security and helped to shift the prevailing theoretical paradigm to incorporate issues of access to food at the individual and household level. First

presented in 1981, Sen's entitlement framework provides a systematic approach to measuring and assessing individual and household vulnerability to hunger (Sen 1981). His approach states that "famine is more than just a crisis in overall food supply; rather, a famine could result from a failure in people's ability to have access to food." (Sen in Burg 2008: 611) Therefore poverty, and not a lack of overall food availability, most often creates the conditions under which people become vulnerable to food insecurity. According to Sen,

"The entitlement approach to starvation and famines concentrates on the ability of people to command food through the legal means available in the society, including the use of production possibilities, trade opportunities, entitlements vis-à-vis the state, and other methods of acquiring food. A person starves either because he does not have the ability to command enough food, or because he does not use this ability to avoid starvation." (1990: 45)

Reflecting this paradigm shift, the World Bank offered the following statement on food security in 1986, "*Food security is defined as access by all people at all times to enough food for an active, healthy life.*" (World Bank 1986) Thus, the essential concepts of availability, stability and access were incorporated into the global food security framework as a result of Sen's work. Within this conceptual framework, *availability* refers to the aggregate food supply at the national and local level and is typically impacted by macro-level natural, economic and social crises (Maxwell and Smith 1991). Food security cannot be achieved or maintained without sufficient supply, therefore, it is the first element addressed in most working definitions of food security. *Access* addresses the fact that individuals (and households) may have differential means of obtaining food at the local and intra-household level for a variety of reasons (Sen 1981; WHO 1996; Pieters et al. 2013). These include but are not limited to social and economic capital, gender, age and health. Finally, *stability* refers to the temporal nature of food (in)security including transitory 'shocks' for example, the sudden loss of employment, as well as the experience of chronic food insecurity (Pieters et al. 2013; Sen 1981).

After Sen's contribution, the next significant paradigm shift within the field of food security came in the 1990s with the recognition that "an adequate intake of food does not automatically imply that micronutrient needs....are met." (Pieters et al. 2013: 4) In other words, it was realized that food sufficiency defined as adequate energy or caloric intake does not in itself impart food security. Rather, the quality and diversity of food consumed are important contributing factors to an 'active and healthy life' elicited as the primary outcome of food security (UN 1998). Reflecting this focus on nutritional quality rather than solely on quantity, the United Nations' Food and Agriculture Organization (FAO) published the following definition of food security in 1998,

*'Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life.' (FAO 1998)*

This definition broadens the scope of food security to include an additional core element – utilization- that must be met to ensure adequate food security. *Utilization* refers to an individual's ability to use food efficiently to meet their physiological needs (Pieters et al. 2013; de Rose et al. 1998). For example, one may have access to adequate supplies of rice but no clean water in which to cook it. Or, due to health conditions left untreated (perhaps from a lack of access to medical care) an individual may not physiologically be able to absorb necessary micronutrients from their food. The expansion of the definition of food security in the late 1990s to include the four core elements of availability, access, stability and utilization significantly broadened the scope of the issue to a more holistic understanding of the determinants of food (in)security.

A final expansion of the definition of food security occurred in the 2000s with an emphasis on "social access" recognizing that food allotment or exclusion may be based more on

social norms than economic stability (Maxwell and Frankenberger 1993). For example, women typically cut their nutritional intake more severely than men in times of crisis (both voluntarily and involuntarily) to shield their families from the impact of food insecurity (Page-Reeves 2014). The 2009 FAO definition of food security reflects this element of social access and places further emphasis on nutritional quality with the following declaration,

*“Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. The four pillars of food security are availability, access, utilization and stability. The nutritional dimension is integral to the concept of food security.’ (FAO 2009)*

While the concept of food security has evolved to include a complex array of overlapping factors, operationalizing it into a quantifiable measure has proven an even greater task than defining it.

The limitations of food security measures to date are several-fold. The first major limitation is the level or unit of analysis. Because food insecurity may exist for only certain individuals within a household, particular groups within a society or specific regions within a state, measuring food security at the state, local or household level will never capture the full extent of food insecurity (Pieters et al. 2013). As a result of its evolution in scope and the wide array of available definitions, institutions, states and agencies may pick and choose to reference and/or measure the definition of food security that best serves their needs (Pieters et al. 2013). In other words, there is currently no agreed-upon standard international measure or definition of the concept making it difficult to generalize food security findings from one setting to another. Additionally, the related concepts of hunger, malnutrition and vulnerability as defined at the beginning of this chapter are often conflated with food insecurity. These concepts should be considered in relation to but not paramount to the same experience.

## **Measuring Household Food Security in the U.S.**

### ***Evolution of the Measure and Elimination of “Hunger” from U.S. Food Policy***

Despite having one of the largest annual food surpluses in the world (United States Department of Agriculture (USDA) 2014; Wunderlich and Norwood 2006) recent estimates indicate that 14.3% of U.S. households experienced food insecurity in 2013 (USDA 2014). While the concept of food security has played a significant role on the world stage in helping to strategize ways to prevent famine and allow for equitable access to food, so too has it been integral in the U.S. to operationalize the food needs of its population (Wunderlich and Norwood 2006). Here I will examine the recent history of the development of a tool to measure U.S. household food security, beginning with the 1980s President’s Task Force on Food Assistance.

The existence of hunger in the U.S. was brought to the mainstream public’s attention with the May 28, 1968 airing of the CBS documentary, ‘Hunger in America’ (Eisinger 1998; Wunderlich and Norwood 2006). The public outcry that followed led to an increased focus on federal food assistance and a call for the elimination of poverty through government action, advocacy and non-profit organizations (Wunderlich and Norwood 2006). With the economic downturn of the early 1980s public attention to the issue of hunger mounted. This prompted the Reagan administration to create the President’s Task Force on Food Assistance charged with “examining programs intended to render food assistance to the needy and making recommendations on how such programs may be improved.” (Executive Order 12439 1983: 1241) The task force did not find evidence “that widespread under nutrition was a major health problem in the United States” (Task Force on Food Assistance 1984: 34) but it did find the term ‘hunger’ to be problematic as an operational concept.

The debate over how best to capture the true measure of hunger in the United States continued through the late 1980s with the passing of the National Nutrition Monitoring and Related Research Act of 1990 (NNMRR). This period marked a shift in focus from ‘hunger’ to ‘food security’ as the operational term to best quantify the issue in the U.S., though ‘hunger’ remained a central concept in the debate. As one of a number of requirements set forth in the NNMRR’s Ten Year Comprehensive plan, the USDA and Health and Human Services (HHS) were jointly charged with creating “a standardized mechanism and instrument(s) for defining and obtaining data on the prevalence of ‘food insecurity’ or ‘food insufficiency’ in the United States” (NNMRR 1990). To develop such a measure, the USDA looked to the food security literature as described in the previous section to inform their method for quantifying food insecurity in the U.S. (Wunderlich and Norwood et al. 2006). Convening a National Conference on Food Security Measurement and Research in 1994, the USDA and HHS brought together the world’s foremost food security experts and federal stakeholders to provide an operational definition and devise a method for to measure its prevalence. The resultant survey tool was based on the following working concept of food security as defined by the Life Sciences Research Office (LSRO) of the Federation of American Societies for Experimental Biology,

*“Access by all people at all times to enough food for an active healthy life. Food security includes at a minimum: 1) the ready availability of nutritionally adequate and safe foods, and 2) an assured ability to acquire acceptable foods in socially acceptable ways (e.g., without resorting to emergency food supplies, scavenging, stealing, or other coping strategies).”* (Anderson 1990)

This definition is similar in scope to the 2006 UN definition, incorporating not only the four primary elements of food security – availability, access, utilization and stability- but also emphasizing nutritional adequacy and “social access” as key dimensions to food security. In addition to defining ‘food security’ the LSRO conceptualized working definitions for the related

concepts of ‘food insecurity’ and ‘hunger’. According to the LSRO, food insecurity was defined as “*limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways*” and Hunger as “*the uneasy or painful sensation caused by a lack of food.*” (Anderson 1990; Wunderlich and Norwood et al. 2006)

The Food Security Supplement (FSS) was the final product of years of research on the topic. Developed as a supplement to the annual Current Population Survey (CPS) administered by the U.S. Census Bureau it was designed to capture only “resource-constrained or poverty-linked food insecurity.” (Wunderlich and Norwood 2006: 14) Since 1995, the full FSS has been administered annually and consists of over seventy questions related to food behavior and experience (spending, consumption patterns and so forth). The FSS includes an eighteen question Household Food Security Survey Module (HFSSM) (USDA; Wunderlich and Norwood 2006) which was designed to “elicit information on whether the household experienced difficulty in meeting basic food needs due to a lack of resources.” (Wunderlich and Norwood 2006: 31) In addition to inclusion with the annual FSS, the HFSSM has been incorporated successfully into a number of national and state surveys as well as translated into several other languages for use in multiple countries indicating that despite some noted concerns, the survey module is widely accepted as an adequate measure of food security (Wunderlich and Norwood 2006).

From 1995 to 2005, the USDA included the concept of hunger in the FSS by classifying households into one of three categories - food secure, food insecure without hunger and food insecure with hunger (Wunderlich and Norwood 2006). In 2005, after ten years of data collection, the USDA commissioned the Committee on National Statistics of the National

Academies (CNSTAT) to conduct a study on the effectiveness of the FSS. As a result of this evaluation, the panel concluded,

“That hunger is a concept distinct from food insecurity, which is an indicator of and possible consequence of food insecurity that can be useful in characterizing severity of food insecurity. Hunger itself is an important concept that should be measured at the individual level distinct from, but in the context of, food security.” (CNSTAT 2005: 5)

This change in policy regarding the inclusion of hunger within the accepted categories of food security stems from disagreement as to whether hunger is actually measured in the survey (National Academy of Sciences 2006). Since the FSS measures food security at the household level and hunger is an individual experience, this is a technically valid critique (Himmelgreen and Romero-Daza 2010). Yet, public opinion in the U.S. perceives hunger to be an increasing concern and “a moral issue that needs to be addressed through government policies that target not only emergency situations but that seek to alleviate the root causes of the problem, including poverty (Himmelgreen and Romero-Daza 2010: 101). Despite this public perception of the importance of capturing the prevalence of hunger, the food security categories were significantly revised in 2006 to remove ‘hunger’ thereafter classifying households into four new categories:

- 1) High Food Security (no reported indications of food access problems or limitations)
- 2) Marginal Food Security (one or two reported indications – typically anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diets or food intake)
- 3) Low Food Security (reported multiple indications of food access problems and reduced diet quality, but few, if any, indications of reduced food intake)
- 4) Very Low Food Security (multiple indications of reduced food intake and disrupted eating patterns due to inadequate resources for food)

**Table 3.1:** Comparison of USDA Food Security Categories

<b>1995-2005 Food Security Categories</b>	<b>2006 Revised Food Security Categories</b>
Food Secure	High Food Security
	Marginal Food Security
Food Insecure without Hunger	Low Food Security
Food Insecure with Hunger	Very Low Food Security

Source: USDA 2006

Referring to table 3.1, we find that marginal food security has now been added as a food secure component, identifying households who live on a precarious edge between food security and fear or anxiety of food insecurity. Households previously classified as ‘Food Insecure without Hunger’ are now considered to have ‘Low Food Security’ and those who were previously classified as ‘Food Insecure with Hunger’ are now considered to have ‘Very Low Food Security’. These revised food security categories are deserving of critical examination given that they essentially remove ‘hunger’ from the public debate on food security. As suggested by Himmelgreen and Daza this may have very real policy implications including a false sense of improvement with regards to addressing hunger in the U.S. and a potential decrease in funding streams to food assistance programs (2010). The authors call for a reconceptualization of the term to include the social aspects rather than framing it solely as a physiological one, and for its return to the public policy lexicon on food security (Himmelgreen and Daza 2010). This study will document the prevalence of hunger in the participant sample by including hunger as a domain for narrative analysis. In so doing, this study recognizes that hunger is a component to food security that should be documented in the literature.

While the FSS is accepted as a robust tool to measure household food security, it is not without its critiques. Despite collecting some information regarding the temporal nature of food insecurity at the household level, the food security statistics reported annually may overstate the severity of food insecurity in the U.S. by not differentiating between chronic and transitory food insecurity (Wunderlich and Norwood 2006). Additionally, since the FSS is administered with

the CPS, homeless households are not included in the annual reports. Finally, measuring food security at the household level does not provide an accurate accounting of who is food insecure in the U.S. While the measure does take into account differences in food security between adults and children in the same household, it does not further evaluate *which* children and *which* adults may be less food secure. For example, research indicates that young children are usually shielded from severe food insecurity while older children may experience food insufficiencies in the same household (Page-Reeves 2014). Likewise, as indicated previously, women are more likely to have inequitable access to food within a household and/or may more readily sacrifice their food intake for the benefit of their families (Page-Reeves 2014). Both of these facts have major implications for policy initiatives to help provide equitable access to food among *all* household members. Finally, by removing hunger from the assessment of household food security we are left without a way to problematize the issue of hunger in the U.S. This is of critical importance as we continue to evaluate our food assistance programs and the macro-level factors contributing to food insecurity, hunger and malnutrition.

### **The ‘Good Mother’: Mothering Discourse in the U.S.**

#### ***Hegemonic Influence of Intensive Mothering***

In addition to food security, central to this research study is the experience and practice of mothering. Symbolically laden and wrought with political, ideological and gendered meaning, mothering is defined and debated in many and varied domains. Common to these various definitions of mothering is the fact that, “Mothering takes place within specific historical contexts framed by interlocking structures of race, class and gender.” (Collins 1994: 56) Simply put, mothering is socially constructed and mothering ideals are based on the dominant social class construction in which mother-work (women’s unpaid work of reproduction and caregiving)

generally takes place. Since mothering is often characterized as the seminal human relationship shaping new generations of normative behavior, values, expectations and priorities it is a natural topic for anthropological inquiry. To investigate mothering in the context of this research setting it is necessary to explore current U.S. ideologies of mothering to drill-down to their role in socially-constructed expectations for the mothers in this study as they relate to food choice and food security.

Widely recognized as the prevailing dominant discourse of modern motherhood, ‘intensive mothering’ was coined by Sharon Hays in her 1996 seminal work, *The Cultural Contradictions of Motherhood*. Defined by Hays as “exclusive, wholly child-centered, emotionally involving, and time-consuming” (Hays 1996:5) the ideology of intensive mothering insists that a ‘good mother’ is self-sacrificing and focused solely on the needs of her children above all else. Based on an idealized white, middle-class, nuclear family model, the intensive mothering discourse has become out-of-touch with the reality and experience of mothering for most U.S. women (Romagnoli and Wall 2012). For example, in 2013, data indicate that 57% of women were employed full-time (U.S. Department of Labor). In the same year, 40% of all live births were to unmarried women (U.S. Census). Though these women represent the majority of mothers in the U.S., they are still considered outside the normative construction of mothering which defines a ‘good mother’ as a middle class, married, stay-at-home mom focused solely on child-rearing. The hegemonic influence of this prevailing ideology creates a scenario in which the experience of mothering has become laden with guilt and feelings of inadequacy as women internalize and self-perpetuate the ‘good mother’ ideal (Hays 1996).

Coined by Italian Marxist intellectual Antonio Gramsci, the term cultural hegemony describes the process by which a dominant social class exercises power over subordinate or

subaltern classes by means of conscripting them into internalizing and reproducing those values of interest to the dominant class. In Selections from his Prison Notebooks Gramsci writes,

“The “spontaneous” consent given by the great masses of the population to the general direction imposed on social life by the dominant fundamental group; this consent is “historically” caused by the prestige (and consequent confidence) which the dominant group enjoys because of its position and function in the world of production.” (2001: 12)

As previously described, intensive mothering ideology, the concept that a mother must focus the entirety of her energy and resources to child rearing, is based on dominant middle-class parenting expectations. Despite the fact that its foundation is based on a middle-class, one income household, model no longer the norm in the U.S., it is the accepted standard by which *all* U.S. mothers are judged as ‘good’ or ‘bad’. This makes the hegemonic theory of mother work particularly relevant to the low-income women who participated in this research study. While some groups of women, especially low-income women, have developed alternative discourses of motherhood that challenge the intensive mothering ideology, the fact that these alternative perspectives are presented as a *challenge* or *reaction* to the dominant ideal “highlights the hegemonic power of intensive mothering.” (Newman and Henderson 2014: 474)

The central concern with intensive mothering as the prevailing modern motherhood practice in the U.S. is that it does not take into account the value and purpose of non-middle class mother-work. In her study examining U.S. family construction, Annette Lareau uses Bourdieu’s theory of habitus to document how parenting practices (emphasizing mother-work) can impart either class privilege or disadvantage (2011). If we consider Bourdieu’s theory of habitus in this context, the hegemonic discourse of mothering becomes problematic since, according to Bourdieu, each social class has a specific set of values, tastes and priorities first learned in the home as a child through the interaction of the family (1984). These values and priorities can be

thought of as a moral compass, a prescription for learning how to navigate and live within one's social class. If all mothers are judged as 'good' or 'bad' based on one dominant social class ideology of acceptable parenting then all other mothering practices must therefore be judged as 'deviant' (Gillis 2005).

Within the public sphere this translates to pathologizing mothers and mothering practices that do not or cannot meet the expectations of the intensive mothering ideal. Most often these mothers are young, poor, and minority women with low educational attainment (Hennessy 2009). While social programs like Healthy Start, Head Start and Healthy Families are aimed at 'narrowing the gap' of disadvantage (HHS 2014), they utilize social class as a proxy for determining risk of potential child neglect, abuse or simply "substandard" parenting practices (Gillis 2005; Castel 1991). By providing parenting classes to low-income families based on the white, middle-class parenting ideal, they also "construct disadvantage as an individual developmental issue rather than a consequence of inequality so that 'a quality upbringing is all that is needed to ensure equal opportunity'" (Gillis 2005: 838). In her work with working-class mothers in England, Val Gillis argues that "the different values working-class mothers hold in relation to their children's upbringing need to be recognized in terms of a distinct moral logic guiding their parenting practice rather than pathologies." (Gillis 2005 *in* Perrier 2013: 657) Gillis further states that these mothering practices are tailored to reflect specific challenges and to pass on resilience and coping skills.

The modern neoliberal ethos of individual and market freedom as previously discussed in this chapter has created the social conditions under which intensive mothering prevails as the dominant discourse of motherhood. In-line with neoliberal notions, intensive mothering emphasizes individual responsibility and risk management, "by constructing children as the

private responsibility of parents, and mothers as responsible for child outcomes.” (Romagnoli and Wall 2011: 273) Further, cultural changes in perspectives on early child development have expanded “notions of risks to children’s well-being” and more frequently portrays “parents as risk factors in their children’s lives.” (Romagnoli and Wall 2011: 273) Given this neoliberal trend towards both risk management and individual responsibility paired with the dominant intensive mothering ideology, government assistance programs aimed at helping low-income mothers increasingly target non-middle class moms as ‘at –risk’ for ‘deviant’ or substandard parenting practices based solely on their social class position (Castel 1991). Put simply, “as a result of this shift, it is no longer necessary to participate in deviant behaviour to become the target of state intervention. Rather, all that is required is membership in what becomes labelled as a high-risk group.” (Castel 1991: 221)

Thus, “today’s American women are in a no-win situation as they are strongly pressured to be mothers and to mother intensively yet they are not immune from social pressure to be productive citizens who contribute to the capitalist economy.” (Newman and Henderson 2014: 474) This especially holds true for the women who participated in this research study who were all connected to the social welfare system through participation in at least one program (WIC, TANF, SNAP, Healthy Start, Medicaid and housing) and felt squeezed between the ideal of ‘intensive mothering’ and the state’s expectation that they look for and procure work as a productive citizen. If we consider findings from a 2005 study that “found that poor, mainly Black, single American mothers associated good mothering with being with their children in order to keep them safe, and felt guilty when their economic circumstances and work obligations” (Romangnoli and Wall 2011: 276), we begin to get a glimpse of the complex ‘riskscape’ in which low-income mothers must navigate to care for their families.

## **The Riskscape: The Intersection of Mothering and Food Security**

Much of the experience of modern mothering has evolved into a language and practice of ‘risk management’ (Hays 1996; Castel 1991; Romagnoli and Wall 2007). I therefore offer a riskscape framework for examining the vulnerability of low-income mothers to food insecurity, hunger and malnutrition. A large body of work concentrates on the geographic dimension of riskscapes in the context of food security (Morello-Frosch and Shenassa 2006). The ‘food swamp’ or ‘food desert’ literature, defines the riskscape of food insecurity within the geographic nexus of one’s neighborhood considering access to (or lack thereof) affordable, nutritiously adequate foods. Moving beyond this rather one-dimensional perspective on risk, this study contends that the paradoxes of food insecurity and obesity, obesity and malnutrition and obesity and hunger (meaning you can be both food insecure and obese, obese and malnourished, obese and hungry) are perpetuated through a complex web of overlapping ‘landscapes of risk’ or ‘riskscapes’ that are “deeply perspectival constructs, inflected by the historical, linguistic, and political situatedness of different sorts of actors.” (Appadurai 2006 [1990]: 628) This study invokes the term ‘riskscape’ in the tradition of Appadurai’s suffix *-scape* which implies an ‘imagined world’ corresponding to a particular point of view. In other words,

“It might be the same stretch of land, but what is perceived and actively apprehended depends on the viewpoint or perspective of the observer. It is never one landscape, which is the same to all observers, but multiple landscapes depending on the range of possible perspectives. The same holds true for risksapes; there is not one riskscape but multiple risksapes...” (Muller-Mahn and Everts 2012: 25).

In the context of this dissertation we must consider not only mothers’ perspectives of risk in terms of food insecurity but the overlapping risksapes they navigate on a daily basis obtaining food and preparing meals for their families. For example, a lack of transportation may mean navigating busy intersections on foot to get to a grocery store. While the riskscape of food

choice for low-income mothers may require weighing the risk of poor nutrition against hunger when choosing to feed their children low-cost, highly processed foods.

Studies indicate that women continue to do the majority of cooking in U.S. households (U.S. Bureau of Labor Statistics 2014). This is, of course, a given in households with a single mother which represents the majority of the households interviewed for this study. The task of feeding the family, however, is not simply a matter of necessity but is imbued with gendered meaning and traditional ideals of mothering and of social class distinction (Afflerbach et al. 2013). As Bourdieu states, “the strongest and most indelible mark of infant learning” would probably be in the tastes of food (Bourdieu 1984). Bourdieu’s statement implies that what we feed our children will impact on their future tastes in food so that children who grow up with a variety of foods and who are exposed to different tastes and textures will likely continue to be open to a wider array of food experiences (and by implication, healthier and more successful individuals). The important point here is that economic capital plays a large role in shaping diet and exposure to foods, thereby also shaping tastes within social class boundaries (Bourdieu 1984).

In addition to Bourdieu’s writing, the anthropological literature on food and eating has a long history whereby anthropologists view the preparation and consumption of food not only as a basic necessity but a lens through which to better examine social organization, cultural world views and value systems (Boas 1921; Codere 1957; Richards 1939; Goody 1982; Whitehead 2000). Anthropological research in the area of food studies has focused on a wide array of political economic, biologic, evolutionary, gender identity, food shifts and ritual topics (to name just a few) couched within food preparation and consumption patterns (Salaman 1949; Mintz 1985; Schepers-Hughes 1992). Relevant to this study is work on factors impacting the

development of eating habits in children. Several studies have shown that caregiver food preferences, beliefs and practices significantly impact a child's eventual preferences and eating habits (Stevenson and Allaire 1991; Lytle and Archterberg 1995; Troiano et al. 1995). A small food budget (among other factors such as time, stress and personal preference) is a limiting factor on the diversity of diet. Thus, poverty imposes "constraints on healthy feeding of toddlers" and infants (Omar, Coleman and Sharon-Hoerr 2001: 94). The intergenerational pattern of a lack of diverse food exposure as infants and children among the poor create the conditions by which poverty effectively dictates taste in food. This is where the experience of mothering and the concept of food security intersect. For if we understand one of the key roles of a mother to be the act of feeding and nourishing her family, we must examine the myriad factors that limit low-income mothers' ability to do so in a way that lives up to the dominant middle-class ideal.

## **Conclusion**

As discussed earlier in this chapter, the 'intensive mothering' ideal is the standard by which all mothers in the U.S. are judged to be 'good' or 'bad' (Hays 1996). In the context of food choices and feeding practices, the 'intensive mothering' ideology may be expressed as an 'organic mothering' ideology (Afflerback 2013). 'Organic mothering' expectations include breastfeeding *exclusively* for at least the first six months of life, moving on to [preferably homemade] organic baby food to supplement continued breastfeeding for at least the first year of an infant's life (Afflerback 2013; Stearns 2013). These feeding practices are not only financially expensive but are costly in terms of energy expenditures and time commitments - luxuries not typically afforded to low-income mothers. Thus, achieving these ideal feeding practices represents a significant amount of symbolic capital, reifying the dominant middle-class ideal of the 'good mother' (Gramsci 2001; Bourdieu 1979; Hays 1996). Returning to the

concepts of food insecurity, malnutrition and hunger we must ask how the riskscape for hunger and malnutrition are produced, lived, interwoven (Muller-Mahn and Everts 2012) and at times, subverted by low-income mothers?

These are the questions explored in this dissertation research and presented in the following chapters. It is ultimately this interplay between risk perception, riskscape navigation and coping strategies employed that we gain a better understanding of the root causes of persistent socioeconomic health disparities.

## **CHAPTER 4: THEORETICAL FRAMEWORK**

The Philosophers have only *interpreted* the world in various ways; the point is to *change* it”

-----Karl Marx

### **Introduction**

As a subfield of social and cultural anthropology, medical anthropology examines how biological and structural factors intersect to impact health. It is “...the cross-cultural study of medical systems and...the bio ecological and biocultural factors that influence the incidence of health and disease now and throughout human history. (Foster and Anderson 1978:1)

Professionalized in the field of anthropology in the 1960s (Singer 2011) the subfield is made up of three approaches to studying human health; medical ecology (or biocultural medical anthropology), critical medical anthropology and the interpretive or cultural approach. Each paradigm offers a distinct perspective leading to unique research questions, hypotheses, and findings.

In this chapter I will build on the research setting and literature review presented in chapters two and three to introduce the theoretical framework employed in this dissertation; the political economy of health. I will begin by first defining and discussing the theoretical foundations of political economy. Next, I will examine its strengths and weaknesses as a construct for medical anthropological inquiry, justifying its utility within the context of this research study. In doing so, I will explore the dynamics of social class construction and the concept of power as presented in the anthropological body of work. Finally, I will end the chapter by discussing this study’s unique contribution to anthropological knowledge, examining

the intimate experience of low-income mothers within the United States' social-class hierarchy and its impact on household food security.

### **Political Economy: Definitions and Theoretical Foundations**

The political economy of health theory is a central component to the subfield of medical anthropology and may be defined as,

“a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the *interaction* between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behavior, and meaning, human physiology, and environmental factors.” (Scheder 1988:81)

Simply stated, this approach offers a critical theoretical framework for studying how the social, economic and political structure of a society impacts health at the individual and community level. Practitioners of critical medical anthropology subscribe to the belief that anthropological research is inherently applied and researchers have an obligation to use their findings to help improve the lives of those with whom they work (Marx 1845 [1992]: 155; Singer 1994; Warry 1992). One of the primary objectives of this research is to translate its findings into practical recommendations to mitigate food insecurity among low-income women. Focused on class-based health disparities in the context of food security and mothering I employ a Marxist political economic framework to couch the call to action within a critical medical anthropology approach.

The theoretical foundation of the political economy of health stems from Engels' seminal work, “The Condition of the Working Class in England in 1844,” which related high rates of morbidity and mortality among the working class to poor living and working conditions resulting from the capitalist mode of production (Engels 2009 [1845]; Baer et al. 1996). Grounded in

Marxist political economy this theoretical paradigm most importantly connects health and its related components with class struggle and inequities stemming from the capitalist world-system. One of the central tenets of Marxist political economy states that the capitalist system inevitably creates class struggle, or more explicitly, that the capitalist system is inherently inequitable (Marx 1992 [1845]).

Inequality creates social classes that by virtue of either owning the means of production or laboring under the system are afforded different standards of living. In Engels' words, "The ruling class benefits materially from placing workers "under conditions in which they can neither retain health nor live long..." (Engels 2009 [1845]: 127) Until the 19<sup>th</sup> century, health and socioeconomic circumstances were not generally recognized to be linked. The mid-to-late 1800's introduced a number of public health activists who espoused this principle: that health is not simply determined by individual biology but by its interaction with the wider conditions in which an individual lives. Building on this concept, Rudolf Virchow's report on the 1848 typhus epidemic in Eastern Europe argued that the etiology of the epidemic stemmed primarily from social and cultural factors (Taylor and Rieger 1984). Generally accepted as the father of social medicine, Virchow's work called for a revolutionary solution to the epidemic, incorporating recommendations such as fair wages and a decent standard of living to help prevent such outbreaks in the future (Schultz 2008).

The idea that social class determines health is now accepted as fact thanks to political economy's predecessors. Today, modern political economists argue that not only does the capitalist system impart health and illness according to class but it has fundamentally changed the state of nature. The anthropological literature implies that capitalism and industrialization have impacted the environment both socially and ecologically in such profound ways that the

study of any form of life be it human, animal, or plant, must include political economic elements. Without incorporating those elements, a true understanding of the state of nature would prove unattainable (Baer 1990: 347). Marx recognized this when he stated,

“Labor is, in the first place, a process in which both man and Nature participate, and in which man of his own accord starts, regulates, and controls the material re-actions between himself and Nature. … By thus acting on the external world and changing it, he at the same time changes his own nature.” (Marx 1992 [1845]: 177)

Thus, the political economy of health theory applies a structural approach to understanding the root causes of community-level health and well-being. While intrapersonal factors also impact health, the political economy of health theory implies that the overriding factor determining an individual’s health status is the social class to which they belong.

### ***Strengths***

Political economy as a theoretical construct has taken shape through generations of social science discourse to its current iteration in modern scholarship (Roseberry 2002). According to the anthropological literature, the current global economic structure perpetuates a class-based system with ever-widening gaps between the wealthy, the middle class and the poor; with the lower classes sharing a disproportionate burden of morbidity and mortality (Engels 1884, Farmer 2005, Singer 1994). The strength of the political economy of health as a tool for anthropological inquiry lies in its ability to link macro-level political economic structures with the lived experience or embodiment of those structural processes at the community and individual level.

Indeed, anthropology’s unique contribution to academia has historically been its ability to highlight the intersections between the lived human experience and myriad macro-level factors that shape it to inform policy and heighten awareness of the structural processes at work in the daily lives of individuals. This critical approach allows the field to contribute to one of the major

goals of political economic research; to effect change. Quoting from Marx's Eleventh Thesis, "The Philosophers have only *interpreted* the world in various ways; the point is to *change* it." (1845 [1986]: 155) Political economists accept a call to action that ideally incorporates theory with practice or "praxis" for political ends. This is best achieved through "non-alienating methodologies that are dialogic and participatory in nature" (Warry 1992: 157) meaning, we can achieve the best ends when our research links structural phenomena with its impact at the micro-level to identify the root causes of disparate health outcomes.

### ***Weaknesses***

Despite its demonstrated validity in addressing health disparities, the political economy of health approach deserves a critical examination. Some scholars claim that the political economy of health places too much emphasis on macro-level factors impacting health while ignoring the importance of the biological body altogether (Wiley 1993). While this critique was valid a decade ago, anthropology as a field has made strides in addressing this issue by bridging the gap between political economy and medical ecology calling for a biocultural synthesis. Leatherman and Goodman offer, "as biological anthropologists our ultimate concern is with understanding the roots of human biological conditions, which are traced to the interaction of political-economic processes and local conditions." (2001: 5)

According to some critics, another weakness of the political economy of health model has been its considerable focus on dependency or world systems theory. Dependency or world systems theory focuses on the "development of underdevelopment" caused by the global economic dominance of the Capitalist model and its impact on global health disparities (Morgan 2009). Simply put, industrialization or "development" requires that resources be taken (often in an exploitative fashion) from one region in order to improve another. Thus, the development of

one geographic location or community requires the “underdevelopment” (or exploitation and stripping of resources) from another geographic location or community. Another phrase that aptly describes this process, coined by anthropologist and geographer, David Harvey, is “accumulation by dispossession” (2006). This is a compelling concept and is useful for envisioning the scope of the dominant global economic system. However, it does not utilize an orthodox Marxist political economic framework. Unlike Marxist political economy, critics claim that dependency theory glosses over or completely negates the political agency of the exploited classes and the phenomenon of class struggle, instead relegating all social, political, and economic power to the capitalist super-structure (Morgan 1987).

### **Examining Food Security through a Political Economy of Health Framework**

Despite its critiques as a theoretical construct, the topical focus of this dissertation benefits from its placement within the political economy of health framework. As the global leader in the capitalist world-system, the U.S. economic model sustains a class-based society resulting in the disproportionate burden of morbidity and mortality among poor and ethnic/racial minorities. It is therefore intuitive to utilize a political economic framework to examine these disparities.

This dissertation focuses on the determining factors of household food security among low-income mothers in Pinellas County, comparing the experience of African American women with their White, non-Hispanic counterparts. My findings corroborate the current topical literature to indicate that household food security status is dependent upon multi-faceted risk factors fitting into the following four thematic categories: 1. Built Environment; 2. Policy Environment; 3. Intrapersonal Factors and 4. Household Economics. The utility of the political economy of health model in providing the framework for exploring these disparate factors is its

ability to connect them back to the overarching U.S. political economic structure. In the next section of this chapter I will briefly connect each of the categorical determinants of household food security to the structural processes in place followed by a discussion of power and social class construction within the political economy of health framework.

### ***Built Environment***

As discussed in chapter two, the built environments of communities in the United States have been shaped primarily by land use policies and residential trends (Hersperger, Franscini and Kubler 2014; Berry 2014; Hu 2014). Urban renewal efforts have historically been formed by public-private partnerships (privatism) that have had a disproportionately negative impact on poor and majority black communities (Andreotti, Gales and Fuentes 2013; Lipsitz 2007; Sager 2011). Because development projects in urban centers require partnerships between the government (political capital) and investors (economic capital), urban renewal efforts inevitably reflect the priorities of those who own the means of production, attracting new middle and high income residents (gentrifiers). This cycle effectively pushes out low-income residents by pricing them out with higher rents and shaping the community to fit the new urban class aesthetic, values and priorities (Boterman 2012; Bridge 2001). As low-income residents have to move further from city centers urban sprawl begins to take shape with the ultimate outcome of a new urban landscape where wealthy residents occupy redeveloped and desirable urban locations, and households living in poverty are relegated to the urban fringe. While this is an oversimplified explanation for a complex phenomenon it accomplishes the task of placing the built environmental determinants of household food security within the overarching political economic framework that defines it.

These macro-level factors directly affect the built environment at the community-level by determining who can afford to live in specific neighborhoods, what types of amenities may be found there and how easily they may be navigated. Quoting Corburn in his work calling to reestablish the link between urban planning and public health, Smit notes, “A plethora of recent evidence suggests that disparities in health … have not narrowed over time, are getting worse, and are increasingly linked to the physical and social environments that fall under the traditional domain of planning.” (2004: 543) This includes disparities in non-communicable diseases of poverty” such as obesity and diabetes, which are associated with poor nutrition and food insecurity (Himmelgreen 2009; 2013).

As also described in the previous chapter, there is a significant body of work focused specifically on the quality and/or scarcity of healthful foods available in low-income neighborhoods popularized by the terms “food deserts” or “food swamp.” This body of work indicates that low-income communities often host disproportionate numbers of fast food restaurants and convenience store chains compared with grocery stores, produce stands and farmers markets creating a paucity of healthful foods available in areas characterized by poverty (Budzynska et al. 2013; Freeman 2007; Ghirardelli, Linares and Fong 2011; Alkon et al. 2013). Notably, this is especially true for majority black low-income communities as compared with majority white low-income neighborhoods (Raja, Ma and Yadav 2008; Walker, Keane and Burke 2010). This fact may be traced to the historicity of racial segregation of the ‘structural violence’ imposed on African Americans in the U.S. through systematic, institutionalized racism. Farmer’s theory of structural violence states, “that suffering is structured by historically given (and often economically driven) processes and forces that conspire – whether through routine, ritual, or, as is more commonly the case, the hard surfaces of life – to constrain agency.” (Farmer

2005: 40) In this example, the ‘hard surfaces of life’ include structural racism in the form of historical racial segregation and disproportionate targeting of African American communities through urban renewal efforts.

Since macro-level political economic structures define where the poor can afford to live and the type of resources available in their neighborhood, the agency of residents living in poor neighborhoods to determine where they shop for food and the food choices they can make is severely limited (Inagami et al. 2006). To the extent that the built environment reflects the values and priorities of the class with the most economic and social capital, low-income residents are often left out of the conversation in gentrifying and ‘mixed income’ communities (Greenbaum et al. 2008) making it an inevitable outcome that new establishments will likely be priced too high or will be undesirable to low-income residents who may feel like outsiders in accessing newly available resources. Thus, we find that the overarching U.S. political economic structure leads to inequitable built environments.

### ***Policy Environment***

A number of federal, state and local policies have a significant impact on the experience of low-income mothers and household food security. Importantly, the policies that impact household food security are not limited to those governing food assistance programs and similar social services but include a number of the policies that also directly impact the built environment as well as the individual and household economy of low-income mothers.

As discussed in the previous section, land use policies shape the community in which low-income mothers live by helping to define the socioeconomic status of neighborhoods (Boterman 2012; Bridge 2001). Development projects requiring the use of eminent domain to displace individuals, businesses and families disrupt community and social cohesion (Bridge

2001). As an extension of land-use policies, housing regulations determine where low-income families may live, the types of housing available to them and who may live together. As indicated in a growing body of work, the end result of many of these policies is the creation and persistence of pockets of poverty defined by the built environmental determinants impacting food security discussed earlier in this chapter.

Due to the global economic recession that has continued for the better part of the past decade, social safety net programs have increasingly come under attack within the U.S. political debate (Currie 2008; Wilde, Park and Nord 2005; Snarr 2013; Danziger 2010). Cuts in unemployment benefits, a reduction in food stamp benefits in 2013 (Daniels 2013) and ongoing negative rhetoric surrounding the needs of the poor in the United States have contributed to the household food insecurity rate remaining constant at 14-15% between 2010-2013 (USDA, Coleman-Jensen and Nord 2013) and an increase in families living in poverty (US Census 2013).

Finally, United States agricultural policy may be one of the most significant, albeit distal, issues contributing to the overabundance of cheap, high density, low nutrient foods available in the U.S. food market (Pollan 2006). Due to continued farm subsidies of corn and soy, the market is flooded with processed and packages foods made from these low nutrient ingredients making them more readily available, more convenient and less expensive than fresh produce and whole grains (Pollan 2006). This translates to an American diet laden with processed foods. And since these foods tend to be less expensive and have longer shelf lives than fresh fruits and vegetables, it is these foods that are abundantly available in most low-income neighborhoods (“food swamps”) further contributing to the food insecurity – obesity paradox.

### ***Intrapersonal/Household Economy***

At the individual level, intrapersonal factors determining household food security include a mother's social network (or lack thereof), employment and relationship status, educational attainment, vehicle access, number of children in the home, physical and mental health and well-being, access to healthcare and so forth. While these micro level indicators are personal and individual, they are indicative of the larger structural landscape in which the participant population resides.

### **Power and Habitus**

One of the stated goals of this dissertation research is to frame the political economic determinants of food security through the daily lived experience of low-income mothers. Couched within that theoretical framework is the ubiquitous concept of power. Classes with greater capital (economic, political, social and symbolic) have the power to shape their environments to reflect their values and serve their needs (Engels 1884, Marx 1867, Bourdieu 1985). Those classes with less capital have limited power over the conditions in which they live including where they live, where (and if) they work, how much education they receive and the foods they consume. The concept of power is not one-dimensional but is instead dependent upon one's status within overlapping *fields of power* or *social spaces* as introduced by Bourdieu (1989). Placing the participants of this research study within the varied *social spaces* they must navigate on a daily basis "allows us to go beyond the alternative of realism and formalism when it comes to social classes." (Bourdieu 1989)

As individual actors, we occupy multiple places within multiple fields that together constitute our social space (Waquant 2013). For example, the women who participated in this study are all defined as "low-income" which represents their social space within the hierarchy of

the overarching United States socioeconomic structure. However, they also occupy many and varied fields as women, mothers, friends, employees, patients and as consumers. Within each of these fields, the women in this study occupy a specific social space that determines their symbolic power defined by Bourdieu as, “a power of constituting the given through utterances, of making people see and believe, of confirming or transforming the vision of the world and, thereby, action on the world and thus the world itself.’ (Bourdieu 1990:170) In other words, symbolic power is created through others’ perceptions of your hierarchical place within the social space. For example, a married middle-class mother buying organic food at the supermarket possesses greater symbolic capital than a low-income single mother purchasing processed foods with government assistance in the context of the prevailing U.S. social class hierarchy and middle class perceptions of ‘good mothering’. The same low-income mother may, however, occupy a different (higher) social space within her peer group as a respected mother who makes sure her children always have something to eat, thus illustrating the varied social spaces we all must navigate on a daily basis.

The persistence of hierarchical social structures may be explained in part by Bourdieu’s related concept of habitus defined as follows in one of his last iterations of the concept, “Systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them. Objectively ‘regulated’ and ‘regular’ without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organizing action of a conductor.” (1990: 53)

In other words, we reify our social position within the field by internalizing and therefore legitimizing the perceived values, tastes, dispositions and practices of the social class to which we belong. Thus, habitus defines “a sense of one's place and a sense of the place of others.”

(Bourdieu, 1989:19) For each field we must navigate, there is a habitus associated with our social position within that field.

### **Food Security and Mothering: Embodied Habitus**

The concepts of power and habitus are significant within the context of this study's focus on low-income mothers and food security. As noted by Lupton (1996) in her examination of the habitus of food and eating, "any discussion of food and bodies in the context of families must incorporate an analysis of the meanings around motherhood and femininity, for in 'western societies, the purchase and preparation of food for the family is the major responsibility of women.' (1996: 39) Since 37% of food insecure households in the U.S. are headed by single mothers with children living in the home (USDA 2012), food security and mothering are dialectically intertwined.

Central to the concept of habitus is the assertion that it is unconsciously absorbed beginning as a child through family practices (Bourdieu 1984). Following Bourdieu's logic, we assume that mothering practices and expectations for their children are shaped by the environment in which mothers themselves were raised as well as the social space they occupy as adults. This in turn informs their expectations for their children's future. Thus, the values and perspectives associated with social class are significantly shaped by mothering practices thereby perpetuating intergenerational class habitus. Since the act of feeding and nourishing the family is central to the practice of mothering as born out in the literature (Groleau and Sibeko 2013; Warin 2008), the theoretical constructs of power and habitus couched within the larger political economic framework are especially significant within the context of mothering and food security.

In their research examining low-income mothers' infant feeding choices (breastfeeding versus formula) Groleau and Sibeko assert that "for mothers living in poverty, the rearing and health of their children become key sources of symbolic capital and power."(2013: 204) They go onto state that "as such their infant feeding choice may be experienced differently depending on the field of power they engage in." (Groleau and Sibeko 2013: 210) In other words, the definition or expectations associated with being a 'good mother' change according to the social space occupied by mothers. Holloway et al. claim that for middle class women, the expectation for 'good mothering' requires self-sacrifice, putting their child's needs in front of their own including breastfeeding even when it is a struggle and source of stress to fit the practice into their lives. Groleau and Sibeko's work with low-income women suggests that the normative construction of a "good mother" within the context of poverty differs in that the expectation is to take care of oneself so as to have the energy and "capacity to protect their baby in the challenging context of poverty." (Groleau, Siguoin and D'souza 2013: 257) This concept will be further explored in the context of my research findings.

Socioeconomic differences in perceptions of 'good mothering' can therefore be examined through the morally-loaded arena of food choice and nutrition. Given the obesity and food insecurity paradox discussed in chapter two, Bourdieu's point that, "the body is the most indisputable materialization of class taste" (1984: 190) is especially salient for this research study. The literature shows that the majority of the U.S. population believe obesity to be a sign of laziness or lack of self-control which in turn creates stigma surrounding the condition (O'Brien et al. 2013; Hunte and Williams 2009; Shulevitz 2013). Since obesity prevalence among women increases as income decreases (CDC 2010) this translates to victim blaming of low-income women for their poor nutritional health. The resulting consequence is diminished symbolic

power for obese individuals based on their body shape and size. While the majority of obese children are not low income (CDC 2010), childhood obesity serves as an indictment of the mothering practices of low-income women according to the dominant paradigm of “good mothering” and the general public’s perception of the causes of obesity (laziness and lack of self-control). It is within this prevailing political socioeconomic structure that low-income mothers are faced with the task of feeding their children under the constraints of time, money, nutritional literacy, access, personal tastes, preferences and culinary heritage.

## **Race**

Finally, even when controlling for income and education, in the United States we see the persistence of health disparities along racial lines with the largest gap between Black Americans and White Americans (CDC 2010). This trend does not hold for other industrialized nations (Unnatural Causes 2008) implying that the United States’ unique history with regards to race relations continues to have a major impact on health. In his analysis of health inequalities in the African American community, Dressler suggests that four different models for analyzing racial health disparities have been presented across various disciplines. These include 1) a racial-genetic model; 2) a health behavior/lifestyle model; 3) a socioeconomic model; and 4) a social structural model (1993: 332). In order to demonstrate how the political economy of health theory may be utilized to examine racial disparities in household food security, it is important to critically examine each of these models.

### ***Racial-Genetic Model***

First, the racial-genetic model, “posits group differences in the distribution of some set of genes that gives rise both to phenotypic differences between groups and to the propensity to poor health.” (Dressler 1993: 333) While the majority of research using this framework does not suggest a biological basis for race but instead a genetically adaptive response to environmental

factors (e.g., the link between malaria and sickle cell) (Goodman and Leatherman 1998), it nonetheless *implies* a biological basis for race. This is one of the central critiques to the medical ecological approach; that by extolling the importance of evolutionary adaptation to the environment without connecting it to the larger political economic framework that influence those environmental changes, we reify the false notion that race is biologically based rather than socially constructed which in turn gives rise to ‘victim blaming’.

### ***Health Behavior/Lifestyle Model***

The second model for examining racial health disparities, according to Dressler, is the “Health Behavior/Lifestyle Model”. This model focuses on individual behavior and choice with regards to health, implying that the difference between health and illness is a simple matter of choosing a healthy lifestyle (Dressler 1993). The central problem with this model is that it does not take into account the structural processes that impact individual efficacy to make healthy choices or live in conditions conducive to health. Applied to racial health disparities, this model can lead to inaccurate assumptions, discrimination, and stereotyping about the poor, Black population. The “Culture of Poverty” theory, coined by Oscar Lewis in 1959, is based on this model and serves as an important critique against its use. The basic premise of the Culture of Poverty is that those born into poverty will make unhealthy choices and continue the welfare cycle because they have been conditioned to do so through behavior modeling (Lewis 1959). It follows then, that with regards to poor African Americans, this model would lead to the assumption that the black community continues to disproportionately represent households living in poverty due to a fundamental flaw in the culture that has been passed on through generations. Thus, this model can easily be used to justify racism.

### ***Socioeconomic status model***

The socioeconomic status model suggests that racial health disparities may be explained by the fact that in the United States, racial and ethnic minorities represent a disproportionate number of the poor as previously discussed. As a previously discussed, the central tenet of the political economy of health theory states that the conditions of poverty lead to poor health which explains a great deal with regards to the persistence of health disparities in the U.S. However, this model cannot entirely account for the existence of racial health disparities. Epidemiological studies of racial health disparities have found that even when controlling for socioeconomic status, African Americans continue to suffer from higher rates of several morbidities (CDC). This means that socioeconomic confounding does not account for all racial health disparities and we must, therefore, look for a further explanation.

### ***Social Structural Model***

Dressler proposes what he terms a social structural model to explore this phenomenon further. The theoretical underpinnings of this model stem from Weber's work on social closure which essentially states "that a dominant group safeguards its position and privileges by monopolizing resources and opportunities for its own group while denying access to outsiders." (Murphy 1988: 42) This echoes Marxist political economic concepts with regards to class power and domination, however, I believe the term "social closure" is more accurately associated with Bourdieu's "habitus".

### **Race as ethnic habitus: Combining Political Economy with the Social Structural Model**

Applied to the experience of African Americans in the U.S., "ethnicized habitus" (Bourgois and Schonberg 2007), or the acquired and habitualized perception that skin color is associated with class, creates and sustains a racially-based social class system. The phenotypic

characteristic of skin color, therefore, defines one's lived experience within the social structure of the United States in important ways. Entry into a higher social class is typically based on factors such as education level, occupation, and material possessions. However, "any convenient and visible characteristic, such as race, language, social origin, religion, or lack of particular school diploma, can be used to declare competitors [for status] as outsiders." (Dressler 1993: 335 quoting Murphy 1986:23) While not implying that dark skin systematically rules out the ability to be upwardly mobile within the United States, the concept of "ethnicized habitus" does imply that the normalized perception of social structure in the United States includes equating dark skin with lower SES by default.

Dressler further explores this theory and its impact on the health of African Americans by conducting research on hypertension, skin color, and lifestyle. In his study, Dressler found that his African American participants with dark skin and high socioeconomic status actually suffered from higher blood pressure than those with low socioeconomic status even after controlling for confounders such as job stress. He suggests as an explanation, that having dark skin and high socioeconomic status means more frequent encounters with racism. He states that ethnic habitus maintains the perception that dark skin color is equated with low socioeconomic status and therefore impacts the way in which one is treated (Dressler 1993: 339-340).

The social structural model applied to racial health disparities is therefore a model for examining "institutionalized racism". It points to an inherently racist political, economic, and social structure within the United States that makes social mobility for African Americans more difficult than for White Americans. This is consistent with the political economy of health theory because it shows that racism is actually a product of social class and domination akin to

Marxist ideology. And this discriminatory perception of social class that equates black skin with low SES has an impact on health.

This applies specifically to the experience of low-income African American mothers and household food security in several important ways. First, as discussed earlier in this chapter, land use policies in this country have had a disproportionately negative impact on African American communities as they have generally shouldered the burden of displacement and community disruption due to urban renewal projects (Gotham 2000; Squires 1994). The fact that the majority of ‘blighted’ urban communities also happen to be majority African American points to institutional racism within the overarching U.S. political economic structure, placing more African Americans in conditions of poverty than any other ethnic group in the U.S (US Census 2012). The persistence of racial economic disparities implies that it is more difficult for poor, African American women to be upwardly mobile within the dominant social hierarchy than their counterparts. This in turn equates to more African American mothers living in low-income neighborhoods with less access to a good education for themselves or their children, less access to healthful foods and more exposure to environmental stress.

According to Dressler, “ethnicized habitus” also results in chronic exposure to negative social interactions whereby the phenotypic characteristic of skin color determines the way in which one is perceived and treated (1993). Within the context of food security this may have an impact on where African American women feel comfortable shopping for food and how they are treated when doing so. For example, instead of shopping at a major supermarket that carries a variety of fresh produce, African American women may choose to shop at smaller or discount grocery stores where they feel they have more symbolic power (Bourdieu 1984, Okolosie 2013).

The findings from this dissertation research study validate these assertions and will be discussed in a later chapter.

Particularly significant to the African American mothers participating in my study is the enduring stereotype of the "Welfare Queen". This term conjures the image of a poor, young, obese, African American woman with several children who lives on government assistance. In other words, "The facets of the "welfare queen" image become fused together so that poor always means black, black always means poor, and these characteristics attached to "woman or queen" symbolize sexual irresponsibility, defective parenthood, and deviancy." (Albiston and Nielsen 1995: 1) With regards to food security and food choice, African Americans mothers on WIC and food stamps may feel particularly vulnerable to judgment and discrimination when shopping for food as compared to their White counterparts which in turn influences where they choose to shop.

## **Conclusion**

The political economy of health framework as presented in this chapter allows for the broad conceptualization of the social, cultural, political and economic factors impacting health. This chapter presents models for framing the related concepts of power, agency, habitus, race and the embodiment of mothering. Thus, the lived experience of mothering in poverty and its impact on health are framed within the macro-level structure. The theoretical framework presented here will be used to anchor the discussion of this dissertation's findings within the critical medical anthropological approach.

## **CHAPTER 5: METHODS**

### **Introduction**

This dissertation was inspired by an exploratory qualitative study entitled *Healthy Futures* (Funding Agency: Agency for Healthcare Administration, PI: Linda A. Detman, PhD) with which I was involved from 2007-2009. The *Healthy Futures* study was conducted by the Lawton and Rhea Chiles Center, University of South Florida College of Public Health in collaboration with the Healthy Start Coalition of Florida. The primary objective of *Healthy Futures* was to evaluate prenatal care access, delivery and quality to African American women in three Florida counties; Leon, Gadsden and Pinellas (Detman et al. 2008). As an interviewer for the *Healthy Futures* project, I conducted approximately fifty semi-structured, ethnographic interviews in Pinellas County. In the course of that work I observed the challenges faced by all new mothers, especially low-income ones: 1) to keep food on the table and 2) to provide balanced, nutritious meals to their families. While no data from *Healthy Futures* were used in this dissertation, these observations sparked my interest in further exploring the issue of household food security as it relates to the experience of mothering in a similar low-income population for my dissertation.

In 2010, the United States Department of Agriculture (USDA) released the 7<sup>th</sup> edition *Dietary Guidelines for Americans*. Reviewed and updated every five years, the 2010 version is intended for Americans ages two years and older, *including* those at increased risk of chronic disease (USDA 2010). Historically intended only for healthy individuals, the inclusion of those at-risk for chronic disease in the current guidelines represents a formal recognition of diet as one

of the key determinants of health in the United States and of the ‘epidemic of overweight and obesity’ affecting all segments of society (USDA 2010). Particularly relevant to this research, the guidelines also refer to the high rates of food insecurity in the U.S., emphasizing that “fifteen percent of American households have been unable to acquire adequate food to meet their needs.” (USDA 2010: viii) Paired with the recent USDA final ruling released February 28, 2014, making permanent the 2007 and 2009 revisions to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) food packages<sup>1</sup> (USDA 2007, 2008 & 2009 Interim Rules) the topical focus of this dissertation is reflective of the current food and nutrition policy climate low-income mothers in the U.S. must navigate

This dissertation employs a mixed methods approach to examine the research objectives. The methods used in this study include semi-structured ethnographic interviews, participant observation, surveys/questionnaires and foodscape analysis. The goal in applying mixed methods to evaluate the research questions was to pair the rich qualitative narrative gained from participants’ voices with a visual representation of their lived experience. From a personal perspective, going through my first pregnancy, giving birth and caring for an infant throughout the data collection period provided a unique and ultimately rich source of participant observation.

I begin this chapter with an outline of the methodological framework and study design. Next, I discuss the major research questions posed, focusing on the methods used to explore each one. I provide a detailed description of the implementation of each method and I end the chapter

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<sup>1</sup> The 2007 and 2009 revisions to WIC food packages include a reduction in quantities of milk (with the addition of 2% and soy milk), eggs, juice and cheese to allow for more fruits and vegetables (fresh, canned and frozen). Cash vouchers for fresh produce were added, more options for whole grain products, inclusion of baby food, allowances for soy products and infant formula quantities based on age represents the primary changes to the packages. These changes are meant to appeal to a more diverse population, allow for greater food choices and flexibility and better meet current dietary guidelines for expectant and lactating mothers and young children (USDA 2014).

with my rationale for the chosen study design, including a discussion of both the positive aspects and challenges encountered in its implementation.

## Dissertation Methodological Overview

**Table 5.1: Methods Overview**

Methodological Approach Utilized	Objective
Semi-Structured Ethnographic Interviews	<ul style="list-style-type: none"> <li>• Examine the unique experience of mothering and the barriers related to maintaining household food security including access to, quality and affordability of food</li> <li>• Explore attitudes towards food including perceptions of health and risk food behaviors to include meal planning, budgeting, meal sharing (e.g., eating together as a family) and frequency of eating out</li> <li>• Analyze food shopping patterns to include preferred food outlets and frequency</li> <li>• Investigate the benefits and/or shortcomings of prenatal nutritional advice and education</li> </ul>
Quantitative Data Collection (Surveys/Questionnaires)	<ul style="list-style-type: none"> <li>• Collect the baseline household food security of each participant household</li> <li>• Define common characteristics of the study sample</li> <li>• Examine and control for confounding variables related to food security and/or the experience of racism or discrimination. For this study, the ‘experience of racism or discrimination’ is characterized as the direct or indirect witnessing of a racist encounter (perceived or real). For example, targeting a black individual for surveillance at a store based solely on the color of their skin would be defined as a racist encounter. The definition also includes the perceived threat of such an event occurring as well as the coping mechanisms used to deal with the stress of encountering racism.</li> </ul>
Community Foodscape Analysis	<ul style="list-style-type: none"> <li>• Assess the participant food environment with regards to accessibility, quality and affordability</li> </ul>
Participant Observation	<ul style="list-style-type: none"> <li>• Record and relate/contrast my own personal prenatal and postpartum experience with those of the participants.</li> </ul>

The following research questions were developed from personal observations made during my time interviewing low-income African American mothers through the *Healthy*

*Futures* project, combined with my reading of the topical literature and current legislative climate surrounding food security and nutritional health in the United States (U.S.).

1. How does the experience of mothering influence the food security of low-income mothers in Pinellas County?
2. How do space and place impact low-income mothers' perceptions of their 'foodescape'?
3. How do racism and discrimination (both perceived and structural) affect the food security and nutritional health of low-income mothers in Pinellas County?

The methods and objectives outlined in table 5.1 on the previous page summarize the approaches used to evaluate the research questions. A detailed description of the implementation of each method is provided in the following sections of this chapter.

## **Participant Selection**

### *Sampling Strategy*

A purposive sampling strategy was used to define the inclusion criteria (listed below) for this study, based on the current literature on socioeconomic and racial disparities in household food security and maternal nutritional risk (Braveman et al. 2010; Park et al. 2009; Gundersen et al. 2009). It should be noted that while the inclusion criteria exclude women whose most recent birth was more than one year prior to study participation, I did not limit participation to first-time mothers nor did I choose to include a single family type (e.g., single mothers). Thus, the family size, structure and dynamics within the final sample vary within and between both cohorts.

Although this added complexity to the data analysis (see chapters 7 and 8), the intention was to include a representative sample of all low-income mothers in Pinellas County.

The mothers in this study therefore included single mothers, married women, mothers living with partners or extended family, first-time mothers and women with up to four children. The sample included mothers who work full-time or part-time outside the home, women who

intentionally chose to stay at home with their children and women who were unemployed but looking for jobs at the time of the interview. There were students, social workers, nannies, caterers, fast food employees, retail clerks, cosmetologists and newspaper deliverers amongst the sample. Some women had a large extended family and social support network on whom they could rely and others had no help at all. Some women with multiple children had them very close together so that they were taking care of a newborn or young infant in addition to a toddler and perhaps one or two additional pre-school age children. Other women with multiple children had older children and were surprised by the pregnancy and the idea of ‘starting over’ again. In other words, the women in this study represented the diversity of low-income mothers in Pinellas County. In the results chapter, I present statistical analyses of the association between these various life circumstances and demographics and food insecurity. However, I intentionally chose to anonymize the narrative comments presented throughout chapters seven and eight (results and discussion) in order to focus on the common experiences of all low-income women with respect to their mothering role and their food secure status.

***Inclusion criteria***

- Age 18-35 years
- Given birth in the past 12 months
- Self-identify as either African American or White
- Annual household income  $\leq \$25,000$
- Reside in Pinellas County
- English Speaker
- Able and willing to provide informed consent

***Exclusion criteria***

- Pregnancy

Since the majority of births (82%) in Pinellas County in 2010 were to women between 18 to 35 years of age (U.S. Census Bureau 2010) this was the age range defined for this study’s participant sample. The twelve month post-partum period was chosen to encourage greater

accuracy in recall to participants' most recent pregnancy (Natland et al. 2012; Launer et al. 1992). Pinellas County was chosen as the research setting because it is the community in which I reside and also builds on my previous work with the *Healthy Futures* project. The annual household income limit of  $\leq \$25,000$  was defined based on the average household size in Pinellas County (2010 Census Summary File 1) and the 2010 Poverty Guidelines for the 48 Contiguous States and the District of Columbia (HHS Policy Document, released August 3, 2010). Finally, participation was limited at the beginning of the study to individuals self-identifying as either White, non-Hispanic or African American for several reasons. First, the literature indicates the greatest disparities in U.S. household food security exist between African Americans and White Americans (Larson and Moseley 2012). Second, the language barrier posed a significant hurdle for including Spanish-speaking mothers. Since the majority of data collection for this dissertation was in the form of qualitative interviews, my lack of Spanish conversational skills did not allow for the inclusion of Spanish-speaking mothers in the participant sample. For these reasons, I purposefully excluded Hispanic mothers despite the fact that Pinellas County is home to a significant Hispanic population <sup>2</sup>

### ***Sample Size***

Sample size selection and justification in qualitative research can appear ambiguous to disciplines unfamiliar with its methods. On the one hand, classic grounded theory teaches us that sample size should be determined based on data saturation, defined as redundancy reached when no new codes or topics are identified in interview transcripts. Ideally, new participants should be continually added until such saturation is achieved (Glaser and Strauss 1967). Long considered

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<sup>2</sup> Due to difficulties meeting the target sample size of twenty women in each participant group, the dissertation committee approved the inclusion of English-speaking Hispanic mothers as of February, 2012. One Hispanic African American participant and one Hispanic White participant were ultimately included in the final sample.

the gold standard of qualitative inquiry, this is not always practical in the current research climate where grant funding is highly competitive and sample sizes are often based on both budget considerations and statistical power. To justify sample size selection in qualitative research, Marshall and Rossman (2014) recommend three best practices; 1) refer to recommended guidelines from qualitative research methodologists; 2) identify similar studies and research design and determine appropriate sample size based on precedence and 3) justify the sample size through statistical demonstration of saturation within a dataset.

Based on these best practice recommendations, the target sample size of forty (twenty in each group) was chosen for this study as appropriate to achieve the research objectives. 1) The majority of researchers working in grounded theory recommend between twenty to fifty interviews with evidence indicating that data saturation is achieved, on average, around interview thirty (Marshall and Rossman 2014). 2) My experience from the *Healthy Futures* study, which included a large sample size ( $n=283$ ) with a similar population, convinced me that data saturation as defined earlier could be achieved with a much smaller sample. As an interviewer and later as I assisted with coding the transcripts for *Healthy Futures*, it became clear that data saturation was achieved in that project with only a fraction of the total participant population (hence, sample size based on precedence). To further demonstrate my commitment to achieving data saturation, the research proposal for this dissertation specified that if, at the end of interviewing forty participants data saturation was not achieved, the study would be amended to accommodate that need. 3) However, even with a smaller final sample size of thirty-one total participants (eleven White participants and twenty African American participants) I am confident that data saturation was achieved. This is based on the fact that my interview transcripts revealed no new codes or topics after the first 20 participants. Thus, the final sample size was appropriate for this study

design. A discussion of the challenges related to achieving my original proposed sample size as well as concerns related to the large inter-group difference in sample size is included in the Limitations section of chapter seven.

### ***Recruitment***

As previously stated, a purposive sampling strategy was used to select the inclusion criteria for this research. Based on these criteria, the recruitment strategy relied on assistance from government and non-profit agencies who serve the defined participant population throughout Pinellas County. Having previously established a relationship with the Pinellas County Healthy Start and Healthy Families organizations those agencies generously assisted with recruitment by allowing home visitor staff to inform their clients about the opportunity. The central advantage of collaborating with Healthy Start and Healthy Families staff was the established rapport and trust they have already built with their clients. While it was made very clear to clients that their decision to participate would in no way affect the services received, participants expressed they felt comfortable contacting me because their caseworker had referred them (as opposed to another referral source). Home visitation staff were provided IRB-approved informational flyers that included a short study description and my contact information (see Appendix C) along with a script outlining IRB-approved recruitment procedures to ensure all clients were presented the same information (see Appendix C).

As indicated in table 5.2, several other organizations serving low-income families throughout Pinellas County allowed for the placement of advertising materials in their waiting and/or common areas. To obtain permission to do so, I approached the manager or director of each agency/office location, explaining the purpose of my study and the expectations for participation. While a few did not grant permission, most were both receptive and supportive

with one WIC location (Clearwater office) allowing me to approach women in the waiting area on a weekly basis. This was allowed provided that I protect individual privacy by screening potential participants in a separate room and in a confidential manner. An amendment to my IRB approval was made to indicate all recruitment locations prior to placing study materials with each agency. Table 5.2 provides a summary of all agencies and organizations that allowed recruitment at their location(s) as well as the strategy(s) employed in each setting.

**Table 5.2: Recruitment Overview**

Agency	Agency Description	Recruitment Locations	Recruitment Method
Healthy Start	<p>The Healthy Start Program provides mothers, newborns and families with the resources, support and help they need to have a healthy pregnancy and a healthy birth. (<a href="http://www.healthystart.org">www.healthystart.org</a>)</p> <p>Healthy Start offers home-visitation services to pregnant women and new moms including:</p> <ul style="list-style-type: none"> <li>• Childbirth Education</li> <li>• Parenting Education</li> <li>• Smoking Cessation</li> <li>• Women's Health Education</li> <li>• Breastfeeding Support</li> <li>• Nutritional Counseling</li> <li>• Confidential Counseling</li> <li>• Support Groups</li> </ul> <p>(<a href="http://www.healthystart.org">www.healthystart.org</a>)</p>	<ul style="list-style-type: none"> <li>• Clients' Homes</li> <li>• St. Petersburg downtown office</li> </ul>	<ul style="list-style-type: none"> <li>• Home Visitation Staff informed their clients of the opportunity to participate</li> <li>• IRB-approved study flyers and brochures were available in the St. Pete downtown office.</li> </ul>

**Table 5.2 (Continued)**

<b>Agency</b>	<b>Agency Description</b>	<b>Recruitment Locations</b>	<b>Recruitment Method</b>
Healthy Families	Healthy Families America (HFA) is a nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. ( <a href="http://www.healthyfamilies.org">www.healthyfamilies.org</a> )	<ul style="list-style-type: none"> <li>• Client Homes</li> <li>• St. Petersburg downtown office</li> </ul>	<ul style="list-style-type: none"> <li>• Home Visitation Staff informed their clients of the opportunity to participate</li> <li>• IRB-approved study flyers and brochures were available in the St. Pete downtown office.</li> </ul>
WIC	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk ( <a href="http://www.fns.usda.gov/wic/women-infants-and-children-wic">http://www.fns.usda.gov/wic/women-infants-and-children-wic</a> ).	<ul style="list-style-type: none"> <li>• Clearwater</li> <li>• Tarpon Springs</li> </ul>	<ul style="list-style-type: none"> <li>• IRB-approved study flyers and brochures were available at the two locations listed.</li> <li>• I approached women in the Clearwater waiting room (per IRB and Clearwater WIC approval) once weekly</li> </ul>
Community Health Centers of Pinellas, Inc.	Community Health Centers of Pinellas, Inc. is a non-profit healthcare organization with 6 primary care facilities throughout Pinellas County offering services on a sliding-scale basis ( <a href="http://www.chcpinellas.org/">http://www.chcpinellas.org/</a> ).	<ul style="list-style-type: none"> <li>• Johnnie Ruth Clarke Health Center</li> <li>• Community Health Centers at Pinellas Park</li> <li>• Community Health Centers at Largo</li> <li>• Community Health Centers at Tarpon Springs</li> </ul>	<ul style="list-style-type: none"> <li>• IRB-approved study flyers and brochures were available at each of the locations listed.</li> </ul>
St. Petersburg Pediatrics	St. Petersburg Pediatrics is a network of Primary Care pediatricians that accept Medicaid with locations throughout Pinellas County ( <a href="http://stpetepediatrics.com/">http://stpetepediatrics.com/</a> )	<ul style="list-style-type: none"> <li>• 2137 16<sup>th</sup> St. N</li> <li>• 7500 Park Blvd. N</li> <li>• 1012 4<sup>th</sup> St. S</li> </ul>	<ul style="list-style-type: none"> <li>• IRB-approved study flyers and brochures were available at each of the locations listed.</li> </ul>

## ***Screening***

All potential participants were encouraged to contact me directly by phone or email. I followed the screening procedure outlined in Appendix C that included providing a brief description of the purpose of the study, the requirements for participation and a confirmation of their interest in taking part. Once their interest was confirmed, eligibility was determined by asking the following screening questions:

1. Are you between the ages of 18-35?
2. Did you have a baby within the past 12 months?
3. Are you currently pregnant?
4. How would you describe your race or ethnicity?
5. What is your approximate annual household income?
6. Do you live in Pinellas County?

For each contact received, the date, time, method of contact, referral source and eligibility was tracked in an excel spreadsheet.

**Table 5.3:** Study Contact Referral Sources

<b>Referral Source</b>	<b>Study Cohort:</b>	
	<b>African American</b>	<b>White</b>
Healthy Start: home visitation staff	16	8
Healthy Families: home visitation staff	1	0
Healthy Start/Healthy Families: In-office recruitment materials <sup>3</sup>	0	0
WIC: In-person recruitment by PI	1	5
WIC: In-office recruitment materials	2	3
Community Health Centers of Pinellas, Inc.	1	4
St. Petersburg Pediatrics	4	1
Friend/family member of participant	1	0
<b>Total # Study Contacts</b>	<b>26</b>	<b>21</b>

<sup>3</sup> The Healthy Start/Healthy Families office does not typically receive clients since they are home visitor programs. Screening and referrals to these programs are done through healthcare providers or service organizations with clients contacted by the program staff once their paperwork is received. As a result, materials placed in the office did not successfully reach their intended population. Despite this, I left materials there as both a reminder to the home visitor staff of the research opportunity as well as the small chance that a potential participant would visit the office since it is housed within the Pinellas County health department which includes the St. Petersburg WIC office and healthcare providers.

If an individual met the inclusion/exclusion criteria, she was scheduled for an interview at a mutually acceptable date and time, at the location of her choice, the majority of which took place in participants' homes. Interviewers were provided the name, address and contact information for each interview by email via a password protected pdf file. All participants were contacted the day prior to their scheduled interview as a reminder of the upcoming appointment. Table 5.3 on the previous page summarizes the referral sources for all study contacts while table 5.4 below documents reasons for ineligibility of all screen fails.

**Table 5.4:** Ineligibility Overview

<b>Study Cohort:</b>		
<b>Reason for Ineligibility</b>	<b>African American</b>	<b>White</b>
Currently Pregnant	3	2
Baby > 12 months old	2	1
Mother > 35 years old	0	1
Self-Identified as Hispanic (prior to 02/2012)	1	5
Does not live in Pinellas County	0	1
<b>Total # Ineligible Study Contacts</b>	<b>6</b>	<b>10</b>

#### *Representativeness of the Sample*

Between 2010-2011, the year in which recruitment for this dissertation began, 79% of all eligible Pinellas County women participated in the WIC program and 90% of all women seeking prenatal care in Pinellas were screened for Healthy Start with a subsequent participation rate of 89% of those eligible for services (Healthy Start 2011). The Healthy Families program that relies on referrals from Healthy Start, the Department of Children and Families (DCF), healthcare providers and other community services, currently serves a total of 138 Pinellas County families (Healthy Families 2014).

National Healthy Start client data indicate that in 2010-2011 approximately 60% of Healthy Start participants were African American compared with 16% White, non-Hispanic (U.S. Department of Health and Human Services (HHS) 2014). Additionally, 67% of Healthy

Start participants lived below 100 % of the federal poverty level (FPL) and 17% of participants were living between 100-185% below the FPL (HHS 2014). National WIC client data, from 2010 show that African American women made up 19% of all WIC participants in the U.S. compared with 36% White, non-Hispanic (USDA 2014). The numbers were similar for national infant and children participation in WIC (USDA 2014).

If these program participation trends are similar in Pinellas County, we would expect to see more Healthy Start referrals to this study for African American mothers since they make up the majority of the Healthy Start client base. Referring again to table 5.3, we find 16 of 20 African American mothers were referred to this study by Healthy Start compared with eight White, non-Hispanic mothers. With White participation in WIC approximately double that of African American participants at the national level, we would again expect to see more WIC referrals for White, non-Hispanic study participants if the same pattern is true for Pinellas County. This trend was also confirmed with eight of 11 White, non-Hispanic mothers recruited through WIC compared with three African American mothers. These data provide an argument for the representativeness of this study's sample to the larger Healthy Start and WIC client base.

The 2010-2012 3-Year rolling rate of births covered by Medicaid in Pinellas County indicates 81% of all births to African American mothers were covered by Medicaid compared to 45% of all births to White, non-Hispanic mothers (Florida Charts 2014). For the same 3-year rolling period, the number of births to uninsured African American women was 1.5% compared with 6.8% of uninsured births to White, non-Hispanic women (Florida Charts 2014). This difference in medical coverage between the two groups implies that we would expect a greater number of referrals for African American women to come from healthcare providers who accept

Medicaid. By comparison, we would expect more referrals for White, non-Hispanic mothers to come from free or sliding-scale clinics for the uninsured or under-insured.

Again, referencing table 5.3, this pattern holds true with four African American referrals from St. Petersburg Pediatrics (the largest pediatric provider group in the County accepting Medicaid) compared with one White, non-Hispanic referral. Community Health Centers of Pinellas (operating on a free and sliding scale) provided four White, non-Hispanic referrals compared with one African American referral. These data therefore support the purposive sampling strategy used for this dissertation and indicate that the results from this study are generalizable to the larger social program participant population in Pinellas County.

As evidenced in table 5.4, a total of 16 ineligible referrals were received. Those who were ineligible due to a current pregnancy were encouraged to check back should they still be interested in participating after the baby was born. Those who self-identified as Hispanic prior to February 2012 were re-contacted once this dissertation's committee approved their inclusion in the sample. One Black, Hispanic<sup>4</sup> mother and one White, Hispanic mother subsequently agreed to participate.

## **Specific Methods**

### ***Semi-Structured Ethnographic Interviews***

Perhaps the most important research method in an anthropologist's toolkit is the ethnographic interview. The interview allows researchers "maximum flexibility in exploring any topic in-depth" (Schensul and LeCompte 1999: 126) and provides the means for collecting rich qualitative data often overlooked in more quantitatively focused research design. A semi-structured interview guide was developed for this dissertation (see Appendix B) to allow for

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<sup>4</sup> I use the term Black here rather than African American as that is how this participant self-identified. Her ethnic heritage was Afro-Cuban.

flexibility in exploring a range of topics related to the experience of mothering and food security. Each participant was interviewed once for approximately two hours in their home or location of their choice. The decision to conduct the interviews in participants' homes was made for three primary reasons. First, given that all participants in this study were mothers with young infants, the offer to meet in their home was an effort to accommodate their needs and be respectful of their time. It also allowed women without access to a vehicle to participate in the study. Finally, the opportunity to observe participants in their own homes and glimpse their everyday lives offers particularly rich opportunities to "build an in-depth understanding of the research context." (Watts 2011) All interviews were audio-recorded and transcribed verbatim, including any social interactions or interruptions that may have occurred during the interview process to better document the challenges involved in this type of research. Participants were given unique numerical IDs and no identifying references such as names or addresses were used during the interviews for reasons of confidentiality. The purpose of maintaining anonymity during the interview was to address any concerns participants may have had in responding to sensitive questions, allowing for more candid responses. As the PI, I am the only person with access to the link between the unique participant ID and the participant's identifying information.

Each interview consisted of five separate components; the informed consent process, the completion of survey/questionnaires, the semi-structured ethnographic interview, anthropometric data collection (body weight in kilograms) and the interview completion/compensation process. Researchers followed the prescribed interview protocol as outlined in the guide referenced earlier (see Appendix B).

### Participant Interview Part I: Informed Consent

Each participant was provided a copy of the IRB-approved informed consent form (ICF) (see appendix C) to review with the researcher and was given ample time to have their questions answered prior to giving consent. One copy of the informed consent form was given to each participant for their records to reference in case of any future questions or concerns. Each participant provided separate consent (in the form of an opt-in section in the ICF) to allow for the audio-recording of the interview. Once the informed consent process was complete and permission to audio-record was confirmed, researchers began to record immediately.

### Participant Interview Part II: Surveys/Questionnaire Completion

Three quantitative surveys/questionnaires were collected during the interview portion of this study including two standard measures; the U.S. Household Food Security Survey Module (18 item) (HFSSM) and the Hopkins Symptoms Checklist-25 (HSCL-25). One additional non-standard measure, the demographics questionnaire developed for this dissertation, was also completed. The justification for these three instruments will be presented in the next section of this chapter. Both the demographics questionnaire and HFSSM were collected orally and audio-recorded for consistency to later validate participant responses. The HSCL-25 was self-administered to protect participants' privacy. The survey/questionnaire portion of the interview took approximately ten minutes to complete. Once all surveys/questionnaires were complete, the researchers began the semi structured ethnographic interview portion of the data collection.

#### ***U.S. Household Food Security Survey Module (18 item) (see Appendix B):***

In order to examine the factors impacting the household food security of the participant sample (the central objective of this research), the food security status of each participant household was measured. This study therefore employed the HFSSM (18 item) (USDA 2008)

described in detail in chapter three, to assess the food security status of each participant household. The version used in this study is the most current 18-item survey module, revised in 2008 (as presented earlier). While there are two shorter versions of the module available including a ten-item adult module (U.S. Adult Food Security Survey Module) and a six-item module (Six-Item Short Form of the Food Security Survey Module), neither of these versions measure children's food security. Since this dissertation focuses specifically on the household food security of low-income mothers, it was imperative that the food security of children be captured. The 18-item survey module was therefore chosen as the most appropriate version for this dissertation.

***Hopkins Symptom Checklist-25 (see Appendix B)***

As discussed in the previous chapter, the persistence of racial health disparities in the U.S. have been hypothesized to be linked to the chronic stress resulting from racism experienced by African Americans (Morello-Frosch 2006; Gravlee 2008; Dressler 1998). In addition to asking all participants about their perceptions of and personal experiences with racist and discriminatory encounters, this study also explored participants' life stressors and coping strategies (see Appendix B). In order to triangulate participants' narratives on these topics with a standard measure, the HSCL-25 was used to capture the prevalence of diagnostic levels of depression and anxiety within the participant sample.

Designed by Parloff et al. at Johns Hopkins University in the 1950's (Derogatis et al. 1974), this screening tool has been widely used as a measure of depression, anxiety and stress for decades (McKelvey and Webb 1995; Mollica et al. 1987; Derogatis et al. 1974). It has been validated for sensitivity, specificity, and appropriateness among myriad population groups worldwide (Lien et al. 2010; Kvam and Loeb 2007; Cote et al. 2009). Recent research validating

the use of the measure among women in the U.S. include a study to evaluate an intervention program for victims of domestic abuse which included low income African American and White, non-Hispanic women (Hansen, Eriksen and Elklit 2014) and a prospective study conducted over three decades evaluating obesity and psychopathology of women in the U.S. (Kasen et al. 2008). Both of these recent studies found the HSCL-25 to be appropriate for use among women in the U.S., including low-income women. The measure is generally accepted as one of the most robust psychometric scales for depression and anxiety available (Tinghog and Carstensen 2010).

While there are several available versions of the Hopkins Symptom Checklist, including 90, 21 and 10 item versions, the 25-item instrument was the most appropriate version for my dissertation project for two main reasons. First, the goal of assessing the prevalence of depression and anxiety in this participant sample was to triangulate participant narratives describing stress and coping mechanisms with a tangible measure of its impact on their health. Participants' scores were measured after the interviews were completed. Therefore, it was not used as a diagnostic screening tool for mental health. Nor would it have been appropriate for me to use it as such. In a mental health setting where the goal is to establish a clinical diagnosis, the longer 90-item version would likely be the most appropriate and robust measure to use. However, for the goals of this study, the 25-item version was much better suited. Additionally, the 90 item version is quite time-consuming and it was important that I maximize the time available during the interviews to capture the participants' narratives. While there are also shorter versions (10 and 21 items) available of the HSCL, they have not been shown to be as robust as the 25-item measure. Thus, the 25-item questionnaire was employed for this research study.

### ***Demographics/Health Questionnaire (see Appendix B)***

The demographics data capture form included questions regarding participants' own birth weight, their infants' birth outcomes (gestational age at birth and birth weight), and demographic data such as educational attainment, employment status, marital status, and access to transportation (see Appendix B for entire data capture form). All information requested on this form was based on its relevance as either a confounding or contributing variable related to food security and/or nutritional health based on the literature as previously discussed in chapter three.

### **Participant Interview Part III: Semi Structured Interview**

The semi-structured interviews were designed to elicit participants' experience of mothering (including pregnancy) and its impact on household food security. As previously stated, the research objectives explored in the qualitative interviews were borne out of my experience with *Healthy Futures* and the observation that motherhood presents unique challenges to maintaining food security. These challenges encompass overlapping political, economic, social, cultural and emotional variables of which anthropological methods are uniquely situated to examine. The interview guide (see Appendix B) includes a majority of "grand tour" questions (LeCompte and Schensul 1999), meaning that they ask the participant to describe the details of events or activities related to the research topic(s) in an effort to gain a broad overview of the participants' feelings and experiences. These questions are followed up with prompts to allow the researcher to engage the same question in different ways in order to obtain different perspectives on each topic (Few et al. 2003).

### **Participant Interview Part IV: Anthropometric Data Collection**

The anthropometric data collected for this study consisted of pre-pregnancy and postpartum body mass index (BMI). These data were collected to record prevalence of

overweight and obesity at the time pregnancy occurred as well as postpartum. BMI is calculated using body weight in kilograms divided by the square of height in meters ( $\text{kg}/\text{m}^2$ ). Resulting scores are categorized as illustrated in table 5.5.

**Table 5.5: BMI Categories**

BMI ( $\text{kg}/\text{m}^2$ )	Category
< 18.5	Underweight
18.5-24.9	Normal weight
25.0-29.9	Overweight
$\geq 30.0$	Obese

Source: CDC Accessed February, 2015

As discussed in chapter three, food insecurity and obesity are positively linked for low-income women (Himmelgreen 2013, Franklin et al. 2012). Thus, capturing the prevalence of overweight and obesity in this sample in combination with the HFSSM allows for the evaluation of whether this trend holds true among this study's participant sample.

Pre-pregnancy BMI was calculated using self-reported pre-pregnancy body weight and self-reported height. Postpartum body weight was measured using a digital scale provided by the PI<sup>5</sup>. Standard procedures for collecting body weight using a digital scale were used to include the scale being placed on a flat, level surface and participants' removal of shoes and socks before being weighed. Prior to each use, the scale was digitally calibrated using a ten pound weight (CDC 2007). By setting the maximum weight mode of the scale to 10 pounds, then placing the weight on the scale and awaiting for it to trigger as the maximum weight then adjust back to zero, the scale was tested for accuracy prior to each interview.

BMI was chosen as the anthropometric measure for this study for two primary reasons. First, postpartum women generally experience some measure of discomfort with their body shape after a baby's birth (Gjerdingen et al. 2010, Clark et al. 2009). I therefore felt that body weight would be the least invasive and most sensitive anthropometric measure to use for this

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<sup>5</sup> The Taylor 7506 digital scale was chosen for this study (Taylor Precision Products, Oak Brook, IL)

sample, despite its limitations, when compared with other methods such as waist-to-hip ratios or skinfold measurements. Second, this study sought to identify patterns of overweight and obesity within the sample as a whole rather than to evaluate or diagnose health status at an individual level.

Yet, BMI certainly has a number of limitations as a tool to measure adiposity. One limitation is the fact that it cannot describe the distribution of fat over the body, meaning that it does not quantify body composition (Nevill et al. 2006, Lee and Gallagher 2008). Thus, BMI is a measure of excess weight, not excess fat (CDC 2002). Second, BMI assumes that all bodies are composed equally and does not take into consideration body shape, relative bone mass and the percentage of total body fat versus muscle. Although women naturally carry a higher percentage of body fat than men (Blake 2001), they are assessed using the same formulation. While more robust measures of body composition are available, BMI nevertheless serves as a convenient tool to reasonably indicate risk for developing health conditions related to obesity (CDC 2002).

An additional limitation in this study with regards to using BMI as a proxy measure of fatness is the fact that pre-pregnancy weight and height were self-reported. While self-reported anthropometric data are limited by recall bias, research indicates that maternal recall for pregnancy-related events is both reproducible and accurate for many factors, including gestational weight gain and pre-pregnancy weight (Githens et al. 1993; Buka et al., 2000). Maternal recall of pre-pregnancy weight and gestational weight gain has been used as valid measures in a number of large epidemiological studies. These include the Nurses' Health Study II and Nurses' Mother Cohort which are longitudinal investigations into women's health with over 24, 000 participants (Stuebe, Forman and Michels 2009; Associated Press 2009). A study (n=810) conducted by Laraia et al. reported a statistically significant independent association

between living in a food-insecure household and severe pregravid obesity and higher gestational weight gain based on self-reported data (Laraia et al. 2009). Finally, the National Longitudinal Survey of Youth (U.S. Bureau of Labor Statistics) uses matched-maternal recall of pregravid weight and gestational weight gain to study associations between long-term youth health and in utero health status (1997-2011). A study by Kuczmarski, Kuczmarski and Najjar (2001) examining the validity of self-reported height, weight and body mass index from the Third National Health Nutrition Examination Survey, comprised of a sample size of over 16,000 men and women ages 20 and older found that self-reported heights and weights can be used with younger adults. Particularly high correlations were found between self-reported and measured height among women ages 20 to 29 years of age representing the majority of this study's sample. Given both their validity and use in large-scale robust research studies, these data served as the anthropometric component of the nutritional health assessment of each participant.

#### Participant Interview Part V: Interview Completion

At the end of the interview, participants were thanked for their time and were compensated with \$35 cash<sup>6</sup>. Each participant signed a receipt indicating they had received the agreed-upon payment. The participants were then reminded that their data would be kept confidential and encouraged to contact me with any questions or concerns. I also indicated that the results of the data would be shared with them and they could expect to receive a report by mail once I finished analyzing and writing.

#### **Justification for the Use of Interviewers in this Dissertation**

According to the literature, racial/ethnic concordance between the researcher and informant is an important component to establishing rapport in qualitative research (Few et al.

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<sup>6</sup> This research was entirely PI-funded.

2003; Childs, 2005; Beauboeuf-Lafontant 2007; Lewis 1996). Specifically, with regards to discussions of sensitive topics, racial/ethnic concordance between the researcher and informant may improve the quality of the data obtained (Few et al. 2003; Childs 2005). This dissertation's research topic necessitated the inclusion of sensitive interview questions regarding racial discrimination and the Black mothering experience. It is an unfortunate truth that racist stereotypes of low-income African American mothers persist (e.g., the "welfare queen") (Lewis 1996; Beauboeuf-Lafontant 2007).

As previously discussed, research tells us that the chronic stress of racism experienced by African American women may impact maternal and child health outcomes contributing to the persistence of racial health disparities (DeGuzman and Kulbok 2012). This makes it particularly important to gather rich, qualitative data in the form of African American mothers' narratives. These should include the experience of mothering and racism in order to provide the data needed to develop programs and policies to counteract these negative perceptions. In order to achieve the research objectives of this study and to solicit honest responses from the African American study cohort, this project benefitted from employing two Black, non-Hispanic research associates to conduct interviews with the African American study group. Each of the research associates met the following position requirements: graduate student in anthropology or public health, previous experience with qualitative research methods, and an interest or background in food security.

Per the requirements of my dissertation committee, I trained each research associate ( $n=2$ ) on the semi-structured interview guide, assessment tools, audio-recording equipment as well as the procedures for measuring body weight as described earlier. I personally attended the

first two interviews conducted by each, the seventh interview facilitated by the second associate<sup>7</sup> and the final interview also done by the second research associate to evaluate consistency in the conduct of the interview. Consistency was evaluated by ensuring that the interview guide was followed as instructed and that the appropriate topical themes were explored as applicable. Feedback was provided to the research associates after each PI-observed interview regarding interview structure and which themes to pursue in-depth. Of twenty completed interviews with the African American sample, I was present as an observer for six and completed two independently. With the exception of the twelve African American interviews I did not conduct or observe, I was responsible for all aspects of recruitment, interview scheduling, and data collection.

### ***Participant Observation***

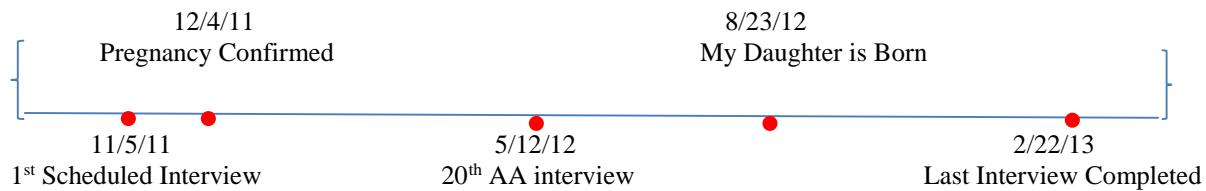
As previously stated, my dissertation data collection coincided with my first pregnancy. The participant observation component of my project therefore, was an intensely personal and meaningful experience. The shared experience of pregnancy and motherhood between my participants and me allowed for instant rapport building, especially after my daughter was born and accompanied me to interviews. But while we are all mothers experiencing many of the same sets of challenges and joys, the stark contrast between my participants lives and mine made this experience difficult, and at times, emotional. Though my fieldwork took place in the county in which I reside, I experienced a sense of personal disorientation when commuting between my life and the lives of my participants. This sense of disorientation (and a small amount of guilt) was due to the difference in socioeconomic status between me and the study participants and the ease with which I could provide for my family without the chronic stress imposed by poverty.

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<sup>7</sup> The first research associate hired conducted only a total of our interviews before time constraints prevented her from continuing.

As has already been described, my personal reflections and experiences are provided as reflections at the end of each relevant chapter as I consider how my own identity as a working, middle-class mom and the life circumstances influencing my mothering experience compared with that of this study's participants.

Figure 5.1 illustrates the overlapping timelines between my pregnancy, the birth of my daughter, and my dissertation data collection.



**Figure 5.1: Pregnancy/Data Collection Timeline**

Participant observation for this study essentially began with the news of my pregnancy in December 2011. Prior to that point, I had limited opportunities to engage with the participant community outside of recruitment and interviews. My pregnancy, however, gave me a new identity; expectant mother, and entrée into the world of prenatal care and perinatal services as an active participant. Participant observation was therefore more of an all-encompassing, 24 hours-a-day experience rather than a research tool selectively employed. On an almost daily basis I reflected on and recorded my experience in a journal that I referred to in my analysis as field notes. After each interview I conducted and/or observed, I recorded notes about the experience, similarities/contrasts between mine and my participants' perceptions, values and experience of motherhood as it related to the research questions as well as my general impression of the immediate neighborhood foodscape of the participants. While I was unable to record similar field notes for the twelve African American cohort interviews for which I was not present, I believe the extent of my participant observation and the careful mapping of the community

foodscapes (see next section) provided me with extensive familiarity and insight into my participant sample.



**Figure 5.2:** Day of 24<sup>th</sup> interview conducted, 37 weeks pregnant; **Source:** PI Photo



**Figure 5.3:** Future Anthropologist? My daughter accompanying me to an interview at 10 weeks old. **Source:** PI Photo

In addition to the journal I kept as field notes, I also used photos to document my pregnancy journey in the context of my dissertation. Figure 5.2 above shows me at 37 weeks pregnant on the day of my last scheduled study interview prior to the birth of my daughter. Figure 5.3 pictures my daughter at 10 weeks old in transit to the first interview I conducted after her birth.

### ***Foodscape Analysis***

The foodscape analysis was used to examine the food environment in which my participants reside. The methods used to complete the foodscape analysis included asset mapping of all food outlets available in selected communities, collection of participant narratives regarding their perceptions of their local foodscape and use of food desert mapping. Each of these methods are described in detail in this section of the chapter.

## Selection of Communities

Zip Codes were chosen as a proxy for community in order to provide a defined geographic area for conducting the foodscape analysis. Compared with census tracts which represent the smallest territorial unit by which population data are reported, zip code areas are much larger and therefore represent a more realistic portrait of the actual foodscape in which participants reside. Two zip code areas selected for analysis (33712 and 33755) were chosen based on the following criteria:

### Zip Code Area 1: 33712

- Predominately African American (> 60% of residents self-report as African American per 2010 U.S. census data)
- At least 4 study participants (10% of total sample, 20% of African American sample) live in the chosen zip code area.

### Zip Code Area 2: 33755

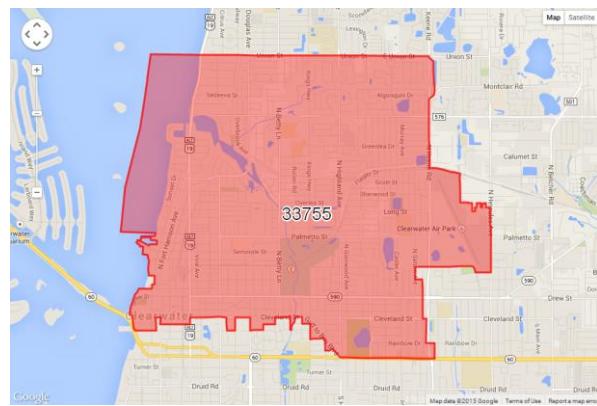
- Predominately White (> 60% of all residents self-report as White, non-Hispanic per 2010 U.S. census data)

At least 4 study participants (10% of total sample, 20% of White sample) live in the chosen zip code area.



**Figure 5.4:** Zip code Area 33712

Source: Google Maps accessed 1/3/2015



**Figure 5.5:** Zip code Area 33755

Source: Google Maps accessed 1/3/2015

Pictured in figure 5.4 is the zip code area boundary map for 33712. Located in south St. Petersburg on the southern tip of Pinellas County, this zip code area is predominately African

American (78%) (U.S. Census 2012) and is the zip code area in which 14 of 20 African American participants reside. Figure 5.5 shows the boundary map for zip code 33755 that is located in the city of Clearwater in the Central West portion of the county. The resident population is majority White, non-Hispanic (70%) (USDA 2012) and is home to five of 11 study participants. Demographic characteristics and detailed data on each of these zip code areas is presented in the foodscape analysis section of chapter six.

As discussed previously, residential segregation has been hypothesized to play a role in the quality, affordability and accessibility of food available within a given neighborhood (Cooper, 2010; Ghirardelli et al. 2010; Morello-Frosch 2006). It has been shown that even when controlling for income, predominately African American communities are less likely to have access to a supermarket or grocery store (Cooper 2010; Walker 2010) and more likely to have a greater number of fast food restaurants compared with food stores (Cooper 2010; Walker 2010). This may have a significant impact on the food security of low-income mothers living in these neighborhoods.

#### Food Outlet Inventories/Mapping

Food outlets in both zip codes were inventoried using windshield ethnography, carried out by walking and/or driving within the zip code boundaries of each selected community to directly observe and record the location of all food outlets. To test the accuracy of this method compared with use of secondary data sources, I used the City of St. Petersburg's occupational license list for retail stores to compile a list of stores that sell food in each zip code. I then compared the list against the one created from my in-person asset mapping exercise and found an approximate error rate of 5% ( $n=9$ ) with secondary data listing stores currently closed as open, documenting the wrong address and/or providing the wrong name of the outlet. While this small

error rate may not be statistically significant, I argue that the in-person asset mapping exercise is an important tool in qualitative research as it provides an opportunity to become intimately familiar with the research setting. It is a time-consuming method that requires walking and/or driving on every street within the field setting, allowing for in-depth participant observation and field note opportunities. The findings from this method of inquiry are presented in this section.

All documented food outlets were categorized by type using classifications employed in similar “foodscape” studies (Liese 2014; Morland and Evenson 2009) as follows (see Appendix B for full list of food outlets in each zip code):

- Franchised Fast Food
- Corner Store
- Corner Store with Gas Station
- Corner Store with Grocery
- Franchised Convenience Store
- Franchised Discount Store
- Chain Supermarket
- Specialty Food Restaurant
- Full Service Restaurant
- Other (Food Pantry)

Once a complete inventory of all food outlets was gathered and categorized, BatchGeo software was used to geo-code the locations of each outlet onto a map of the zip code area. Geocoding is defined as the “process of matching records in two databases: an address database (without map position information) and a reference street map or other “address dictionary” to literally pinpoint a location on a map.” (SGSI 2011) The geographic mapping of available food resources in each community provides an important visual snapshot of each community “foodscape”. These data were also used to calculate the fast food to supermarket ratio, compare and contrast locations of supermarkets and grocery stores versus corner stores, and ultimately provide a holistic view of the community foodscape.

Windshield ethnography was also used as a method of participant observation, allowing me to physically get to know the communities of my participants and to gain sense of both their assets and disadvantages. For example, as described in chapter two, several community resources and assets were identified and photographed through this method including the historic Royal Theatre in the midtown district of St. Petersburg now repurposed to host the Boys and Girls club after school during the weekdays and a monthly Spoken Word event for teens. In the same district, a weekly Farmer's market takes place on Sunday mornings. These community events and resources signify a move back toward social cohesion and community identity. While I did not fully investigate community assets available in my participant neighborhoods, my observations through windshield ethnography identified some positive improvements with regards to available social resources in both zip code areas.

### Hunger Mapping

The Tampa Bay Network to End Hunger has made available to the public ArcGIS mapping tools to help visualize issues of concern related to food security in the greater Tampa Bay Region. For the purposes of this study, I have chosen to include food desert maps, SNAP retail outlet location maps and missing meals for each of the zip code areas. These are compared with the maps of food outlets generated for this project to examine geographic paucity in access to affordable foods within each selected community. Additionally, these maps provide evidence of hunger, further supporting the need to include hunger as a variable of interest in food security research, policy and reporting.

### Qualitative Data Collection

An important missing link in the foodscape literature connecting the food environment with household food security is residents' perceptions of their foodscape. This study sought to

fill that gap by asking participants about their food shopping habits, their perceptions of the food in their neighborhoods, to include its availability, quality and affordability as well as their ability to access it. These data are presented as a critical component to the foodscape analysis presented in chapter six.

### Community Demographics

Neighborhood demographics and characteristics are also presented in the foodscape analysis in chapter six to provide additional context and background. As stated earlier, majority African American neighborhoods have been shown to have a greater ratio of fast food/corner stores to supermarkets in the U.S. Demographic, income, and housing data provided in this section help to analyze whether or not trends such as these hold true for the selected communities in this dissertation. To do this I provide data on unemployment, vacant housing, walkability scores, government assistance participation and so forth to characterize the socioeconomic environment of each community.

### **Data Analysis**

The final dataset for this dissertation comprised multiple source data including final interview transcripts, field notes and memos, quantitative survey data and foodscape analyses incorporating food outlet inventories and participant narratives. To harmonize the source material, I utilized Atlas.ti software (Atlas.ti version 9, 2013) to import all appropriate documentation for coding and analysis.

### ***Qualitative Data Analysis***

To analyze the transcripts for this study using Atlas.ti, I began with open coding to create an initial codebook of 116 unique codes generated from the transcripts. This initial open coding cycle allowed for emergent themes to develop including those of maternal stress and coping

strategies, food shopping preferences, reported staple food items, food habits (meal planning, budgeting), prenatal care experiences and life changes due to the transition to motherhood. A second focused or axial coding cycle produced a hierarchical codebook of participant statements connected with the larger themes identified in open coding. This coding cycle revealed the underlying patterns of maternal isolation as the primary finding of this dissertation. A third coding cycle was conducted to further elucidate the lived experience of maternal isolation within this participant sample. This coding cycle helped to connect the experiences of maternal isolation to the larger themes identified in the second cycle coding as well as to the analytical memos and field notes completed. In addition to this coding process, I also chose to enumerate the interview data. This process allowed for a more nuanced understanding of the differences between the two cohorts related to their mothering experiences and risk factors for food insecurity. It also helped to illustrate differences in the mothering experience related to food security between pregnancy and the postpartum period. Enumerating these differences was a critical component to the data analysis as it helps to translate the narrative into discrete recommendations for policy changes.

### ***Quantitative Data Analysis***

Each HFSSM was coded per USDA instructions (see Appendix B for survey module and coding instructions) (USDA 2014). All affirmative responses were coded to provide a raw score for households with one or more children as follows (USDA 2014):

- Raw score zero – High food security
- Raw score 1-2 – Marginal food security
- Raw score 3-7 – Low food security
- Raw score 8-18 – Very low food security.

Raw scores were entered into an excel spreadsheet and categorized accordingly to produce the overall prevalence of household food insecurity in this participant sample presented in chapter six.

HSCL-25 results were likewise scored per the measures instructions. The scale includes 25 items, divided into two parts. The first part includes ten anxiety-related symptoms, the second includes 15 items for depression symptoms (Veijola et al. 2003). Each item includes four categories of response (“Not at all”, “A little”, “Quite a bit”, and “Extremely”, rated one to four respectively. Two scores are calculated. The total anxiety score is the average of all 25 items while the depression score is the average of the 15 depression items. A threshold of  $\geq 1.75$  is used to identify diagnostic levels of depression and anxiety (Nettelbladt et al. 1993, Sandanger et al. 1998). Participants meeting this threshold for depression, anxiety or both were entered into the excel spreadsheet also capturing the HFSSM results with prevalence rates enumerated in chapter six.

The Demographics/Health Questionnaire produced for this dissertation included a number of discrete numeric variables, all captured again, on an excel spreadsheet for ease of enumeration in chapter six. Variables of interest in the form of descriptive statistics calculated from these data were included as appropriate to contextualize the narrative analysis and foodscape mapping presented in chapter six.

Pearson Chi-square tests of independence were run to determine whether any statistically significant associations exist between variables of interest. Statistical analysis was conducted using SPSS version 21.0 with data imported from the excel spreadsheet described in the previous paragraph. Due to the fact that most of the variables had expected cell counts of less than five, a Fisher’s Exact Test was included in the output tables for each of the Chi-Square Tests conducted

to provide further support for the accuracy of the Pearson findings. The statistical results are presented throughout chapter six.

### **Dissemination of Results**

The dissemination of results to research participants is one of the most significant tenets of human subject research and is perhaps especially important in the ethnographic research context. As anthropologists we build and establish rapport with research participants and are oftentimes intimately involved in their lived experience. Thus, ensuring that they are aware of the results of their contributions is of utmost importance. Upon completion of my final data analysis and write-up, the findings will be mailed to all participants at their last known address. Findings will also be disseminated to staff at each of the study recruitment locations.

### **Conclusion**

The methodological framework for this dissertation created an abundance of disparate data to synthesize into a coherent structure for analysis and discussion. Using the analytic methods described, the qualitative interview data, survey/questionnaire results and foodscape analysis were used to produce a holistic understanding of the lived experience of mothering in poverty and its impact on food security. Data collection for this project, however, was not without its challenges.

One such challenge included a wide differential in recruitment patterns between the two participant cohorts. I reached the target sample size of 20 African American participants within 6 months but only reached a final sample size of 11 White participants after continuous recruitment for 15 months. It is not clear to me why such a large disparity in motivation to participate existed between the two groups. I would hypothesize, however, that since the majority of participants were referred to me by Healthy Start this is a potential indication that the

African American cohort on average, had a better rapport with their caseworkers than the White participants. There are several other factors that could also have played a role in differential motivation; compensation offered, interview availability, word of mouth referrals between friends or family, and so forth. Regardless of the reason, the slow accrual to the White participant cohort significantly delayed the progress of this dissertation.

I also encountered resistance at a few potential recruitment locations approached. Several organizations had strict policies disallowing any type of solicitation materials to be placed in their waiting/common areas. Others, I believe, were not convinced of the merit of the study. While the majority of locations I approached did generously allow me to leave materials, the potential for those materials to remain untouched and unseen or later lost or thrown away after being picked up, was probable. On a weekly basis I physically checked each location for diminishing supplies and re-stocked as needed, while reminding reception staff of the study. This task was quite time consuming considering the number of recruitment locations employed in this effort throughout Pinellas County.

It is important to acknowledge these challenges to conducting qualitative research in this participant sample. As one of this study's ultimate recommendations to be presented in chapter eight, I call for additional qualitatively-focused research on the lived experience of mothering in poverty. Thus, an understanding of those challenges to enrolling this population may help to develop more efficient recruitment and incentive strategies.

### **Reflection – Notes on the Challenges and Advantages to the Research Design**

As described in this chapter, this dissertation employed two Black research assistants to conduct the African American cohort interviews. This presented both challenges and advantages in the conduct of this study. First, the selection process proved to be more difficult than

anticipated as I was anxious to hire an assistant with enough qualitative research experience and similar research interests to be able to quickly clue-in to important cues or salient topics within the interview process. I had to address my fear of not having control over all aspects of my data collection in order to obtain a richer, more honest narrative. In the end I found two wonderful research assistants, Ethel Saryee and Athalie Ashley. Ethel is a fellow PhD student in Anthropology at USF with an interest in nutritional health and was my first research assistant. Unfortunately, she was no longer able to continue with the study after her fourth completed interview in January 2012. I was therefore without an interviewer for approximately three weeks while I selected her replacement. Athalie was an MPH student in the College of Community and Family Health at USF with similar research interests. She was able to complete all but two of the fourteen remaining African American cohort interviews at the time she was hired in February 2012.

While the process of employing an assistant to conduct the interviews created more effort for me in the form of scheduling, screening, tracking availability and payment (they were compensated \$50 per interview for a total of \$85 out-of-pocket for each African American cohort interview) it was absolutely worth the effort. I believe those interviews elicited much richer data than would have been possible if I had conducted them. While I cannot systematically compare them with racially discordant interviews within this research project to evaluate that statement, my experience with *Healthy Futures* convinced me of the challenges encountered when probing sensitive topics in a racially discordant interview setting and the disappointing resulting data.

The food outlet inventories conducted as part of the foodscape analysis were tedious and time consuming and difficult to accomplish as an individual. As previously indicated, the windshield survey method employed for this component of the foodscape analysis was, I believe,

important. However, since zip code areas are not necessarily demarcated by major roads or in patterns conducive to easy navigation, each inventory took approximately 15 hours over a few days to complete. This points to a potential limitation in using this method for larger studies.

Finally, while my daughter's presence provided an instant connection with my participant, it also highlighted our differences in significant ways. For example, I breastfed my daughter and while a number of participants initiated breastfeeding, only one did so exclusively and for longer than 3 months. Thus, when I needed to breastfeed during an interview, it became a conversational topic. Given the incredibly nuanced and emotional decision behind every mother's decision to breast or bottle feed, my need to do so during interviews may have given participants the impression that I was judging their infant feeding choices. This is but one example of many that highlighted the difference between my socioeconomic status and the participants in this study. This type of tangible difference in my experience of mothering as compared to my participants' is the topic of a large portion of my personal reflections included at the end of each relevant chapter throughout this dissertation.

## **CHAPTER 6: RESULTS**

### **Introduction**

In this chapter I present the results of data collected through the methods described in the previous chapter. These results will help to answer this study's three primary research questions:

1. How does the experience of mothering influence the food security of low-income mothers in Pinellas County?
2. How do space and place impact low-income mothers' perceptions of their foodscape?
3. How do racism and discrimination (perceived and structural) affect the food security and nutritional health of low-income mothers in Pinellas County?

As a mixed methods study, this dissertation employed a variety of data collection techniques, each with its own purpose, objective, and unique findings. I will therefore begin this chapter by summarizing separately the findings from each approach; participant interviews, surveys/questionnaires, foodscape analysis and participant observation, followed by a brief discussion of the highlights and primary results of each method. I will present demographic data and descriptive statistics related to the participant sample where relevant, in order to contextualize the findings and to illustrate patterns or trends within the narrative. The descriptive statistics presented, therefore, should not be interpreted as robust statistical analysis but instead as numerical representation of the narrative. Statistical analyses were conducted using Chi-Square tests for independence between variables of interest, the results of which are also presented in this chapter. I will end the chapter by triangulating the results into two primary findings to be examined in chapter seven.

## **Semi-Structured Interview Findings**

The narratives of the women who participated in this research were captured through semi-structured ethnographic interviews (see Appendix B for interview guide). The purpose of these interviews as described in chapter five was to elicit personal experiences across a number of social, economic and environmental domains associated with food security (Dubois and Tremblay 2013). These domains included social support, stress (maternal, social, economic and cultural) and coping mechanisms, perceptions of the local foodscape (access, availability, affordability and quality of food in one's community), preferred food outlets, and daily food habits (fast food/takeout consumption, sharing meals as a family, cooking processed foods or using fresh ingredients). Since the primary objective of this study is to examine the factors impacting food security within the context of mothering, the interviews also touched on pregnancy and/or birth complications, long-term life changes attributed to the transition to motherhood (career goals, education, etc.), daily life changes attributed to pregnancy and/or caring for an infant and nutrition education and advice received through prenatal care.

Structured to capture differences between the prenatal and postnatal period, the interview guide was formatted to repeat each set of questions, asking participants to respond first based on recollections from their prenatal experiences and second on their postpartum period. The rationale for using this interview structure is the underlying assumption that pregnancy and expectant motherhood present different challenges to maintaining food security compared with mothering an infant. The following section will present the findings from the interview data collected.

### ***Social Support***

As a coping strategy to mitigate or prevent food insecurity, low-income households often rely on extended social support networks to provide meals during times of scarcity as well as other forms of assistance such as transportation to the grocery store or financial help (Yoshikawa, Weisner and Lowe 2006). This point will be discussed in detail in chapter seven but is presented here as the rationale for focusing a portion of the interviews on the social support networks of participants. Mothers were asked to identify on whom they could rely for help (intentionally left open-ended to allow for a variety of responses) and to describe the types of assistance received, both during their pregnancy and after the birth of their baby. Tables 6.1 and 6.2 quantify participants' responses to these questions.<sup>8</sup>

As shown in table 6.1 on the following page, participants' mothers were reported to have provided the most social support both prenatally (84%) and postpartum (84%) followed by partners, mothers-in-law and/or partners' mothers, siblings and friends in descending order with "Church family", neighbors and co-workers reported once each. The data indicate that for both cohorts, partners were relied upon significantly less frequently after the baby was born. African American mothers reported a 25% decrease in postpartum reliance on fathers compared with an 18% decrease for White mothers. This suggests a significant shift in paternal involvement after the baby's birth. Also conspicuous in table 6.1 are the small number of women (23% during the prenatal period and 16% postpartum) reporting friends as a source of support. This points not only to a potential pattern of a loss of friendships after the baby's birth but also implies an overall lack of a strong peer network within this participant sample. Finally, it should be noted

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<sup>8</sup> Quantitative data presented in tables 6.1-6.9 were tallied from participants' responses to the relevant interview questions. These data are included to provide a summary snapshot of the findings, examined further through the narrative analysis presented in each section.

that only one participant out of 31 reported that they rely on neighbors for support. Participant narratives discussing their social support networks are presented after table 6.2. The points raised from the data in table 6.1 will be further examined in chapter seven as they indicate important findings related to the social networks of low-income mothers in Pinellas County.

**Table 6.1:** Responses to Social Support Questions: Individuals who provided prenatal/postpartum support

<b>Social Support Network<sup>9</sup></b>				
	Prenatal: Frequency (n) <sup>10</sup>	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Mother</b>	<b>26</b>	<b>84%</b>	<b>26</b>	<b>84%</b>
African American (AA)	17	85%	17	85%
White	9	82%	9	82%
<b>Partner (husband, baby's father and/or boyfriend)</b>	<b>22</b>	<b>71%</b>	<b>15</b>	<b>48%</b>
AA	14	70%	9	45%
White	8	73%	6	55%
<b>Mother-in-law/ Boyfriend's mother</b>	<b>16</b>	<b>52%</b>	<b>13</b>	<b>42%</b>
AA	9	45%	6	30%
White	7	64%	7	64%
<b>Sibling</b>	<b>9</b>	<b>29%</b>	<b>10</b>	<b>32%</b>
AA	6	30%	6	30%
White	3	27%	4	36%
<b>Friend</b>	<b>7</b>	<b>23%</b>	<b>5</b>	<b>16%</b>
AA	5	25%	3	15%
White	2	18%	2	18%
<b>"Church Family"</b>	<b>1</b>	<b>3%</b>	<b>1</b>	<b>3%</b>
AA	1	5%	1	5%
White	0	N/A	0	N/A
<b>Neighbors</b>	<b>0</b>	<b>N/A</b>	<b>1</b>	<b>3%</b>
AA	0	N/A	1	5%
White	0	N/A	0	N/A
<b>Co-Workers</b>	<b>1</b>	<b>3%</b>	<b>0</b>	<b>N/A</b>
AA	0	N/A	0	N/A
White	1	5%	0	N/A

<sup>9</sup> The majority of respondents reported more than one person they relied upon both prenatally and postpartum which is why the columns do not equal the total number of participants (n=31). This is true for most of the quantitative data presented in this chapter since the information was obtained through the narrative and were not collected as discrete data.

Table 6.2 below describes the types of assistance received to include rides, meals, emotional support, financial help, baby supplies and “somewhere to stay” in descending order of frequency.

**Table 6.2:** Responses to Social Support Questions: Types of support received

<b>Types of Support Received</b>				
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Rides</b>	<b>26</b>	<b>84%</b>	<b>25</b>	<b>81%</b>
AA	18	90%	17	85%
White	8	73%	8	73%
<b>Meals</b>	<b>18</b>	<b>58%</b>	<b>20</b>	<b>65%</b>
AA	12	60%	13	65%
White	6	55%	7	64%
<b>Emotional Support<sup>11</sup></b>	<b>16</b>	<b>52%</b>	<b>13</b>	<b>42%</b>
AA	9	45%	7	35%
White	7	64%	6	55%
<b>Financial Help</b>	<b>15</b>	<b>48%</b>	<b>14</b>	<b>45%</b>
AA	10	50%	10	50%
White	5	45%	4	36%
<b>Baby Supplies</b>	<b>5</b>	<b>16%</b>	<b>8</b>	<b>26%</b>
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
AA	3	15%	6	30%
White	2	18%	2	18%
<b>“Somewhere to Stay”</b>	<b>1</b>	<b>3%</b>	<b>0</b>	<b>N/A</b>
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
AA	1	5%	0	N/A
White	0	N/A	0	N/A

Given that 84% (n=26) of the participant sample did not own or have access to a vehicle (see table 6.6), transportation represented an unmet basic need for the majority of participants. Thus, rides to the store, doctor or other location(s) were the most frequently reported form of social support received. For some, even coming up with bus fare proved difficult as one woman stated,

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<sup>11</sup> In this context, responses to the type of help received were categorized or defined as “Emotional Support” if they did not describe material or tangible support. For example, responses such as “she [friend] was just there for me, she was just someone to talk to” or “he [boyfriend] was there for me emotionally” are examples of responses categorized as “Emotional Support”.

*My mom would take me to the store, give me money to get on the bus or what not. My friends, they would come take me to the store if I needed it or take me wherever I needed to go.*

For those who did not own or have access to a car, most reported walking as their primary means of transportation with rides typically provided only when requested. This point is alluded to in the following participant statement,

*Um, my little sister, she, she would give me rides if it was something that I had to go to that was far but besides that I always walked. I love walking. But um, she would give me a ride if it was somewhere far.*

In addition to rides, participants reported relying on their family and friends for meals intermittently as captured in the following quote,

*Umm, food sometimes. You know like if they cook something, they'll be like, ya'll want some of this? Uh they leftovers.*

Although rides and meals represent the most frequently reported types of social support received, most participants identified multiple types of assistance provided by a number of people in their lives. Thus, the majority of quotes on the topic of social networks are multi-layered. For example, the following statement describes both financial and food assistance received,

*Like, um, financially or even they bought me, like um, a meal or something. It was usually, if it wasn't like a meal or something, it was like my phone bill or something.*

Another woman indicated that the majority of people in her life, particularly her church family, provided some type of support,

*P: Everybody. Everybody was excited.*

*I: In what ways did they support you?*

*P: Whether it was money, clothes, diapers..I mean, I had too much stuff for her even before she was born. SO, I really really did. I had a lot of help. Especially from my church family.*

Yet another participant describing the type of help she often received from her friends stated,

*Kind of everything, like if it was just emotional help, you know just sit there and talk to me or if I needed a couple bucks just to kinda survive they'd let me borrow money or like my one friend [name redacted] the one time, I was hanging out with her and she went and got me something to eat because I was starving and we didn't have money, so.<sup>12</sup>*

These quotes suggest the importance of material support during the prenatal and postpartum period. The last quotes involving social support refer to the importance of the emotional assistance participants received. On balance, partners were reported to have provided the majority of emotional support while family and friends provided the bulk of material assistance received. With fewer than half of the participant sample married, living with a partner, or in a relationship (see table 6.4) this finding may point to a deficit in emotional support provided to low-income mothers (discussed further in chapter 7). The following participant statement describes the encouragement and assistance she received from her boyfriend during her pregnancy,

*P: His dad. He was with me during the whole pregnancy this time and with him [referring to her older son].*

*I: Ok. And in what ways did his dad help you?*

*P: A lot. It's like really no explanatory. He... basically did everything. If my stomach was hurting, if I needed a back rub; help me with my boys you know what I am saying. He was there through the whole thing both times.*

Another participant referring to her boyfriend's help stated, *Um, but [boyfriend's name redacted]* *he was just there for me. He held it down through all my bs.* Similarly, a few women reported that their boyfriends' families, particularly their boyfriends' mothers were there for them when their own families were not. One mother stated,

*Um, they give me, she, his mom gave me somewhere to stay cause actually I got into a fight with my dad when I was a week pregnant, so she let me move in with them, um, so I lived with them so I guess that's something that boyfriend's mom did.*

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<sup>12</sup> This quote describes an incidence of prenatal hunger, an issue reported by a number of women in this sample which will be described in further detail later in this chapter.

This quote alludes to the fact that over half (n=18) of the participants had moved at least once since the beginning of their pregnancies and a significant percentage (32%) did not occupy the same house or apartment after the baby's birth they had lived in during their pregnancy. The reasons for these moves were varied to include financial issues such as eviction, issues with family or friends (as in the quote above) or the desire to be close to friends and family. One mother described the circumstances that led to her move shortly after her baby's birth,

*Actually, half of my pregnancy we were living in this park, just a different trailer, and then the rest of my pregnancy we actually got a house, and like for the first two or three months of her being born we were living at the house. But then our landlord, when he went to renew the lease, he didn't wanna...he wanted to sell, so he pretty much kicked us out. We had paid that month's rent and everything and he said, "You have three days to leave." And we were like, "We can't leave a two bed-room house in three days, I just had a baby." It's because of the house down the street that he had rented out, the people had left and trashed it. So he came down to do our lease and to clean up their mess, but the mess was so bad that he just, "I'm selling 'em I'm getting done and over with." So he made us leave.*

This mother, her boyfriend and baby were currently sharing her boyfriend's parent's trailer at the time of the interview. This illustrates again, the importance of a strong social support network as a safety net for families living in poverty; without the assistance of their parents, this family may have been forced into homelessness.

### ***Social Support Findings Summary***

In summary, without specific prompting during the interview (meaning, the question regarding who they relied upon for help and in what ways they received support was left open-ended), food was expressed as the most common type of support received which included rides to the grocery store and meals provided by family and friends. This supports the point to be addressed in the next chapter that strong social support networks are an important strategy employed by low-income mothers to mitigate food insecurity. Additionally, frequent moves, a

decrease in partner involvement after the baby is born and a lack of friends and/or neighbors on which they can rely signify important missing links in an adequate social support network for the mothers in this study.

### ***Stress and Coping***

Table 6.3 below summarizes the types of stress participants reported to have encountered both prenatally and postpartum. These include stress related to finances, relationships, transportation, discrimination and/or racism and “No Break” in descending order.

**Table 6.3:** Responses to Questions about Stress: Types of stress reported

<b>Types of Stress Reported</b>				
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Financial</b>	<b>22</b>	<b>71%</b>	<b>24</b>	<b>77%</b>
AA	13	65%	15	75%
White	9	82%	9	82%
<b>Transportation</b>	<b>21</b>	<b>68%</b>	<b>23</b>	<b>74%</b>
AA	16	80%	17	85%
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
White	5	45%	6	55%
<b>Relationship</b>	<b>11</b>	<b>35%</b>	<b>14</b>	<b>45%</b>
AA	8	40%	10	50%
White	3	27%	4	36%
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Discrimination/Racism<sup>13</sup></b>	<b>10</b>	<b>32%</b>	N/A	N/A
AA	7	35%		
White	3	27%		
<b>No Break from Mothering</b>	<b>0</b>	<b>N/A</b>	<b>2</b>	<b>7%</b>
AA	0	N/A	1	5%
White	0	N/A	1	9%

Referring to table 6.3, financial concerns were the primary source of stress for participants with White mothers reporting finances as a major source of stress at higher rates than their African

<sup>13</sup> Interview questions regarding experiences with racism and/or discrimination were posed generally and were not tied to the prenatal vs. postnatal structure of the rest of the interview (see Appendix B). The rationale for this was to allow participants to think broadly about their experiences with this issue, including encounters that may have occurred during their childhood or that were directed towards their own children. This was done to provide a broad understanding of how racism/discrimination had impacted participants’ lives to this point.

American counterparts both prenatally and postpartum . Specific financial concerns included worry about not having enough money to pay the rent or utilities, not having enough money for food or basic necessities such as diapers for their children, not having the means to pursue further education or to search for and obtain employment, and not having enough money for leisure activities or treats for their children. One woman spoke about the stress of losing her income because of her inability to work once she had her baby,

*Umm...not being able to go back to work. Well not being able to work. When I stopped working that's when all my stress came, because I am used to a paycheck with my name on it. And, it's my money and I can do what I want to do and what I have to do with it. When I stopped working and I started going through unemployment and I was finding out how much they were going to give me a month, I mean I would just sit here and cry. I was really really depressed. I'm used to \$900, no less than \$900 every two weeks. To go to \$300 a month hurt me, because it's like, what am I supposed to do with my kids? Like me and my daughter we have girls days out, you know, like we just may happen to go to IHOP or Chucky Cheese and stuff and I can't do that now because all I get is \$300 a month for two kids....And that's, yea, and that drove me crazy. And her father he's a big help. He helps me out all the time. But, he..he knew that I wasn't going to be...I told him that, it stressed me, I was depressed, because I'm like, "Look at my check". This is what I went from and now this is what the state is giving me. How am I going to survive on \$300 a month? If it wasn't for my boyfriend I really don't know how I would have made it. And then my mom, she's a big help, I mean my family, we a close knit family.*

This quote illustrates the negative emotional impact financial stress can create in households where there is no room for flexibility or money for leisure. Another participant describes having to save up for her child's basic necessities and to forego her own needs to provide for him,

*P: Well, with [baby's name redacted], with getting him things that he might need and everything, I cut back on stuff that I do for myself just to focus on him, and everything. That's just probably it... I mean it makes me stress a little bit that I feel like I can't provide for my own son. So it gets me kind of upset, but you know, I know ways to just like, save-up money and I know that I can do what I have to do for him.*

Similarly, another mother stated,

*P: Yeah its hard now because there is four of them now, two in diapers, so it's expensive just on his, you know with him working its expensive and the cash, it is a problem.*

*I: So how do you guys handle that type of stress?*

*P: We have to budget, budget tight. The kids come first regardless; rent has to be paid first but then after that the kids. It's always what they need. It's never, it's always what they need first*

*I: So do you ever find that you have to prioritize what utility gets paid now and what utility gets paid later?*

*P: Yeah*

*I: Is that on a monthly basis?*

*P: Yeah*

*I: But budgeting helps you to manage the stress of that?*

*P: Yeah*

The quote above not only describes the daily stress encountered in providing for children's basic necessities but also hints at the common coping strategy employed by low-income households of prioritizing or juggling bills on a monthly basis (Heflin, London and Scott 2011). This was a commonly reported occurrence as described in the next quote and illustrates the precipice on which most of these participant households balance, between just getting by and falling behind.

Commenting on how different monthly expenses are prioritized, one participant stated,

*Umm...normally like the electric company and stuff will work with you and let you make payments and stuff. So normally if anything needs to get pushed off, it'd be that because they work with you. Or sometimes like our landlord will work with us, you know a little bit here and there. So pretty much anything that won't work with us and it has to get paid or it's going to be shut off, that's what gets paid first. Or if it comes down to a bill or something for the baby, then the baby obviously. But a lot of times it doesn't come down to that, because like I said, we do have a lot of help when it comes to the baby stuff. So, but pretty much like if the electric company doesn't want to work with us this month and the rent will, then we pay the electric and you know, make payments for the rent, kinda like that. We just try to get it ...yea whoever wants to work with us that month.*

Another woman described the difficult task of making ends meet when relying on a minimum wage job to support her family and the necessity of having financial help from family to survive,

*Like we're always..our...we are always pretty much late on our bills no matter what just because we really don't have the money and before he was working at McDonald's only making \$200.00 every two weeks So it's like a lot of times our*

*bills were behind, but luckily right now his grandparents are helping us out and stuff.*

To cope with financial stress, women reported “tight budgeting”, praying, asking friends or family for help or “just trying not to think about it”. Despite these reported coping strategies, many participants described financial issues as a constant source of stress and worry. The following quote illustrates the pervasive nature of financial stress on these households,

*If I just had my bills paid I honestly wouldn't have any stress. I mean, yeah, its stress...I just don't like sitting in my house all day, that stresses me out too. But mostly finances. If I just didn't have any...if I could just pay all the bills, like 95% of my stress would go away. I don't stress about much else besides bills.*

Similarly, another woman said, *Um, that's like the first thing I think about when I wake up in the morning is what has be paid next.* Thus, finances represent a chronic source of stress for a large majority (approximately 75%) of this study’s sample. A discussion of the macro level structural factors contributing to these families’ inability to get ahead and make ends meet will be provided in chapter seven.

**Table 6.4:** Participants’ Prenatal vs. Postpartum Marital/Relationship Status

<b>Marital/Relationship Status</b>				
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Married</b>	<b>5</b>	<b>16%</b>	<b>5</b>	<b>16%</b>
AA	2	10%	2	10%
White	3	27%	3	27%
<b>Living with Partner</b>	<b>10</b>	<b>32%</b>	<b>6</b>	<b>19%</b>
AA	6	30%	3	15%
White	4	36%	3	27%
<b>Single<sup>14</sup></b>	<b>16</b>	<b>52%</b>	<b>20</b>	<b>65%</b>
AA	12	60%	15	75%
White	4	36%	5	45%

<sup>14</sup> Participants who stated they were in a relationship but not living with the boyfriend or married were categorized as single in table 6.4. The rationale being that it was unclear, based on the interview transcripts1) whether the relationship they referred to was with the baby’s father and/or 2) if the boyfriend provided any support for the baby.

Of 31 participants, less than half (n=11) were either married or living with their baby's father at the time of the interview. Table 6.4 on the previous page outlines the prenatal and postpartum marital/family status of each participant. For the single mothers in this sample, the majority of their baby's fathers were not involved which was reported on numerous occasions as a major source of stress.

The first quote is from a woman who went into labor and arrived at the hospital alone, with her partner showing up for a few minutes and leaving before the baby's birth,

*You know, her dad came by [referring to the hospital during labor] and he was gonna come back and stay but I don't know what happened with his situation but um, after that I just remember them being like, they were screaming they couldn't stop the blood, I wouldn't stop bleeding, my uterus wouldn't clamp back down ... Yeah, I was just up under a lot [of stress], I mean, thinkin' like her dad shoulda been at the hospital with me when I was givin' birth and stuff like that to where, like you know, me and my mom don't have a good relationship so it was like, it was uncomfortable, it was very uncomfortable. So, and then to hear, you know um, you might not make it, was very stressful. So it's like, I was constantly worried [during labor] about whose goin' to take care of my baby if I die?*

While this may represent an extreme example of both relationship stress and birth complications, it highlights the fact that during their pregnancies, many of the women reported having had the expectation that the father would contribute after the baby's birth. The data in table 6.4 show that for more than half of this study's sample, fathers were absent postpartum. For those mothers whose expectation of their partner's involvement after the baby's birth was not met, this added a particularly stressful nuance to the already challenging time of transitioning to new motherhood.

Another woman reported, *His dad is not with me that stresses me out. I do it all myself. He just don't mess with me anymore. Or, he don't help me like [financially].* This quote is also illustrative of the fact that it was difficult to know, based on the interview transcripts, whether the stress of an absent father was due more to the lack of emotional support or a lack of financial help. The next two quotes discuss partner substance abuse as a source of stress and ultimately the

primary reason for his absence. First, a 20-year-old mother of twin girls provided the following statement,

*Their father and his drinking [was stressful]. He would get mad at me because I didn't want to hang out with him and our friends because I can't obviously do it so why is it fun for me? And I'd be sick and he'd be too busy drinking with them to help me so...he was here for the first month until he got his car back...then he left.*

Next, a 30-year-old social worker stated,

*Her father unfortunately is a drug addict...and he was in jail...he got arrested for a DUI hit and run when I was in the final trimester so my free time I spent a lot of time going to, unfortunately, to visit him because regardless that's a time you want to share with the father...so I was pissed. Of course I was pissed, but I needed to feel like he was there even behind bars, that somebody – her father – was there so I visited him.*

Perhaps reflecting the fact that for 84% (n=26) of the sample, their last pregnancy was unplanned and for one-third of the women (see table 6.5 below), this was not their first child, some mothers reported their baby's father feeling conflicted over the pregnancy.

**Table 6.5:** Total number of participants with unplanned pregnancies/multiple children

Percentage of Unplanned Pregnancies and Multiple Children				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
<b>Total # Participants for Whom last pregnancy was Unplanned</b>	<b>17</b>	<b>85%</b>	<b>9</b>	<b>82%</b>
<b>Total # Participants with &gt; 1 Child</b>	<b>10</b>	<b>32%</b>	<b>4</b>	<b>36%</b>
2 children	5	25%	3	27%
3 children	4	20%	1	9%
4 or more children	1	5%	0	N/A

One participant indicated that the father made it clear he did not want the pregnancy to progress,

*The [stressful] situation is with my baby's father. He wasn't, didn't want the baby at first, and it really stressed me out and everything, but I had to just get over it and let it go.*

This participant's statement that she had to "just get over it and let it go", represents one of the coping strategies women used to deal with the stress of an absent father. Interestingly, this strategy was employed, at times, to the financial detriment of the mother by choosing not to pursue (formal or informal) child support. Though there may be a number of complex and overlapping reasons for a woman not to pursue child support, the most commonly reported reason not to pursue it in this sample was that it was easier emotionally to separate themselves completely from the father than to keep him around for money<sup>15</sup>. Finally, one woman reported that as a result of the father's absence, she found motivation to improve her own life circumstances by returning to school to better support her child in the future,

*Well, me and my baby's father separated, so it made it kind of difficult. And it made me for the better about pregnancy, 'cause I know that had I had somebody I had to take care of then, somebody who depended on me, and I don't want nobody else raising my son but me. So I enrolled back at SPC and I took one class while I was pregnant and then came here.*

This type of self-motivation is another important coping mechanism used by the women in this sample and one that was repeated often. For example, one participant discussed how having her baby changed her priorities and gave her responsibility,

*My baby has changed my life, to the utmost of um, I enjoy and I love being her mother and I love you know, just getting up and preparing her for the day and doing her hair and feeding her and um when before the baby I just lived life as a young person, um, that's young and just didn't have no responsibilities and no um, priorities. She gave me priority and responsibility.*

Another woman who is raising her baby alone stated,

*OK, well, I'm back in school now. And, you know, umm, I was doing at SPC, going to just get my regular AA and then, you know, I was thinking that I need to make some money now. I'm supporting him by myself. So I went here and trying to do medical billing which starts in April so I can start doing something good for him.*

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<sup>15</sup> This statement is a peripheral observation based on field notes and conversations with participants that occurred prior to the start of the interview. It was not a direct line of questioning pursued in the interview itself, thus, there are no quotes associated with this finding.

Shifting priorities as an outcome of the transition to motherhood was a common thread repeated by several participants, represented by the following quote,

*We've been together since we were like 15 or 16 so when we were young we kind of got into something we shouldn't have. You know, that party crowd and stuff. But when I got pregnant with her, it was just like, you know, I kinda looked at it as a sign to get my life together. Since I've had her and stuff, like she's been motivation to keep me...like I'm only 21 but I feel like I'm 30. I don't want to go out and party, you know? I'd just rather be at home on a Saturday night, reading a book with her rather than partying with my friends. So she just kinda, opened my eyes a lot to, you know...there's a lot more stuff out there. It's not all about, you know, oh I'm young I wanna party so, I dunno, she just keeps me on track. Like you know, I want a good life for my daughter. I don't want her to go through what I went through when I was younger so it just makes me even wanna just wanna keep her away from all the bad.*

These statements collectively illustrate the theme of self-motivation in the form of taking control, reorganizing priorities and shifting focus towards caring for the baby in place of the self. To be examined in detail in chapter seven, this coping strategy may point to the need for women to portray and/or exert a measure of control over their lives amidst the chaos of the chronic stress of poverty.

As stated earlier, of 20 African American participants, two either owned or had access to a car compared with three of 11 White participants (see table 6.6) though the majority of those who reported access to a vehicle shared it with their partners or a family member.

**Table 6.6:** Access to a Vehicle

Access to a Vehicle				
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Own/Have Access to a Vehicle</b>	<b>5</b>	<b>16%</b>	<b>5</b>	<b>16%</b>
AA	2	10%	2	10%
White	3	27%	3	27%

As a result, transportation (or a lack thereof) was reported as a source of prenatal stress for 68% of women and for 74% of the sample postpartum (refer to table 6.3). Commenting on how she had to wait to be offered a ride to get to the store while pregnant, one woman stated,

*When I was pregnant it wasn't ok to, "Oh can I get your car to go?" I'd have to wait on them to go on their own time you know what I'm sayin'?*

When discussing generally the things that cause her stress, another participant specifically referred to a lack of transportation as a major source of worry,

*I worry about like, just different stuff, well how am I gonna get here, how am I gonna get there or I need to go take care of, you know, this and when I am I gonna be able to do this? Am I gonna call them? Are they gonna pick up? Are they gonna call me back or just stuff like that so...*

Yet another woman described the stress of meeting the expectations placed on her by the state to keep her daughter in subsidized childcare without the transportation resources she needed to comply with the program's rules,

*Like right now what's stressing me out is like a car issue. Like, trying to get...trying to worry about how she's going to get picked up from day care because we only have one car and my boyfriend works from 9 in the morning to like 10 at night. And he has the car, I don't drive. So we can take her to day care in the morning, but it's like how are we going to pick her up? Like today she couldn't go to day care because I'm not going to send her to day care not knowing how she's going to get picked up. I'm not going to take that chance. So she didn't go to daycare today. But with the program that we're in, she's only allowed to miss like 1 day a month. So, she has to go to day-care or we lose our funding.*

The data in table 6.3 (page 129) captured a small overall increase (6%) of women reporting transportation as a major source of stress postpartum compared with their prenatal period. Given that women also reported fewer people on whom they could rely for help postnatally, this again could signify a lack of social support, to be discussed in the next chapter.

With a median age of 24 and an average age of 24.2 at their most recent birth<sup>16</sup>, the majority of participants were ‘young mothers’ compared with the U.S. average age of 25.8 yrs. for women at their first birth (CDC 2014). Consequently, many felt that they were targets of unsolicited mothering advice and believed other women assumed they were inadequate or unfit mothers because of their age, socioeconomic status and/or marital status. For example, one 20-year-old mother stated,

*I just feel like they are..I feel like certain things that I may do because I am young and a new parent, like older people don’t approve of it so they’re like looking at me like...like if I let her play, like I’ll let her play with my cell phone or something and people are like, why are they giving the baby the cell phone . Just and like, places we go, the way people talk to me, they talk down to me. That’s why a lot of times I like to have my mother-in-law there because they don’t talk to her like that because she is older and she’s been there. They just look at me like I am a new mom.*

Another woman discussed her anxiety about being judged because she was not married,

*I mean think that I think about maybe being that way because I don’t have a wedding ring on, you know, I think “oh my gosh, what do people think?” but it’s not very often that I preoccupy myself with that it’s just kind of maybe a passing thought...It’s mostly the older people you know if they’re coming up to see the baby. “Oh how is your husband” you know, and I don’t ever correct them but I think, “oh my gosh if they knew they would think I was some awful person or something”.*

In addition to feeling judged by their age and/or marital status, many of the mothers reported feeling as if they were under a microscope when grocery shopping because they used WIC coupons and/or food stamps to purchase their food. Several indicated that other customers often felt entitled to comment on their food choices because of their participation in WIC and/or SNAP,

*Well, when I do go food shopping...There are different types of races and I am not racist at all but some of the black people look at me, like, why . I had a couple of*

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<sup>16</sup> As recorded in table 6.5, one-third of participants had more than one child. However, dates of birth for other children in the household were not collected for this study. Thus, the average age at first birth for this participant sample can be assumed to be < 24, but a discrete average age cannot be calculated from the interview data collected.

*people say something to me the other day while I was shopping, like “oh, I couldn’t afford to go shopping like that,” I was like whatever. It’s just people look at you funny when you use Food Stamps or WIC. I was kind enough to tell people the other day, like look, this is going to take a few minutes and they were like, oh no it’s okay. I was like “it is going to take a few minutes. “ They see all the formula and the food. It’s just weird how people look at you.*

The first sentence in the above statement alludes to the perceived experience of racism reported by some of the White participants. One woman reported this as a common occurrence at one of the local Food Stamp offices,

*P: Well, I was down there [at the food stamp office] with a class mate at the time but they just didn’t seem very nice.*

*I: And what do you mean when you say they aren’t that nice?*

*P: They just are rude and basically because I was white they didn’t think I should’ve been there.*

*I: So what made you feel like it was because you were white that they...?*

*P: Because they were treatin’ every, you know, everybody else there with more respect.*

Typically regarded as a non-White issue, this points to the fact that racism is still a pervasive issue in the U.S., further evidenced by the fact that several African American women acknowledged having experienced racist encounters directed at themselves or their children. The following comment represents a generalized expectation of racism rather than a specific encounter,

*You know, when people, like, put you in that category. Like, “Oh, you’re just another teen black mom.” And you know that it’s hard for you to get back in school, that you might not do nothing with yourself. That’s not everything, like you know, that’s so stereotyped.*

Some women reported having encountered racism as a child as evidenced in the following statement,

*One of my teachers told me that my race and the person that I am, that you can’t get into medical school, that you won’t amount to nothing in the medical field or nothing like that. And I was just, like, looking at her and was just like, OK. You know, just, like... Just some people you’ve got to prove wrong, and everything.*

Most commonly reported, however, were incidents of racism encountered in public spaces such as stores,

*I try not to think about it but I've dealt with a lot of encounters like, working at Wal-Mart is where I get it, um and I, I'll get customers that come in my line and treat me very nasty but I try to look over them no matter the race they are and you get some of my color too that treat you the same way. I tell some customers, "hey, my line's open" and they'll rather stand in a white person's line rather than my line and I really didn't realize that racism, I mean racism still exists until I start, you know, working at Wal-Mart and dealing with different people, different colors that it's still there and it's not going away.*

Another women commented on her experience as a customer at a grocery store,

*Yea, I was in the umm...I was in the [grocery] store, and this lady...I guess I was in her way, but she just did not want her skin to touch me...So I made it my business to rub up against her arm and I was like, "Oh, Oh. I'm so sorry". And she just, I mean her whole face went like pale and she had an attitude. She was yelling at whoever the man was with her. And she was like, "Let's go. I wanna go now." And I'm like...that's not even like...is it that serious? My boyfriend was like, "Wow. She just did not want you to touch her."*

Finally, one of the mothers described an incident where the racist encounter was directed towards her six-year-old daughter,

*I had this situation where my daughter was playing with this lady's daughter [in a store] and my daughter was standing by me at the basket. And this little girl came up to my daughter and she's like, "Hi. I like your hair." And my daughter was like, "Oh thank-you. I love beads." You know? And she was like, "Oh, can I see?" and my daughter was like, "Yea." And I mean her mom like snatched her but she was pattin' my daughter hair so she like, when she snatched her, she yanked my daughter and that was the end of that. They thought I was gonna tear their whole store up.*

One additional gradation to these statements regarding racism is the number of African American mothers (n=4) who expressed concern over their daughters' skin color due to Black on Black racism. Some, as indicated in the following quote, reported having been the target of bullying as children, due to what they perceived to be jealousy over their light skin.

*I was more so picked on because I was light skinned not because I was black but because I was light skinned. Yeah that played a big part and I had really long hair. I was picked on for being, I don't want to sound conceited and say I was cuter than everybody, LOL. No but I think it was probably just because I was light skinned. I was the only light skinned girl amongst my peers in my class.*

Mothers who categorized their daughters as ‘light-skinned’ indicated that they worried about them being bullied in school by their peers but did not worry about them encountering racism from the general public. One mother who had a school-aged daughter she referred to as light-skinned stated that bullying was a major issue for her daughter who had a difficult time making friends because she was “*too light for the Black girls and too dark for the White girls*”. Interestingly, no mothers stated that this was a concern for their sons though they did report anxiety about their sons’ chances of encountering racism in the general public.

The coping mechanisms employed to deal with racism included denial of its existence, ignoring it, rising above it, “blowing up” or “being the bigger person”. Although racism and discrimination were cited least frequently as a source of stress, these participant statements illustrate the fact that, particularly for African American women, the lived experience of racism happens across the life course (Lu et al. 2010). Racist encounters can and do occur in the course of everyday life and the chronic stress associated with this may have significant health implications (Lu et al. 2010; Geronimus 1992) to be explored in the next chapter. These points are further supported by participants’ responses to the question, “What types of situations make you think about race?” Responses signified a general perception of persistent social injustice based on race. For example, one mother of an infant son stated that she thinks about race because of *what's going on in the news* – referring to the Trayvon Martin case<sup>17</sup> in Florida that

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<sup>17</sup> The Trayvon Martin shooting in Sanford, Florida on February 26, 2012 occurred a few months into the data collection period for this study. The shooting of Trayvon Martin, an unarmed 17-year-old African American high school student by George Zimmerman, a 28-year-old Hispanic man and volunteer neighborhood watch coordinator,

was prominent in the headlines at the time. Another woman referred to what she perceives as a double standard, making it easier for white people to get ahead,

*Umm...I have a couple of friends, white friends, and I just feel like it's a lot easier for them than it is for me to accomplish a lot of things. A lot of people say, "Oh, there is no more racism" but yes there is...*

Finally, one mother responded by indicating that she feels black people continue to self-segregate,

*I: What sort of situations make you think of being black?*

*P: On the bus, how we still sit in the back and we can sit in the front now {I and P giggle}. I dunno, it's like they all go to the back of the bus still. It's like come-on, we can sit in the front now, why do you have to go to the back?*

### ***Stress and Coping Findings Summary***

The examples of stress encountered by this study's participants are indicative of their socioeconomic status including severe financial worries, a significant percentage of absent fathers, stress related to transportation issues, the experience of discrimination based on age, socioeconomic and/or marital status and being confined to the home. Additionally, racist encounters and the perceived persistence of institutionalized racism were reported. While all of these factors indicate work to be done at the macro level to mitigate continued socioeconomic disparities, each of these stressors may also be partially alleviated by strong social support networks, again, to be explored in the next chapter.

### ***Food Shopping Patterns***

Table 6.7 quantifies responses to the interview question, “where do you shop most often for food?” The data clearly indicate that supermarkets were the preferred food resource for all

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spurred national protests, including in St. Petersburg, FL, and served as a reminder that racial tension and injustice persist in the U.S.

women in this study with specialty meat markets and produce markets used to supplement the items bought at large chain stores.

**Table 6.7:** Responses to Food Resource Interview Questions – Where participants grocery shop most often

<b><sup>18<sup>19</sup></sup></b> Food Stores Frequent				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
Wal-Mart	16	80%	5	45%
Winn-Dixie	6	30%	2	18%
Publix	4	20%	4	36%
Save-A-Lot	3	15%	2	18%
Specialty “Meat Market”	2	10%	1	9%
Aldi	1	5%	0	N/A
Gordon Food Service (GFS)	1	5%	0	N/A
Specialty “Produce Market”	1	5%	0	N/A

Referring to table 6.7, we find that Wal-Mart is the preferred shopping destination overall (n=21 or 68% of the total sample). Participants reported price and convenience (being able to buy more than just groceries) as the reasons why they shopped there. For example, one participant stated,

*P: Because they have the best sales. Like, umm..I stay closer to Publix, but they too expensive. Like, even with my food stamps, I can go to Publix spend \$200 and not really have anything. I can go to Wal-Mart and spend \$200 and my freezer and refrigerator is full like now.*

Referring to the convenience of doing both grocery and non-grocery shopping at one store, one participant stated,

*P: They..they have a grocery store in there. So I shopped...I like to shop at Wal-Mart because they got just about everything in there....Yea. Not only groceries. They have other stuff you can go get as well while you grocery shopping. So it's convenient.*

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<sup>18</sup> While this question was posed in the prenatal vs. postnatal structure of the interview, no differences in shopping patterns between these two time points were discovered. Thus, the data are presented in Table 6.7 as one time point capturing only the differences between the African American cohort and the White cohort.

<sup>19</sup> Several participants named more than one store as their primary food resource, thus, the columns do not add up to the total sample size.

A small number of women reported shopping in multiple stores in order to find the best deals on a variety of items,

*Publix or Aldi's or GFS. Kinda like...mainly Publix. But like meats and stuff, Save-A-Lot. So kinda everywhere we would go, depending on what sales were going on.*

However, this type of shopping pattern was not reported often in the sample as I would argue that it requires both access to a reliable source of transportation and time, neither of which were in large supply for this group of women. This is yet another point to be further examined in chapter seven.

### ***Food Shopping Findings Summary***

The data on food stores frequented by this study's participants indicate that chain supermarkets are the preferred source of groceries with Wal-Mart the clear overall leader. While 80% of the African American cohort reported Wal-Mart as their first choice, only 45% of White participants chose it as their first option. Conspicuously absent from the data in table 6.7 are corner stores, associated in the literature as a common source of food items for people in low-income neighborhoods (Webber, Sobal and Dollahite 2010). It was not until participants were asked about the food available within walking distance to their homes that corner stores were mentioned as a food resource. As the data in the foodscape analysis section of this chapter will show, these stores were frequented as a last resort.

### ***Daily Food Habits***

Table 6.8 tallies responses to interview questions regarding daily food habits to include how/if they plan meals ahead of time, how/if they budget for food and how and where they eat their meals, for example, do they eat together as a family or in shifts, in front of the television or

at the table? This section of the interview also asked about the frequency of eating out summarized in table 6.9 (see page 147).

**Table 6.8:** Responses to Food Habits Interview Questions

<b>Food Habits</b>				
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal Frequency (n)	Postnatal: % of sample
<b>Food Habits</b>				
<b>Budgeting<sup>20</sup></b>	<b>8</b>	<b>26%</b>	<b>6</b>	<b>19%</b>
AA	5	25%	2	10%
White	3	27%	4	36%
<b>Sharing Meals</b>	<b>6</b>	<b>19%</b>	<b>8</b>	<b>26%</b>
AA	3	15%	5	25%
White	3	27%	3	27%
<b>Meal Planning<sup>21</sup></b>	<b>2</b>	<b>10%</b>	<b>4</b>	<b>13%</b>
AA	1	5%	1	5%
White	1	9%	3	27%

As indicated in table 6.8 above, only a few participants stated they plan meals ahead of time or budget on a daily, weekly or biweekly basis. Of the four women who stated they try to plan meals ahead of time, one said, *I try to have them all planned out every couple of weeks.* This participant had a culinary degree, lived with her parents and cooked for her family as one of the expectations of living at home. Another participant referred to making a grocery list ahead of time to help her stay within budget,

*Oh like when I go to the grocery store yea. When I go in there I know what I am going to get. What I need to get for the ingredients. Yea, I do that ‘cause I don’t want to go and start pickin’ up stuff.*

The majority of comments regarding meal planning, however, indicated that for most households, meal planning is done on a day-to-day basis. When asked how she plans her meals, one participant responded,

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<sup>20</sup> For purposes of analysis, ‘making it stretch’ (e.g., using a few low cost, energy-dense food items for a period of time) is included as a budgeting strategy in table 6.8 though no participants who discussed this coping mechanism explicitly defined it as a ‘budgeting’ tool.

<sup>21</sup> Defined as planning meals ahead of time compared to day-to-day meal preparation.

*Umm..it just depends. If it's like a day that I am tired, whatever quicker. Umm, if not...just whatever. Like they [her children] ain't had in a while I might make it this day or something like that.*

Another woman indicated that she sometimes thought about meals the night before,

*I think probably like the night before what I want to eat and if I gotta thaw it out of the freezer I let it sit-out and cook it with room.*

During the prenatal period, food cravings, morning sickness and fatigue impacted women's ability and motivation to plan ahead for meals. Postpartum, their children's preferences (allowing them to choose what they want at meal time) and a lack of time both played a role in whether or not meal planning occurred.

In addition to advance meal planning, budgeting on a daily or weekly basis for food expenditures is reported in the literature as another way to mitigate food insecurity (Cohen and Garrett 2009). The majority of participant statements on the topic of budgeting referred to the tactic of 'making it stretch', a common strategy employed by low-income households at the end of the month prior to food stamp distribution (Wilde and Ranney 2000). As one woman stated, *the hard days would be when you gotta stretch the food out.* For most families, this strategy means relying on a few low cost, energy-dense foods for a period of time each month. The following quote is an example of this,

*I: What kinds of things do you buy during those times where you are trying to make it really stretch? Would you say?*

*P: Umm...like they have these hamburger...they have this hamburger roll, I forget how many pounds it is, but like we'll use that and make a couple meals out of just one. Umm..or we'll just get like noodles, butter noodles, to make butter noodles, and like just some other little side. I mean, I don't know...kinda we just..we pretty much just live day to day {giggles}.*

One participant reported a healthy spin on making it stretch, however, when she provided the following comment,

*I: So how...what kinds of things did you come up with to help stretch it?*

*P: Umm, I tried to get..for me you know, for most people when they try to go to eat healthy, they only think about lettuce, tomato, salad, and you know, that's it. You know? So I try to get stuff that's filling, you know, like broccoli and umm, cauliflower or potatoes and yams. You know, stuff that fills you up. That way I can stretch it more.*

When asked where they eat most often (meaning at the table, on the sofa, in bed, etc.) and whether they share meals as a family, the majority of women (n=17 or 55% of the sample) (see table 6.8) did not report eating together as a family. For some, this was simply the result of logistics due to a lack of space for a table in their home or apartment. For others, having small children was simply not conducive to sitting down and eating together. For still others, a lack of energy and “being tired” translated to eating in front of the television either together as a family or in separate rooms. This was reported most frequently as having occurred during the prenatal period.

**Table 6.9:** Frequency of Eating Out

<b>Eating Out/Fast Food/Takeout Frequency per Week</b>				
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal: Frequency (n)	Postnatal: % of sample
<b>Did not report eating out weekly</b>	<b>14</b>	<b>45%</b>	<b>19</b>	<b>61%</b>
AA	10	50%	13	65%
White	4	36%	6	55%
	Prenatal: Frequency (n)	Prenatal: % of sample	Postnatal: Frequency (n)	Postnatal: % of sample
<b>1-2 times per week</b>	<b>11</b>	<b>35%</b>	<b>9</b>	<b>29%</b>
AA	6	30%	5	25%
White	5	45%	4	36%
<b>&gt;3 times per week</b>	<b>6</b>	<b>19%</b>	<b>3</b>	<b>10%</b>
AA	4	20%	2	10%
White	2	18%	1	9%

Lastly, as summarized in table 6.9, about 55% of women reported eating out or getting fast food or takeout at least once per week during their pregnancy. A 15% decrease in frequency of eating out was reported postpartum. Reasons for this shift in food consumption patterns postpartum are likely varied to include an initial bias in under-reporting of eating out and fast

food consumption but may also point back to a lack of transportation, added financial constraints postpartum due to basic necessities required for the baby like diapers and formula, a lack of time and logistical challenges to toting an infant to a restaurant versus staying at home.

### ***Daily Food Habits Summary***

The data reported in this section indicate that very few families employ budgeting or meal planning techniques to mitigate food insecurity. The need to ‘make it stretch’ is indicative of chronic food insecurity in this sample, meaning that these households rely on a few low-cost, energy-dense foods on a cyclical basis to get by until their next food stamp distribution. Though a significant percentage of women (55%) reported eating out (including fast food and takeout) at least one time per week during their pregnancy, this pattern shifted after their baby’s birth with a reported 15% decrease in frequency of eating out postpartum. Finally, sharing meals as a family was reported by only one-fourth of the sample with a slight uptick in eating together reported postpartum. A discussion of these findings as they relate to the topical literature will be presented in chapter seven.

### ***Pregnancy: Daily Life Changes***

Participants were asked how their daily lives were affected by both their pregnancy and their transition to motherhood (which applies to both first-time mothers and mothers of multiple children) after the baby was born. The majority of responses to these questions focused on the changes that occurred in their social lives. These reported changes included a loss of or a change in friendships and more frequent time spent at home. The following quote is representative of the frustration many women expressed that their friends were no longer there for them in the same way they had been prior to their pregnancies,

*Um, yeah when I was pregnant um, I would say friends when I was pregnant, they really stressed me out. Um, when I had my baby shower I invited thirty people and one person showed up.*

Related to this loss of friendships, most participants reported a shift in personal behaviors, for example, no longer partaking in social drinking or “partying” due to the news of their pregnancy. This predictably resulted in more time spent at home and less time socializing with friends as evidenced by the following quote,

*Um, I stay home a lot more... I stopped drinking (laughs). I don't do drugs, so...basically him, he changed me. I don't do most of the stuff I used to do.*

Changes in self-identity, for example, transitioning from being a working, single woman to a new mom, and its impact on women's daily routines were also reported as illustrated in the following statement,

*Yeah, it changed my life a lot. I had three jobs and no kids so I was always on the go I always can do something no matter what it was and then when I got pregnant, um it stunned me for a minute but then once I grasped the fact that “I'm pregnant” and about to have a baby and it's real and this is reality, um, I took it well.*

This shift in self-identity was generally characterized as a positive change in women's lives as indicated by another woman,

*Because when I wasn't pregnant I used to have just like a carefree life. Just do what I want and stuff. Then I got pregnant I started taking my responsibility.*

This quote is representative of the reported positive influence the baby had on these mothers' lives as summarized in the quotes regarding self-motivation provided earlier in this chapter. Although as discussed previously the majority of pregnancies in this sample were unplanned, women unequivocally regarded their transition to motherhood as a transformative event in their lives that brought with it renewed motivation and a positive shift in priorities.

Aside from impacting on their social lives, women also described how the embodiment of pregnancy affected their personal habits, to include sleeping a lot as evidenced in the following quote,

*Mmmm, I was allowed to sleep. I didn't work. Um, they mostly just let me sleep. Um, I stayed with my mom and my sister most of the time when I was pregnant. Um, but yeah, they just let me sleep, I didn't have to do anything.*

Morning sickness and fatigue were the most commonly reported pregnancy issues affecting daily routines as one woman recalled,

*I was like...I always felt like I was sick. And then ummm...I slept a lot; then I get up. I get up at night, but in the day time I feel like, I don't wanna get up.*

Similarly, another mother said,

*I just liked to sit at home and just do nothing special, with the throwing-up and everything.*

In some instances, the embodiment of pregnancy interfered with the ability to continue working as referenced by one participant,

*And I couldn't work 'cause I was real big and pregnant. I was high risk, but nothing risky, wrong with me during the pregnancy.*

In addition to the changes that occurred during pregnancy, women overwhelmingly reported being confined to their homes after the baby was born. Given that a large percentage of this sample was single mothers and the responsibility of caring for a newborn can be an all-consuming task, this was an expected finding. Yet, participant responses to this question provide some additional nuances to consider. For example, in the following quote, a mother discusses the fact that she does not associate with her neighbors of whom the majority are other single mothers,

*The only person I talk to is the girl that stay next door to me but that's it. But never a go over to their house and sit in their house. My kids play with the little*

*boys behind the street and I keep an eye on them out there. But that's it, I don't have any associates.*

Similarly, in reference to her neighbors in the apartment complex in which she lives, one woman stated, *Nobody really come out the door. Like with the neighbors.* Discussing how the majority of her time is spent at home with her baby, another mother stated,

*I can't just get up and go. You gotta have a babysitter. We just be chillin' at the house. Watching TV.*

Yet another woman talked openly about the challenges of adjusting to new motherhood,

*Oh my gosh! I did not realize how hard it was. All my friends made it look so easy. And, you know, you don't have any sleep and you are responsible for this little thing. It's crazy; you have to think, little things like running to the gas station to get a pop and you can't do that now and it's crazy. It's a big adjustment. It takes half an hour to get ready, you just get a diaper bag ready, you know, to go somewhere. I know everyone says when they get a little older it's not as bad but...*

Similarly, a mother of four children with two under the age of three stated,

*Whoo. I'm busy, busy. It's like 10x worse now because [baby's name redacted] is cryin out for attention and she need things, I have diapers up the wall, cleaning up behind him and holding her. And he's spoiled and it's just way, way, way busier than I was before like 10x. And I got overwhelmed. I remember coming home and having to take her to the doctor and [baby's name redacted] had a doctor's appointment the same day so I had all four kids and I'm trying to get them up, I had to take him to work and I just, I just broke down and just cried and I called him "like I can't do it, I am such a sucky mom." I think that was by breaking point because it just felt like everything just fell on me and I was like I have to come home, clean up, and cook...Its harder now. Because when I was pregnant I did not have to worry about oh well she need her diaper changed, so now I gotta make bottles, clean bottles, change diapers, wash cloths, keep [baby's name redacted] from beating her up.*

These last two statements not only refer to the daily challenges of caring for infants but also allude to feelings of being overwhelmed, anxious, sleep-deprived and stressed, all of which could be alleviated with help and support from family and friends.

## **Daily Life Changes Summary**

This section highlights the enormous life changes that accompany the transition to motherhood for both first-time moms and mothers of multiple children. These include changing friendships, a marked decrease in socializing or “getting out” and being confined to the home in ways not previously imagined as evidenced in the last quotes in this section. These statements indicate not only a shift in social priorities but also illustrate what I term as “maternal isolation” defined as “a state in which the mother lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and/or they are deficient in fulfilling and quality relationships as a direct result of her transition to motherhood.” (Terry 2015) Adapted by the PI from a 2009 paper on social isolation in older adults (Nicholson), this concept of maternal isolation is one of the primary findings to be discussed in chapter seven. The next section of narrative analysis will focus on long-term life changes women reported as a result of their transition to being a mom.

### **Pregnancy: Long-Term Life Changes**

Despite a general overall perception of their new role as mother being a positive change in their lives, the fact of having an infant to care for also precluded some mothers from achieving their educational goals or continuing employment. One woman stated,

*Um, yeah, yeah I was supposed to go ahead and um start school again and I didn't because I ended up getting pregnant.*

Within the context of this particular interview, it was implied that a lack of childcare was the primary reason she could not continue to attend school. Similarly, another mother said,

*Well, I couldn't work and I was expecting to work after [child's name redacted] but I didn't even know I was pregnant until after two and a half months after with her. I was trying to go back to school but then I had to put that on hold for a while because I had her.*

Again, a lack of childcare and transportation were the reasons both work and school had to be ‘put on hold’ for this mother. These two quotes point to a pattern of low-income mothers being unable to achieve their long-term goals due to a fractured social safety net and perhaps, the lack of a strong social support network. Although every participant in this study, without exception, expressed happiness and joy in mothering their infant, for some, the news of an unplanned pregnancy was unwelcome at first. The following quote illustrates this fact, reiterating what an enormous change the transition to motherhood represents,

*Yea. At that point when I did get pregnant, life was kinda hard. I was going through a lot. I was in a bad situation. So...I looked at it as like, Wow, I'm pregnant. I really...it's a mistake. I shouldn't, you know, I'm too young.*

### ***Long-Term Life Changes Summary***

The primary long-term life changes reported by women were difficulty in continuing their education and finding/sustaining employment. These concerns point again to larger structural issues such as inadequate social safety nets to assist mothers who are attending school with childcare and transportation. These are points again to be addressed in the next chapter.

### ***Prenatal Nutrition Advice***

Participants were asked about the nutrition advice they received from their prenatal care providers. These questions were posed to assess the types and format of nutritional information and/or education women receive from Ob/Gyn practices as compared to food assistance programs like WIC. The first few participant quotes in this section provide evidence that some prenatal care providers do not address nutrition in their practice. One woman described the format of her visits which included assessments such as weight gain and a pelvic exam but no nutritional education,

*He really didn't give me no advice. He just {giggles}...they'll weigh me and I go in and he'll check me. But, he really didn't like..eat this, eat that. He didn't tell me that.*

Similarly, the following statement alludes to a focus on weight as the critical measure of nutritional health during pregnancy,

*Basically they just told me like, this is what you're supposed to gain and if you go past this, this is too much, they didn't really like tell me...*

Supporting the focus on weight in prenatal care as a proxy for nutritional status, another mother provided,

*P: Um, she, she really didn't say anything. Only thing I can remember that she said anything about like eating wise or drinking was for me not to drink whole milk.*

*I: Okay, why was that? Why would she say that?*

*P: Oh, because I'm already big.*

Some women, however, were provided nutritional advice in the form of what not to eat or drink (as opposed to advice on what constitutes a healthy diet during pregnancy) as evidenced by the following quote,

*Just stay away from the sodas, stop drinking too much soda. Stay away from the sweets period. Cause I was drinking sodas, eatin' candy almost every day. That was the only thing, just stay away from the sweet stuff.*

One woman who was diagnosed with gestational diabetes was again provided advice about foods to avoid and/or restrict but little in the way of advice about what types of food could improve her health,

*P: To eat less fruit because of the gestational diabetes, that had a lot of um, high glucose in it, um, and that's basically it and they told me just make sure, um, my diet was strictly enforced because of complications can be during birth.*

*I: What was the diet that was strictly enforced?*

*P: Uh, less carbs, no pastas, you know, say off the breads, more vegetables, more juices, you know, 100% juices and stuff like that. Milk and stuff I didn't eat I had to eat.*

Other women reported having received nutritional advice in the form of pamphlets but not as an interactive conversation with their provider,

*Umm, she gave me pamphlets about eating more healthier with greens, green vegetables. Eating fruit, at least three to six times a day and drinking water. Umm, I tried to do a lot of it.*

A few women did acknowledge having received nutritional advice during their prenatal visits.

Yet, there was no evidence that these conversations occurred within the context of assessing their ability to meet the recommendations. One mother stated,

*Um, like they wanted me to eat like a nice good-sized meals, makin sure I had my vegetables, my fruits and a nice piece of meat whether it was like a piece of chicken or even a piece of fish but it had to be the right piece of fish.*

Perhaps as a result of a lack of nutritional education provided during prenatal care, one woman mentioned WIC as her source of nutritional advice,

*I just needed to, with WIC, I just needed to eat more as far as bread, they wanted me to eat bread and drink whole milk because I was on 1% milk. I just remember them telling me to eat more.*

Still other women reported having received prenatal nutritional education only after a risk factor such as anemia, gestational diabetes or hypertension was discovered as illustrated by the following statement,

*Yes, once they diagnosed me with diabetes, umm, I went to the [Provider Practice Name Redacted]. And then I met with a nutritionist and they gave me a plan and we talked about the 'Do's and Don'ts and all that stuff, so.*

Finally, one mother aptly noted that even though she received nutritional advice from her provider and was encouraged to 'eat healthy', the high cost of healthy foods (either perceived or real) made it difficult to comply with that recommendation,

*It costs more to eat healthier. Like, it really does cost a lot more to eat healthier, that's what my concern was. How is it, everyone wants everybody to eat healthier and healthier but the food is so expensive.*

One final note on the topic of prenatal nutritional education is the fact that several instances of pica were reported within the narrative. Pica, “the craving for and consumption of nonfood items, including the ingestion of earth (geophagy), raw starch (amylophagy), and ice (pagophagy)” (Miao, Young & Golden 2015; 84) is thought to be associated with micronutrient deficiencies, particularly low-iron. Five participants in this study reported pica behaviors to include cravings for and significant consumption of ice (n=3), and corn starch (n=1) with one participant reporting cravings for bleach during pregnancy. The following participant statements provide examples of these types of non-food cravings. The first statement describes the compulsion to eat profuse amounts of ice during pregnancy,

*I: So, did you have any particular cravings?*

*P: Ice. That was it. I had to have it. I was getting it from the store and from the freezer. I had to have ice. I didn't know how bad it was for me. I was going to the mall just to get crushed ice. I did not know it was that bad for me until I told my doctor. She was like, how much ice are you eating, I was like maybe 6 cups a day and she like, WHAT? And I'm like, yeah, gotta have it.*

Another women discussed her cravings for cornstarch during pregnancy,

*P: Cause I had high blood pressure, low iron...I just had low iron. And then when I ate...well I can't say that..because with her I ate more corn starch an ice.*

*I: Corn starch? Really?*

*P: And I crave it till this day! {giggles} I don't know why!*

Finally, one participant reportedly craved bleach products during her pregnancy,

*I mean, like, at work [Domino's pizza shift manager] at the end of the night I had to, you know, make sure all the stations and stuff were clean and the bleach just smelled so good. I mean, I had to force myself not to drink it...I wanted it so bad. It's really weird. I mean, of course I never tasted it or anything but...*

### ***Prenatal Nutrition Advice Summary***

The descriptions of the nutritional advice (or lack thereof) received during standard prenatal care signify an overall lack of time and attention on the part of prenatal care providers to this issue. The high rates of prenatal anemia reported (n=19 or 61%) (see table 6.13) by

participants in this sample and evidence of pica as described in this section indicate prenatal micronutrient deficiencies. Thus, it is critical to examine why nutrition in prenatal care is not emphasized and to consider what steps may be taken to address this gap; points to be discussed in chapters seven and eight.

### **Semi-Structured Interviews Summary of Findings**

Analysis of the narrative data collected through the semi-structured interviews for this study reveal important insights about mothering in a low-income setting. First, as illustrated in the types of support they receive from partners, family and friends it is evident that many of these mothers' basic needs are going unmet. These include transportation, adequate resources to provide child necessities such as diapers and formula, food, housing, and emotional support. Most of the maternal, social, economic and cultural stressors reported appear to be connected to those unmet needs. These include worry about finances, transportation, and relationships. Additionally, women report concern about being perceived as 'unfit' mothers due to age, socioeconomic status and/or marital status. This suggests an internalization of the 'intensive mothering' paradigm discussed in chapter three, a point to be further explored in the next chapter. Finally, African American mothers' narratives regarding both blatant racist encounters as well as perceptions of persistent social injustice in the U.S. signify racism as a chronic source of stress with potential health implications. I argue that the common thread linking all of these factors is the need for a strong social support network to help alleviate them.

Participants' responses regarding their consumer food habits found chain supermarkets to be the preferred type of food outlet, regardless of location. For women without access to a vehicle, this means they must wait to do their grocery shopping when they are able to arrange a ride or take public transportation with an infant in tow. This may have consequences related to

diet quality as infrequent trips to the grocery store may discourage purchase of fresh produce and public transportation creates logistical challenges to ‘stocking up’ due to unwieldy grocery bags while toting an infant. These points, again, will be further examined in chapter seven.

Interview questions regarding food habits such as budgeting, meal planning and meal sharing suggested that women generally do not plan meals ahead or budget on a daily, weekly or biweekly basis. Instead, most mothers reported putting meals together at the last minute. Likewise, a majority of mothers indicated that they do not share meals as a family on a regular basis. Finally, more than 50% of women said they eat out or get takeout at least once per week. Reasons for these patterns of meal behaviors may be due to a complex number of factors, not least of which include constraints on both time and resources.

A number of daily and long-term life changes occurring as a result of the transition to motherhood were reported. These included diminished social outlets, being confined to the home and challenges to pursuing educational or employment goals. These findings again suggest the importance of strong social support networks for mothers living in poverty. Finally, reports of the prenatal nutrition advice received indicated that there is an overall lack of nutrition education provided during standard prenatal care. All of these findings will be examined further in chapter seven, framed within both the topical literature and the theoretical concepts presented earlier in this dissertation.

### **Survey/Questionnaire Findings**

As outlined in chapter five, participant interviews included the completion of three surveys/questionnaires; the U.S. Household Food Security Survey Module (18 Items), the Hopkins Symptoms Checklist (25 items) and the Demographics/Health questionnaire composed for this study (see Appendix B). In the following section I provide the results of the

survey/questionnaire data collected. As in the narrative analysis portion of this chapter, I will refer to participant demographics where relevant and include participant statements as appropriate to frame the quantitative statistics.

### ***Tampa Bay Region Household Food Security Data***

While the U.S. rate of household food insecurity has held steady at approximately 14% (USDA 2013) since the 2008 financial crisis, the overall food insecurity rate in Florida remains higher than the national average at 17.9% (Feeding America 2014). Recent estimates of food insecurity in the Tampa Bay region (encompassing Citrus, Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas, Polk and Sumter counties) are also higher than the national average at 15.8% (Feeding America 2014), translating to 646,520 people who experienced food insecurity at some point in the past year, including 218,340 children. In Pinellas County, this study's field site, 15.7% of households (or 144,350 individuals, 38,940 of whom were children) were food insecure in 2012.

According to Feeding America (2014), the average cost of a meal in Pinellas County was \$2.98 with an additional \$75,231,000 required to meet the food needs of all households. At \$2.98 per meal, households in Pinellas County would need to spend a daily average of at least \$8.94 per person (with no snacks) to meet the food needs of the entire household. Referring to table 6.10, we find that the average daily food expenditure per person in the household for this participant sample was \$3.82 with a median daily expenditure of \$4.08. This means that the mothers in this study, on average, spent the total cost of one meal (2.98) plus \$1.00 as their entire daily expenditure per person in their family. The data also show that African American households spent approximately 25cents less per person per day than their White counterparts

**Table 6.10:** Average Daily Household Food Expenditure per Person

<sup>22</sup> Average Daily Food Expenditure per Person in Household		Mean	Median
<b>Overall</b>		<b>\$3.82</b>	<b>\$4.08</b>
AA		\$3.76	\$3.67
White		\$4.03	\$4.21

Given that all of the mothers participating in this study received WIC and 95% received food stamps (see table 6.11), these data suggest a large gap to be filled between assistance received and the true cost of feeding a family.

**Table 6.11:** Participation in Government Assistance Programs (Participant Sample)

<sup>23</sup> Participation in Government Assistance Programs				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
WIC	20	100%	11	100%
Food Stamps	19	95%	9	82%
Healthy Start	17	85%	10	91%
Healthy Families	1	3%	0	N/A
Medicaid	20	100%	11	100%

### ***U.S. Household Food Security Survey Module – 18 Item Results***

**Table 6.12:** Participant Sample Household Food Security Status

<b>Household Food Security Status</b>				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
High Food Security	4	20%	1	9%
Marginal Food Security	6	30%	4	36%
Low Food Security	7	35%	2	18%
Very Low Food Security	3	15%	4	36%

Table 6.12 above summarizes the participant household food security survey results. Of the 31 participants in this study, only five (16% of the total sample) were Highly Food Secure. The largest percentage of participants fell into the marginally food secure category with a total of

<sup>22</sup> Extrapolated from data collected on the demographics/health questionnaire (see Appendix B). Calculated using the reported total monthly household food budget divided by number of people in the household divided by 30 (average number of calendar days/month).

ten or 32%, followed closely by the Low Food Security category with nine participants (29% of the total sample) and 23% (n=7) reporting very low food security. Though there was a 52% prevalence of household food insecurity, half of whom experienced very low food security (formerly categorized by USDA as food insecure with hunger) at some point in the last year<sup>24</sup>, no households reported child food insecurity on the HFSSM. This finding corroborates the literature that states that children are typically shielded from food insecurity within households reporting it (Coleman-Jensen, Nord and Andrews 2011). Additionally, since two-thirds of this sample had only one child under the age of 12 months in the household, it is reasonable that the majority of children would have been protected as many were not yet consuming solid foods.

Referring again to table 6.12, we find that both cohorts reported food insecurity at approximately equal rates. However, there were categorical differences documented between the two groups with White mothers experiencing very low food security at a rate of 5 to 1 compared with the African American cohort. Whereas African American mothers experienced low food security at a rate of approximately 5 to 1 compared with White mothers, both groups reported close to equal rates of marginal food security with a slightly higher prevalence (6%) among White mothers. While these differences exist within the sample, a Chi-Square Test of Independence between race and food security did not show a statistically significant association as indicated in the output table shown in table 6.13 on the following page. This means that White mothers and African American mothers were equally likely to report food insecurity within this participant sample.

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<sup>24</sup> The interviews took place over 15 months between 2011-2013. Thus, the “last year” refers to either 2010, 2011 or 2012 depending on the date of the interview.

**Table 6.13:** Association between Food Security Status and Race

	Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	4.505 <sup>a</sup>	4	.342	.378		
Likelihood Ratio	5.349	4	.253	.356		
Fisher's Exact Test	4.001			.443		
Linear-by-Linear Association	.621 <sup>b</sup>	1	.431	.467	.274	.106
N of Valid Cases	31					

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .35.

b. The standardized statistic is .788.

Additional Chi-Square Tests for Independence were conducted for associations between food security as the independent variable and other demographic factors related to poverty and mothering such as education, employment, marital status, number of children and the baby's age. Figures 6.14-6.18 below provide results of these tests indicated that no statistically significant associations exist within this participant sample between food security status and multiple risk factors.

**Table 6.14:** Association between Food Security Status and Education

	Chi-Square Tests			
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)
Pearson Chi-Square	25.990 <sup>a</sup>	27	.519	.587
Likelihood Ratio	27.097	27	.459	.453
Fisher's Exact Test	28.323			.394
N of Valid Cases	31			

a. 40 cells (100.0%) have expected count less than 5. The minimum expected count is .10.

Table 6.14 above provides results of a Chi-Square test for association between food security status and highest level of educational attainment among the participant sample. It is perhaps not surprising that no correlation was found within this participant sample since despite some mothers' having obtained a college or graduate degree, all women participating in this

study were low-income. This signifies that their income rather than education was the central contributing factor to food insecurity. However, those with a college degree or higher are clearly advantaged in that their future earnings potential is greater than that of women with a high school education or less and are more likely to achieve and maintain food security than their less educated counterparts.

**Table 6.15:** Association between Food Security Status and Employment Status

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	11.713 <sup>a</sup>	9	.230	.221		
Likelihood Ratio	13.092	9	.159	.230		
Fisher's Exact Test	10.290			.233		
Linear-by-Linear Association	2.484 <sup>b</sup>	1	.115	.151	.075	.032
N of Valid Cases	31					

a. 14 cells (87.5%) have expected count less than 5. The minimum expected count is .19.

b. The standardized statistic is 1.576.

An association between food security and employment status would seem to be common sense, with those employed more likely to be food secure than those who are not. However, given the current economic climate with large numbers of individuals underemployed and a lack of a living wage as previously discussed in chapter three, employment does not necessarily impart food security. In fact, it can negatively impact food security by disqualifying those who work or make a certain income from receiving needed social benefits like food stamps. Thus, the results of Chi-Square test shown in table 6.15 examining an association between food security status and employment status within this participant sample showed no statistically significant findings.

**Table 6.16:** Association between Food Security Status and Marital Status

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	3.905 <sup>a</sup>	6	.690	.748		
Likelihood Ratio	4.804	6	.569	.760		
Fisher's Exact Test	4.380			.697		
Linear-by-Linear Association	.025 <sup>b</sup>	1	.875	1.000	.502	.126
N of Valid Cases	31					

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .58.

b. The standardized statistic is -.158.

As discussed earlier in this chapter, a small minority of the participant sample were married or living with a partner at the time of the interview (11 of 31). While being married or living with a partner may impart more financial security to households that benefit from two incomes, none of the couple-households in this sample fell into that category. For those women who were married or living with their partner, about half of their spouses or boyfriends were employed and of those, all were either employed full-time in a minimum wage job such as fast food restaurants or were employed temporarily in manual labor positions such as carpentry. Thus, it is not surprising that for this participant sample, no statistically significant association was found between food security status and marital status as shown in table 6.16.

Another Chi-Square test (see table 6.17 on the following page) was conducted to determine whether any association exists in this sample between food security status and the number of children in the households. The results indicate there is no statistically correlation between the two variables. If we consider the fact that all households in this study received food stamps and 95% of the participant sample (and each of their children) received WIC benefits,

this result is again not surprising. I would expect to see an association between number of children and food security status within low-income households that make too much to qualify for benefits but not enough to provide basic necessities. No participant household fell into this category.

**Table 6.17:** Association between Food Security Status and Number of Children

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	3.482 <sup>a</sup>	6	.746	.820		
Likelihood Ratio	3.811	6	.702	.890		
Fisher's Exact Test	3.986			.752		
Linear-by-Linear Association	.930 <sup>b</sup>	1	.335	.383	.211	.076
N of Valid Cases	31					

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .39.

b. The standardized statistic is .965.

**Table 6.18:** Association between Food Security Status and Baby's Age

	Value	df	Asymp. Sig. (2- sided)	Exact Sig. (2- sided)
Pearson Chi-Square	43.197 <sup>a</sup>	39	.297	.326
Likelihood Ratio	42.145	39	.337	.274
Fisher's Exact Test	41.543			.234
N of Valid Cases	31			

a. 56 cells (100.0%) have expected count less than 5. The minimum expected count is .10.

Finally, one additional Chi-Square test for independence was conducted to determine if an association exists within the participant sample between food security status and the baby's age. As table 6.18 above indicates, no statistically significant result was found. Since all mothers in this sample had a baby less than one year old, this is a predictable finding given that WIC benefits cover the majority of infants' nutritional needs at that age. Other financial factors such as diapers, wipes, and other baby necessities would be equal across the age distribution for

this study and so would not make a difference in terms of income available for food versus other household necessities.

The statistical analyses presented in this section imply a more complex explanation for food security status than simply an association between key demographic variables. The participant narratives as presented throughout this chapter offer a much more nuanced examination of the factors impacting food security than quantitative methods are able to capture. Thus, the fact that no statistically significant results were found in this section does not imply that food security is not greatly impacted by the unique experience of mothering in poverty. In fact, not only did half of the women in this study report food insecurity but the prevalence of marginal food security translates to approximately one-third of participant households reporting some measure of vulnerability to food insecurity in any given month. While this is an alarming statistic, perhaps even more concerning is the fact that 23% of the total sample would have been classified as “Food Insecure with Hunger” under the previous USDA food security definitions described in chapter three.

### ***Adding Hunger***

While hunger is no longer documented within the USDA food security lexicon, this dissertation noted several instances of hunger defined as “the inability, even occasionally, to obtain adequate food and nourishment.” (U.S. President Task Force on Food Assistance: 34) Additionally, despite the fact that no households reported child food insecurity through the HFSSM results, I would argue that the narrative paints a different picture with a number of households describing cyclical food shortages and reliance on low-cost foods to feed their children that do not impart adequate nutritional intake. These transitory shocks and coping

strategies employed by participant households clearly fall within the broader definition of hunger invoked in this study.

Given the significant proportion of households reporting what would have been categorized as “Food Insecure with Hunger” prior to 2006, I have chosen to include all accounts of hunger captured through the narrative analysis. The definition of hunger I invoke in this dissertation allows for a broad range of experiences to be categorized as such, including dependence on a few low-cost, energy-dense foods, ‘making it stretch’, reliance on emergency food banks (also called food pantries), the inability to cope with transitory ‘shocks’ such as a reduced number of work hours or a delay in food stamp distribution, and a total reliance on food assistance programs. The following section provides participant narratives regarding their experiences with hunger.

First, several women reported the use of emergency food banks to supplement their monthly food supply. For some, this occurred on occasion as a way to avoid prioritizing food over other necessities as illustrated in the following quote,

*I: Did you ever feel that you had to go without certain things in order to buy enough food or more food while you were pregnant?*

*P: Ugh uh [no]. I could go to the food pantry. I gotta have my lights and stuff on.*

Similarly, another mother described using the food pantry when she runs out of money,

*I ain't hungry because I don't gotta feed no body [reference to no longer being pregnant], but I'm just sayin' like, I try to get food if I can. It's the money situation. But if I run out, I just go to the food pantry.*

Yet another women spoke of relying on the food bank to fill the gap during the renewal process for food stamps,

*P: I get food stamps so when they're reaching the end of the termination process, if they delay that we're in trouble.*

*I: How often would you say that happens?*

*P: Yeah, it depends how busy they are. Like um, we are about to do our review*

*now at the end of this month and I already sent my paperwork to make sure that for March I have food for us. So if they are slow we have to wait until we get money.*

*I: So how often do you have to do that whole process?*

*P: Usually they give us food stamps every six months. We have to go through that process. Um, it depends because I like to, I'm trying to lose the baby weight and I feed her very healthy food, you know? So, cause I want her to enjoy healthy food, you know? So obviously I buy stuff that is more high quality, I don't just buy things...so I have to be very mindful of how I use my food stamps. So you know, I would say we run into that problem, probably every 2 months if I run out of food stamps because, I don't know, I bought these meats or vegetables and, or salads, you know, stuff like that, then that's when we, we have to like, we go to the food bank but usually, and we joke about this all the time, because the food bank gives you very unhealthy food. Like they give us bags and bags of pastries and breads and like, everything the doctor says don't eat is in that bag. So I have to sort it out and work with what I have, you know, but 99% of the time I end up giving away most of it or getting rid of it because it's very unhealthy. You know, and she can't eat all that sugar...I don't give it to her. They do give us baby food at the food bank when we go so I use that and for me, I just keep the canned vegetables, you know, the beans, the canned beans so that's how we work that out.*

The above statement makes several important points to be examined further in chapter seven.

First, a number of women noted similar issues with the application process for food stamps with delays reportedly a common occurrence. Second, this quote also alludes to the fact that this mother does not have people on whom she can rely for nutritional support, clearly indicating that the emergency food bank is her coping strategy when faced with a food shortage. Third, her statement that “the food bank gives you very unhealthy food” is a salient point well documented in the topical literature (Loopstra and Tarasuk 2012, Story et al. 2008) again to be examined later. Next, she implies that her choice to feed her child healthful foods keeps her on the brink of chronic food insecurity due to the increased cost of eating balanced, nutritious meals. All of these points are critically important in addressing the determinants of food insecurity among low-income mothers and will be addressed in the next chapter.

Other women reported “having enough” but not always the kinds of food they want as evidenced by the following statement,

*I mean there's always something in there but whether I want to eat it or not is...but I mean there's always something in there to eat.*

Describing her prenatal food access, one mother noted that she could not afford to eat the way she wanted to during her pregnancy,

*I: Was there ever a time when you were pregnant that you felt there wasn't enough money to buy certain foods or that you didn't have enough time to prepare something?*

*P: Sometimes I felt there wasn't the money. Then, you can't eat that. You gotta decide to eat something else or whatever we have in there.*

Commenting on the need to protect her child from hunger, one mother provided the following quote,

*I mean they've always gotten something. It's not like our cabinets are bare, you know, I mean he's never hungry it's just we don't really have much.*

Again, providing evidence of the cyclical nature of monthly food shortages reported by participants, one woman stated,

*It was like that a couple of times because maybe I would get my food stamps on the 11<sup>th</sup> and on the 22<sup>nd</sup> or 24<sup>th</sup> we would run out of meat but then we'd have all the sides for the meat but no meat.*

Finally, the following excerpt describes reliance on a few of the same low-cost foods each month,

*I: Is there anything that you would consider, this is my staple food I always have to have it in the house?*

*P: I dunno really. 'Cause it seems like we buy the same thing every month.*

*I: Ok.*

*P: Everything. It seem like nothing ever change.*

*I: Ok. What kind of foods do you buy?*

*P: Ravioli. We don't cut off the noodles [referring to ramen], I don't know why but. Chips. We got like a lot of the Capri Suns. So they with the Raviolis. My son he like to eat the macaroni cups. So I get the ones like Sponge Bob and stuff like that. That's about it.*

Admittedly, it is difficult to ascertain from a statement like the one above whether the food choices described are due to preference, convenience, personal likes and/or dislikes or if they are purchased solely because they are more affordable than healthy options. However, given the evidence presented thus far, it is safe to assume that price plays a significant role in the food choices of mothers living in poverty.

The next two participant statements refer to their sole reliance on food assistance programs to provide food for the household. These households are particularly vulnerable to food insecurity due to a lack of alternative coping mechanisms in times of shortage. As one woman notes, she does not have any additional income with which to supplement food expenditures above what she receives through government assistance,

*We get food stamps every month and that's the only way that we buy food, I mean we don't ever have money to like out of our own pocket to buy food with so and it, food stamps only last us maybe like 2 weeks so 2 weeks where we're scrounging up change and anything we can to like, get some kind of food together so...*

This mother described having to plan for monthly food shortages on a regular basis,

*Yea. I try not to get...since my boys are older, I try to save my expenses because when it comes to the end of the month we have nothing. We have nothing. And then I have boys so their metabolism is so high, I have to keep something around.*

These two statements are indicative, again, of the importance of a strong social support network as a coping strategy for mitigating food insecurity. Finally, the last participant statement indicative of hunger (as defined previously) describes reliance on food assistance programs to provide adequate diet diversity,

*As far as keepin, they keep me and the kids fed and they keep being able, I mean with WIC they give you \$16 in coupons for fruit so normally when I go to the market I would pick up, like when I use my food stamps I pick up a bag of apples and a bag of oranges but now I do the strawberries, cherries, blueberries, watermelon, the melon, like, they eat kiwi. I even bought some, I don't even know what it is...mangoes, they eat mangoes now. I did not even know if they liked mangos*

*but now I buy mangos because I have the money to do it. They eat different things because WIC offers different stuff and then when I go to the market with my food stamps I can get things they want and you know, things they need compared to having a budget and being like, well I can't get the fruit they want so I'll just get these two bags knowing they will eat them. There are other things out there that they like.*

### ***Hunger Findings Summary***

The participant statements I have included as evidence of hunger provide important insight into the complexities of conceptualizing the term. While none of the participants noted physiological symptoms of hunger, statements in this section all imply “the inability, even occasionally, to obtain adequate food and nourishment.” If we consider again the gap between the average cost of a meal in Pinellas County (\$2.98) and the average daily household food expenditure per person reported by this sample (\$3.87), it is intuitive to assume that mothers in this study (and likely their children) experience hunger. This point will again be discussed in chapter seven.

### ***Hopkins Symptoms Checklist (HSCL) -25 Results***

Referring to table 6.19, we find the results of the HSCL used to assess the prevalence of both depression and anxiety within the participant sample. Looking first at the depression scores, we note that cases of depression were indicated for African American participants at a 2% increase over the White cohort. However, cases of anxiety were reported for White participants at an 11% increase over their African American counterparts.

**Table 6.19:** HSCL-25 Results

<b>Hopkins Symptoms Checklist - 25</b>				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
Depression Prevalence <sup>25</sup>	4	20%	2	18%
Anxiety Prevalence	5	25%	4	36%

<sup>25</sup> See chapter five for discussion as to how these results were scored and calculated.

To test the statistical significance of the association between race and the HSCL-25 results, a Chi-Square Test of Independence was conducted with results showing no statistical significance for this sample (see table 6.20 below). While this is a departure from the literature presented in after table 6.20, this participant sample is not representative of the U.S. general female population that encompasses women across the spectrum of income, education and life circumstances. Since this sample includes only low-income mothers living in Pinellas County, it is reasonable that all participants were equally as likely to report anxiety, depression or both, regardless of race.

**Table 6.20:** Association between Race and HSCL-25 Score<sup>26</sup>

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	2.141 <sup>a</sup>	3	.544	.739		
Likelihood Ratio	2.389	3	.496	.855		
Fisher's Exact Test	2.470			.662		
Linear-by-Linear Association	1.310 <sup>b</sup>	1	.252	.279	.188	.094
N of Valid Cases	31					

a. 6 cells (75.0%) have expected count less than 5. The minimum expected count is .35.

b. The standardized statistic is 1.144.

In 2012, the prevalence of major depressive disorder among adult females in the U.S. was 8.4% (National Institutes of Health (NIH) 2012) with rates of postpartum depression in the U.S. general population estimated at between nine to 16% (American Psychological Association (APA) 2013). Low-income mothers with young children are reported to experience depression at a 1.5% increase over mothers across all income groups (McDaniel and Lowenstein 2013).

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<sup>26</sup> HSCL-25 Scores were collapsed into three ordinal categories for purposes of analysis: 1= Anxiety (based on case threshold score of  $\geq 1.75$ ; 2=Depression (based on same case threshold; 3=Both Anxiety and Depression (based on case thresholds.

Finally, there is conflicting data related to the prevalence of depression by race with the CDC reporting African American depression rates at 12.8% compared with 7.9% for Whites (2010), while the National Institute of Mental Health (NIMH) reports a lower lifetime risk of depression for African Americans compared with Whites (2012). If we consider these statistics within the context of this study, it is evident that the prevalence rate of depression for both cohorts is greater than that of the general population. This may be explained by a number of factors to include under-reporting of depression rates in the general population and the likelihood that some of the cases of depression identified in this sample are actually postpartum depression.

According to the CDC, 18.1% of all U.S. adults have experienced generalized anxiety disorder in the past 12 months (2012) with women 60% more likely than men and African Americans 20% less likely than Whites to experience anxiety disorder. The prevalence of anxiety within the participant sample is therefore much closer to the general U.S. statistics than the depression rates, though still significantly higher. I suggest that the higher rates of both anxiety and depression within the participant sample compared with the general U.S. population are indicative of the stresses related to mothering in poverty and a lack of social support to mitigate those stressors. To test this assumption, several Chi-Square tests were conducted to identify any statistically significant associations between the variables of interest related to mothering and poverty and participants' HSCL-25 scores. As tables 6.21-6.26 indicate, no statistically significant results were found.

Despite the fact that within the first 12 months of life, a baby goes through several developmental phases, each requiring different levels of physical and emotional support and attention from a mother, the baby's age did not appear to be associated with this sample's reported rates of depression and/or anxiety as indicated in table 6.21 on the following page. This

implies that the mental health of mothers may be impacted more by social circumstances than by the physical and emotional demands of mothering

**Table 6.21:** Association between Baby's Age and HSCL-25 Score

Chi-Square Tests				
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)
Pearson Chi-Square	50.272 <sup>a</sup>	39	.107	.222
Likelihood Ratio	29.783	39	.856	.144
Fisher's Exact Test	53.859			.144
N of Valid Cases	31			

a. 56 cells (100.0%) have expected count less than 5. The minimum expected count is .03.

**Table 6.22:** Association between Marital Status and HSCL-25 Score

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	2.665 <sup>a</sup>	6	.850	1.000		
Likelihood Ratio	3.232	6	.779	1.000		
Fisher's Exact Test	3.997			.785		
Linear-by-Linear Association	.187 <sup>b</sup>	1	.666	.689	.390	.099
N of Valid Cases	31					

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .19.

b. The standardized statistic is .432.

Table 6.22 above indicates that like baby's age, race and the other demographic variables of interest tested (see tables 6.23-6.26), no statistically significant association was shown between participants' marital status and their mental health. Marriage and/or committed long-term relationships are often touted as promoting emotional stability to partners. However, within this participant sample, neither marriage nor living with a partner was protective against major financial strain which may explain why single mothers, married mothers and those living with a partner were equally likely to report anxiety, depression or both.

**Table 6.23:** Association between Number of Children and HSCL-25 Score

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	5.464 <sup>a</sup>	6	.486	.506		
Likelihood Ratio	5.937	6	.430	.547		
Fisher's Exact Test	5.929			.438		
Linear-by-Linear Association	.202 <sup>b</sup>	1	.653	.715	.359	.083
N of Valid Cases	31					

a. 10 cells (83.3%) have expected count less than 5. The minimum expected count is .13.

b. The standardized statistic is .450.

While a common assumption exists that the number of children one has impacts stress levels for parents, with more children assumed to cause higher rates of stress among parents, no statistically significant association was detected in this sample between number of children and mental health outcomes as shown in table 6.23. This finding again supports the notion that mothers' mental health is likely impacted to a greater extent by life and social circumstances than by the physical and emotional demands of mothering.

**Table 6.24:** Association between Food Security and HSCL-25 Score

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	9.185 <sup>a</sup>	9	.420	.406		
Likelihood Ratio	8.869	9	.449	.490		
Fisher's Exact Test	9.717			.327		
Linear-by-Linear Association	2.428 <sup>b</sup>	1	.119	.134	.074	.027
N of Valid Cases	31					

a. 14 cells (87.5%) have expected count less than 5. The minimum expected count is .10.

b. The standardized statistic is 1.558.

Though several women reported food insecurity as a major source of stress within the participant narrative, results of a Chi-Square test of independence between food security status

and HSCL-25 scores indicated no statistically significant association as shown in table 6.24. This may be explained by the fact that food insecurity is often an end result of multiple risk factors which cause stress. Additionally, as discussed in the previous section, food security status in this participant sample was clearly temporal in nature. Meaning that women reporting high food security at the time of the interview for the prior year have been food insecure at some point in their lives and worry that they may be again. Thus, women in this sample were equally likely to report anxiety, depression or both regardless of household food security status.

**Table 6.25:** Association between Employment and HSCL-25

	Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	6.773 <sup>a</sup>	9	.661	.615		
Likelihood Ratio	6.930	9	.644	.651		
Fisher's Exact Test	8.103			.690		
Linear-by-Linear Association	.809 <sup>b</sup>	1	.369	.437	.215	.054
N of Valid Cases	31					

a. 14 cells (87.5%) have expected count less than 5. The minimum expected count is .06.

b. The standardized statistic is .899.

The majority of women who were unemployed at the time of the interview stated they were looking for a job. Additionally, the major source of stress expressed by this participant sample was finances. Yet, employment status was not found to be statistically linked to HSCL-25 scores as shown in table 6.25. One explanation for this result may be that despite an expressed interest in employment among women in this sample, employment for these women comes with risks to include potentially losing their government benefits like Medicaid and food stamps, having to pay for child care and dealing with the expense of transportation to get to and from their jobs.

**Table 6.26:** Association between Mother's Age at her Last Birth and HSCL-25

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	31.716 <sup>a</sup>	36	.673	.659		
Likelihood Ratio	23.732	36	.942	.525		
Fisher's Exact Test	44.222			.647		
Linear-by-Linear Association	.557 <sup>b</sup>	1	.455	.478	.250	.014
N of Valid Cases	31					

a. 52 cells (100.0%) have expected count less than 5. The minimum expected count is .03.

b. The standardized statistic is -.747.

Finally, given that this participant sample was young (median age of 24) compared with the U.S. average age of first-time mothers (25.8) as previously discussed, a Chi-Square test was conducted to look for an association between mother's age at her last birth (one-third of this participant sample had multiple children (see table 6.26 above) and HSCL-25 results. The results again, were statistically insignificant. The participant narrative offers some insight into this finding showing that the mothers in this study, without exception, regarded their transition to motherhood as a positive influence in their lives.

The output tables for the statistical tests included thus far clearly show that none of the Chi-Square tests conducted with Food Security status or HSCL-25 results as the independent variables indicated statistically significant associations with demographic variables of interest. However, I do not believe this implies a lack of a correlation between mothering in poverty, food security and overall maternal health. Rather, it indicates that the political economic factors at work in the daily lives of low-income mothers influence risk of food insecurity in complex, interrelated and overlapping ways that together provide a fuller understanding of the phenomenon than can be described through statistical analysis. The statistical results presented

in this section help to further support the argument for the use of qualitative methods in examining complex social issues.

### ***Demographics/Health Questionnaire***

All participants completed a general demographics/health questionnaire (see Appendix B). The health data collected included pre-pregnancy morbidities, pregnancy complications, birth complications/outcomes, gestational weight gain, and self-reported height and pre-pregnancy weight. Summarized in tables 6.27 – 6.30, the findings indicate few adverse health conditions within this participant sample with a couple of notable exceptions.

**Table 6.27:** Pre-Pregnancy Morbidities

<b>Self- Reported Pre-Pregnancy Morbidities</b>				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
Asthma	1	5%	1	9%
Hypertension	2	6%	0	N/A
Hyperthyroid	0	N/A	1	9%
Polycystic Ovaries	0	N/A	1	9%
Seizures	1	5%	0	N/A

Referring to table 6.27 above, we find that very few pre-pregnancy health conditions were reported. Of those identified, two are associated with poverty; asthma and hypertension (Wadsworth and Rienks 2012, Schneider et al. 2009). Hypertension has also been linked with nutritional health and related conditions such as overweight and obesity (Reddy and Katan 2004). As discussed in chapter four, prenatal exposure to maternal health conditions such as hypertension, overweight and obesity have been linked to an increased lifetime risk for disease (Barker 1995) making preconception and interconceptual health important areas of focus for improving inter-generational health.

**Table 6.28** Pregnancy Complications

Self- Reported Pregnancy Complications				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
<sup>27</sup> Anemia/Low Iron	12	60%	7	63%
Preeclampsia/Hypertension	0	N/A	2	18%
Gestational Diabetes	1	5%	1	9%
MRSA	0	N/A	1	9%
Cyst on Ovary	1	5%	2	18%
Seizures	1	5%	0	N/A
Fibroid Tumors	1	5%	0	N/A
Kidney Infection	0	N/A	1	9%

Table 6.28 summarizes all self-reported pregnancy complications. As shown, the frequency of anemia or low iron during pregnancy was particularly high in this sample with both cohorts reporting approximately a 60% prevalence. According to the World Bank, the most recent estimates document an overall prevalence of iron deficiency in pregnant women in the U.S. to be 17% (2011). Among low-income women, however, those rates increase to 37% in the third trimester (CDC 2000) with rates for African American women twice that of their White, non-Hispanic counterparts (Killip, Bennett and Chambers 2007). These high rates of iron deficiency are important to document within the participant sample since they not only point to an increased the risk for preterm and low-birth weight babies (Yi, Han and Ohrr 2013) but they may also signify other underlying nutritional deficiencies.

Despite the high reported rates of iron deficiency in this sample, very few adverse birth outcomes associated in the literature with maternal nutritional deficiencies (pre-term and low-birth weight) were reported as indicated in table 6.29 on the following page. The two incidents of pre-term and low-birth weight births were due to a multiple birth (twins) rather than to pregnancy complications.

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<sup>27</sup> Not all reports of anemia/low iron were captured as “pregnancy complications” on the demographics/health questionnaire. Reports of anemia/low iron were also tallied from the interview transcripts and compared with the questionnaires to be sure each instance was captured but only counted once.

**Table 6.29:** Birth Complications/Outcomes

Self- Reported Birth Complications/Outcomes				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
Jaundice	0	N/A	2	18%
Irregular Heartbeat/Heart Murmur	2	10%	1	9%
Pre-Term	0	N/A	<sup>2</sup> <sup>28</sup>	18%
Low Birth Weight	0	N/A	2	18%
Collapsed Lungs	1	5%	0	N/A
Pneumonia	1	5%	0	N/A
Meconium Aspiration	1	5%	0	N/A
Not Breathing at Birth	1	5%	0	N/A
Sacral Dimple	0	N/A	1	9%
Fibroid Tumors	0	N/A	0	N/A

Finally, referring to table 6.30 below, we find that approximately one-third of the White cohort compared with 15% of their African American counterparts reported smoking during pregnancy. Both groups initiated breastfeeding at the same rate (45%) with African American participants indicating exercise during pregnancy at twice the rate of White participants. These data agree with the county-level statistics provided in chapter two, documenting that African American women in Pinellas County were less likely to smoke during pregnancy and more likely (in this case equally as likely) to initiate breastfeeding than their White counterparts

**Table 6.30:** Pregnancy Health Behaviors

Self- Reported Pregnancy Health Behaviors				
	AA Frequency (n)	AA % of sample	White Frequency (n)	White % of sample
Smoked During Pregnancy	3	15%	3	27%
Alcohol Use During Pregnancy	0	N/A	0	N/A
Drug Use During Pregnancy	0	N/A	0	N/A
Initiated Breastfeeding	9	45%	5	45%
Exercised During Pregnancy	13	65%	6	55%

<sup>28</sup> The two pre-term and low birth weight infants reported were twins born at 36 weeks weighing 4lbs. 10oz. and 4lbs. 13oz.

### ***Anthropometric Data***

As described in the previous chapter, pre-pregnancy BMI was calculated for all participants using self-reported height and pre-pregnancy weight (see table 6.31 below). These data were collected to assess prevalence of underweight, overweight and obesity at the time pregnancy occurred. Postpartum BMI was calculated using self-reported height and PI-measured current weight at the time of the interview per the methodology described in chapter five.

**Table 6.31:** Pre-pregnancy BMI and PI-Measured Postpartum BMI

<b><sup>29</sup>Self-Reported Pre-Pregnancy BMI and PI- Measured Postpartum BMI</b>				
	Pre-Pregnancy BMI Frequency (n)	Pre-Pregnancy BMI % of sample	Postpartum BMI <sup>30</sup> Frequency (n)	Postpartum BMI % of sample
<b>Underweight ( BMI &lt; 18.5)</b>	<b>1</b>	<b>3%</b>	<b>0</b>	<b>N/A</b>
AA	1	5%	0	N/A
White	0	N/A	0	N/A
<b>Normal Weight (BMI= 18.5-24.9)</b>	<b>12</b>	<b>39%</b>	<b>10</b>	<b>50%</b>
AA	10	50%	7	35%
White	2	18%	3	27%
<b>Overweight (BMI = 25-29.9)</b>	<b>10</b>	<b>32%</b>	<b>6</b>	<b>19%</b>
AA	5	25%	3	15%
White	5	45%	3	27%
<b>Obese (BMI 30-40)</b>	<b>6</b>	<b>19%</b>	<b>12</b>	<b>39%</b>
AA	2	10%	8	40%
White	4	36%	4	36%
<b>Morbidly Obese (BMI &gt; 40)</b>	<b>2</b>	<b>6%</b>	<b>3</b>	<b>10%</b>
AA	2	10%	2	10%
White	0	N/A	1	9%

The purpose of collecting these data in the context of this study was to gain some insight into the perinatal health status of the participant sample, both at the time pregnancy occurred and

<sup>29</sup> Self-reported pre-pregnancy BMI was recorded by asking how much each participant weighed prior to her pregnancy along with self-reported height. Limitations of using this method of reporting are discussed in chapter 7.

<sup>30</sup> Average length of time since birth as of the date of the interview was 5.5 months.

postpartum. As discussed in chapter two, African American women experience a greater number of adverse maternal and child health outcomes such as pre-term birth and low birth weight in Pinellas County. As described in chapter three, there is strong evidence of a higher risk of overweight/obesity among food insecure women. With more than half of this participant sample reporting overweight, obese and morbidly obese both preconceptionally and postpartum, paired with high rates of reported food insecurity as evidenced earlier, these data support the obesity/food insecurity paradox discussed in chapter four.

Referring to table 6.31, we find only one incident of underweight pre-pregnancy. Half of the African American cohort and 18% of the White cohort reported normal weight pre-pregnancy compared with 35% and 27% respectively postpartum. For overweight, White participants reported a 20% higher rate pre-pregnancy than the African American cohort with the gap narrowing postpartum with 15% overweight African American and 27% overweight White participants. Obesity rates for African American participants was reported at 10% pre-pregnancy, increasing to 40% postpartum while staying equal for White participants at 36% both pre-pregnancy and postpartum. Finally, 10% of the African American cohort reported morbid obesity pre-pregnancy with that number staying the same postpartum and one White participant moving from obese to morbidly obese postpartum. To test the association between pre-pregnancy BMI and food security, race and number of children, Chi-Square Tests of Independence were conducted with results shown in tables 6.32-6.34 on the following pages.

One underlying assumption of this study is that having children may negatively impact a mother's nutritional health because children introduce time constraints, financial burden and other factors that could lead to the consumption of nutrient-poor diet, thereby potentially increasing the risk for overweight and obesity.

However, as shown in table 6.32 below, no statistically significant association was found between pre-pregnancy BMI and number of children. This means that first-time mothers (women with no children at the time point for which BMI was calculated) and mothers with one or more children were equally as likely to report overweight and obesity pre-pregnancy. Given that this sample included only low-income women who had, for the most part, been raised in low-income households themselves, this finding is perhaps not surprising since social class seems to play a more significant role in determining nutritional health than individual lifestyle factors.

**Table 6.32:** Association between pre-pregnancy BMI and number of children

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	31.716 <sup>a</sup>	36	.673	.659		
Likelihood Ratio	23.732	36	.942	.525		
Fisher's Exact Test	44.222			.647		
Linear-by-Linear Association	.557 <sup>b</sup>	1	.455	.478	.250	.014
N of Valid Cases	31					

a. 52 cells (100.0%) have expected count less than 5. The minimum expected count is .03.

b. The standardized statistic is -.747.

As discussed in chapter three, food insecurity and overweight/obesity have been shown in the literature to be correlated among low-income women. A test for this association within this study's sample revealed no statistically significant results for pre-pregnancy BMI and food security (see table 6.33 on the following page). In other words, participants reporting High Food Security and Marginal Food Security were equally likely to report overweight/obesity as those in the Low and Very Low Food Security categories. Yet, I do not believe these findings argue against the literature. The participant narratives indicate that even those women reporting high

food security at the time of the interview have been food insecure in the past and are not immune to anxiety or worry about food insecurity in the near future. This implies that food security may be more of a transitory situation within this participant sample than the larger general population.

**Table 6.33:** Association between Pre-pregnancy BMI and Food Security

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	11.357 <sup>a</sup>	12	.499	.531		
Likelihood Ratio	11.955	12	.449	.569		
Fisher's Exact Test	11.127			.561		
Linear-by-Linear Association	.682 <sup>b</sup>	1	.409	.467	.240	.061
N of Valid Cases	31					

a. 19 cells (95.0%) have expected count less than 5. The minimum expected count is .10.

b. The standardized statistic is .826.

Finally, given that African American women in Pinellas County report higher rates of overweight and obesity in the general population, I tested for this association within the participant sample. Table 6.34 below does not indicate statistically significant results for an association between race and pre-pregnancy BMI within this sample.

**Table 6.34:** Association between pre-pregnancy BMI and Race

Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)	Point Probability
Pearson Chi-Square	4.505 <sup>a</sup>	4	.342	.378		
Likelihood Ratio	5.349	4	.253	.356		
Fisher's Exact Test	4.001			.443		
Linear-by-Linear Association	.621 <sup>b</sup>	1	.431	.467	.274	.106
N of Valid Cases	31					

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .35.

b. The standardized statistic is .788.

While this is somewhat curious since the reported general statistics report higher rates among African American women even after controlling for income, I contend that this sample's complex and overlapping risk factors for obesity (e.g., neighborhood, transportation, children, social support network, etc.) equalize the risk for overweight and obesity across racial lines.

While postpartum BMI was collected and reported, I did not choose to test for associations between it and multiple variables for several reasons. First, because the women in this sample were at various postpartum time points from newborn to one year at the time of the interview, I felt that any statistically significant result would be difficult to interpret.

Additionally, postpartum weight loss is affected by so many interrelated factors such as breastfeeding, exercise, stress, smoking, diet, and so forth, that again, any associations would be difficult to interpret without controlling for these many and varied confounding factors which was outside of the scope of this project.

### **Summary of Survey/Questionnaire Findings**

This section of the chapter revealed a number of important characteristics regarding the study sample. First, the prevalence of food insecurity was found to be just over 50% with an additional one-third of women reporting marginal food security, meaning they are at risk for becoming food insecure in any given month. While hunger is no longer captured by the USDA, this study presented numerous examples from the narrative of the existence of hunger, providing further support for including hunger in public policy reporting in the context of food insecurity. The health data collected suggested evidence of a high prevalence of iron deficiency that may also signify additional underlying nutritional deficiencies among the mothers participating in this study. The high rates of both pre-pregnancy and postpartum overweight and obesity in this

sample provide more evidence for the link between food insecurity and overweight/obesity among women.

## **Foodscape Findings**

As described in chapter five, two Pinellas County zip code areas were chosen for further foodscape analysis; 33712 and 33755. The two zip code areas were selected based on the criteria outlined in chapter 5, re-stated here:

### Zip Code Area 1 (33712)

- Predominately African American (> 60% of residents self-report as African American per 2010 U.S. census data)
- At least 4 study participants (10% of total sample, 20% of African American sample) live in the chosen zip code area.

### Zip Code Area 2 (33755)

- Predominately White (> 60% of all residents self-report as White, non-Hispanic per 2010 U.S. census data)
- At least 4 study participants (10% of total sample, 20% of White sample) live in the chosen zip code area.

To frame the foodscape findings, I first present a demographic overview with variables of interest for each zip code area. Variables included in this section were chosen based on their ability to document potential vulnerability to food insecurity including income, family type, housing, and access to a vehicle. Next, I present the findings from the visual mapping of food outlets in each zip code area, adding geographic representations of the hunger gap in Pinellas County. Finally, I end the chapter with a narrative analysis of participants' perceptions of the local foodscape to provide a holistic overview of the community foodscapes of this participant sample.

Referring to table 6.35, we find that the two zip codes selected are fairly racially segregated with majority African American residents (78%) living in 33712 and majority White

residents (70%) in 33755. Additionally, both communities have much higher rates of single female householders at 15% and 9% respectively above the overall county rate.

**Table 6.35:** Community Demographics

<b>Population Demographics</b>	<b>Zip code</b>		<b>Pinellas County</b>
	<b>33712</b>	<b>33755</b>	
Total Population	23,353	24,324	916,542
% African American	78%	25%	10%
% White, non-Hispanic	19%	70%	82%
% Single Female Head of Household	27%	21%	12%

Moving to table 6.36 below, we note that annual median income for both of these areas is approximately \$10,000 less than the county median income of \$45,535. For each additional income statistic and poverty indicator in table 6.36, both zip codes report approximately twice the county rate.

**Table 6.36:** Community Income and Poverty Data

<b>Income Statistics</b>	<b>Zip code</b>		<b>Pinellas County</b>
	<b>33712</b>	<b>33755</b>	
Median Income	\$35,354	\$35,971	\$45,535
% Households with children < 5 below poverty	29%	43%	18%
% Households Receiving Supplemental Security Income (SSI)	9%	7%	4%
% Households Receiving Cash Public Assistance Income	4%	6%	2%
% Households Receiving Food Stamps/SNAP	25%	23%	11%
% Civilian Labor Force $\geq 16$ Unemployed	16%	11%	11%

Finally, looking at table 6.37 on the following page, we see that there are fewer owner-occupied homes and more vacant houses in each zip code compared with that of the county. Similarly, families in both of these communities pay a higher percentage of their income in rent than the county average with 82% of all residents in 33712 paying  $\geq 30\%$  of their monthly income on housing, compared with 65% of residents in 33755. Households in both zip code

areas are three times less likely to have access to a vehicle compared with all households in the county translating to more residents relying on public transportation or walking to get to work than the county average. Finally, both zip codes rated “car dependent” as their walkability score<sup>31</sup>, meaning that a car is required for most daily errands in both of these communities.

**Table 6.37:** Community Housing/Transportation Data

<b>Housing/Transportation Characteristics</b>	<b>Zip code</b>		<b>Pinellas County</b>
	<b>33712</b>	<b>33755</b>	
% Owner Occupied Housing	52%	57%	67%
% Vacant Properties	18%	23%	17%
% of Households Paying Gross Rent $\geq$ 30% of income	82%	65%	57%
% Households with No Vehicle Available	13%	13%	4%
% Residents who Take Public Transport to Work	7%	8%	2%
% Residents who Walk to Work	3%	3%	2%
Zip Code Area Walkability Score	38	46	

The data in tables 6.35-6.37 provide an overview of those variables that represent potential vulnerability to food insecurity. The next section will provide the findings from the foodscape analysis conducted for this dissertation.

### ***Food Resources***

Windshield ethnography (as described in chapter five) was used to document all food outlets available within the two zip code areas chosen for analysis; 33712 and 33755. To test the accuracy of this method compared with use of secondary data sources, I used the City of St. Petersburg’s occupational license list for retail stores to compile a list of stores that sell food in each zip code. I then compared the list against the one created from my in-person asset mapping

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<sup>31</sup> Walkability was evaluated using the online Walk Score program which calculates the walkability of an address or in this case a geographic area by “calculating hundreds of walking routes to nearby places, measuring the depth of choice in each category, analyzing pedestrian friendliness and using local data” and providing a score between 1-100 with higher scores indicating better walkability ([walkscore.com](http://walkscore.com)).

exercise and found an approximate error rate of 5% (n= 9) with secondary data listing stores currently closed as open, documenting the wrong address and/or providing the wrong name of the outlet. While this small error rate may not be statistically significant, I argue that the in-person asset mapping exercise is an important tool in qualitative research as it provides an opportunity to become intimately familiar with the research setting. It is a time-consuming method that requires walking and/or driving on every street within the field setting, allowing for in-depth participant observation and field note opportunities. The findings from this method of inquiry are presented in this section.

Categorized based on accepted foodscape analysis terminology also previously described (Liese et al. 2007), all food outlets were recorded by name and address. Addresses were entered into an online geocoding software package (BatchGeo) which translated each address to its longitudinal/latitudinal coordinates then mapped the locations by type. Table 6.38 summarizes the total number of food outlets available within each zip code by category.

**Table 6.38:** Food Store Outlets

<b>Food Store/Resource<sup>32</sup></b>	<b>Zip code</b>	
	<b>33712</b>	<b>33755</b>
Franchised Fast Food	12	16
Corner Store	15	17
Corner Store with Gas Station	12	8
Corner Store with Grocery	5	2
Franchised Convenience Store	2	1
Franchised Discount Store	5	1
Chain Supermarket	2	4
Specialty Food Restaurant	13	12
Full Service Restaurant	14	35
Other (Food Pantry)	1	0
<b>Total</b>	<b>81</b>	<b>95</b>

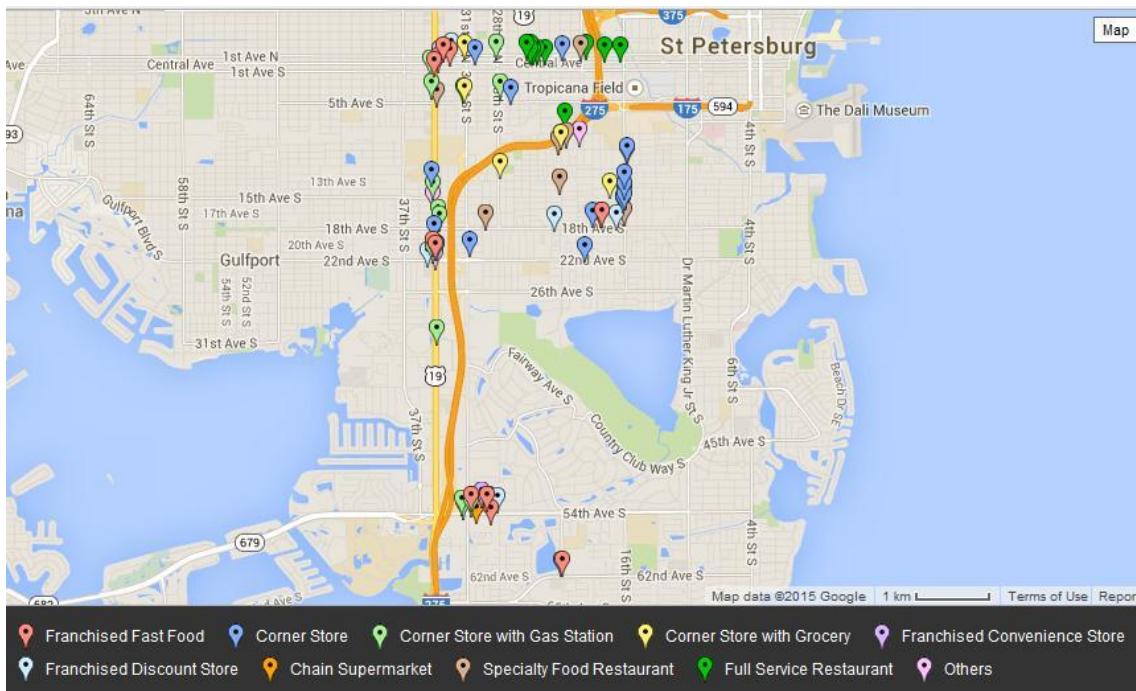
While distance to food retail outlets is an important element in foodscape analysis, the type of store that is present is equally critical as it speaks to the variety, quality and affordability

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<sup>32</sup> See Appendix A for tables of all food stores/food resources in each Zip code area.

of foods within a given community. Looking at table 6.38 we find a few key differences with regards to the types of food outlets between the two zip codes. First, the overall food availability is slightly higher in zip code area 33755 with 95 total retail outlets versus 81 in 33712. With an approximate total population difference of only 1,000 residents between the two communities, 33755 offers more available food per person compared with 33712. With twice as many chain supermarkets serving close to the same number of residents, 33755 likely also offers a greater variety of foods than are available to residents in 33712. Although there are four more fast food restaurants located in 33755, the fast food to supermarket/grocery store ratio is 4 to 1 compared with 6 to 1 in 33712. The graphics in the following section will help to visualize the community foodscapes for this study.

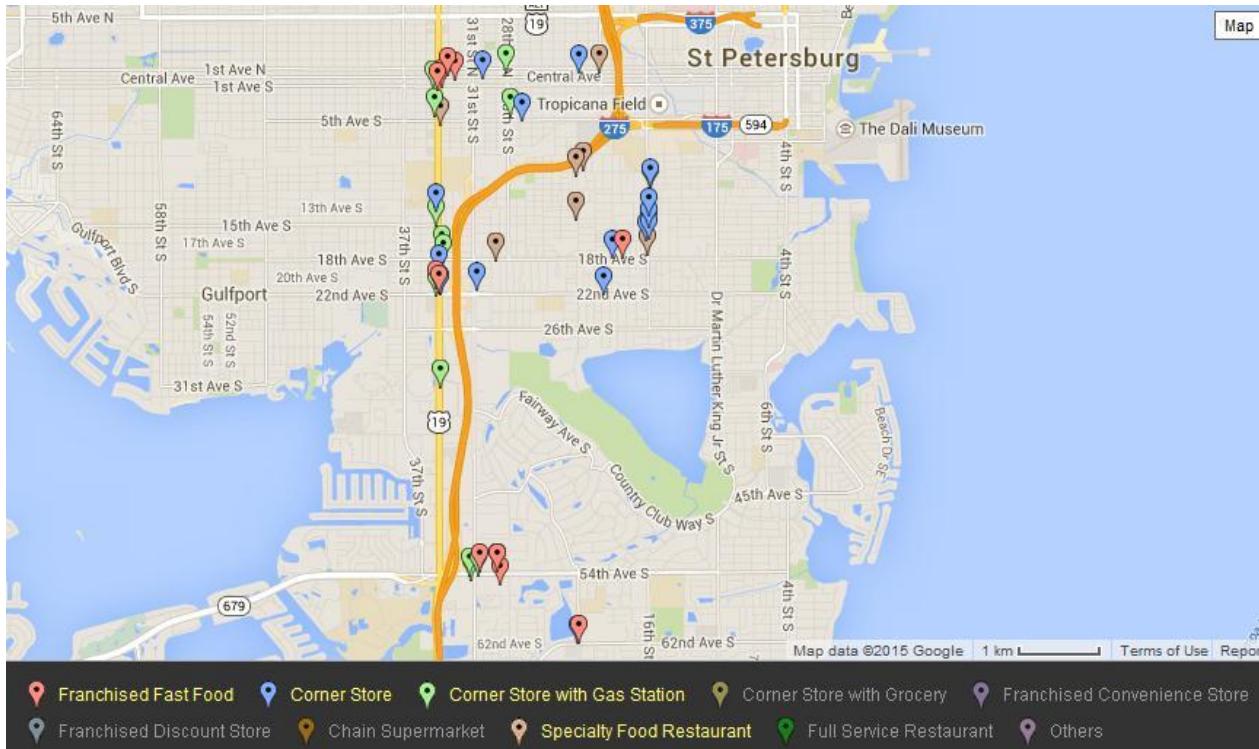
### ***Foodscape Mapping: 33712***



**Figure 6.1:** 33712 All food outlets by type; **Source:** PI, BatchGeo

Looking at figure 6.1 above, we note that the majority of food outlets in area code 33712 are clustered in specific locations, mostly lining the busy 34<sup>th</sup> street corridor marked on this map

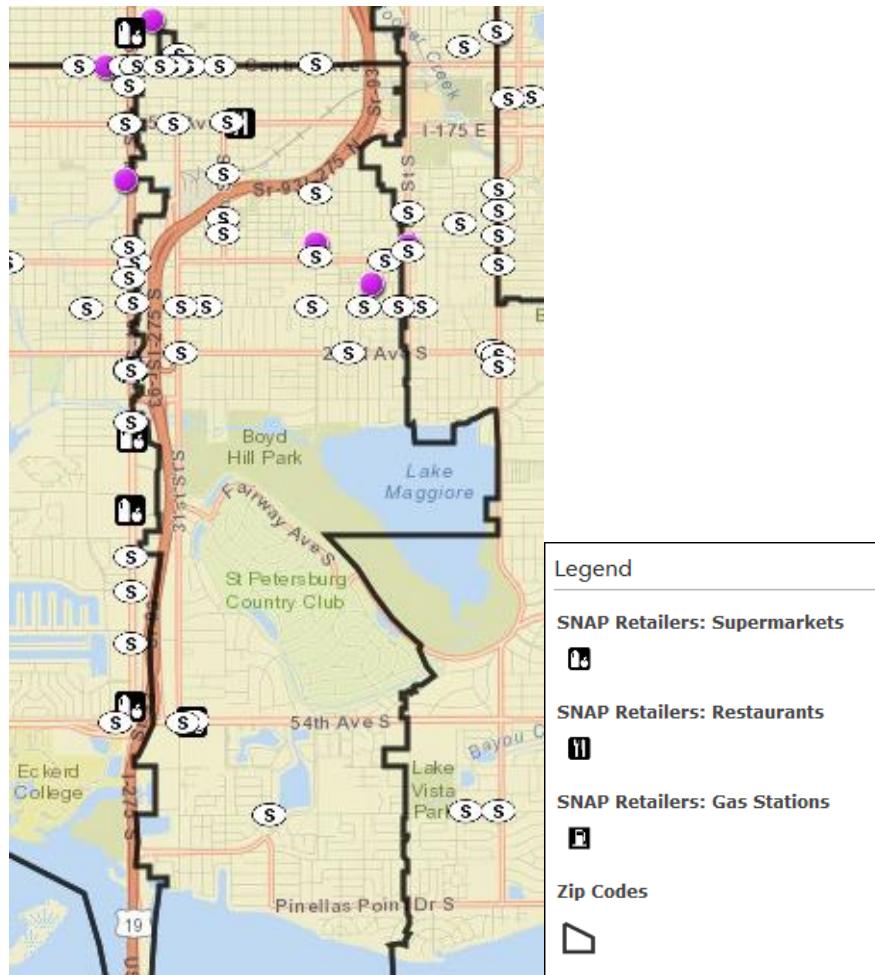
as U.S. 19. This is a busy four-lane highway lined with fast food chain restaurants and gas stations and is the primary link for all of Pinellas County. The next map referring to zip code 33712 is figure 6.2 below. Looking at the legend provided in this image, we see that this map represents food outlets most likely to carry processed, nutrient deficient food options.



**Figure 6.2:** 33712 Corner Store/Fast Food/Convenience Outlets; **Source:** PI, BatchGeo

Comparing the location of corner store and fast food outlets in figure 6.2 with all SNAP retail locations shown in figure 6.3 on the following page, we find significant overlap. For example, the western border of zip code 33712 is made up primarily of U.S. 19, a four-lane highway and serves as the central thoroughfare connecting all of Pinellas County. This section of St. Petersburg, it is a high-traffic area lined with gas stations and fast food restaurants and very little else. Figure 6.2 provides further evidence that the majority of corner stores and fast food restaurants in 33712 are located along the U.S. 19 corridor. This implies that the majority

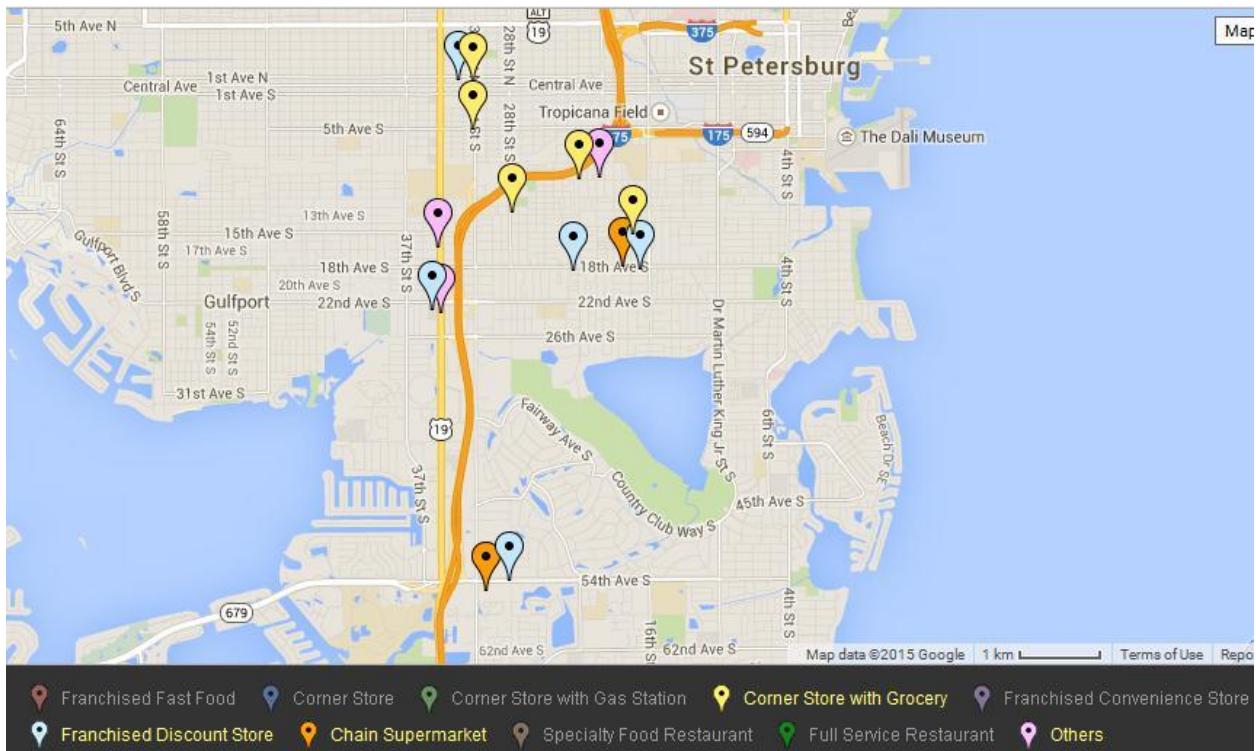
of food outlets in this community that accept food stamps are corner stores, gas stations and franchised fast food restaurants. This represents an important finding as we consider how and where low-income mothers are able to use their food stamps within their local neighborhood foodscape.



**Figure 6.3:** 33712 SNAP Retail Outlets;      **Source:** TBNEH Hunger Gap, Accessed 1/11/2015

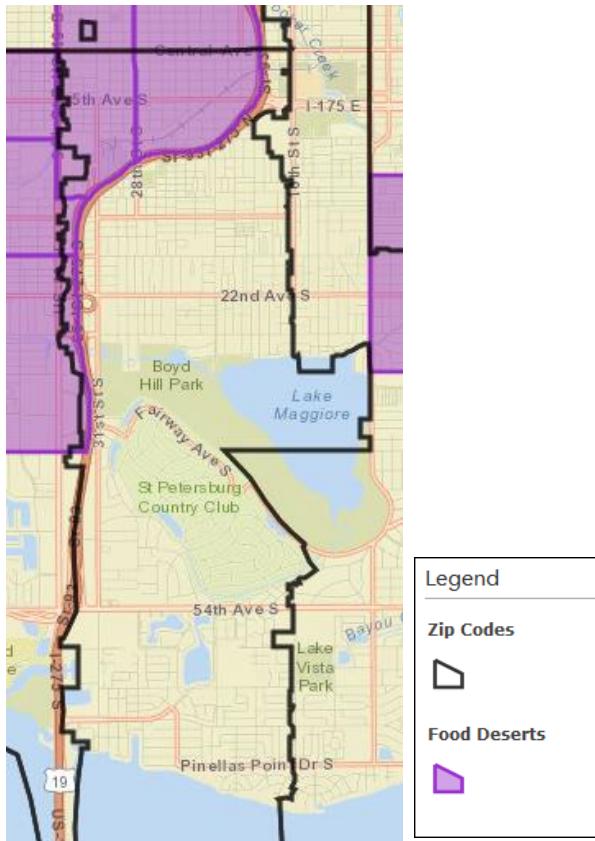
Referring to figure 6.4 on the following page, we find the locations of chain supermarkets, franchised discount stores (e.g., Family Dollar), corner stores with grocery and independent grocery stores. Compared with figure 6.2 (page 191) we notice a significant decrease in food options with this set of food outlets. Figure 6.5 (page 194) documents food

deserts in zip code area 33712. Comparing figure 6.4 below with 6.5 on the following page, we find the designated food desert locations signify that the stores categorized as “franchised discount store” and “corner store with grocery” located in the food desert region likely do not carry healthful food options.



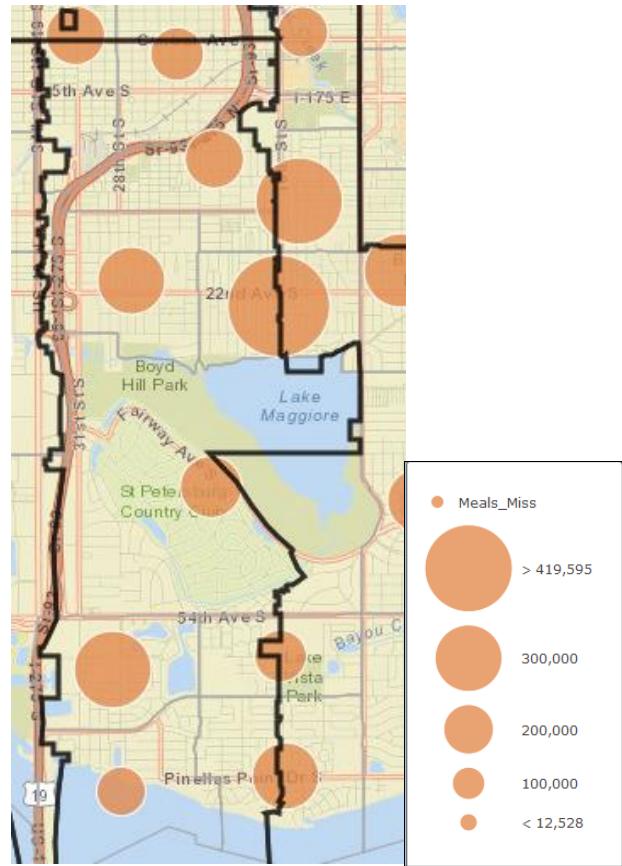
**Figure 6.4:** 33712 Supermarkets and Grocery Stores; **Source:** PI, BatchGeo

Finally, figure 6.6 found on the next page, shows residential locations in which individuals “missed meals” defined as “meals not provided by oneself, public assistance, school meals and other programs or from private sources such as food banks.” In other words, the missing meals (calculated by Feeding America using statistics from the USDA, the US Census Bureau and the US Bureau of Labor Statistics) illustrated in figures 6.6 and 6.12 represent the number the meals needed to allow all individuals in the two zip code areas to eat three meals per day. They are the number of meals skipped or not eaten because residents simply cannot afford them (<http://www.foodbank.org.php5-11.dfw1-1.websitetestlink.com/missingmeals/>).



**Figure 6.5:** 33712 Food Deserts;

**Source:** TBNEH Hunger Gap, Accessed 1/11/2015



**Figure 6.6:** 33712 Missed Meals;

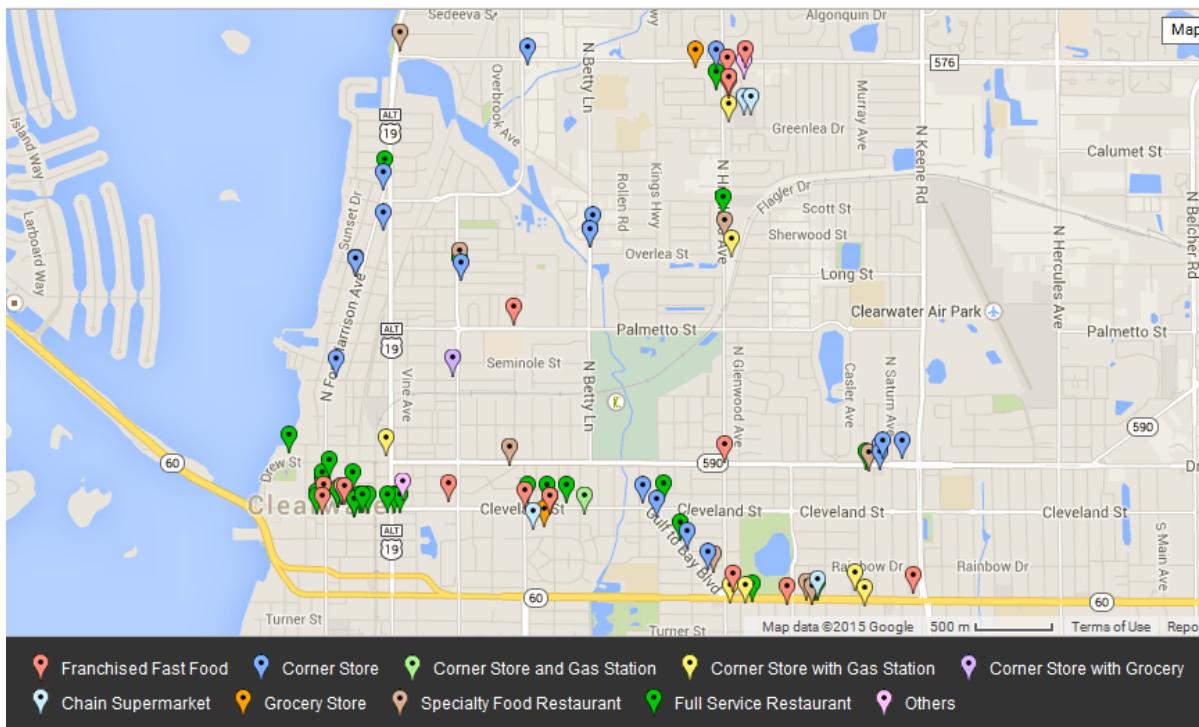
**Source:** TBNEH Hunger Gap, Accessed 1/11/2015

The data shown above in figure 6.6 indicate that well over one million meals were missed in zip code area 33712 in the year 2012. This corroborates the earlier finding that participants in this study do not expend the daily amount required to provide three full meals per day to all members of the household.

To complete the visual foodscape mapping portion of this study, the same graphics will be used to compare the availability, affordability and accessibility of food retail outlets in zip code area 33755.

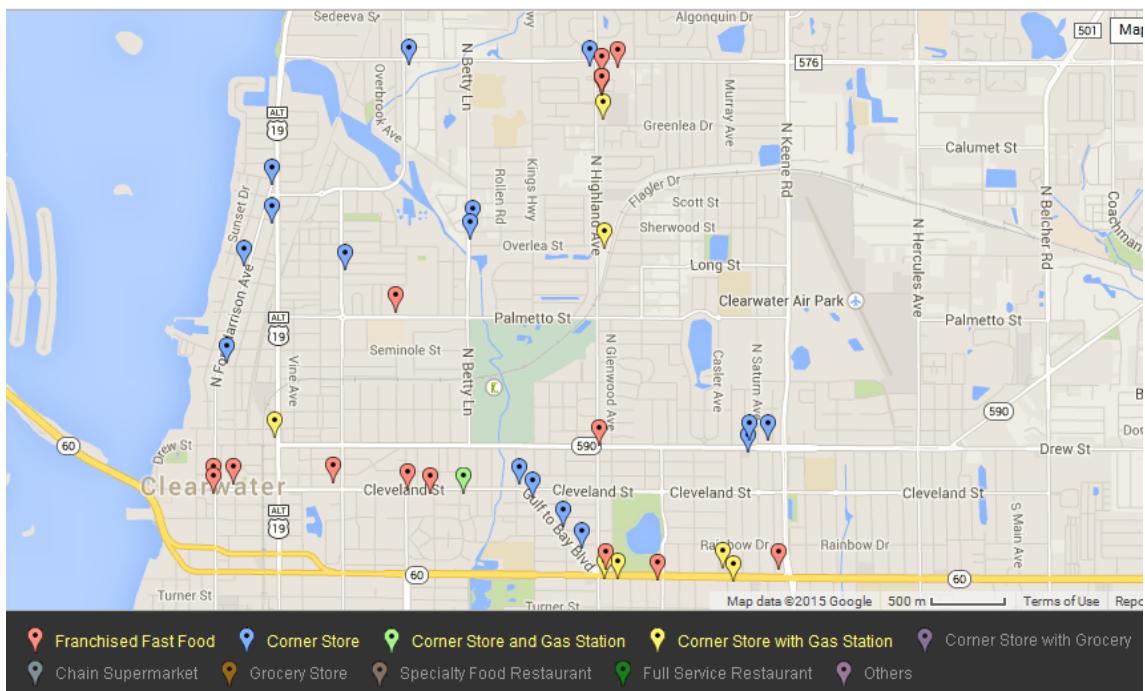
## **Foodscape Mapping: 33755**

Figure 6.7 below shows all food outlets in area code 33755. Similar to 33712, the majority of outlets are located along busy roads and thoroughfares that connect this area of Clearwater with the rest of Pinellas County.

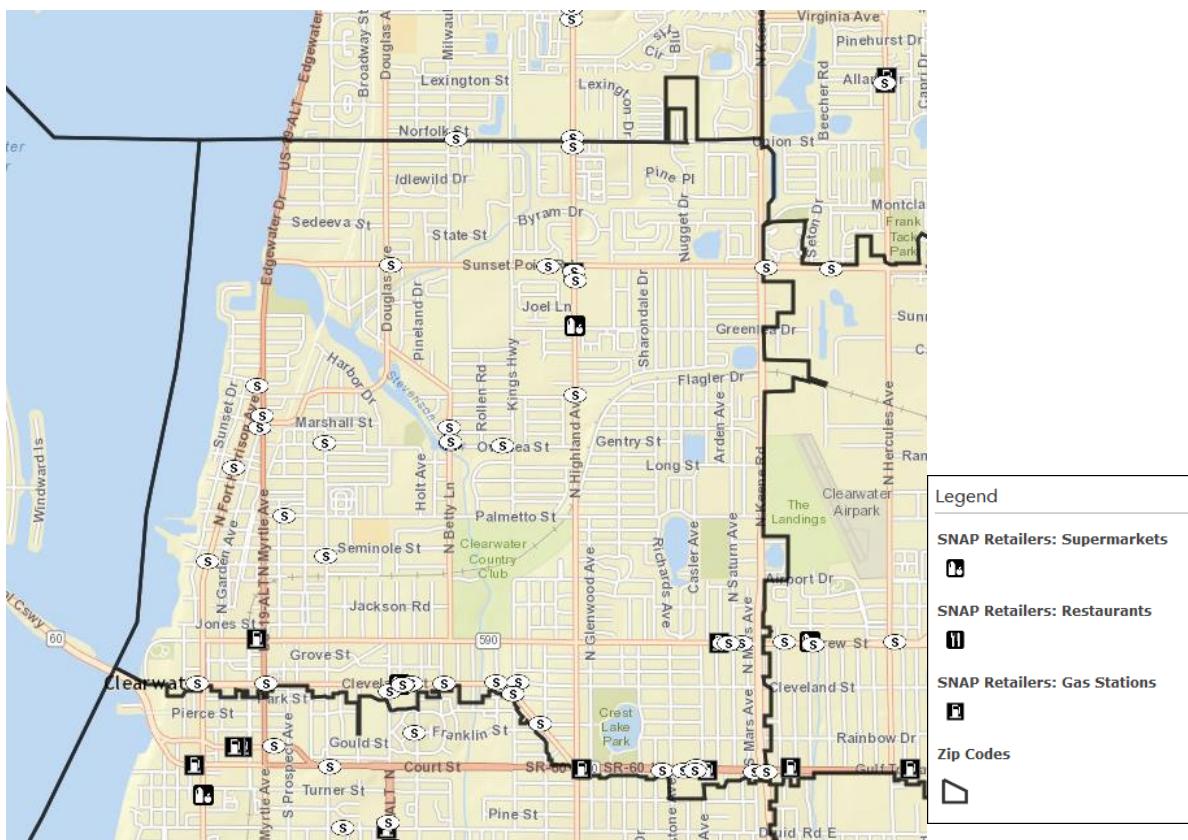


**Figure 6.7:** 33755 All Food Outlets; **Source:** PI, BatchGeo

Comparing figures 6.7 above and 6.8 (found on the next page), we find that the majority of corner stores and fast food restaurants in 33755 are located in the same general area with wide gaps of underserved zones. Referring to figure 6.9 (also found on the next page), we see a similar pattern as in 33712 with regards to SNAP retail outlets overlapping with gas stations and corner stores, again indicating a lack of diverse options for women to spend their food stamps and purchase healthy foods within their local neighborhood foodscape.

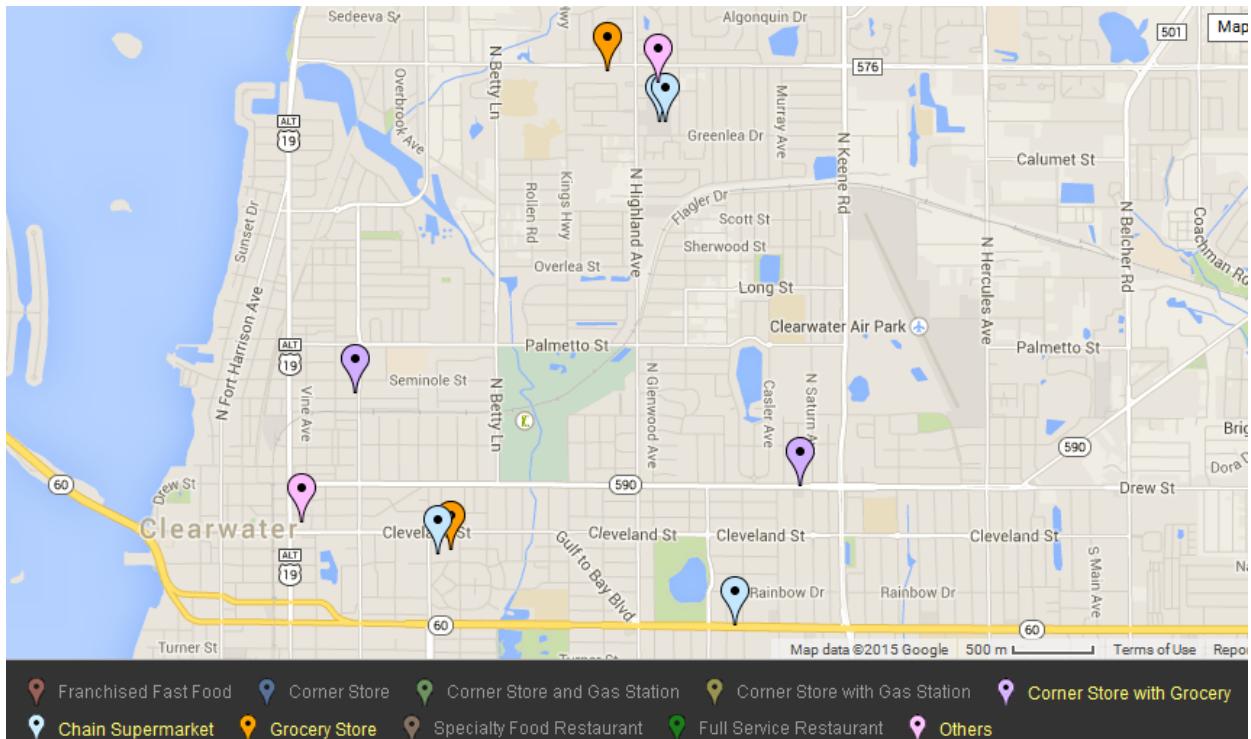


**Figure 6.8:** 33755 Corner Store/Fast Food/Convenience Outlets; Source: PI, BatchGeo



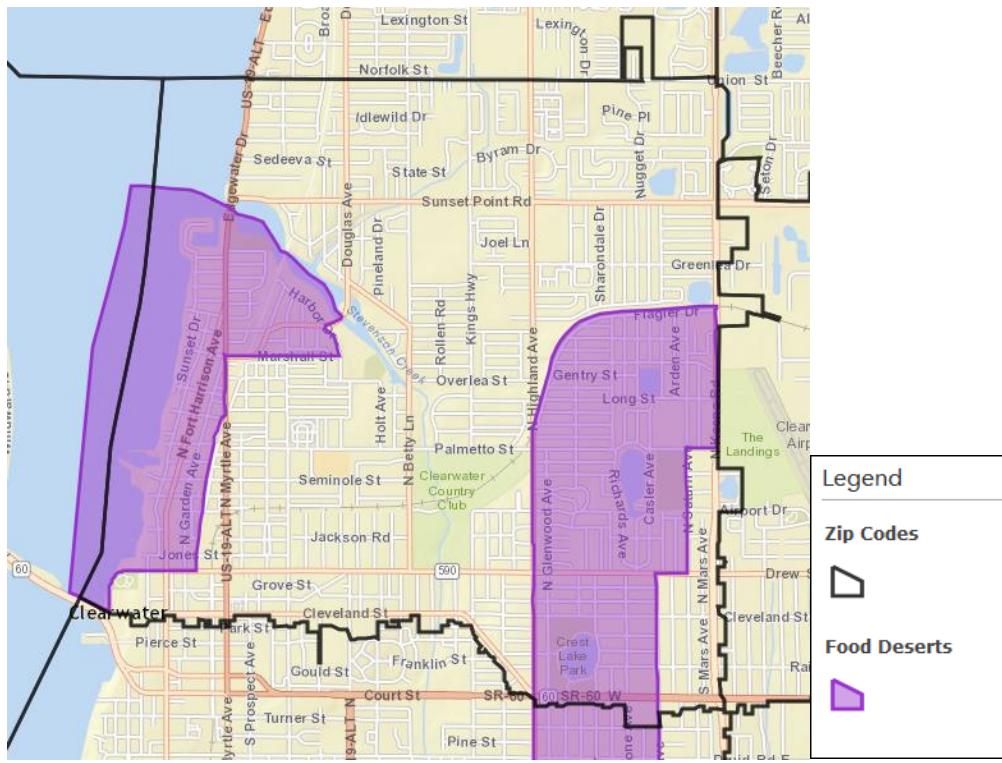
**Figure 6.9:** 33755 SNAP Retail Outlets; Source: TBNEH Hunger Gap, Accessed 1/11/2015

Looking at figure 6.10 below, we see that grocery store availability is quite sparse within this zip code area. Comparing this figure to the food deserts shown in figure 6.11, we again see overlap between areas with no supermarket availability and large regions designated as food deserts.

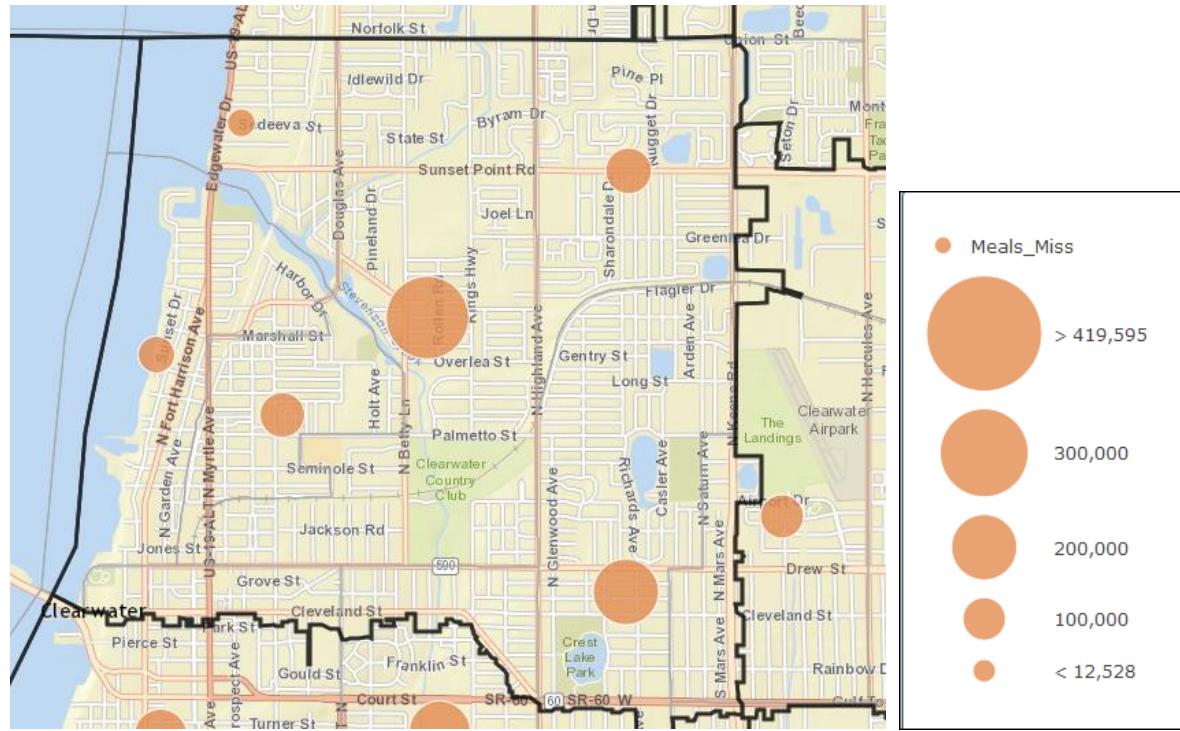


**Figure 6.10:** 33755 Supermarkets Grocery Stores; **Source:** PI, BatchGeo

Finally, referring to figure 6.12 on the following page, we find missed meals scattered throughout the zip code area. Comparing figure 6.12 with the missed meals for zip code area 33712 (figure 6.6) clearly indicates that individuals living in 33712 experience approximately twice the amount of missed meals as residents in 33755.



**Figure 6.11:** 33755 Food Deserts; **Source:** TBNEH Hunger Gap, Accessed 1/11/2015



**Figure 6.12:** 33712 Missed Meals; **Source:** TBNEH Hunger Gap, Accessed 1/11/2015

## **Foodscape Mapping Summary of Findings**

The foodscape mapping component of this dissertation revealed several key findings regarding access and quality of food available in each of the selected zip code areas. First, both communities had a high ratio of fast food restaurants to grocery stores, 4 to 1 in 33755 and 6 to 1 in 33712. The maps illustrate what this ratio means from a geographic perspective as there are clearly large gaps within each zip code not serviced by a supermarket or grocery store. These areas also appear to overlap with the food deserts mapped by the Tampa Bay Network to End Hunger. While there are a large number of SNAP retailers in each zip code area, the majority are made up of corner stores, gas stations and fast food restaurants signifying a potential lack of healthful options for mothers who wish to use their food stamps in their local community. Finally, the missed meals maps reveal a significantly larger number of missed meals in 33712 compared with 33755. Since both zip code areas' demographic and housing characteristics are similar with the exception of race, this finding implies that there may be a lasting legacy of racial segregation and institutionalized racism impacting the resources available to households living in majority black neighborhoods in Pinellas County.

### ***Perceptions of the Local Foodscape***

As part of the foodscape analysis for this study, participants were asked to describe the food available in their neighborhood. This question was left open-ended to capture all variety of available food and food outlets to include stores and restaurants as well as perceptions of the quality, variety and affordability of food in the community. The types of food outlets reported included corner stores, gas stations, discount stores (e.g., Family Dollar) and fast food restaurants with a handful of participants noting they had a grocery store within walking distance (though it may not be the store they choose to frequent).

Discussing the variety (or lack thereof) of the food offered at the local corner store, one participant stated,

*The vegetables and everything, they be in the store going rotten and, you know, like, that just makes it more hard, like just to drive across town to get the fresh produce and everything.*

This lack of variety was noted by several other women with the primary concern that their only option was to buy ‘junk’ in their neighborhood as illustrated in the following quote,

*P: I mean, yeah, I mean Wal-Mart's the main place I go but like if I need something for...for now I'll go to the corner store and get something but mostly I go to Wal-Mart as far as shopping*

*I: So what kinds of things would you buy at like the corner store?*

*P: Junk (laughs). Chips, candy, whatever. I mean they don't really have like food and of course we're not really close to any grocery stores so that's really my only option. Chips, junk.*

Commenting on the high price of food at the local corner store, one mother said,

*That's what we talk about..like cause if I go to the grocery store and I miss somethin I don't wanna go to these stores around here. Because if you go in there, you'll be like...we gotta call somebody or something..because like...like sometimes I'll forget bread.. their bread is like maybe 2 something almost 3 dollars for one loaf of bread and you can go to Save-A-Lot and get three loaves of bread for that. And, um like, they oil that they have...you only get like these little pints and that's like..almost 4 dollars. And if you get a bigger pint of oil , you know cooking oil, at Save-a-lot or Winn-Dixie for 3 dollars.*

This statement about the high prices of food at corner stores was corroborated by another woman,

*Umm, it's convenient, like, driving-wise. The prices it's not. It's too high and everything. So it's like, once you go there and try to buy something, it's like, "Wow, look how much money I got" and you gotta cut-back on a lot of stuff that you probably need to do and everything, just to buy food.*

While most indicated they could find rides to the store when they needed it, a handful of women noted that at times they had to resort to buying things at the corner store for lack of other options.

One woman said, *Yea...I'd be like..I really don't be wantin to get it, but if I don't have no other way and I'll just get it.* Similarly, one participant stated,

*Cause it out of convenience. It's the same with umm, when she was smaller, you know how it is, you have to buy this type of juice, you have to buy. You don't have that option of umm, sometimes I would run out of stuff for her during the week and you just want to go across the street and...a juice in the store is maybe \$1.59 and over there its \$3.49. But you have to do it, you know.*

In addition to the preponderance of corner stores and a general paucity of grocery stores located within participant's neighborhoods (to be described later in this chapter), several women commented on the number and variety of fast food options available within close proximity illustrated by the following quote,

*... there's a Subway, there's a McDonald's, there's a Burger King and there's a Wendy's. Well, not to mention they're like right across the street from each other. There's a IHOP, there's a Bob Evans, there's a Denny's, I just feel like if there was a Chik-fil-A, I'd be so much better with life right now. A Chik-fil-A or perhaps a Sonic, I mean I would appreciate a Sonic, I mean they have pretty good stuff on there but, I mean, as far as like we have like Burger joints, I mean, yes....oh yeah, we have Church's, we have Popeye's, we have KFC, so I don't, I don't know.*

### ***Perceptions of the Foodscape Findings Summary***

The data presented in this section clearly illustrate that the participants perceived their local foodscape (within walking distance from their homes) to be lacking in variety, quality and affordability. With frustration expressed over the high price of convenience and the abundance of "junk" versus healthy options available to them, the narrative is indicative of the 'food desert' and 'food swamp' literature discussed in chapter three. This point will be explored in the next chapter.

### ***Household Staple Food Items***

While no nutritional assessment measures (24 hour dietary recall, food diaries, etc.) were used in this study, during the course of the interviews, participants were asked to name the staple food items they always keep in their home. Table 6.39 summarizes the responses to this question.

**Table 6.39:** Household Staple Foods

<b>Food Item</b>	<b>Frequency Reported</b>	<b>Beverage Item</b>	<b>Frequency Reported</b>
Pizza	2	Milk	7
Ramen	2	Juice	4
Cereal	4	Soda	3
Bread	5	Water Bottles	1
Scallions	1	Sunny D	1
Peppers	1	Kool-Aid	1
Tomatoes	1		
Cucumbers	1		
Cookies	1		
Chicken	6		
Steak	2		
Pasta	4		
Hot Dogs	3		
Macaroni and Cheese	2		
Yogurt	2		
Eggs	2		
“Canned Goods”	2		
Butter	1		
Rice	3		
Potatoes	1		
Lunch Meat	3		
Beans	2		
Peanut Butter	1		
Canned ravioli	1		
Apples	1		
Oranges	1		
Instant mashed potatoes	1		
Pop Tarts	1		
Cheese	1		
Waffles	1		
Chicken nuggets	1		
Salad	1		

The food and beverage items listed as “staple” items for participant households indicate a reliance on a number of processed, energy-dense and low cost foods such as pasta, pizza and hot dogs. Fruits, vegetables and milk were reportedly only affordable to the majority of women in this study through WIC.

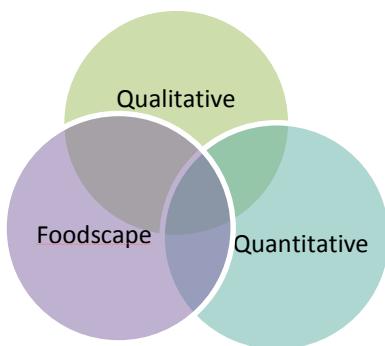
### **Participant Observation Findings**

As previously stated, participant observation was an important method for this dissertation given the fact that my personal life circumstances were so relevant to the topic. Findings from the data collected through participant observation have been summarized in the personal reflections included at the end of each chapter throughout this dissertation. However, some additional notes provided here reflect on the living environment and foodscape of these two communities.

In spending hours driving and walking through both of these communities a number of similarities were documented within my field notes. These include a general lack of sidewalks in residential areas that also happen to be located adjacent to busy thoroughfares. Though buses appeared to be readily available in both communities with numerous stops located throughout each zip code area, very few women reported using them to run errands. Women’s homes that I visited tended to be quite small and cluttered with baby gear often piled into corners and a lack of personal space for mom apparent. Most of the women interviewed lived in apartment complexes that looked to be occupied by majority single mother and young families. As evidenced in the foodscape analysis presented in this chapter, fast food restaurants and corner stores were indeed ubiquitous in both communities compared with grocery stores. And while I did not personally feel unsafe spending time in these communities, the crime data and statistics

for both of these zip code areas reflect hotspots of both drug and gun crimes in Pinellas County.

## Triangulation of the Findings and Conclusion



**Figure 6.13:** Venn Diagram of Data Triangulation

One of the central challenges to

conducting exploratory research is the need to narrow the focus of its results to the common thread tying seemingly disparate findings, together. The results of data as presented in this

chapter reflect a diverse collection of findings.

The triangulation of results for this study was

accomplished by identifying the primary finding of the narrative analysis; the existence of social, geographic and cultural patterns of maternal isolation that will be examined in detail in chapter seven. The bi-directional impact of maternal isolation on food security is supported by the questionnaire results to include the high prevalence of both marginal food security and food insecurity which included over three quarters of the participant sample, reports of depression and anxiety at higher rates than expected for this sample and the existence of prenatal nutritional deficiencies. The foodscape analysis provides further support for the primary finding by documenting geographic lack of access to healthy foods, few participant reports of eating together as a family, racial residential segregation and meal deficit disparities. Finally, the Chi-Square tests of independence conducted on a number of key variables related to both poverty and mothering and their impact on food security. The fact that no statistically significant results were found implies that the patterns of maternal isolation identified in the narrative, which cannot be quantified, play a key role in the complex dynamics of mothering in a low-income setting and the challenges it presents to maintaining food security.

Thus, the combination of findings presented in this chapter reveal two central themes to be examined in chapter seven; Maternal Isolation and Missed Opportunities. These themes represent gaps in the current topical literature and important new ground for anthropological inquiry with the goal of applying that knowledge in the form of recommendations to shift or change public policy and food program delivery.

### **Reflection – The Exhaustion of Mothering**

The findings presented in this chapter summarize the challenges to mothering in poverty. Reflecting on the multitude of barriers to providing even the most basic of necessities to their children, I cannot help but admire the tenacity of these women to persevere in the face of so much struggle. One of the most pervasive stereotypes regarding low-income mothers is that of the ‘lazy welfare queen’. While long debunked, this stereotype persists, I believe, because of a lack of public awareness of just how hard it is to be a poor mother. To feed, clothe, diaper and bathe an infant requires not just time and patience but money to buy food, clothes and diapers, a way to get to the store, enough resources to pay the water bill and so forth. Essentially, everything I take for granted as a mother occupies these women’s daily thoughts and concerns. I could empathize with the mothers I spoke with about many of the typical struggles of motherhood like not having time to myself, worrying about whether my baby was reaching her milestones and the constant, inescapable sleep deprivation. I could only sympathize, however, with the struggles they related about their finances, their baby’s fathers, their inability to continue their education or even treat their child to a day out.

What struck me most when reflecting back on the findings presented in this chapter is again the fact that food security and nutrition research do not capture the unique challenges of mothering which go beyond whether or not women have access to a vehicle or can walk to a

nearby food outlet to buy produce. What are not documented are the all-consuming physical and emotional demands of caring for an infant that exacerbate any additional barriers to food security. As a new mom I struggled on a daily basis to get myself fed between my daughter's marathon nursing sessions, her refusal to nap anywhere but on top of me and her constant fight against being placed in a carrier so I could free up both of my hands. I know from speaking with the women in this study about our shared experiences as new mothers that they too faced some of the same challenges. Combined with chronic sleep deprivation and, for these women, the additional stressors of relationship issues, finances and a lack of a strong social support network, being unmotivated to go through the hassle of meal planning, budgeting or meal preparation is both understandable and expected. What is also often missed in the literature, is the sheer physical exhaustion that comes with carrying an infant round-the-clock, despite their small size. Infants are utterly helpless and therefore create logistical challenges to getting out of the house not often captured in the literature. Tasks that would, to someone on the outside, seem simple, require planning and forethought when factoring in an infant. Babies eat every 2-3 hours, requiring you be prepared every time you leave the house to feed the baby while you are out. Strollers can be burdensome and difficult to fold, often requiring two hands to do so making it difficult to fold while holding a baby to get on a bus if needed. These are just a few of the unique challenges new mothers face to maintaining food security beyond the financial and environmental constraints imposed on low-income women and are important topics for further research on food security and nutrition among women.

## **CHAPTER 7: DISCUSSION OF RESULTS**

### **Introduction**

The purpose of this chapter is to examine the dissertation findings as they relate to the original research questions:

1. How does the experience of mothering influence the food security of low-income mothers in Pinellas County?
2. How do space and place impact low-income mothers' perceptions of their foodscape?
3. How do racism and discrimination (perceived and structural) affect the food security and nutritional health of low-income mothers in Pinellas County?

First, I will introduce the central theme of Maternal Isolation in which the discussion of the findings will be conceptualized. Next, I will present a visual model of the links between the risk factors for maternal isolation and food security. I will use the conceptual model to examine the dissertation results identified in chapter six, connecting them to the topical literature and to the original research objectives. Following the discussion of the maternal isolation results, I will present a secondary theme, Missed Opportunities, which will build a case for translating the findings into recommendations for action. Finally, I will outline the limitations of this study and close the chapter with a brief conclusion.

### **Framing the Discussion: Maternal Isolation Background**

The transition to parenthood is a significant moment in the life course of every parent, be it their first child or their fourth. For most, it is a time of great joy accompanied by exponentially increased physical, social and emotional demands required to meet the needs of an infant

(Cowan and Cowan 1995). To buffer the stress related to those increased demands, the transition to parenthood is also a period in which additional social support is beneficial for the health of the infant and new parents (Cowan and Cowan 1995; Belsky and Rovine 1990). Research suggests that new parents who receive adequate social support experience better health outcomes, express greater satisfaction in their relationships, feel more confident in their parenting roles, and have better child outcomes than those who do not receive adequate support (McDaniel et al. 2012; Meadows 2011; Crnic et al. 1984). In contrast, social isolation, defined as “a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and/or they are deficient in fulfilling and quality relationships” (Nicholson 2009: 1346) is framed in the literature as a public health issue as a contributor to adverse health conditions (Nicholson 2009).

In the past forty years, as American culture has become more socially isolated, more new parents are transitioning into their parental roles in a state of social isolation than ever before (Fischer 2009; Parigi and Henson 2014). The ‘lost community hypothesis’ is a conceptual paradigm of social isolation focused specifically on the United States (Wellman 1979; Putnam 2000). It asserts that contemporary Americans participate less in ‘associational life’ resulting in a decrease in social capital within communities and less trust among neighbors or reliance on extended social networks (Putnam 2000). This paradigm is tied to both the trappings of modernity (e.g., cars, phones, computers/internet, large houses, mobility) and to ‘American exceptionalism’ – the neo-liberal ideology championed in the United States that encourages self-reliance and independence (Giddens 1990). The implication of this concept is that American society is more insular and inwardly focused on the nuclear family than in other countries. In contrast, in certain regions of the world children are raised within a large extended family

network in which they belong collectively to all of the adults in the group supplying new parents with an abundance of social support (Barlow 2004). These types of extended familial patterns are a rarity in the United States (Humenick 2003). Paired with the fact that we have the highest rates of postpartum depression in the industrialized world (between 11-15% of all new moms) (CDC 2008) and an ‘epidemic of loneliness’ (Joiner 2011), American social isolationism is particularly relevant to the findings of this dissertation.

There is a large body of work showing that parents living in poverty have an even greater need for social support than their more affluent peers due to increased chronic stress in their daily lives (Hashima and Amato 1994; Belsky 1990). These may include difficulty paying their bills, food insecurity, lack of transportation and child-care, poor access to medical care and so forth. For single mothers living in poverty, the demands of mothering can be particularly overwhelming as they must cope with these chronic stressors, along with the increased demands of caring for an infant in the absence of a partner’s support (Hashima and Amato 1994). Paired with the expectation in the U.S. that ‘good mothers’ conform to the dominant intensive mothering ideology (Hays 1996) (see chapter three) espoused by the social services upon which they rely for help, many poor mothers live in overwhelming fear of asking for help, making a mistake, not having someone to call upon in an emergency, and a lack of competency in their new role as mother (Campbell-Grossman et al. 2005).

Drawing on the dominant intensive discourse of mothering in the U.S., the media, and entertainment industry often portray mothering as an essentialist experience meaning that “women naturally possess innate female qualities that drive them to pursue maternal goals above all others.” (Coulter *in* O’Reilly 2010: 393) For example, we are inundated with television commercials for household products portraying stay-at-home moms as the norm with the adage

‘moms know best’ tagged at the end. This essentialist perspective on mothering argues for a universal and biological ‘maternal instinct’ independent of the social and cultural environment(s) in which mothering occurs. In her work with women living in poverty in Brazilian shantytowns, Nancy Scheper-Hughes argues instead for a social construction of mothering stating:

“Theories of innate maternal scripts such as “bonding,” “maternal thinking,” or “maternal instincts” are both culture and history bound, the reflection of a very specific and very recent reproductive strategy: to give birth to few babies and to invest heavily in each one”...this does not reflect the maternal thinking of a great many women living in the Third World.” (1985: 310)

The ethnocentric tendency in the U.S. to confine mothering universally to the private domain of the nuclear family ignores the fact that “mothering occurs in the broader context of other relationships and expectations.” (Barlow 2004: 518) That is, to understand the experience of mothering we must consider it as a “dynamic and culturally informed process.” (Barlow 2004: 514)

Thus, the American popular culture version of motherhood has very little to do with the complex reality of the mothering experience where “(dis)junctions prevail between the ideologies of mothering and motherhood and the experiences of real women.” (Arendell 2000: 1196) The ‘real experiences’ of mothers are often characterized by competing tensions. For example, tension between the erosion of self on the one hand and the expansion of self-identity on the other. The transition to motherhood is often accompanied by loneliness, a sense of isolation, stress and fatigue while simultaneously providing a source of joy, contentedness, personal pride and confidence (Rokach 2004). The popular culture version of motherhood tends to ignore these complexities, making taboo the feelings of isolation and loneliness that can accompany new motherhood within the U.S. Nor does it adequately account for or value the alternative mothering strategies of women who do not or cannot meet the ‘intensive mothering’

standards associated with being a ‘good mother’. This perpetuates reluctance on the part of mothers to voice their honest concerns to providers, friends and family resulting in the persistence of inadequate social support at a time when it is perhaps needed most.

While the topic of maternal isolation is beginning to be addressed in the literature (if not in popular culture) there are very few studies that examine how it [maternal isolation] may impact the health of both mothers and babies beyond psychological and developmental concerns (e.g., post-partum depression). The findings presented in chapter six suggest that prenatal and postpartum isolation may have a significant impact on the food security of low-income households. This could have wider policy implications for developing more ways to improve the social connectedness of expectant and new mothers. The next section of this chapter will examine this issue by exploring five central themes related to maternal isolation that emerged through the data analysis. The five themes to cover a range of constructs including social, geographic and cultural isolation experienced by this study’s participants. As discussed previously:

“social support appears to have a salutary effect on parenting behavior by making mothers feel less isolated and overwhelmed by their parenting situation and more gratified by the maternal role... In addition, it can foster a sense of efficacy and confidence in one’s ability to deal with problems and promote a redefinition of problems so that they are less threatening.” (McLoyd et al. 1994: 566)

It follows then that maternal isolation in its varied forms would serve to exacerbate the chronic stress experienced by low-income mothers and to place these women and their children at greater risk of exposure to poor health outcomes.

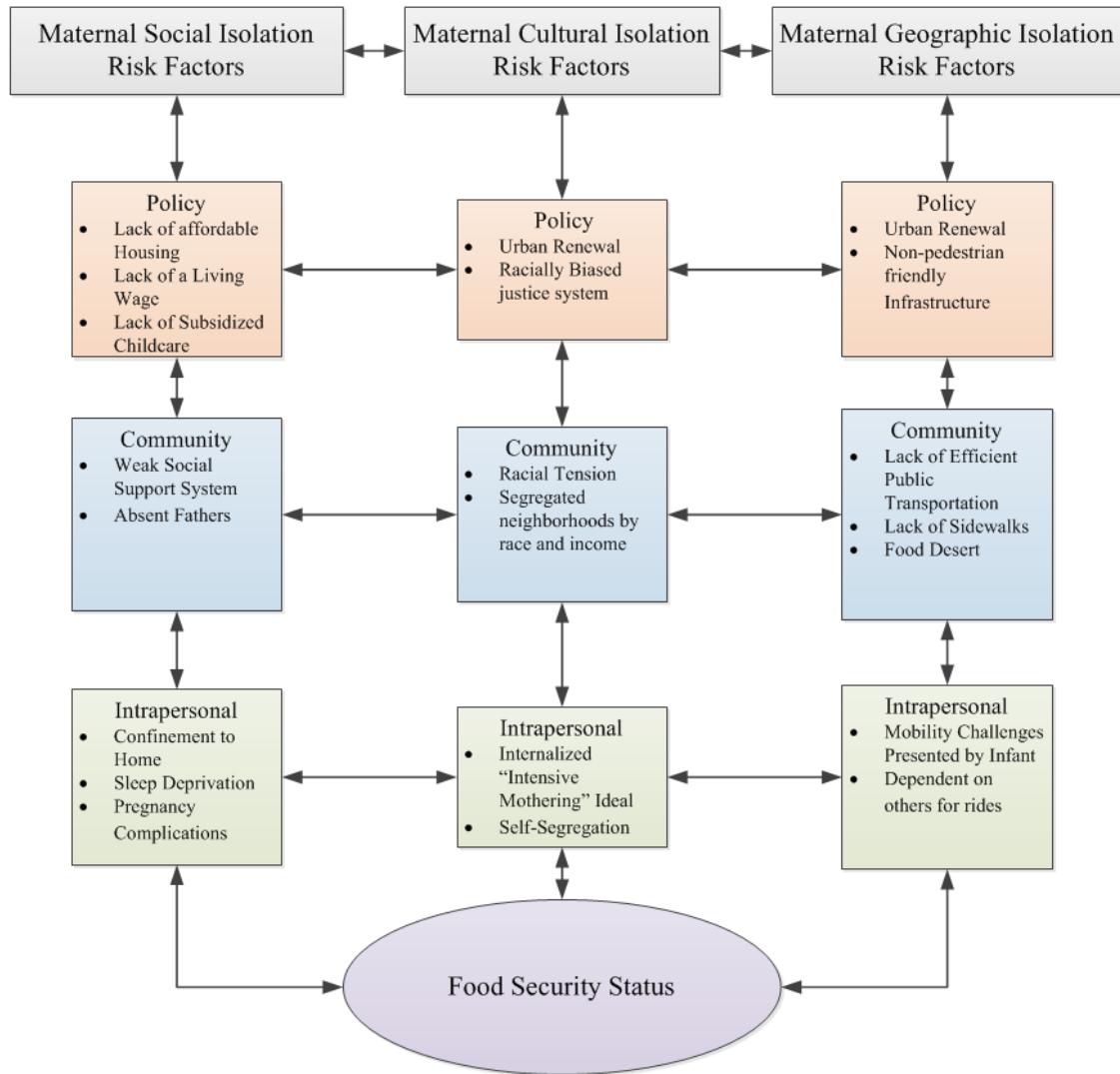
## **Maternal Isolation: Discussion of Findings**

Though discussed in chapter six, I present again the concept of maternal isolation defined in this context as, “a state in which the mother lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and/or they are deficient in fulfilling and quality relationships as a direct result of her transition to motherhood.” (Terry 2015) This definition allows for a broad conceptualization of the intersection between the macro and micro-level risk factors for maternal isolation, the lived experience of mothering and the food security status of low-income households. Figure 7.1 provides a visualization of these complex and overlapping relationships.

### ***A Conceptual Model of Maternal Isolation and its Link to Food Security***

Referring to figure 7.1, this model notes three patterns of maternal isolation identified in the course of this study; social, cultural and geographic. Each of the headings in the model are linked to three tiers of risk; Policy (macro-level), Community (meta-level) and Intrapersonal (micro-level), connecting each of the three patterns of isolation with food security status. Examples of risk factors included in the boxes in the model are meant to be representative and not inclusive of all variables associated with maternal isolation. The use of bi-directional arrows emphasizes the overlapping nature of these multi-level risk factors and signifies that any approach to mitigating food insecurity should incorporate action at each layer to address the issue holistically.

## Modeling the Link Between Maternal Isolation Risk Factors and Food Security Status



**Figure 7.1:** Maternal Isolation and Food Security Model

In the following section of this chapter I will review the primary findings of this study as they relate to each of the maternal isolation patterns described in the model, beginning with maternal social isolation. To further frame this discussion within the participant narrative, I use direct

quotes from the narrative analysis to identify the risk factors associated with maternal isolation.

I will begin with maternal social isolation.

### ***Social Isolation***

#### *Tina's Story<sup>33</sup>*

*Tina's case provides a firsthand example of the impact of social isolation on food insecurity as illustrated in figure 7.1. As a full-time social worker, Tina, a 32-year-old single mother of an 11 month-old daughter reports struggling on a monthly basis to keep her and her daughter fed. She gets up every morning at 6:00am and prepares for the day, then wakes up her daughter, bathes her and takes her to daycare by 7:00am where she is provided breakfast. Tina then goes on to work as a caseworker at a methadone clinic where she makes an annual salary of just under \$25,000 (with a bachelor's degree). At 5:00pm, she leaves work, picks up her daughter from daycare and heads straight to the YMCA (where she qualified for a free membership) for her 30 minute daily work-out. At 6:00 or 6:30pm, Tina heads home, cooks dinner for her and her daughter, eats, then starts her daughter's bedtime routine which consists of playtime, story time then bedtime. Tina then cleans her two bedroom apartment (for which she pays over 50% of her monthly income in rent since she does not qualify for subsidized housing), spends about an hour relaxing, goes to bed and does it all over again the next day.*

*Originally from Puerto Rico, most of Tina's family still live on the island and do not visit. Her daughter's father was arrested for a DUI and drug possession during her last trimester of pregnancy. He was released when her daughter was approximately five months old, but she does not allow visits due to his continued substance abuse. He is unemployed and does not provide child support of any kind. She explained that most of her friends and family have shut her out since she had her daughter because they feel "she should have known better" than to be*

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<sup>33</sup> Pseudonyms are used in all vignettes to protect the identity of participants.

*involved with a man who has a drug history given her career choice. Thus, other than the time she spends with co-workers, Tina does not have a social support network on which she can rely and does not have anyone with whom she socializes.*

*Tina's responses to the HFSSM place her in the very low food security category. She reports struggling at the end of every month to keep enough food in the house, usually resorting to the food bank to supplement that critical period. What is interesting about Tina's case is that she developed gestational diabetes during her pregnancy at which point she was referred to a dietitian and learned about healthy eating. She has tried to continue to eat healthy since she had her daughter which she believes is the reason she often runs out of food stamps and money for food at the end of the month – because the healthy foods she buys are more expensive than processed, less nutritious options.*

*Tina's case thus illustrates the Social Maternal Isolation pathway in figure 7.1. Beginning with the policy level risk factors, it is evident that Tina's income is not sufficient to provide for basic necessities despite working full-time as a licensed social worker. The fact that despite her low income level she does not qualify for subsidized housing further supports the need to address the issue of both living wages and more affordable housing at the macro-level. If Tina did not spend over half of her monthly income on rent, it follows that she could better afford nutritious foods for her and her daughter.*

*At the community level, it is evident that Tina's lack of a social support network also impacts her food security status, relying on the food bank rather than friends or family to help her cope with monthly food stamp shortages. With no partner and no support from extended family or friends, her ability to cope with 'shocks' such as car repairs, a change in her daughter's daycare rates or other unexpected expense can have a significant impact on her*

*household food security. This translates to chronic anxiety about covering her expenses on a monthly basis and attempting to save (she's never quite able to put any money away) for whatever may arise.*

*At the intrapersonal level, Tina stated that her diagnosis of gestational diabetes served as a motivating factor to start eating more healthfully, to learn about nutrition, exercise, and to more carefully monitor her daughter's diet. She prides herself on feeding her daughter a mostly organic diet with lots of fruits and vegetables. The downside of this choice she says, is that she runs out of food and money at the end of every month due to the increased cost of a healthy diet. Because she is so exhausted from doing it all herself, she does not commit time to developing relationships with neighbors (most of whom are also single mothers) despite the fact that she believes having neighbors she could rely on would be emotionally beneficial.*

Tina's story thus provides one case study illustrating social maternal isolation identified in this study sample. Taking a wider lens, the rest of this section will focus on the participant narrative on social isolation as a whole. To achieve this, three participant quotes were selected as representative of the risk factors of maternal social isolation expressed by participants. These statements include, *I don't do most of the stuff I used to*", "*Their dad, he is just a walkin' stress*" and "*I stay in the house.*" The following section will discuss the interview findings represented by these three quotes.

*I don't do most of the stuff I used to.* This statement illustrates the shifts in behavior participants reported as a result of the news of their pregnancy and the effects those changes had on their social lives. These included changes in friendships, relationships, employment, and future plans. For women, the transition to motherhood begins with the knowledge of the pregnancy. Even before the signs of pregnancy are externally visible, medical recommendations

for healthy gestation suggest that most women need to shift their personal behaviors to include changing what they eat, how/if they exercise, what products they use in their homes and on their bodies, how much rest they get, the elimination of alcohol and tobacco use, limitations on caffeine intake and so forth (Deave, Johnson and Ingram 2008). Thus, the news of a pregnancy is also typically accompanied by the medicalization or subjectivity of the pregnant body as ‘at-risk’. This normalizing construction of pregnancy as a ‘complication’ requiring regulation of maternal exposures and frequent medical monitoring regardless of a woman’s life circumstances can have a major impact on a woman’s life in a variety of ways.

For women who experience unplanned pregnancies (two-thirds of this participant sample), especially low-income women with limited social support, the suddenness of the transition to expectant mother may make compliance with the standard recommendations for healthful behaviors during pregnancy particularly difficult (Kost, Landry and Darroch 1998). Financial constraints, poor diet, pre-existing co-morbidities, substandard living conditions, low educational attainment, little to no partner involvement and a lack of emotional investment in or ambivalence toward the pregnancy are just some of the factors that may contribute to a difficult transition to expectant motherhood for low-income women (Paris and Dubus 2005; McCabe et al. 2012). Within the expectation that women conform to the recommended prenatal care and pregnancy behaviors is an inherent bias whereby those women who have the resources and life circumstances to comply with the recommendations are considered ‘good mothers’. Those who do not or cannot comply are deemed discursive or ‘at-risk’ (Barlow 2004; Estrin 2014).

This period of adjustment to the pregnancy and resulting new self-identity along with the expectations of constant bodily monitoring can be socially isolating for expectant mothers (Bailey 1999). Friendships and relationships often change as pregnancy limits the ability to

partake in some social activities (e.g., social drinking). Fatigue and morning sickness may likewise limit a pregnant woman's ability to continue to engage in her social life as she had done previously (Paris and Dubus 2005). Continuing employment and/or education may also present challenges during pregnancy due, for example, to constraints on lifting or the simple fact of fatigue (National Partnership for Women and Families 1999). Finally, the pregnant body becomes a source of public scrutiny as family, friends, strangers and colleagues often feel entitled to comment on the shape and/or size of the growing body. This experience can produce feelings of alienation as the embodiment of pregnancy overshadows a woman's self-identity (Young 1984). These various concerns were evidenced by the participant statements included in chapter six.

Though all participants stated unequivocally that having their children was positively transforming, descriptions of their pregnancies point to a number of stressors with which they were forced to cope. Based on this study's findings, pregnancy appears to be a barrier to ongoing employment and/or the completion of an education (National Partnership for Women and Families 1999). It was evident from the interview data collected that African American participants were encouraged by their families, mostly their mothers and/or partners, to rest and take care of themselves during their pregnancy rather than work. Of the 20 African American mothers, over half were employed or attending school at the time they learned of their pregnancy. All but two chose to quit their jobs and/or school at the encouragement of their social support network compared with five of eleven White mothers continued to work or attend school through their pregnancies. As discussed in chapter three, ethnographic data suggest that low-income mothers may feel it is necessary to preserve their energy in order to be able to adequately shield and protect their children from the rigors of poverty (Laraeu 2011; Gillis 2005; Castel

1991). This is contrasted with the intensive mothering model of complete self-sacrifice at the expense of one's energy among other things (Hays 1996). What is interesting here is that all participants were living in poverty, yet the African American mothers were more likely to emphasize that caring for themselves during pregnancy was particularly important, potentially indicating differences in perceptions of perinatal risk and coping strategies between these two cohorts.

Reliance on a social network of friends and family to help provide essentials like food is one of the coping strategies employed by low-income families (Yoshikawa, Weisner & Lowe 2006). As presented in the previous chapter, participants were asked to describe on whom they could rely for help and in what ways they received that help, both during their pregnancy and after the birth of their baby. The findings suggest that other than immediate family and partners, this participant sample generally had a very small social support network on whom they could rely.

*Their dad, he's just a walkin' stress.* The interview data suggest that a lack of partner involvement is certainly a source of stress for many of the participants. As described in chapter six, African American women reported a 25% decrease in partner involvement postpartum with the White cohort reporting an 18% decrease. Yet, in some cases, as evidenced by the statements included in chapter six, a father's absence also served as a motivating factor to return to employment or further their education.

Addressing the causal factors of the high number of non-residential fathers in low-income families is somewhat precarious as it can easily cross the line into victim blaming. We must be careful to connect the immediate causes of absence with the structural framework that creates them. The literature reports high incarceration rates, substance abuse, low-educational

attainment, a lack of role models, housing concerns and high rates of depression (Coates and Phares 2014; Anderson, Kohler and Letiecq 2005) as a few of the factors impacting low-income fathers' involvement. Each of these factors may be connected to the overarching political economic policy structure that disproportionately places more of these men behind bars, does not provide for a living wage, makes it difficult for unmarried couples to qualify for housing assistance (Parker 2010; Sorensen 2010). Paired with the expectation that fathers "provide" when they have little opportunity or means to do so is a major social concern and one that needs to be addressed. What is clear is from these findings is that the lack of partner involvement in this participant sample is a risk factor for food security and there is an enormous unmet need for living wages, more affordable or subsidized childcare, and affordable housing. These needs are required to be met in order to produce the economic and social environments that can foster and empower low-income couples to comfortably support their families and to provide more opportunity to young, low-income men so they may have the confidence to father their children.

*I Stay in the House.* This statement refers to the isolation of new mothers who, without resources or transportation are confined to their homes with their children. This statement supports the literature on new mother isolation which suggests that low-income mothers are particularly susceptible to social isolation because of their inability to financially support activities outside of their home (Bove 2006). In a study working with low-income service providers, one provider stated,

"a lack of finances can lead to isolation for single, low-income mothers....They don't have cars. They can't get out. They haven't figured out yet how to bundle everything together on a bus...there's a sense of isolation for them...They feel hopeless and many of their friends have abandoned them." (Campbell-Grossman et al. 2005: 251)

As described in the findings presented in chapter six, a number of women reported stress related to not being able to afford to “go out” as well as the logistical challenges of toting an infant on daily errands. These statements, again, indicate both a lack of strong family/social network support and a lack of community that could help to mitigate these stress factors. For example, in conducting and/or attending the majority of the interviews, I documented the surprising number of women who did not know any of their neighbors even though the majority of them appeared to be young, single moms as well. Considering the demands on time and energy required to meet an infants’ needs, it is understandable that a community of neighbors may not readily exist in primarily low-income single mother housing. However, given that so many of these women expressed frustration with their lack of social lives and/or their loss of earlier friendships due in part to their transition to motherhood, it would seem to be a natural social outlet and provide much-needed.

The Maternal Social Isolation findings as presented here help to answer the first of this study’s research questions, “*How does the experience of mothering influence the food security of low-income mothers in Pinellas County?*” A summary of the findings that inform this research question are presented below using the conceptual model’s tier-level framework as presented in figure 7.1.

1. Policy (macro-level)

- a. Minimum wage level is too low to provide basic necessities such as housing and food
- b. Low availability of affordable housing
- c. Federal and state law treat drug addiction as a crime which leads to increased numbers of incarcerated fathers.

2. Community (meta-level)

- a. Non-residential fathers are common in a low-income setting
- b. A lack of a strong social support network is reported for low-income women
- c. Neighbors do not rely on one another for support

3. Intrapersonal (micro-level)
  - a. The physical and emotional strain of stress, depression and anxiety may lead to a lack of motivation to seek healthful foods
  - b. Infants present challenges to mobility, requiring preparation and large amounts of effort to go to the grocery store, for example.

### ***Geographic Isolation***

#### *Rachel's Story*

*Rachel is a White, twenty-one year old mother of two boys, one twenty months and one six months old. She does not work but would like to find a job or return to school to complete an associate's degree. She lives with her boyfriend, the father of her two boys, in an 800 square foot, one-bedroom apartment (for which they pay \$800 per month in rent). Her boyfriend works long days installing and refinishing hardwood floors when there is work but due to the recession, there are weeks when nothing is available.*

*Rachel starts her day when her youngest son wakes up around 6:00am for his morning bottle. After he finishes, he usually naps for about an hour until her oldest son wakes up and her day officially begins. She spends her days playing with her boys, cooking, cleaning and trying to find creative ways to keep them entertained with no outdoor space, very little room inside, no car and living in a neighborhood with no park or sidewalks. She admits that her and her children are often inside for entire days with little to do except watch television. Aside from worrying about finances and putting food on the table, Rachel states that her living situation creates a large amount of stress for her and that she often feels lonely, isolated and depressed about her situation.*

*Since Rachel chose not to file formal child support, this young family does not qualify for subsidized housing. Instead, because of their credit score and former eviction record, their housing choices are limited to landlords who either do not check credit or who rent to "high-*

*risk” tenants at an exorbitant rate. Rachel and her boyfriend moved to this apartment right after being evicted from their previous rental soon after her youngest son’s birth. She says it was the only apartment they could find on short notice that would rent to them and they had to take it or they would have been homeless. The apartment happens to be located in an isolated pocket of low-income housing close to the congested U.S. highway 19 which serves as the main thoroughfare connecting Pinellas County. Rachel complains that she cannot walk with her sons anywhere as the community she lives in does not have a neighborhood park, does not have sidewalks and no easy access to a grocery store. Since the family does not own a car (Rachel says she and her boyfriend have points on their licenses they need to pay off before they can get one), they are limited in their food shopping choices and recreational activities.*

*Rachel states that this is part of the reason why she feels she eats poorly. She says she often relies on her mother to bring her food (but she thinks her mom eats an unhealthy diet and often brings them fast food) or she walks to the neighborhood corner store to fill the gaps and “buy junk” when necessary. At twenty-one, Rachel says most of her friends are still single with no children so they are not available to help or do not really know how to support her. Rachel’s responses to the HFSSM placed her household in the “Low Food Security” category suggesting that although she does have the support of her partner and her mother, food is a chronic source of stress for this young family.*

*Illustrating the Geographic Maternal Isolation pathway in figure 7.1, Rachel’s story begins with the larger macro-level land use trends that have resulted in urban renewal, gentrification and inaccessible urban pockets of poverty. As previously discussed, Pinellas County is an exceptionally difficult place to live without a vehicle, leaving those families who live in isolated low-income communities with few options for food.*

*At the community level, the lack of efficient and affordable public transportation translates to families like Rachel’s relying on family and friends to offer a ride to the grocery store or bring food to them. These families also report resorting to corner stores more often than low-income families who own a vehicle or who live in more walkable areas. Rachel states that she believes her diet is negatively impacted due solely to where she lives.*

*At the intrapersonal level, Rachel admits that the geographic isolation she lives in translates to feelings of social isolation, loneliness, boredom and depression. She stated throughout her interview that having a vehicle would “change everything”; enabling her to pursue employment outside the home, contribute to the household income and perhaps explore opportunities to further her education. She reports chronic stress and anxiety related to finances and being “stuck in the house.”*

Rachel’s story is not unique within the study sample. The following section discusses the theme of geographic isolation identified as one of the primary findings in chapter six across the study sample as a whole. Here, it is represented by the participant statement, *How am I gonna get there?*

*How am I gonna get there?* This statement refers to the geographic isolation and lack of access to transportation experienced by the majority of the mothers who participated in this study. As discussed previously, Pinellas County is a particularly difficult and hazardous place to live without a vehicle. This is especially true for the participants in this study who live not only in racially segregated neighborhoods but also within urban pockets of poverty that are densely populated with fast food restaurants and convenience stores, bordered by high-traffic roads with no sidewalks and very little access to public transportation. These statements are supported by the evidence presented in both chapter two and chapter six. For example, both selected

communities for the foodscape analysis scored as “car-dependent” for their walkability scores (see chapter six) which means that daily errands are difficult to accomplish without a vehicle in both communities.

For new mothers, especially low-income mothers without a vehicle or discretionary income, this geographic maternal isolation can translate to social isolation in the form of confinement to the home. may have a very real impact on diet including immediate *availability* of food (e.g., what do they have to eat in their home or within very short walking distance?), *access* (e.g., are they able to leave their home or find a ride to get to a store to buy food when they need it?), *utilization* (e.g., do the demands of caring for an infant diminish the ability to utilize food? For example, is there adequate time to cook and prepare fresh foods in a given day?) and *stabilization* (e.g., are low-income moms able to counter chronic food shortages at the end of each month once food stamps run out?). Having friends and family to rely upon for help in meeting these needs and mitigating these barriers to food security is particularly important for new mothers (Freeman and Dodson 2014).

As referenced in an earlier quote, infants add a difficult logistical element to getting out of the house as they must be carried or placed in a carrier, car seat or stroller to allow for mobility outside of the home (Campbell-Grossman et al. 2005). Since caring for an infant is both emotionally and physically exhausting, low-income women may feel especially overwhelmed at the prospect of getting to a grocery store to buy food alone, particularly if they lack access to a vehicle. Having people to rely on for rides to the store who can help them transfer from the house to the car to the store and back home with groceries is both logically helpful and emotionally supportive as it may alleviate some of the stress of figuring how to handle an infant, grocery bags and potentially other young children on one’s own. Thus, social

networks can improve household food security for low-income women by addressing the four core elements of availability, access, utilization and stability.

While low-income families are more likely to stay within closer proximity to one another due to a lack of economic and social mobility, a lack of access to transportation and other challenges can make just a few miles distance almost as difficult as if they lived in separate towns (Skoba and Goetz 2013; Cohen, Wardrip and Williams 2010). This fact was corroborated by several participants who talked about their mothers living ‘far away’ although they were within an approximate five mile radius based on participant reports of how long it took to get to their homes. Without the ability to easily stop in to one another’s homes, drop children off for childcare needs, share meals and assist with the day-to-day responsibilities of life, low-income mother work often takes place in isolation despite the fact that family and friends are nearby.

Finally, as discussed in chapter four, the built environment in which mothers live has a significant impact on their social network. Isolation and loneliness may be caused or exacerbated by neighborhoods with no community spaces or sidewalks where one can get out and walk with children and perhaps strike up conversations with other parents. This is especially true in the field setting of this study in which the majority of participants lived in neighborhoods bordered by high-traffic streets, were not pedestrian-friendly and were not conducive to establishing community relationships according to participant accounts and data collected for the foodscape analysis presented in chapter six.

The geographic patterns of maternal isolation presented in this section help to answer this study’s second research question, “How do space and place impact low-income mothers’ perceptions of their foodscape?” As with the summary of maternal social isolation risk factors,

the findings from this section will be summarized as potential risks for food insecurity based on the conceptual model presented in figure 7.1.

1. Policy (macro-level)
  - a. Urban renewal projects that contribute to displacement of poor families.
2. Community (meta-level)
  - a. Lack of efficient public transportation
  - b. Lack of food outlets with healthy options available in the immediate neighborhood
3. Intrapersonal (micro-level)
  - a. Frequent moves and lack of transportation contribute to not knowing neighbors and not having access to family and friends when needed

### ***Cultural Isolation***

#### *Sarah's Story*

*Sarah is a 26 year-old African American mother of four; three girls ages seven, four and three months and one boy of 18 months. She lives with her boyfriend (the father of all four of her children) and her kids, in a two bedroom apartment in a neighborhood where she states there is a lot of drug and criminal activity. They do not own a car and she does not work, however, her boyfriend works full-time for McDonald's which she says brings in about \$800 month.*

*Sarah's youngest still wakes up every two to three hours during the night for a bottle and her day begins around 5:00am when her infant wakes for her morning feeding. After her bottle, she puts the baby back to bed and sleeps until her alarm wakes her again at 6:00am. She wakes up her seven year old daughter to get her ready for school and begins to make breakfast. Her 18 month-old son wakes around 6:30am and she stops preparing breakfast to get his diaper changed and find something to occupy his attention while she finishes making breakfast and makes sure her oldest daughter is ready for the school bus at 7:15am. She gets her son and*

*oldest daughter fed, then wakes her four-year old and infant daughter, places her baby and son in her double stroller and walks everyone to the bus stop.*

*The rest of the day is spent playing with her children, cleaning the apartment, cooking and doing laundry. She does not allow her children to play outside for fear for their safety. Her boyfriend tries to work overtime as often as he can get the hours so he typically works six days per week, sometimes 10 hour days, which leaves Sarah alone with the kids most days. She says that on his days off, her boyfriend is usually so tired that she tries to let him sleep in the mornings but often resents him for it since she too is exhausted. On his days off, the family usually takes a taxi to the grocery store to buy the week's groceries with their food stamps and WIC coupons. Sarah lost her grandmother while she was pregnant with her youngest daughter who she says was the only person in their lives they could rely on for help. She says that neither her nor her boyfriend have family or friends who can help them so they "do it all themselves". With no car and two children in diapers, this is no small feat.*

*Sarah's responses to the HFSSM placed her household in the Marginal Food Security category. She says that since she is still receiving WIC as well as her youngest three children, they are able to make it with their food stamps and not have to come out of pocket for food. She does worry, however, about what will happen once she loses her WIC benefits and her four-year old ages out of the program. When they are low on food, her boyfriend brings home McDonald's which he is sometimes able to get for free if there is extra food at the end of the shift.*

*Sarah openly discusses the fact that she is "light-skinned" which she believes has affected her ability to make Black friends. She says she was teased and bullied throughout school and was perceived as "too White for the Black girls and too Black for the White girls".*

*Her eldest daughter is also light-skinned and Sarah reports that she has been dealing with bullying at school since the first grade (she is now in second). Sarah struggles with how to cope with this, telling her daughter that she is “cuter” than the other girls and that they are jealous and not to let it bother her. However, she worries about her daughter’s ability to make peer connections and to develop a social support network which she recognizes is missing from her own life.*

*Sarah’s story illustrates the Cultural Maternal Isolation pathway described in figure 7.1. At the macro-level, Sarah’s community is a perfect example of the negative impact urban renewal has had on many Black neighborhoods. She does not know her neighbors and reports witnessing drug deals and gun crime on a regular basis, implying that there is a lack of social cohesion in her neighborhood. With little to no community investment (there are no parks or community resources she can walk to), a lack of public transportation and little in the way of job prospects, poor Black communities like Sarah’s make upward social and economic mobility difficult for residents to achieve.*

*At the community level, Sarah reports feeling ostracized within the African American community because of the color of her skin. She believes that her light-skin is one of the major reasons she does not have a strong peer network on whom she can rely. The issue of Black on Black discrimination was reported by other women in this sample and Sarah’s narrative is presented here as a case study. Yet, because she is Black, she also feels discriminated against by White society which she reports feeling most acutely when she is out in public by herself with all of her children. For example, at the grocery store with all four kids, she reports often enduring snide comments about her food choices and the fact that she is young and has so many children (the implication being, I believe, that she is being stereotyped as a “welfare queen”).*

*Finally, at the intrapersonal level, Sarah is socially, geographically and culturally isolated. She is exhausted with the day-to-day stress of caring for four small children, financially burdened by the low wages her boyfriend makes despite his long hours, limited to her neighborhood in which she feels unsafe due to her lack of access to a vehicle and the fact that she has no support network on which to lean.*

Sarah's story is just one example of the ways women in this sample reported Cultural Maternal Isolation, further discussed in the following section and represented by the participant statement "*They just look at me like I am a new mom.*" This statement refers to the various types of (real or perceived) discrimination experienced by the low-income mothers as a result of their socioeconomic status, age and/or marital status. These statements point to both the hegemonic influence of the dominant intensive mothering discourse in which mothers that do not fit the social norm (White, middle-class, married, stay-at-home mom) perceive themselves to be judged against that norm. In addition to feeling judged by their age, socioeconomic and marital status, several of the participants, both African American and White, acknowledged that they had experienced racist encounters directed at themselves or their children. This fact adds a particularly poignant nuance to the issue of maternal isolation and food insecurity as it may impact where and when new mothers are willing to go to access food resources. For example, one African American participant stated that she shops at Wal-Mart for her food because it is conveniently located to her house but that she believes the quality of food is better in the grocery stores in the White section of town. Given that this participant had access to a vehicle that she used to travel to Wal-Mart, I would argue that perhaps another possible (potentially subconscious) reason that she does not shop at the grocery stores she believes to have superior

products is due to a fear of encountering racism there. I did not, however, find evidence in the literature to support this claim.

Similarly, Black on Black racism was introduced in the findings in chapter six with ‘light-skinned’ women reporting they had been bullied as children, the same pattern holding true for their own children. This particular issue’s potential impact on food security may be a bit anecdotal in nature. However, it suggests that due to the potential for black initiated racist encounters, (self-identified) light-skinned women may prefer shopping in majority White neighborhoods. I suggest that ‘light-skinned privilege,’ the practice of discrimination by which those with lighter skin are treated more favorably than those with darker skin (Phoenix 2014; Wilder 2010) may impart greater food security to these women. Given that a greater proportion of Whites reside in middle to upper class communities with a greater diversity of food resources and nutritious options, light-skinned African American women who shop in those communities have access to a better quality diet than their counterparts who do not feel comfortable shopping in majority White neighborhoods.

In the context of food security, a fear (either conscious or subconscious) of discrimination may limit where and when women shop for food and their willingness to utilize social services available to them. For instance, two White participants indicated dissatisfaction with food stamp delivery due to what they perceived as racism directed towards them by staff at the registration office. The discomfort was great enough that one participant had allowed her coverage to lapse as she had avoided going back to re-certify. Incidentally, this participant was a single mom with twin girls but lived with her parents and had a culinary degree. This strong social support network made it possible to allow for the lapse in coverage without significantly affecting her family’s well-being. The other participant who expressed discomfort with her interactions at the

food stamp office continued to re-certify despite these feelings and did not report social support outside of her boyfriend's assistance.

Several participants also expressed discomfort using their WIC and SNAP benefits at the grocery store for fear of being judged. Participant quotes included in chapter six illustrate the types of encounters these mothers anticipate when using their benefits to include comments made about the products they are purchasing and complaints about the extra time required during check-out to comply with WIC benefits. Findings from this study indicate that low-income women may self-segregate or self-select to frequent only those stores they perceive to be friendlier towards low-income clientele (e.g., majority low-income shop there) regardless of whether these stores objectively have lower prices or are more conveniently located to them. This may impact food security, particularly diet quality, since being limited to certain stores also limits the variety of food options.

The findings on cultural maternal isolation presented in this chapter indicate several potential barriers to maintaining food security due to fear of discrimination. These risk factors inform this study's third research question, "How do racism and discrimination (perceived and structural) affect the food security and nutritional health of low-income mothers in Pinellas County?" Responses are summarized below using the same framework as presented previously.

1. Policy (macro-level)
  - a. Urban renewal policies disproportionately impact low-income African American communities leading to greater residential segregation.
2. Community (meta-level)
  - a. A history of underlying racial tension in a community may impact where African Americans are willing to shop
3. Intrapersonal (micro-level)
  - a. Internalized normative construction of motherhood induces shame of needing government assistance and/or not being married.

- b. Perceived likelihood of racist or discriminatory encounters influence where low-income women, particularly African American women shop.

### **Maternal Isolation: Conclusion**

The results from this study provide strong evidence that a large social support network for low-income mothers can help to mitigate vulnerability to food insecurity. Recalling the USDA's working definition of food security given below, it is noted that adequate social support addresses the four pillars of food security (i.e., availability, access, utilization and stability):

*Access by all people at all times to enough food for an active healthy life. Food security includes at a minimum: 1) the ready availability of nutritionally adequate and safe foods, and 2) an assured ability to acquire acceptable foods in socially acceptable ways (e.g., without resorting to emergency food supplies, scavenging, stealing, or other coping strategies). (Anderson 1990)*

By increasing the social connectedness of low-income mothers, we can improve their availability and access to food (rides to grocery stores, meals provided by family or friends) their utilization of foods (caretaking assistance provided by family or friends to provide a break or allow for meal preparation as needed) and stability (reliance of family and friends to help fill the gap when shortages arise). In contrast, isolation can serve to exacerbate food insecurity as described in this chapter. Before I present the second theme in this chapter, I provide a brief personal reflection on the concept of maternal isolation.

### **Maternal Isolation Reflection**

Isolation and loneliness were not domains included in the interview guide developed for this dissertation. It was not until I gave birth to my daughter (near the end of my data collection period) that I realized how very real and ubiquitous these feelings are for new mothers and the potential impact they can have on health decisions and behaviors, including nutritional intake and food security. This experience allowed me to utilize a critical lens in coding the interview

data revealing the maternal isolation constructs presented in this chapter. The purpose of this reflection is to empathize with my participants' experiences of social isolation both during pregnancy and postpartum and to reiterate the value in participant observation as a methodology for anthropological inquiry.

Since my pregnancy was planned, I prepared in advance for the behavior changes I knew to be recommended for a healthy pregnancy. Despite my planning for this enormous transition, I found some aspects of my pregnancy to be both unsettling and surprising. First, my social life diminished as I became too tired to find the motivation to go out with friends regularly as I had done before. The focus of my marriage gradually shifted to center on the baby and our future plans as a 'family' rather than on our relationship. Even my interactions with family and friends changed as I was suddenly an expectant mother first and foremost with my other self-defining characteristics relegated to the background. At times during my pregnancy I experienced these changes as unsettling and often felt isolated as I was the first of my close group of friends to start a family. Since I chose to focus first on my career and education before having a baby, I had spent my entire adult life identifying at various times as a motivated student, PhD candidate, employee, friend and wife. I found this new as-yet-unknown role of mother both exciting and frightening as I was unsure of how these disparate pieces of my self-identity would come together once I was officially a mother.

I also found it difficult to connect emotionally with my pregnancy – another surprise which gave way to feelings of maternal inadequacy despite the fact that I disavowed had (consciously though perhaps not subconsciously) the essentialist notion of 'maternal instincts' and the like. Popular culture portrays the act of finding out you are pregnant as a transformational moment in which you seamlessly take on the new identity of 'expectant

'mother'. While it is true that I felt everything had changed at that moment it was not as much of an emotional reaction as a measured one – the news meant strict regulation of my new 'at-risk' pregnant body. I often found the embodiment of pregnancy - which included so many restrictions prescribed by the medical establishment - to be burdensome rather than joyful. At times, I even felt resentful that carrying a baby required such a significant shift in personal habits and required me to give up some of my self-identity months before officially becoming a mother. This is not to say that I was not excited and joyful about my growing family or that I did not enjoy my pregnancy. I loved the experience of pregnancy and was in awe of my body's ability to change so rapidly. I simply found it difficult to respond emotionally to these experiences as I could not connect my growing belly and the attendant sacrifices with a soon-to-be newborn for which I would be responsible and whom I would love unconditionally.

After the birth of my daughter, I had the assistance of both my husband and my parents for one week before my parents returned home and my husband returned to work. Again, I found the experience of caring for my newborn and of maternity leave surprisingly different than I had imagined it. I found myself chronically sleep deprived with an infant who nursed every two hours around the clock. I did not have the time or capacity to foster any social relationships or pursue intellectual pursuits as I had assumed I would during my six-month maternity leave. Instead, I was mostly confined to my home all day until my husband arrived home from work at which point I would regularly take a small break in the form of going for a walk or going to the grocery store. These breaks were short-lived, however, as I was tethered to the clock because of my daughter's feeding schedule making me all the more aware of the fact that I could no longer exercise my independence as I had in the past. Like this study's participants, I unequivocally and emphatically agree that my daughter's birth and my transition to motherhood have been

positively transforming. I find overwhelming joy and gratitude in caring for my daughter and I believe that the self-sacrifices required are undoubtedly worth the price. But in those early days and especially during the first six months postpartum while I was on maternity leave, one of the most frequent emotions I felt was loneliness due to the isolation I felt in being confined to my home.

What I describe here as loneliness is fundamentally different than the ‘baby blues’ or ‘postpartum depression’ as I did not experience the requisite symptoms of those disorders. I found joy in caring for my daughter, was always able to respond appropriately to her cries, etc. What I did feel was alone. Most days I did not speak with another adult until my husband arrived home from work. My friends (who do not have children) were working during the day and I did not feel I had an outlet for meeting other mothers who might be home during the day. And importantly, even if I had met them, I would not have shared these feelings for fear of being judged as a ‘bad mother’. The transition to motherhood for me represented isolation from the adult world in which I was free to self-identify with my career, my chosen academic field, as a friend, a sister, a wife – in my transition to motherhood I felt that ‘mother’ had become my sole-defining characteristic.

I was fortunate not to have the additional chronic stressors related to poverty discussed to this point while planning for the arrival of my daughter and to have the unwavering support of my husband. I had paid maternity leave for six months, access to a car, an adult to speak with after a long day of caring for an infant, a constant supply of healthful foods and an academic background focused on maternal and child health. Despite these advantages, I found it difficult at times to adhere to the diet and lifestyle recommendations for a healthy pregnancy and to feel confident in my ability to care for my daughter after she was born. This is to say that while on

paper my life circumstances were very different than that of the majority of this study's participants, I too experienced some the same challenges and forms of maternal isolation during my pregnancy expressed by my participants. This allowed for genuine, shared empathy between my participants and me during our interviews and gave me the perspective to fully appreciate the myriad barriers they encountered to maintaining household food security within the context of mothering.

Given this experience, what is perhaps most disconcerting to me is the lack of information available to expectant mothers regarding isolation and loneliness. The fact is that having a newborn *is* by its very nature an isolating period of time as infants require round-the-clock care making even basic measures of self-care like showering and feeding oneself difficult to accomplish. Yet, mothers, especially low-income mothers, are reluctant to voice these issues for fear of being labeled a 'bad mother', 'at-risk' or depressed. It is important to create a space for this conversation in the public eye so that women who are truly isolated can be identified and connected with services, like food delivery and mom's groups to mitigate the potential for food insecurity during this vulnerable period of parental transition.

### **Missed Opportunities**

The food security literature and dissertation data presented thus far make it clear that the food choices people make are greatly influenced by the choices and resources they have. For low-income mothers this is particularly salient as the chronic stress related to poverty creates not only additional daily burdens but also barriers to accessing and choosing a nutritious, healthful diet (points explored in earlier chapters) (Hashima and Amato 1994; Belsky 1993). The findings from this dissertation suggest that the unique experience of mothering plays a role in the food security status of low-income mothers. While the social isolation that often accompanies new

motherhood may adversely affect the food security of low-income women, the transformational experience of mothering may alternately provide motivation to seek more healthful diet choices. Paired with the foodscape analysis presented earlier, these findings point to a number of potential ‘missed opportunities’ to positively impact the food security status of low-income women in Pinellas County as they transition to motherhood.

As previously discussed, the transition to parenthood occurs within the broader context of the political, economic and sociocultural environment (Scheper-Hughes 1985; Barlow 2004). The experience of mothering in the U.S. is therefore not universal for all women since it is a socially constructed role (Rokach 2004; Arendell 2000; Scheper-Hughes 1985). Yet, there are some shared experiences that most women who have had a baby can relate to such as encountering prenatal care, the shift in self-identity that comes with the transition to motherhood and the need for social connections during that time. The missed opportunities identified from the interview data to be examined in this chapter deal primarily with the medicalization of pregnancy within prenatal care delivery, intrapersonal food behaviors and preferences and the role of personal motivation in mitigating barriers to food security.

### ***Missed Opportunity Themes***

Again, I use representative participant statements to introduce the theme of missed opportunities to be discussed here. These statements include, *It was just kinda, here's a list of things you should stay away from; Always eat healthy, just remember what I take in the baby takes in; I don't do much planning at all and I got my head on straight, I got my goals right.*

*It was just kinda, here's a list of things you should stay away from.* Responding to the question about the nutritional advice she received from her prenatal care provider this participant's statement illustrates the current ‘risk’ model of perinatal care typical in the U.S.

(Shaw 2012; Halfmann 2012). The medicalization of pregnancy and childbirth over the last century has produced the U.S. standard model of prenatal care delivery defined as “organized medical care to screen and identify risk factors during pregnancy and to address risk factors that are identified.” (March of Dimes 2012) This definition is telling in that it does not address wellness or prevention – in other words the stated goal of prenatal care is not to optimize the health of all pregnant women but to address prescriptive risks in a subset of expectant mothers. Since eighty percent of all U.S. pregnancies are without identified prenatal risk factors (March of Dimes 2012), the question becomes, what benefit do the majority of pregnant women receive from prenatal care? Education is touted as the primary benefit, implying that prenatal care for most women involves a significant educational component. Yet, when it comes to prenatal nutritional education, few women report relying on their providers for advice. For many, the nutritional recommendations they receive from their providers are less about what they *should* eat and more about what they should *avoid*.

The medicalization of pregnancy and childbirth has long been a topic of anthropological inquiry as it relates feminist theory, human reproduction, traditional life ways and social power structure – topics certainly within the scope of interest to anthropologists (Fordyce 2013; Theodorou & Spyrou 2013; Conrad 1992). The majority of critiques regarding standard prenatal care and childbirth in the U.S. center on the idea that prenatal care delivery occurs in a vacuum exclusive of and often blind to the social and cultural context of the woman carrying the pregnancy (Theodorou & Spyrou 2013; Halfmann 2012). Or put another way, prenatal care in the U.S. could largely be defined as the business of monitoring pregnant bodies and fetuses rather than treating and/or supporting pregnant women and their babies. With regards to prenatal nutritional intake and food security, this model does not allow for consideration of a woman’s

barriers to accessing healthful foods – a problem instead delegated to government food assistance programs like WIC and SNAP to address (Lucas, Charlton & Yeatman 2014; Whaley 2012). Given that the formal point of entry into expectant motherhood for most women is their first prenatal care appointment and the touted benefit for eighty percent of them is education, it would seem that prenatal visits present an important opportunity to address food security concerns.

*Always eat healthy, just remember what I take in the baby takes in.* This participant statement is closely related to the primary finding just discussed and represents another common response to the question about nutrition advice given by their providers. While many participants reported receiving either no advice from their providers, information in pamphlets with no discussion, or simply lists of items to avoid, others reported being encouraged by their providers to ‘eat healthy’ and could recite specific nutritional advice given. This corroborates with the literature on this topic (Lucas, Charlton & Yeatman 2014; Alexander 2001) and my own prenatal experience receiving advice and education from my ‘provider’ which consisted of a new patient bag including a plethora of pamphlets to read on a variety of perinatal topics.

As one participant stated,

*It costs more to eat healthier. Like, it really does cost a lot more to eat healthier, that's what my concern was. How is it, everyone wants everybody to eat healthier and healthier but the food is so expensive.*

Given that all participants in this sample were low-income and relied on Medicaid for perinatal health insurance, it may be assumed that the providers discussed in this section regularly see women who would be categorized as marginally food secure or food insecure according to the 2006 USDA definition of household food security. The large body of evidence connecting interconceptional and perinatal nutrition to birth outcomes and long-term disease

susceptibility has shown that adequate prenatal nutritional intake is vital to a healthy pregnancy (Drake et al. 2012). Moreover, we understand that there are certain critical points within the gestational period with specific nutritional needs (e.g., folic acid within the first few gestational weeks) (Alwan et al. 2014; Symonds et al. 2013; Drake et al. 2012). While providers are of course aware of these facts, there appears to be a missing link between understanding the nutritional needs of pregnant women and the barriers women face in addressing them.

The most common prenatal health concern or pregnancy complication reported by participants (twenty-two of thirty-one total participants) in this study was anemia or low-iron followed by gestational diabetes (four of thirty-one)<sup>34</sup> both of which point to nutritional deficiencies (CDC 2014). Data from the CDC indicate that 33.8% of all pregnant women in the U.S. are anemic during their third trimester with that percentage increasing to 49.5% African American women compared with 27% of White, non-Hispanic women (CDC 2011). Of the twenty-two women reporting low iron and/or anemia in this study, most reported that their prenatal care providers recommended foods high in iron (dark green, leafy vegetables and red meat) and prescribed iron supplements. None reported their providers asking them whether or not they had the resources to follow this advice. The fact that a little over one-sixth of the sample population reported symptoms of pica without specific prompting during the interview and seventy percent reported a diagnosis of anemia or low iron points to a need for more preventive nutritional education both interconceptionally and prenatally.

*I don't do much planning at all.* This participant quote illustrates the fact that very few of the participants in this study reported planning meals ahead of time. Data indicate that meal

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<sup>34</sup> It should be noted that a few women also reported overweight or obesity in the periphery through comments such as being told to limit weight gain during pregnancy, etc. but did not report it as a pregnancy complication or condition. Thus it is not captured here though according to the self-reported pre-pregnancy weights and gestational weight gain, twenty-five of thirty-one participants were overweight or obese at the time they became pregnant

planning on a weekly or monthly basis can help to lower grocery costs (USDA 2014) and may also positively impact diet by limiting the number of meals eaten out or ordered in (Mayo Clinic 2015). Both the WIC and SNAP programs provide meal planning and budgeting education, including mobile apps, on their websites. Yet, no participants reported having used these applications or having received such training from government agencies. There are myriad reasons why low income mothers would have difficulty planning meals ahead and budgeting for groceries to include limited monthly income, a lack of regular transportation to the grocery store, limits on time and so forth. However, making sure women have the tools, resources and knowledge to do so could help to mitigate some of these barriers and increase food security.

One of the consequences of not being able to adequately plan ahead for meals or to budget food expenditures is the need to ‘make it stretch’ by relying on a few low cost, energy dense foods. This is particularly important for families relying on once monthly food stamp distribution with food consumption patterns characterized by overconsumption at the beginning of the month followed by a deterioration of nutrient intake to the end of the month when they must ‘make it stretch’. Known as the ‘food stamp cycle’ this phenomenon has been associated with disordered eating and higher rates of obesity among low-income women (Ver Ploeg and Ralston 2008).

*I got my head on straight, I got my goals right.* This statement illustrates the transformational experience of becoming a mother and the positive effects the participants of this study reported it had had on their personal growth and development. The enormous capacity of new mothers to consider the needs of their children as a strong motivational factor in improving their own lives, including their health, is an important factor that should be considered in the context of nutritional education with this population. Despite the barriers discussed thus far in

achieving optimal food security for low-income mothers, the desire to care for, protect and nurture their children as illustrated above may be a tool to inform novel methods of addressing food security in the study population.

### **Missed Opportunities Conclusion**

As a multi-layered and multi-faceted issue, addressing barriers to food security represents a complex public health challenge. Yet, precisely because of its complexity, food security may be significantly impacted with targeted interventions. The findings from this dissertation point to a number of missed opportunities to improve the food security of low income women within perinatal care delivery and food assistance programs.

### **Missed Opportunities: Reflection**

The findings presented in this chapter resonated personally with my own perinatal experiences. At my first prenatal care appointment at nine gestational weeks I was told by the nurse practitioner that I likely would not be able to deliver a baby greater than six pounds. She went on to state that they were not a “C-Section happy” practice but that their job was to manage risk. With my academic background I knew enough to be critical of this advice yet it left lingering doubts in my ability to perform what I had imagined to be a quintessential female rite of passage. This was my first indoctrination into the world of medicalized pregnancy and child birth and it left me feeling as though I had ceded all power to my provider to decide in what manner I could or should both carry my baby and bring her into the world. I switched to another Ob/Gyn practice immediately after that first prenatal visit but found that experience equally lacking. What I felt to be reasonable questions regarding the practice’s typical birthing protocol and statistics on interventions were met with what I perceived as patronizing responses about ‘how everything would be fine’ and the ‘goal is a healthy baby’. I received very little in the way

of nutritional information or education and what I did receive came in pamphlets provided in a stock welcome bag.

Looking back on the experience I realize what I felt was lacking in the care I received was an interest in me as a person rather than a pregnant body. My life circumstances, goals, relationship status, employment, feelings about my pregnancy, social support, nutritional intake (with the exception of prenatal vitamins and weight gain) appeared to be immaterial to the process of managing and monitoring my body's prenatal progress. Yet, it was the combination of these factors that encompassed the maternal environment in which my daughter was developing. This disconnect between a pregnant woman's body/developing fetus and the life circumstances in which her pregnancy progresses is of seminal importance in addressing myriad prenatal health concerns including nutritional intake and food security.

It was not until at thirty-two weeks gestation when I decided to pursue a home birth with a licensed midwife that I was asked about my personal life circumstances within a prenatal care setting.<sup>35</sup> Upon entering prenatal care with my midwife I was asked to keep a three-day food diary three days prior to each of my visits which we reviewed together. Based on that information she made tailored recommendations and suggestions about how to improve my diet across the board. She asked how I was feeling about my pregnancy and impending birth at each visit and left it open-ended to discuss any potential concerns be they emotional or otherwise. She encouraged my husband to come with me to my appointments and ask questions, understanding that his opinions and feelings were not only valid but contributed to the overall health of my pregnancy. Thus, it was not until nearing the end of my pregnancy and choosing to deliver at home that I felt I received the type of prenatal care I had originally anticipated and that

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<sup>35</sup> It is important to note that while I was covered under private insurance, Florida Medicaid is legally required to cover home births delivered by a licensed nurse midwife. Thus, the majority of my midwife's clients were low-income.

all women deserve. In receiving this type of care, I felt I had regained autonomy and power over my body, my pregnancy and my baby's birth. It was also the first point in which I received the benefits of prenatal education touted as the primary benefit of prenatal care for eighty percent of women.

Since the current model for prenatal care typically includes a large practice where the patient may see each Ob/Gyn or midwife just once before delivery, there is no standard to encourage providers to get to know their patients. This makes it difficult to deliver continuity of care and engender trust in patients. It is not surprising, therefore, that one of the findings from this dissertation indicated that most participants did not anticipate receiving nutritional advice from their doctors but relied instead on WIC to provide that education.

I did not qualify for WIC or SNAP benefits so I was unable to have direct participant observational experience with those programs. Despite this fact, my original participant observation plan included a one month period living on an average food stamp budget for my family size (2 at that time) with the additional WIC benefits that would have been provided during my pregnancy. However, as a result of my pregnancy I chose not to follow through with that plan. I felt it would have introduced a risk of inadequate nutritional intake that I was not willing to entertain during my pregnancy. I find this to be a significant personal observation of the (in)adequacy of these programs to fully address and optimize the nutritional health of expectant mothers. While I do think these programs go a long way in filling the gaps in food access and addressing the micronutrient needs of pregnant women, my own perception of risk, as a clear indication of my socioeconomic status compared with that of my participants, includes avoiding non-organic products for fear of exposure to antibiotics, pesticides and chemicals.

## **Limitations of the Research**

There were a number of limitations to this dissertation research that should be noted. First, the final sample size of 31 did not meet the original target sample size of 40. With an African American cohort of 20 and a White, non-Hispanic cohort of 11, the significant difference in the sample size between the two study cohorts precluded the ability to perform inter-group statistical analyses. The small sample size was partially due to the difficulty in recruiting for this study which should also be noted as a potential limitation. Over the course of 15 months with 13<sup>36</sup> recruitment locations, I reached my target sample size of 20 African American women within the first 6 months but struggled to enroll White, non-Hispanic participants.

Another limitation of this study is the potential for recall bias. Participants were asked to recall specific events and facts from their prenatal period that could have been as long as 12 months prior to their study participation. This could potentially introduce the possibility of inaccurate statements about that time. Specifically, with regards to the self-reported pre-pregnancy weight and gestational weight gain, there is certainly room for potential error.

Recruiting primarily through government assistance programs may also be considered a limitation to this study in that it restricts participation to only women who have sought out those services. Not all low-income mothers receive government assistance, therefore, these results may not be considered generalizable to the general low-income population of women.

## **Conclusion**

The findings presented in this chapter indicate that low-income women experience a wide-range of stressors related to maternal isolation that can and do impact on their general health and well-being and specifically on their food security status. Due to the common experience of maternal isolation, evaluation of the social connectedness of expectant and new

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<sup>36</sup> Healthy Start and Healthy Families Home Visitor Staff are each counted as one recruitment “location”

mothers should be a priority for all providers serving this population to include healthcare providers, social services, government assistance programs and so forth.

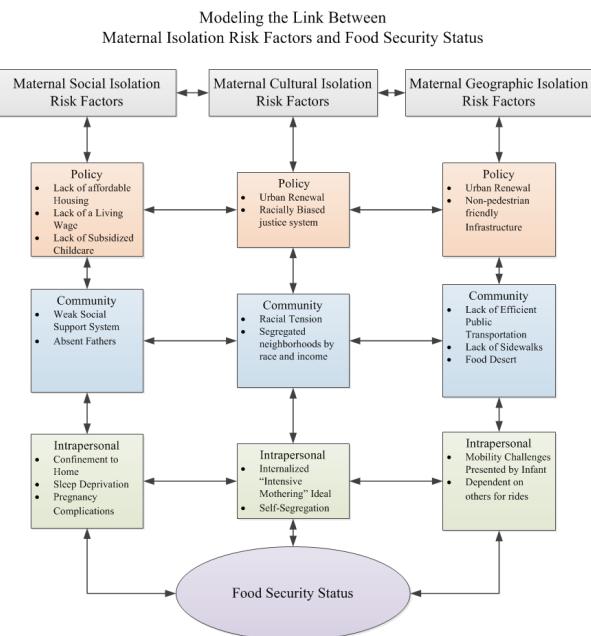
## CHAPTER 8: APPLICATION AND RECOMMENDATIONS

### Introduction

Anthropology's strength as a discipline is its ability to capture and represent the embodiment of macro-level systems in the lived experience of the individual. Using a political economic framework and critical medical anthropology approach, this study seeks to translate its findings into recommended actions and policies at both the macro and individual level. In this chapter I will describe this dissertation's contribution to the anthropological literature, I will present my recommendations for action and conclude the chapter with final thoughts.

### Contribution to the Literature

As a contribution to the anthropological literature on food security and nutrition, this study fills a number of important gaps. First, this dissertation's topical focus on the lived experience of mothering in a low-income setting and its impact on food security is novel in its findings. The social, geographic and cultural patterns of maternal isolation as presented are not conceptualized elsewhere in the literature as they are presented here. I produced a



**Figure 8.1:** Maternal Isolation and Food Security Model

visual framework for thinking about the complex and overlapping nature of these maternal

isolation patterns also not currently available in the scholarly body of work. Finally, I incorporate a narrative analysis on the topic of hunger as it relates to household food security status, providing further support for incorporating ‘hunger’ back into the policy framework of food security. The purpose of these contributions is to provide further evidence of the need to commit public interest and resources to alleviating food insecurity among U.S. households, particularly those headed by low-income mothers.

## **Recommendations**

The recommendations for action resulting from this dissertation include a number of suggestions to be implemented at the Policy (macro-level), Community (meta-level) and Intrapersonal (micro-level). These recommendations are related directly to the findings of this dissertation as presented in chapters six and seven and are provided in the hopes that their implementation can help to mitigate the risk of food insecurity among low-income mothers. I recognize that many of the policy-level recommendations represent major political barriers to implementation. I nonetheless offer them as one more argument towards a federal system of governance that levels the playing field and creates a system under which income equality and social mobility are both valued and possible for all citizens.

### **1. Policy (Macro-Level)**

- a.** Evidence from this study suggests that low-income families experience a great deal of chronic stress related to finances in their daily lives.

This stress stems from a lack of a safety net on which they can rely in times of shortage. This includes the inability to put food on the table when times are tough. Thus, I recommend a holistic approach at the

Federal policy level to mitigate these financial constraints in an effort to mitigate the risk factors for food security as follows:

- i. Currently, the Federal minimum wage of \$7.80 equates to \$15,080 annual salary for a full-time worker (Economic Policy Institute 2015). This is below the federal poverty line for a family of two. Thus, families cannot subsist on the current minimum wage. My first recommendation, therefore, is to increase the minimum wage to a living wage adjusted to the cost of living.
- ii. Affordable housing is also in short supply with this study's participants paying close to 50% of their monthly income in rent. This leaves little room in the budget for other basic necessities, including food, as evidenced by the constant juggling of monthly bills reported by participants. I therefore believe that more needs to be done at the policy level to ensure affordable housing is available to all families in need.
- iii. Given that transportation was the key barrier cited to participants' ability to finish their education or seek employment, I recommend that transportation assistance be provided as part of government assistance programs such as TANF, SNAP and WIC in the form of taxi or bus vouchers in the absence of a robust public transportation system.

iv. Another nuance related to transportation is the fact that subsidized childcare does not currently assist with transportation needs. This presents challenges in meeting the requirements of the program which stipulate strict attendance policies. This ‘use it or lose it’ policy does not account for the daily transportation challenges low-income families face.

Again, this program would benefit from the use of transportation vouchers provided to families in times of emergency so they do not lose their benefits.

v. Finally, this study provided ample evidence of hunger within even this small participant sample. Current USDA definitions of food security, however, would fail to capture the prevalence of hunger in this sample, effectively, sweeping it under the rug. As discussed in chapter three, this removal of the concept of hunger from the rhetoric of food security and nutrition policy renders it invisible to the public reporting agencies. It is vital, therefore, that we continue to capture evidence of hunger as a full measure of food insecurity in the U.S.

## 2. Community (meta-level)

- a. At the local level, programs serving this population could incorporate a number of initiatives to help improve the social connectedness of low-income mothers.

- i. I recommend incorporating peer-led mom support groups into local Healthy Start/WIC coalitions to improve social connections among moms of the same age group and socioeconomic background. These groups should target communities and housing/apartment complexes with majority single mothers to help them form friendships and connections that could serve them in times of need.
- b. There are a number of evidence-based models for developing Healthy Corner Stores, meaning, incentives are provided to corner stores to carry fresh produce. A recent NIH request for proposal to develop local Healthy Corner Store programs would be a perfect opportunity to put this work into practice.
- c. The data presented in chapter six suggest that prenatal care providers could benefit from a continuing education module on the topic of food security including suggestions for incorporating its assessment into their practice. The purpose of such a program would be to help physicians connect the nutritional needs of pregnancy with the lived experience of their patients.

These community-level recommendations represent actions that are undeniably more doable than those at the federal level. Working with local Healthy Start and WIC coalitions to create model programs improving the social connectedness of low-income mothers is practical in that such a program is already within their scope of practice and institutional mission. Without studies like this one, however, the need for such program development may go unrecognized.

With the dissemination of this study's results to these stakeholders I hope to be able to create momentum for further researching and developing a local program that could eventually serve as a model for the rest of the country.

Another tangible recommendation for action resulting from this study is the introduction of healthy food options into currently available neighborhood food stores. This model to address issues of food access within low-income communities is evidence-based and has been used in a variety of locations and settings. Given the prolific amount of corner stores, gas stations and convenience stores located in the participant communities examined in this study, I believe this is an appropriate and practical step to improving neighborhood food resources in Pinellas County.

Finally, working with the Pinellas County Medical Association and the Department of Health, an online continuing education module on the topic of food security targeted to obstetric and pediatric care providers (initially) could be developed and disseminated locally for evaluation. The goal of such a module would be to educate providers on the barriers their patients may face in eating a healthy diet and following dietary recommendations. By better understanding the difference between patient's personal choices and the structural factors that impact them, providers may be better able to assess patient's additional social needs and provide referrals outside resources on a more frequent basis. This, I believe, could improve patient outcomes and connect more individuals with the resources they need to achieve and maintain food security.

In addition to these recommendations for action, I suggest that more mixed methods, interdisciplinary research is needed on the topic of maternal isolation to tease out further

evidence of its impact on food security and identify more potential areas for targeted intervention.

### **Final Thoughts**

The results of this study find that mothers of all social classes experience many of the same challenges, concerns and joys in their role as mother. Yet, this study illustrates that mothering in poverty presents a number of additional barriers with which to contend in order to provide basic necessities to one's family. The recommendations presented in this chapter represent a multi-layered approach to alleviating vulnerabilities related to food insecurity among low-income mothers in Pinellas County. It is the author's contention that mothering presents enough challenges in the daily lives of women. In this land of plenty, having enough healthful food to put on the table should not be one of the concerns that occupies the daily thoughts of mothers

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## APPENDIX A: ADDITIONAL TABLES AND FIGURES

**Table A.1: 33712 Food Resources**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Category</b>	<b>Name</b>
3313 Central Ave.	St. Petersburg	FL	33701	Franchised Fast Food	China Pearl
3210 Central	St. Petersburg	FL	33701	Franchised Fast Food	Popeye's
1605 16th St.	St. Petersburg	FL	33701	Franchised Fast Food	Salem's
2202 Roy Hanna Dr.	St. Petersburg	FL	33701	Franchised Fast Food	Subway
2261 34th St. S	St. Petersburg	FL	33701	Franchised Fast Food	China 1
175 34th St. S	St. Petersburg	FL	33701	Franchised Fast Food	Salem's
1762 18th Ave. S.	St. Petersburg	FL	33701	Franchised Fast Food	China Star
3018 54th Ave. S.	St. Petersburg	FL	33701	Franchised Fast Food	Top China
2960 54th Ave. S.	St. Petersburg	FL	33701	Franchised Fast Food	Popeye's
2195 34th St. S.	St. Petersburg	FL	33701	Franchised Fast Food	Church's
2824 54th Ave. S.	St. Petersburg	FL	33701	Franchised Fast Food	West Shore Pizza
100 34th St. S.	St. Petersburg	FL	33701	Franchised Fast Food	Checker's
2157 Central Ave.	St. Petersburg	FL	33701	Corner Store	Discount Food Mart
1040 16th St. S	St. Petersburg	FL	33701	Corner Store	3 Brothers
1404 16th St. S.	St. Petersburg	FL	33701	Corner Store	Johnnie's Food Mart
1500 16th St. S	St. Petersburg	FL	33701	Corner Store	Manny's
1600 16th St. S	St. Petersburg	FL	33701	Corner Store	Blue Nile Food Store
2208 Roy Hanna Dr.	St. Petersburg	FL	33701	Corner Store	Sunshine Foods of St. Pete
1940 22nd Ave. S.	St. Petersburg	FL	33701	Corner Store	Lake View Market
3095 22nd Ave. S.	St. Petersburg	FL	33701	Corner Store	Champs Food Store

**Table A.1 (Continued)**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Category</b>	<b>Name</b>
3002 Central Ave.	St. Petersburg	FL	33701	Corner Store	Central Ave. Food Mart
2208 34th St. S	St. Petersburg	FL	33701	Corner Store	Big Men Corner Store
1751 34th St. S	St. Petersburg	FL	33701	Corner Store	Manna Heaven
1345 34th St. S	St. Petersburg	FL	33701	Corner Store	The King's Market
1701 16th St. S.	St. Petersburg	FL	33701	Corner Store	Red's Snak Shack
2680 5th Ave. S.	St. Petersburg	FL	33701	Corner Store	Fat Boy Mini Mart
1856 18th Ave. S.	St. Petersburg	FL	33701	Corner Store	Midtown Supermarket
2801 Central Ave.	St. Petersburg	FL	33701	Corner Store with Gas Station	Liberty Gas Station
3400 22nd Ave. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Citgo
1800 34th St. S	St. Petersburg	FL	33701	Corner Store with Gas Station	Shell Station
1750 34th St. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Chevron
3344 34th St. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Exxon
1501 34th St. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Valero Gas Station
3401 5th Ave. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Citgo
101 34th St. S	St. Petersburg	FL	33701	Corner Store with Gas Station	Chevron
2753 5th Ave. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Pure Gas Station
3090 54th Ave. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Marathon Gas
3100 54th Ave. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	Mobil Gas Station
5451 31st St. S.	St. Petersburg	FL	33701	Corner Store with Gas Station	7 Eleven
3101 Central Ave.	St. Petersburg	FL	33701	Corner Store with Grocery	Meat House of St. Pete
3100 5th Ave. S.	St. Petersburg	FL	33701	Corner Store with Grocery	Express Meat Market
22nd St. and 9th Ave. S.	St. Petersburg	FL	33701	Corner Store with Grocery	South City Grocery and Meat Market
1664 15th Ave. S.	St. Petersburg	FL	33701	Corner Store with Grocery	CJ's Meat Market
1228 28th St. S.	St. Petersburg	FL	33701	Corner Store with Grocery	Wildwood Meat Market
3030 54th Ave. S.	St. Petersburg	FL	33701	Chain Supermarket	Publix
1794 18th Ave.	St. Petersburg	FL	33701	Chain Supermarket	SweetBay
2333 34th St. S.	St. Petersburg	FL	33701	Grocery Store	Bravo
3350 Central	St. Petersburg	FL	33701	Franchised Convenience Store	Walgreen's

**Table A.1 (Continued)**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Category</b>	<b>Name</b>
3077 54th Ave. S.	St. Petersburg	FL	33701	Franchised Convenience Store	Walgreen's
3201 Central Ave.	St. Petersburg	FL	33701	Franchised Discount Store	Family Dollar
2301 34th St. S.	St. Petersburg	FL	33701	Franchised Discount Store	Family Dollar
2216 18th Ave. S.	St. Petersburg	FL	33701	Franchised Discount Store	Dollar General
1628 18th Ave. S.	St. Petersburg	FL	33701	Franchised Discount Store	Family Dollar
2810 54th Ave. S.	St. Petersburg	FL	33701	Franchised Discount Store	Dollar General
1617 34th St. S.	St. Petersburg	FL	33701	Specialty Food Store	J and A Produce Palace
2005 Central	St. Petersburg	FL	33701	Specialty Food Restaurant	Wild Cajun
1100 16th St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Seafood and Grill
2216 34th St. S	St. Petersburg	FL	33701	Specialty Food Restaurant	Jupiter's Pizza
1538 16th St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Fay's Deli and Subs
1795 16th St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Annie's BBQ
2255 34th St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Live Blue Crab Market
530 34th St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Big Tim's BBQ
927 22nd St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Lorraine's Fish House
1421 22nd St. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Hunt Brother's Pizza
2930 18th Ave. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Novell's Food and Deli Express
3010 54th Ave. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Golden Crust Caribbean Bakery and Grill
2163 9th Ave. S.	St. Petersburg	FL	33701	Specialty Food Restaurant	Night Flow Takeout
2501 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	Queen's Head
642 22nd St. S.	St. Petersburg	FL	33701	Full Service Restaurant	Sylvia's Restaurant
901 22nd St. S.	St. Petersburg	FL	33701	Full Service Restaurant	Chief's Creole Café
2462 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	Nitally's
2451 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	Butler's Old Key West Bar and Grill
2444 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	Parrot Café
2410 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	The Queen and I
2324 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	Taco Bus

**Table A.1 (Continued)**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Category</b>	<b>Name</b>
2231 34th St. S.	St. Petersburg	FL	33701	Full Service Restaurant	Taste of the Islands
1939 Central	St. Petersburg	FL	33701	Full Service Restaurant	Smoked
1752 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	The Burg Bar and Grill
1620 Central Ave.	St. Petersburg	FL	33701	Full Service Restaurant	Semararo's
3114 5th ave. S.	St. Petersburg	FL	33701	Full Service Restaurant	Miller's Jamaican Spice Cuisine
1717 16th st. S.	St. Petersburg	FL	33701	Full Service Restaurant	Kaieteur Garden Restaurant
2021 9th Ave. S.	St. Petersburg	FL	33701	Food Pantry	Mercy Keepers Food Pantry

**Table A.2 33755 Food Resources**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Name</b>	<b>Title</b>
1895 N Highland Ave	Clearwater	FL	33755	Franchised Fast Food	Subway
201 N Highland Ave	Clearwater	FL	33755	Franchised Fast Food	Checkers
1575 Gulf to Bay Blvd	Clearwater	FL	33755	Franchised Fast Food	Church's Chicken
1237 Cleveland St	Clearwater	FL	33755	Franchised Fast Food	Popeye's
1506 Gulf to Bay	Clearwater	FL	33755	Franchised Fast Food	Asia Express
1201 Cleveland St	Clearwater	FL	33755	Franchised Fast Food	Panda Chinese Restaurant
1835 N Highland Ave	Clearwater	FL	33755	Franchised Fast Food	Shanghai Express
1875 N Highland Ave	Clearwater	FL	33755	Franchised Fast Food	China One
1835 N Highland Ave	Clearwater	FL	33755	Franchised Fast Food	China Express
1764 Gulf to Bay Blvd	Clearwater	FL	33755	Franchised Fast Food	Yama's Flamebroiled Chicken
1000 N Missouri Ave	Clearwater	FL	33755	Franchised Fast Food	Little Caesars Pizza
433 Cleveland St	Clearwater	FL	33755	Franchised Fast Food	Starbucks Coffee
1010 Cleveland St	Clearwater	FL	33755	Franchised Fast Food	Mr. Submarine-Mr. Gyros
534 Cleveland St	Clearwater	FL	33755	Franchised Fast Food	Dunkin' Donuts
1877 N Highland Ave	Clearwater	FL	33755	Franchised Fast Food	Checkers
432 Cleveland St	Clearwater	FL	33755	Franchised Fast Food	Jamba Juice
1427 N Betty Lane	Clearwater	FL	33755	Corner Store	Shop & Save
1362 Cleveland Street	Clearwater	FL	33755	Corner Store	Wanna Save
1452 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store	Shop 'n Save

**Table A.2 (Continued)**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Name</b>	<b>Title</b>
1501 N Betty Lane	Clearwater	FL	33755	Corner Store	Betty Lane Food Mart
1205 N Martin Luther King Jr. Ave	Clearwater	FL	33755	Corner Store	Greenwood Food Mart
1201 Sunset Point Rd	Clearwater	FL	33755	Corner Store	Circle A Food Store
1712 N. Fort Harrison Avenue	Clearwater	FL	33755	Corner Store	Sunshine Foods
1391 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store	Hillcrest Food Store
1208 N. Fort Harrison Avenue	Clearwater	FL	33755	Corner Store	Pop's Food Mart
701 N Fort Harrison Avenue	Clearwater	FL	33755	Corner Store	Quick Check Food Mart
1898 N Highland Ave	Clearwater	FL	33755	Corner Store	7-Eleven
1504 N Garden Ave	Clearwater	FL	33755	Corner Store	Discount Food Mart
2099 N Highland Ave	Clearwater	FL	33755	Corner Store	Happy Foods
1736 Drew St	Clearwater	FL	33755	Corner Store	Kwikstop Foodmart
1760 Drew St	Clearwater	FL	33755	Corner Store	Shop-N-Go
1725 Drew St	Clearwater	FL	33755	Corner Store	7-Eleven
1478 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store	El Chicanito Store
1285 Cleveland Street	Clearwater	FL	33755	Corner Store and Gas Station	Citgo
1501 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store with Gas Station	Circle K
1519 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store with Gas Station	Amoco Food Shop
1301 N Highland Ave	Clearwater	FL	33755	Corner Store with Gas Station	BP
1801 N Highland Ave	Clearwater	FL	33755	Corner Store with Gas Station	Highland Sq. Marathon
706 Drew St	Clearwater	FL	33755	Corner Store with Gas Station	Chevron
1698 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store with Gas Station	Thornton's
1701 Gulf to Bay Blvd	Clearwater	FL	33755	Corner Store with Gas Station	Shell
1732 Drew Street	Clearwater	FL	33755	Corner Store with Grocery	Viva Mexico
700 N. Martin Luther King Jr. Avenue	Clearwater	FL	33755	Corner Store with Grocery	C & C Meat Market
814 Cleveland St	Clearwater	FL	33755	Franchised Convenience Store	Walgreens
1883 N Highland Avenue	Clearwater	FL	33755	Franchised Discount Store	Dollar General
1803 N Highland Avenue	Clearwater	FL	33755	Chain Supermarket	Wal-Mart
1815 N Highland Avenue	Clearwater	FL	33755	Chain Supermarket	Wal-Mart Neighborhood Market
1209 Cleveland Street	Clearwater	FL	33755	Chain Supermarket	Save-A-Lot
1661 Gulf to Bay Blvd	Clearwater	FL	33755	Chain Supermarket	Gordon Food Service
1465 Sunset Point Rd	Clearwater	FL	33755	Grocery Store	La Comercial Mexican Store

**Table A.2 (Continued)**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Name</b>	<b>Title</b>
1225 Cleveland Street	Clearwater	FL	33755	Grocery Store	Natures Food Patch
1484 Gulf to Bay Blvd	Clearwater	FL	33755	Specialty Food Restaurant	El Mexquital
1194 NE Cleveland St	Clearwater	FL	33755	Specialty Food Restaurant	Dodges Chicken Store
1423 N Betty Ln	Clearwater	FL	33755	Specialty Food Restaurant	Freddy's Seafood & Subs
1621 Gulf to Bay Blvd	Clearwater	FL	33755	Specialty Food Restaurant	Bar-B-Q Queen
1719 Drew St	Clearwater	FL	33755	Specialty Food Restaurant	Royal Pizza
1208B N Fort Harrison Ave	Clearwater	FL	33755	Specialty Food Restaurant	Granger Rib Shack
1303 N Martin Luther King Jr Ave	Clearwater	FL	33755	Specialty Food Restaurant	Big Jim Bar-B-Q
1901 Edgewater Dr	Clearwater	FL	33755	Specialty Food Restaurant	Edgewater Deli
1615 Gulf to Bay Blvd	Clearwater	FL	33755	Specialty Food Restaurant	Pizza Vittoria 24/7 and Catering
1208 N Fort Harrison Ave	Clearwater	FL	33755	Specialty Food Restaurant	Clearwater Caribbean Cuisine & Roti Shop
530 Cleveland St	Clearwater	FL	33755	Specialty Food Restaurant	B Aggie's Pizza
1333 N Highland Ave	Clearwater	FL	33755	Specialty Food Restaurant	Highland Food & Deli
530 Cleveland Street	Clearwater	FL	33755	Full Service Restaurant	Old Moscow Art Café and Deli
725 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Angie's Restaurant
1653 Gulf to Bay Blvd	Clearwater	FL	33755	Full Service Restaurant	Capogna's Dugout
1724 N Fort Harrison Ave	Clearwater	FL	33755	Full Service Restaurant	Castillo's Restaurant
415 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Chiang Mai Thai Restaurant
1237 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	El Paisa Restaurant
1230 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Greek Town Grille
1844 N Highland Ave	Clearwater	FL	33755	Full Service Restaurant	Golden Coin Restaurant
1623 Gulf to Bay Blvd	Clearwater	FL	33755	Full Service Restaurant	Marcella's Restaurant
1200 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Los Mayas Mexican Restaurant
105 N Fort Harrison Ave	Clearwater	FL	33755	Full Service Restaurant	Café Milano
811 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Casanova
1617 N Highland Ave	Clearwater	FL	33755	Full Service Restaurant	Giovanni's
1237 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	La Perrada Colombiana
1436 Gulf to Bay Blvd	Clearwater	FL	33755	Full Service Restaurant	La Feria Del Sabo
623 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Street Side Café
601 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Llonni's Sandwiches

**Table A.2 (Continued)**

<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Name</b>	<b>Title</b>
34 N Fort Harrison Ave	Clearwater	FL	33755	Full Service Restaurant	Hispania Tapas Bar and Café
200 N Osceola Ave	Clearwater	FL	33755	Full Service Restaurant	Sandcastle Restaurant
528 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Top 40 Bar & Grill
635 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	La Cachette
421 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Café 421
601 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Grahame's Gourmet Café
22 N Fort Harrison Ave	Clearwater	FL	33755	Full Service Restaurant	Fine Italian Restaurants
1406 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	El Ranchito De Pepe
1215 N Martin Luther King Jr Ave	Clearwater	FL	33755	Full Service Restaurant	Wick City Grill
1264 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Viva Mexico Restaurant
1709 Drew St	Clearwater	FL	33755	Full Service Restaurant	La Cabania Del Tio
801 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Café Supreme
615 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Cleveland Street Café
428 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Tony's Pizzaria & Ristorante
33 N Garden Ave	Clearwater	FL	33755	Full Service Restaurant	Bogies Food & Flicks
528 Cleveland St	Clearwater	FL	33755	Full Service Restaurant	Mixx Bar & Grill
1535 Gulf to Bay Blvd	Clearwater	FL	33755	Full Service Restaurant	Pierogi Grill
1732 Drew St	Clearwater	FL	33755	Full Service Restaurant	Angie's Grill

## **APPENDIX B: SURVEYS AND QUESTIONNAIRES**

### **U.S. HOUSEHOLD FOOD SECURITY SURVEY MODULE: THREE-STAGE DESIGN, WITH SCREENERS**

Economic Research Service, USDA

July 2008

**Revision Notes:** The food security questions are essentially unchanged from those in the original module first implemented in 1995 and described previously in this document.

**July 2008:**

- Wording of resource constraint in AD2 was corrected to, "...because there wasn't enough money for food" to be consistent with the intention of the September 2006 revision.
- Corrected errors in "Coding Responses" Section

**September 2006:**

- Minor changes were introduced to standardize wording of the resource constraint in most questions to read, "...because there wasn't enough money for food."
- Question order was changed to group the child-referenced questions following the household- and adult-referenced questions. The Committee on National Statistics panel that reviewed the food security measurement methods in 2004-06 recommended this change to reduce cognitive burden on respondents. Conforming changes in screening specifications were also made.  
NOTE: Question numbers were revised to reflect the new question order.
- Follow up questions to the food sufficiency question (HH1) that were included in earlier versions of the module have been omitted.
- User notes following the questionnaire have been revised to be consistent with current practice and with new labels for ranges of food security and food insecurity introduced by USDA in 2006.

**Transition into Module (administered to all households):**

These next questions are about the food eaten in your household in the last 12 months, since (current month) of last year and whether you were able to afford the food you need.

**Optional USDA Food Sufficiency Question/Screener: Question HH1 (This question is optional. It is not used to calculate any of the food security scales. It may be used in conjunction with income as a preliminary screener to reduce respondent burden for high income households).**

HH1. [IF ONE PERSON IN HOUSEHOLD, USE "I" IN PARENTHEICALS, OTHERWISE, USE "WE."]

Which of these statements best describes the food eaten in your household in the last 12 months: — enough of the kinds of food (I/we) want to eat; —enough, but not always the kinds of food (I/we) want; —sometimes not enough to eat; or, —often not enough to eat?

- [1] Enough of the kinds of food we want to eat
- [2] Enough but not always the kinds of food we want
- [3] Sometimes not enough to eat
- [4] Often not enough to eat
- [ ] DK or Refused

**Household Stage 1: Questions HH2-HH4 (asked of all households; begin scale items).**

[IF SINGLE ADULT IN HOUSEHOLD, USE "I," "MY," AND "YOU" IN PARENTHETICALS; OTHERWISE, USE "WE," "OUR," AND "YOUR HOUSEHOLD."]

HH2. Now I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

The first statement is "(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more." Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true
- [ ] DK or Refused

HH3. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true
- [ ] DK or Refused

HH4. "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

- [ ] Often true
- [ ] Sometimes true
- [ ] Never true
- [ ] DK or Refused

**Screener for Stage 2 Adult-Referenced Questions:** If affirmative response (i.e., "often true" or "sometimes true") to one or more of Questions HH2-HH4, OR, response [3] or [4] to question HH1 (if

administered), then continue to ***Adult Stage 2***; otherwise, if children under age 18 are present in the household, skip to ***Child Stage 1***, otherwise skip to ***End of Food Security Module***.

**NOTE:** In a sample similar to that of the general U.S. population, about 20 percent of households (45 percent of households with incomes less than 185 percent of poverty line) will pass this screen and continue to Adult Stage 2.

**Adult Stage 2: Questions AD1-AD4 (asked of households passing the screener for Stage 2 adult-referenced questions).**

AD1. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

- Yes
- No (Skip AD1a)
- DK (Skip AD1a)

AD1a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

- Almost every month
- Some months but not every month
- Only 1 or 2 months
- DK

AD2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

- Yes
- No
- DK

AD3. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

- Yes
- No
- DK

AD4. In the last 12 months, did you lose weight because there wasn't enough money for food?

- Yes
- No
- DK

**Screener for Stage 3 Adult-Referenced Questions:** If affirmative response to one or more of questions AD1 through AD4, then continue to *Adult Stage 3*; otherwise, if children under age 18 are present in the household, skip to *Child Stage 1*, otherwise skip to *End of Food Security Module*.

**NOTE:** In a sample similar to that of the general U.S. population, about 8 percent of households (20 percent of households with incomes less than 185 percent of poverty line) will pass this screen and continue to Adult Stage 3.

**Adult Stage 3: Questions AD5-AD5a (asked of households passing screener for Stage 3 adult-referenced questions).**

AD5. In the last 12 months, did (you/you or other adults in your household) ever not eat for a whole day because there wasn't enough money for food?

- Yes
- No (Skip 12a)
- DK (Skip 12a)

AD5a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

- Almost every month
- Some months but not every month
- Only 1 or 2 months
- DK

**Child Stage 1: Questions CH1-CH3 (Transitions and questions CH1 and CH2 are administered to all households with children under age 18)** Households with no child under age 18, skip to *End of Food Security Module*.

SELECT APPROPRIATE FILLS DEPENDING ON NUMBER OF ADULTS AND NUMBER OF CHILDREN IN THE HOUSEHOLD.

**Transition into Child-Referenced Questions:**

Now I'm going to read you several statements that people have made about the food situation of their children. For these statements, please tell me whether the statement was OFTEN true, SOMETIMES true, or NEVER true in the last 12 months for (your child/children living in the household who are under 18 years old).

CH1. “(I/we) relied on only a few kinds of low-cost food to feed (my/our) child/the children) because (I was/we were) running out of money to buy food.” Was that often, sometimes, or never true for (you/your household) in the last 12 months?

- Often true
- Sometimes true
- Never true
- DK or Refused

CH2. "(I/We) couldn't feed (my/our) child/the children) a balanced meal, because (I/we) couldn't afford that." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

- Often true
- Sometimes true
- Never true
- DK or Refused

CH3. "(My/Our child was/The children were) not eating enough because (I/we) just couldn't afford enough food." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

- Often True
- Sometimes true
- Never true
- DK or Refused

**Screener for Stage 2 Child Referenced Questions:** If affirmative response (i.e., "often true" or "sometimes true") to one or more of questions CH1-CH3, then continue to **Child Stage 2**; otherwise skip to **End of Food Security Module**.

**NOTE:** In a sample similar to that of the general U.S. population, about 16 percent of households with children (35 percent of households with children with incomes less than 185 percent of poverty line) will pass this screen and continue to Child Stage 2.

**Child Stage 2: Questions CH4-CH7 (asked of households passing the screener for stage 2 child-referenced questions).**

**NOTE:** In Current Population Survey Food Security Supplements, question CH6 precedes question CH5.

CH4. In the last 12 months, since (current month) of last year, did you ever cut the size of (your child's/any of the children's) meals because there wasn't enough money for food?

- Yes
- No
- DK

CH5. In the last 12 months, did (CHILD'S NAME/any of the children) ever skip meals because there wasn't enough money for food?

- Yes
- No (Skip CH5a)
- DK (Skip CH5a)

CH5a. [IF YES ABOVE ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

- Almost every month
- Some months but not every month
- Only 1 or 2 months
- DK

CH6. In the last 12 months, (was your child/were the children) ever hungry but you just couldn't afford more food?

- Yes
- No
- DK

CH7. In the last 12 months, did (your child/any of the children) ever not eat for a whole day because there wasn't enough money for food?

- Yes
- No
- DK

## HOPKINS SYMPTOM CHECKLIST-25

Listed below are some symptoms or problems that people sometimes have. Please read each one carefully and decide how much the symptoms bothered or distressed you in the last week, including today. Place a check in the appropriate column.

### -Part I-

Extremely	Quite a Bit	A Little	Not at All	Anxiety Symptoms	
				Suddenly scared for no reason	1
				Feeling fearful	2
				Faintness, dizziness, or weakness	3
				Nervousness or shakiness inside	4
				Heart pounding or racing	5
				Trembling	6
				Feeling tense or keyed up	7
				Headaches	8
				Spells of terror or panic	9
				Feeling restless, can't sit still	10

## HOPKINS SYMPTOM CHECKLIST-25

### -Part II-

Extremely	Quite a bit	A little	Not at all	Depression Symptoms	
				Feeling low in energy, slowed down	11
				Blaming yourself for things	12
				Crying easily	13
				Loss of sexual interest or pleasure	14
				Poor appetite	15
				Difficulty falling asleep, staying	16
				Feeling hopeless about the future	17
				Feeling blue	18
				Feeling lonely	19
				Thoughts of ending your life	20
				Feeling of being trapped or caught	21
				Worrying too much about things	22
				Feeling no interest in things	23
				Feeling everything is an effort	24
				Feelings of worthlessness	25

## **DEMOGRAPHICS QUESTIONNAIRE**

Participant ID \_\_\_\_\_

Please complete the following questions:

**Demographics**

1. What is your Date of Birth? \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
                            D      M      Year

2. Are you currently...? (Please Circle One)

- Married
- Living with a Partner
- Divorced
- Separated
- Never married

3. What is the highest degree or level of education you have completed? If currently enrolled in classes, please mark ONLY the highest level COMPLETED (Please circle one)

- Some high school, no diploma
- High school graduate - high school diploma or GED
- Some college
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree (for example: MD, DDS, DVM, LLB, JD)
- Doctorate degree (for example: PhD, EdD)

4. Are you currently...? (Please circle one)

- Employed
- Unemployed but looking for a job
- Unemployed but NOT looking for a job
- A student
- Unable to work

If employed, please provide a brief description of your current job:

Name of Employer: \_\_\_\_\_

Position Held/Job Title: \_\_\_\_\_

Brief Description of Your Job Duties:

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5. What is your total household income? (Please circle one)

- Less than \$10,000
- \$10,000 to \$20, 000
- \$20,000 to \$30, 000
- \$30,000 to \$40,000
- \$40,000 to \$50, 000
- Over \$50,000

6. Do you own a vehicle? Y or N (Please circle one)

7. Do you own or rent your home? Own or Rent (please circle one)

If you rent, do you live in government subsidized housing? Y or N (please circle one)

8. Approximately how much do you spend monthly on housing? (including rent/mortgage payment and utilities) \_\_\_\_\_ dollars

9. Do you consider yourself the head of your household? Y or N (please circle one)

10. How many people (including yourself) live in your home? \_\_\_\_\_

Please describe the relationship of all individuals living in your home to yourself (for example, "grandmother"). Please do not use any names:

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11. Do you currently receive Food Stamps or WIC? Y or N (please circle one)

If yes, how much do you receive per month? \$\_\_\_\_\_

12. What is your approximate total monthly food budget? (including Food Stamps/WIC if you receive these benefits)

**Your Health Information**

1. How much did you weigh when you were born? \_\_\_\_ lbs. \_\_\_\_ oz. \_\_\_\_ don't know
2. Were you born premature, late or on-time? \_\_\_\_\_  
If premature or late, by how long? \_\_\_\_\_
3. Were you breastfed by your mother? Y N Don't Know (Please circle one)
4. How much did you weigh at the beginning of your pregnancy? \_\_\_\_\_ lbs.
5. How much weight did you gain during your pregnancy? \_\_\_\_\_ lbs.
6. How much do you currently weigh? \_\_\_\_\_ lbs.
7. How tall are you? \_\_\_\_ feet \_\_\_\_ in.
8. Have you ever been diagnosed with a medical conditions? Y or N (please circle one)

If yes, please describe:

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9. Did you experience any health-related complications during your pregnancy?  
(ex. gestational diabetes, hypertension, etc.) Y or N (please circle one)

If yes, please describe:

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10. Do you smoke? Y or N (please circle one)

If Yes, did you smoke during your pregnancy? Y or N (please circle one)

**Your Baby's Health Information**

1. How much did your baby weigh when he/she was born? \_\_\_\_ lbs. \_\_\_\_ oz.
2. What was his/her date of birth? \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
D    M    Year
3. At how many weeks into your pregnancy did you give birth? \_\_\_\_\_ weeks
4. Did your baby experience any medical issues when he/she was born?  
Y or N (please circle one)

If yes, please describe:

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5. Did/do you breastfeed your baby? Y or N (please circle one)

If yes and you have now stopped, how long did you breastfeed? \_\_\_\_\_  
Did you breastfeed exclusively or also give some formula? \_\_\_\_\_

If you are currently still breastfeeding, how long do you plan to continue? \_\_\_\_\_  
Do you breastfeed exclusively or also give some formula? \_\_\_\_\_

## **INTERVIEW GUIDE**

### **Introduction (No Audio-recording)**

Hi, my name is (Name) and as you know, I'm here today to talk to you about the types of foods you eat, how you make your food choices, and how you feel about the food that's available in your community. I want to start by thanking you for agreeing to meet with me today. During our meeting, I will also be asking you to complete some brief questionnaires prior to our interview. These questionnaires will ask you about the specific kinds of foods you eat and whether you feel you always have enough food. The questionnaires will also ask you for information about the stress and/or anxiety you feel in your daily life as well as health information related to your pregnancy and recent delivery.

Before we begin, we will read through the informed consent form together and I will answer any questions you might have. Please remember that your participation in this study is completely voluntary and you do not have to answer any questions you do not want to.

### **Read-through Informed Consent Form. The following process will be followed:**

- 1) All questions will be answered in a thorough and comprehensible manner to the participant.
- 2) The interviewer will verify that the participant is able to independently consent to taking part.
- 3) Privacy will be maintained while obtaining informed consent (e.g., informed consent will be obtained in a private room)
- 4) The participant will be given ample time to have their questions answered and consider taking part in the study.
- 5) The participant will be reminded that their participation is completely voluntary and they may withdraw at any time.
- 6) The participant will be given a copy of the informed consent form to keep in case they have questions in the future or choose to withdraw their data from the study.

In order to accurately record our conversation today, I would like to ask permission to audio-tape our discussion. This is a digital recorder. The audio-recording of our conversation today will be saved as an encrypted file on my computer. I will then transcribe the conversation and destroy the audio-file. I will not record your name or any other identifying information on the audio-recorder except the random id you have been assigned. Do I have your permission to audio-record our conversation today?

### **While setting up recorder:**

So how is (baby name)? How are you feeling now? .... small talk related to the baby, etc.

**Start of Interview:**

This is (Name of Interviewer). Date of interview is (Date) with Participant (#)

**Prenatal**

I would like to begin our conversation by asking you about your diet and overall health during your pregnancy. When I ask you these questions, try to think back to your prenatal period and answer as accurately as possible.

Please describe a typical day for you while you were pregnant.

**Prompt:** Did you have a job?

**Prompt:** What was your schedule like?

**Prompt:** What kinds of responsibilities did you have during your pregnancy?

How did your pregnancy change your life?

**Prompt:** Did it change any of your long or short-term goals?

**Prompt:** Did it change any of your daily routines?

How would you describe your diet during your last pregnancy?

**Prompt:** Did you have any particular cravings?

**Prompt:** What types of foods were recommended by your doctor? Did you eat these foods?

**Prompt:** Did you mostly cook at home or eat out/buy prepared foods?

Please talk about how your diet changed during your pregnancy compared with your pre-pregnancy diet.

What do you remember about the nutrition advice your doctor gave you during your pregnancy?

Did you receive WIC or food assistance during your pregnancy?

**If YES - Prompt:** How would you describe your experience with those services?

**Prompt:** Did they provide the kind of help you needed?

**Prompt:** Is there anything you would change about the services you received?

**If NO – Prompt:** Why did you choose not to participate in these programs?

Where did you shop for food most often during your last pregnancy?

**Prompt:** A grocery store, convenience store, market, fast food restaurant?

**Prompt:** What was the main reason you shopped there? (Location, convenience, healthier options,

less expensive, etc.)

When you shopped for food during your last pregnancy, what were the main factors that influenced which foods you bought?

**Prompt:** Personal likes/dislikes, money, convenience/easy preparation, doctor recommendations?

How would you describe the food that was available in the neighborhood you lived in while pregnant?

**Prompt:** Did/do you have a variety of options?

**Prompt:** Did/do you have to travel far to get healthy food? (e.g., fresh fruits and vegetables?)

**Prompt:** What types of food stores were/are nearby?

Were you ever bothered by either a lack of variety or what you feel are too high of prices for certain foods within your neighborhood?

**Prompt:** Have you ever felt you were being “ripped off” when buying food from stores in your neighborhood?

How did you get to the store to buy food while you were pregnant?

**Prompt:** Did you have a car, take public transportation, ride with friends/family?

**Prompt:** How long did it take you to get to the store to buy food?

**If participant did not have a car:**

Did not having a car affect your diet?

**Prompt:** Did you ever feel you had to “settle” on less healthy options because they were more convenient?

**Prompt:** If you had to walk, did you feel safe in your neighborhood?

When you were pregnant, where did you usually eat your meals?

**Prompt:** At the table, in the car, on the couch...?

**Prompt:** Did you typically share your meals with anyone?

How did you plan meals during your pregnancy?

**Prompt:** Did you plan in advance for the week/month or just take it day by day?

Did you ever feel stressed out about meals during your pregnancy?

**Prompt:** For example, you felt you didn’t have enough money for a meal or you didn’t have enough time to prepare something healthy, etc....

Did you ever feel you had to go without certain things (for example, not pay a utility bill) in order to buy enough food during your pregnancy?

What did you do to be healthy during your pregnancy?

**Prompt:** Exercise, eat right, cut back on stress, please describe.

Did you have people (friends, family) you could rely on for help if you needed it?

**If Yes –** In what ways did they help you? (Cook, clean, give you rides, provide emotional support, baby-sit for other children, give financial help?)

Were there any situations you experienced during your pregnancy that stressed you out? These could be anything, they don't have to be related to food or nutrition

**Prompt:** In your daily life..(work, family, friends)

**Prompt:** Any major incidents that caused stress while you were pregnant?

If yes, how did you cope with them?

**Prompt:** Family and friends supported you

**Prompt:** You knew you could handle it on your own

**Prompt:** You became upset or depressed and weren't sure what to do

Did you experience any medical complications during your pregnancy?

**If yes:** What did you have to do to stay healthy?

### **Post-partum**

Now I'm going to ask you some questions about your current lifestyle since you've had the baby.

So how has the baby changed your life?

**Prompt:** Your priorities, your schedule...

Please describe a typical day for you.

**Prompt:** Do you work, have a schedule, go to school?

**Prompt:** How has the baby affected your schedule?

What do you currently do to be healthy?

**Prompt:** exercise, eat right, etc.

Are you living in the same neighborhood you lived in while pregnant?

How would you describe your neighborhood?

**Prompt:** Do you feel safe? Do you know your neighbors? Do most people work? Is it

ethnically/racially diverse or mostly one racial/ethnic group? What is the average income level of your neighborhood?

How would you describe your diet now that the baby has arrived?

**Prompt:** Do you mostly cook at home or eat out/buy prepared foods

**Prompt:** Do you feel you eat a healthy diet?

What foods do you consider to be healthy?

Are you currently receiving WIC or food assistance?

**If YES - Prompt:** Do they still provide the kind of help you need?

**Prompt:** Is there anything you would change about the services you received?

On average, what is your total food budget each month?

**Prompt:** Do you feel that is enough to purchase everything you need and/or want?

Where do you currently shop for food most often?

**Prompt:** A grocery store, convenience store, market, fast food restaurant?

**Prompt:** What is the main reason you shop there? (location, convenience, healthier options, less expensive, etc.)

When you shop for food now, what are the main factors that influence which foods you buy?

**Prompt:** Personal likes/dislikes, money, convenience/easy preparation?

What types of food do you like?

**Prompt:** What are your “comfort” foods?

**Prompt:** What food items would you consider “staples” like food you always have in the house?

What types of food does/do your child/children like?

**Prompt:** Do they/he/she come with you when you shop for groceries?

Who taught you how to cook?

Are there any foods you grew up eating that you would consider part of your heritage?

**If Yes –** What are they?

**Prompt:** Who taught you how to make them?

**Prompt:** How often do you still make them?

How does your culture or heritage influence the types of foods you eat?

**Prompt:** Do you feel you have access to the same foods as other racial/ethnic groups?

**Prompt:** Do you eat certain foods because they're part of your culture? What kinds?

How would you describe the food that is available in your neighborhood?

**Prompt:** Do you have a variety of options?

**Prompt:** Do you have to travel far to get healthy food? (e.g., fresh fruits and vegetables?)

**Prompt:** What types of food stores are nearby?

Please describe any changes you would like to see in the food available in your neighborhood.

How do you get to the store to buy food?

**Prompt:** Do you have a car, take public transportation, ride with friends/family?

**Prompt:** How long does it take you to get to the store to buy food?

**If participant does not have a car:**

In what ways does not having a car influence your diet?

**Prompt:** Do you ever feel you have to "settle" on less healthy options because they were more convenient?

**Prompt:** If you have to walk, do you feel safe in your neighborhood?

Where do you usually eat your meals?

**Prompt:** At the table, in the car, on the couch...?

**Prompt:** Do you typically share meals with anyone? (your children, friends, family)

How do you plan meals?

**Prompt:** Do you plan in advance for the week/month or just take it day by day?

Do you ever feel stressed out thinking about food? For example, figuring out what to make for dinner, pack for lunch, etc.?

Do you have people you can rely on for support if you need it?

**If Yes -** Who are they and what do they do for you?

Are there any situations you're currently going through that are causing you stress? These could be anything, they don't have to be related to food or nutrition

**Prompt:** In your daily life..(Work, family, friends)

**Prompt:** Any major incidents?

Have you experienced any health concerns since you had the baby?

**If Yes – Please describe**

### **Daily Life Stress and Coping Mechanisms**

Now I would like to talk to you about the kinds of stress you may encounter in your daily life. I'm going to ask you about different common stressful situations and I would like for you to tell me if you have personally experienced them and if so, how you deal/dealt with them.

**If participant is employed:**

Please tell me about some stressful situations you have encountered on the job. How did you resolve them?

**Prompt:** Do you feel respected at work?

**Prompt:** Please tell me about dealing with a difficult supervisor/co-worker/or customer.

**Prompt:** Do these types of situations arise often?

Do you ever feel anxious or stressed about having enough time to get everything done in your daily life? What are your main concerns with time? What factors contribute to your worry? How do you cope with this?

Do you ever experience conflicts with friends or family members? If so, what types of conflicts?

**Prompt:** Feeling like you're taken advantage of, have too many responsibilities, owe money, disagree with you/their choices, lifestyles are different, etc.

**Prompt:** How do you resolve these conflicts?

**If participant is in a relationship**

Do you ever feel stressed or anxious as a result of your relationship with your spouse/boyfriend? How do you resolve conflicts within your relationship?

How about cash-flow issues? How do you handle stress related to finances? What types of difficult financial decisions have you had to make?

**Prompt:** Have you had to prioritize different needs? If so, what were they? (i.e. paying utility bills versus paying for medication)

How would you describe the safety level of your neighborhood?

**Prompt:** Do you feel safe walking around by yourself? What about at night?

**Prompt:** Is crime or drug activity an issue in your neighborhood?

**Prompt:** Do you allow your kids to play outside?

**Prompt:** How is the traffic?

**Prompt:** Does living in your neighborhood cause you stress?

What other types of situations cause you stress? How do you cope with them?

### **Experience of Racism (African American participants)**

Finally, I'd like to discuss with you your feelings and experiences related to being an African American mother living in the U.S.

How often would you say you think about race?

What types of situations make you think about it?

How often would you say you personally experience racism in your daily life?

**Prompt:** Someone treats you differently because you're Black.

Please describe some of these experiences.

How do you react when these situations arise?

**Prompt:** How do you cope with the situations?

When you were growing up, do you remember encountering racism directed towards you?

Please describe some of those experiences.

How did you cope with those situations as a child/adolescent?

Did your parents, friends, or family prepare you for those encounters when you were young? If so, what advice did they give you?

How will you discuss these things with your children?

Are you concerned that your children will experience racism?

Of all the different situations in your life that cause you stress, where does racism factor? Does it cause you more or less stress and anxiety than other issues in your life?

### **Experience with Discrimination (White participants)**

Finally, I'd like to discuss with you your feelings and experiences related to being a low-income mother living in the U.S.

How often would you say you think about your financial situation or your socioeconomic status?

What types of daily situations or interactions make you think about it?

How often would you say you personally experience discrimination in your daily life?

**Prompt:** Do you ever feel people make assumptions about you or treat you differently?

Please describe some of these experiences.

How do you react when these situations arise?

**Prompt:** How do you cope with the situations?

When you were growing up, do you remember encountering discrimination of any kind directed towards you?

Please describe some of those experiences.

How did you cope with those situations as a child/adolescent?

Did your parents, friends, or family prepare you for those encounters when you were young? What type of advice did they give?

How will you discuss these things with your children?

Are you concerned that your children will experience prejudice or discrimination?

Of all the different situations in your life that cause you stress, where does discrimination factor? Does it cause you more or less stress and anxiety than other issues in your life?

## **APPENDIX C: IRB APPROVAL AND PARTICIPANT MATERIALS**



**RESEARCH INTEGRITY AND COMPLIANCE**  
Institutional Review Boards, FWA No. 00001669  
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799  
(813) 974-5638 • FAX(813)974-7091

9/22/2014

Amanda Terry, M.A.  
USF Department of Pediatrics  
3650 Spectrum Blvd.  
Suite 100  
Tampa, FL 33612

**RE: Expedited Approval for Continuing Review**

IRB#: CR3\_Pro00002700

Title: The Political Economy of Food Security Among Low-Income Mothers: Disentangling the Roles of Class and Race in the U.S.“Foodscape”

**Study Approval Period: 10/1/2014 to 10/1/2015**

Dear Ms. Terry:

On 9/21/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

**Approved Item(s):**

**Protocol Document(s):**

[Amanda Terry dissertation proposal](#)

The IRB determined that your study qualified for expedited review based on federal expedited category number(s):

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to,

research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

A handwritten signature in black ink that reads "John Schinka, Ph.D." The signature is fluid and cursive, with "John" and "Schinka" connected and "Ph.D." written in a smaller, more formal script.

John Schinka, Ph.D., Chairperson  
USF Institutional Review Board



## **Informed Consent to Participate in Research Information to Consider Before Taking Part in this Research Study**

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You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. We encourage you to talk with your family and friends before you decide to take part in this research study. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:

### **“Food in Your Community: How your Environment Impacts your Diet and your Health”**

The person who is in charge of this research study is Amanda Terry. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge. She is being guided in this research by David Himmelgreen, Ph.D.

The research will be conducted throughout Pinellas County, Florida.

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#### **Purpose of the study**

The purpose of this study is to:

- Explore how new mothers choose the types of foods they eat, describe their nutritional health, and examine the quality and affordability of food in Pinellas County neighborhoods.
- This study is being conducted as dissertation fieldwork for the fulfillment of the investigator's Ph.D.

#### **Study Procedures**

If you take part in this study, you will be asked to:

- Participate in 1 interview which will include completion of four short surveys/questionnaires and an open-ended discussion with the investigator about the foods you eat, the foods available in your neighborhood, and your overall health.
- The expected duration of the interview will be 2.5 hours.

- The interview will be conducted in your home or other designated location of your choice.
- In order to help the interviewer record your information accurately, you will be asked for permission to audio-record the interview. This will be a digital recording and, once transcribed, will be destroyed. Only the investigator will have access to the recording.

**Total Number of Participants**

About 40 individuals will take part in this study in Pinellas County.

**Alternatives**

You do not have to participate in this research study.

**Benefits**

We are unsure if you will receive any benefits by taking part in this research study.

**Risks or Discomfort**

This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

**Compensation**

You will be compensated \$35.00 for participation in this study. Should you choose not to answer all the questions asked or choose not to complete the interview, you will still receive the \$35.00.

**Cost**

There will be no additional costs to you as a result of being in this study.

**Privacy and Confidentiality**

We will keep your study records private and confidential. Certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).
- The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study, staff in the USF Office of Research and

Innovation, USF Division of Research Integrity and Compliance, and other USF offices who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are.

**Voluntary Participation / Withdrawal**

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

**New information about the study**

During the course of this study, we may find more information that could be important to you. This includes information that, once learned, might cause you to change your mind about being in the study. We will notify you as soon as possible if such information becomes available.

**You can get the answers to your questions, concerns, or complaints**

If you have any questions, concerns or complaints about this study, or experience an adverse event or unanticipated problem, call Amanda Terry at 813-480-9624.

If you have questions about your rights as a participant in this study, general questions, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

**Consent to Take Part in this Research Study**

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

**I freely give my consent to take part in this study.** I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

I consent to being audio-taped

YES\_\_\_\_\_ NO\_\_\_\_\_

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Signature of Person Taking Part in Study

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Date

---

Printed Name of Person Taking Part in Study

**Statement of Person Obtaining Informed Consent**

I have carefully explained to the person taking part in the study what he or she can expect from their participation. I hereby certify that when this person signs this form, to the best of my knowledge, he/ she understands:

- What the study is about;
- What procedures/interventions/investigational drugs or devices will be used;
- What the potential benefits might be; and
- What the known risks might be.

I can confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in the appropriate language. Additionally, this subject reads well enough to understand this document or, if not, this person is able to hear and understand when the form is read to him or her. This subject does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give legally effective informed consent. This subject is not under any type of anesthesia or analgesic that may cloud their judgment or make it hard to understand what is being explained and, therefore, can be considered competent to give informed consent.

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Signature of Person Obtaining Informed Consent / Research Authorization

---

Date

---

Printed Name of Person Obtaining Informed Consent / Research Authorization

---

Date

## IRB-APPROVED RECRUITMENT FLYERS

# Food in your Community: How Does Where you Live Impact your Nutritional Health?

**Be part of an important  
research study!**

- Are you between the ages of 18-35?
- Have you had a baby in the past 6 months?
- Are you interested in nutrition and the food available in your community?

The purpose of this research study is to explore the factors that influence the types of foods new mothers eat. Volunteers will be asked to complete short surveys and participate in a one-to-one interview.

Volunteers will be given \$25.00 for their time.

This research is approved by the University of South Florida

If you are interested in participating, please take one and call or email Amanda Terry:

(813)480-9624 • [aterry3@mail.usf.edu](mailto:aterry3@mail.usf.edu)



Amanda Terry

(813)480-9624

[aterry3@mail.usf.edu](mailto:aterry3@mail.usf.edu)

# Food in your Community: How Does Where you Live Impact your Nutritional Health?

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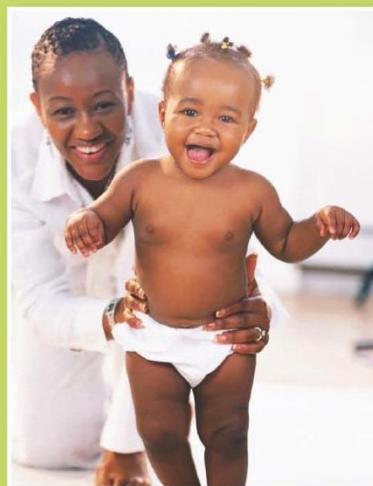
If you take part in this study, you will be asked to:

- Participate in 1 interview which will include completion of four short surveys/questionnaires and an open-ended discussion with the investigator about the foods you eat, the foods available in your neighborhood, and your overall health.
- The expected duration of the interview will be 2.5 hours.
- The interview will be conducted in your home or other designated location of your choice.

Volunteers will be given \$25.00 for their time.

This research is approved by the  
University of South Florida

If you are interested in participating, please call  
or email Amanda Terry at 813-480-9624 or  
[aterry3@mail.usf.edu](mailto:aterry3@mail.usf.edu)



## **HEALTHY START HOME VISITOR RECRUITMENT SCRIPT**

I would like to share some information with you today regarding a research study being conducted at USF for which you may be interested in volunteering. The study is completely independent of Healthy Start and whether or not you decide to participate will not affect the services you receive from Healthy Start. In fact, no one at Healthy Start will ever know whether or not you choose to volunteer for the study. The person conducting the research is not affiliated with Healthy Start in any way.

The research is about how new mothers like you choose their diets and the types of foods you like to eat. The goal of the study is to take a closer look at the types of foods available in your community and focus on their quality and affordability. If you volunteer, you will meet with the person conducting the research for a one-time interview and you will be compensated \$35.00. She will come to your home or wherever you are comfortable meeting with her. She will ask you to complete some short surveys about the types of food you eat and then she will interview you. The total interview time will be around 2.5 hours.

It is up to you whether you would like to participate. If you are interested in taking part and would like me to give your name and phone number to the person conducting the study, you will need to sign the informed consent form which states that you gave me permission to pass along your contact information. If you would prefer to contact the researcher yourself, I will leave an information sheet with you today which lists her phone number and email address.