

# Chapter 2

## Managing the Lactating Body: The Breastfeeding Project in the Age of Anxiety

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### 2.1 Introduction

For most of human history, feeding infants at the breast was a fact of life. Although feeding practices varied widely (Maher 1992) with regards to the timing of weaning, the extent and variety of supplementary foods and the source of breast milk (maternal, maternal networks, or a hired wetnurse), infants depended on breast milk for survival in their first several months or years of life. The introduction of safe breast milk alternatives ('formula') in the twentieth-century rendered breastfeeding an increasingly less appealing option in Western countries until breastfeeding advocates and public health campaigns began to intervene to reverse the trend in the 1980s.

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Public health campaigns are based on two premises: ‘the breast is best’ and breastfeeding as ‘natural’ (Kukla 2006; Wolf 2007). This chapter demonstrates that these premises are flawed. Like other parenting, reproductive, health and lifestyle choices, breastfeeding is an option framed by access to resources, corporate interests, public policy, competing ideas about science, motherhood and standards of infant care. Drawing on interviews with class-privileged American mothers, this chapter sheds light on how breastfeeding is shaped at the crossroads of moralised motherhood, public health campaigns and grass-roots activism, economic disparities and the commercialised, medicalised and professionalised contexts that characterise contemporary parenting. Specifically, I demonstrate that this group of women constructs the lactating body as a carefully managed site and breastfeeding as a mothering project – a task to be researched, planned, implemented and assessed, with reliance on expert knowledge, professional advice and consumption. The construction of breastfeeding as a maternal project sheds light on breastfeeding disparities (‘successful’ breastfeeders tend to be white, educated, older and heterosexually partnered mothers) and on the fallacy of the ‘breast is best’ and ‘breastfeeding is natural’ slogans.

## 2.2 Breastfeeding Trends in the United States

When breast milk alternatives were first introduced in the late 1800s, results were disastrous, spurring the first wave of breastfeeding campaigns (Apple 1987; Wolf 2006). As safer alternatives became widely available in the 1920s, breastfeeding rates began to decline worldwide and by the 1930s breastfeeding was viewed as a matter of choice in Western nations. Breastfeeding came under scrutiny in the 1950s, as part of the process that brought reproduction and parenting under the purview of experts. Many mothers were diagnosed with insufficient milk syndrome and advised to discontinue breastfeeding. According to Apple (1987) and Carter (1995), this syndrome was typically the by-product of hospital practices and child care advice that interfered with lactation mechanisms, such as maternal–infant separation in hospitals following childbirth and the promotion of strict breastfeeding schedules. In this climate, physicians and public health officials began to promote formula as a more convenient and nutritiously equivalent alternative to breast milk; formula was sometimes touted as a *superior* alternative (Apple 1987; see also Chapter 9 in this volume). Amidst this culture of scientific motherhood, in the 1950s a group of women in Chicago founded a breastfeeding advocacy and support organisation, La Leche League (see Gorham & Andrews 1990; Ward 2000; see also Chapter 7 in this volume).

By the early 1970s, breastfeeding initiation rates in the United States dropped to an all-time low of 25%, coinciding with the large-scale entry of mothers of young children to the workforce. Initially, breastfeeding rates declined most rapidly among privileged mothers, but by the 1970s all demographic groups exhibited low breastfeeding rates. In a trend that continues today, low-income, uneducated and

African-American mothers exhibited the sharpest declines in breastfeeding rates (Ryan 1997, Ryan, Wenjun, & Acosta 2002).

Since the late 1970s, breastfeeding rates have rebounded. By the mid-2000s, 70% of American mothers initiated breastfeeding, and about 35% of infants were receiving some breast milk at 6 months. Both rates are short of the goals of the United States Department of Health and Human Services (2000) and of the World Health Organisation (WHO). At the same time, breastfeeding has become even more stratified. Once associated with poor, immigrant and unsophisticated mothers, in Western nations breastfeeding has become a marker of privileged motherhood (Apple 1987; Blum 1999), where white, middle-class, educated, heterosexually partnered and older mothers are more likely to initiate breastfeeding, continue breastfeeding beyond the first few days and upon return to paid employment and breastfeed exclusively (Ryan et al. 2002; Ahluwalia, Morrow, Hsia, & Grummer-Strawn 2003). Given the emphasis that breastfeeding experts put on mothers' access to adequate nourishment, rest and a relaxing environment (Sears & Sears 1993; Huggings 1995), these disparities are hardly surprising. This chapter shows that this advice plays a key role in the construction of breastfeeding practices of 'successful' breastfeeding mothers.

Breastfeeding disparities are a product of two intersecting processes. First, public policies in the United States that privatise childrearing responsibilities offer little support to mothers whose short maternity leaves, inflexible schedules and work environments interfere with breastfeeding routines and are inhospitable to establishing pumping as an alternative. Mothers who take longer maternity leaves, work part time or on a flexible schedule and pump their breasts regularly while separated from their infants are able to breastfeed their infants longer (Avishai 2004). Countries that offer more generous support to new mothers such as New Zealand, Australia and Canada, exhibit higher breastfeeding rates across the population and less significant racial and socio-economic disparities.

These disparities are also a product of racialised and sexualised public discourses. Blum (1999) argues that the 'breast is best' frame creates a standard of good mothering that faults mothers who cannot comply with this standard or do not wish to comply with it. These mothers are usually poor, uneducated and minority women, some of whom resist what they see as imposition of white, middle-class mothering standards (see Ladd-Taylor & Umansky 1998; cf Chapter 9 in this volume).

### **2.3 Within 'Breast Is Best': Public Health Campaigns**

Oblivious to breast milk and breastfeeding throughout much of the twentieth century, in the mid-1970s medical and nutrition scientists and practitioners began to investigate breast milk composition, lactation physiology and the correlation between breast milk and a range of medical and psychological conditions and diseases, including ear infections, asthma, gastrointestinal ailments, diabetes, allergies,

intelligence, obesity, autism and infant death syndrome (AAP 2005). The cumulative data suggest that breast milk has a positive effect on various health conditions. This evidence is captured by the now-axiomatic notion that ‘the breast is best’ for infants, mothers, families, populations and the environment (AAP 2005). On the heels of this evidence, the WHO, national medical associations and international breastfeeding advocacy organisations (such as WABA, the World Alliance for Breast-Feeding Advocacy) recommend that infants be breastfed without any supplementary foods (including breast milk alternatives) during their first 6 months of life, followed by a combination of breastfeeding and complementary foods (excluding breast milk alternatives) up to age two (see policy statements and calls for action of the American Academy of Pediatrics, 1997, 2005; the Department of Health’s 2000 Blueprint for Action on Breastfeeding; WHO 2002 Global Strategy on Infant Feeding).

These guidelines are accompanied by public health campaigns that tout breast milk as ‘liquid gold’, vital for the health, intelligence and emotional well-being of infants. These campaigns promote breastfeeding as a natural, medically informed, rational and responsible parenting choice (Kukla 2006; Wolf 2007). Supporting these campaigns, parenting books and magazines offer mothers expert advice as to why they should breastfeed (*‘Why Breast is Best’*; *‘The Secret to Quick Weight Loss’*; *‘Avoid Ear Infections’*) and how (exclusively and ‘on demand’, in response to the infants’ needs rather than according to a pre-set feeding schedule (Sears & Sears 1993; Huggings 1995). Public health campaigns are further supported by grass-roots anti-corporate activists, advocates of natural parenting methods and, most recently, by feminist ‘lactivists’ (lactation activists; see Carpenter 2007).

Critics of the science of human lactation caution that the data are not unequivocal, especially with regards to the benefits of breastfeeding beyond the first few months and exclusive breastfeeding (Blum 1999; Law 2000; Wolf 2007). Some also argue that when formula feeding is sanitary and breastfeeding rates mirror class disparities, these benefits may be the product of confounding socio-economic effects. They further charge that contemporary breastfeeding campaigns that are framed by privatised risk, choice and moralism are divorced from the cultural and institutional realities that structure breastfeeding in Western nations that offer little support to parents and sexualise women’s breasts (Kukla 2006; Wolf 2007). This very conversation suggests that breastfeeding is far from a natural practice, but rather one that needs to be understood in specific cultural contexts.

## **2.4 Breastfeeding at the Age of Anxiety: Expert and Consumerist Regimes**

While *infant* feeding has been subject to expert and medicalised control for decades, breastfeeding was largely left unregulated by experts (Fildes 1986; Apple 1987). As physicians promoted ‘formula’ as the modern, responsible, scientific and ‘American’ way of feeding babies starting in the 1950s and legions of mothers were diagnosed with ‘insufficient milk syndrome’, mothers who persevered enjoyed a

relatively expert-free cultural space; the description of breastfeeding as a counter-hegemonic, natural, symbiotic and simple practice in the 1973 version of *Our Bodies Ourselves* is instructive.

This has changed with the confluence of studies that establish the benefits of breastfeeding with feminist, anti-corporate and maternalist breastfeeding advocates' efforts to increase breastfeeding rates (Palmer 1988; Van Esterik 1989). In addition, a new profession – lactation consulting – emerged in the mid-1980s as an alternative to the free breastfeeding advice offered by La Leche League. Working within a clinical frame, this profession boasts formal training and certification procedures, a vibrant professional association, the International Lactation Consultant Association (ILCA),<sup>1</sup> and a peer reviewed journal (Spangler 2000; Bailey 2005). Breastfeeding is additionally supported by a vast market of goods and services, including lactation classes and books, nursing clothes, bras, pillows, chairs and breast pumps and related paraphernalia. Numerous websites also provide breastfeeding advice, support and merchandise.

To researchers conversant in the social history of reproduction and mothering and in theories of bodily disciplinary practices, the emergence of breastfeeding as a medicalised, expert, disciplinary and consumerist regime is hardly surprising. Such regimes govern health and reproduction (Davis-Floyd 1992; Martin 1992; Rapp 1999; Clarke, Mamo, Fishman, Shim, & Fosket 2003; Davis-Floyd 2004) and appearance (Bartky 1988; Bordo 1993; Gimlin 2002). The consumerist, technological, medicalised, professionalised and expert-reliant contexts that shape contemporary parenting and mothering are well documented (Hays 1996; Rapp 1999; Litt 2000; Hochschild 2003; Hulbert 2003; Lareau 2003; Taylor, Layne, & Wozniak 2004; Pugh 2005). Warner (2005) argues that this parenting context is indicative of an age of anxiety where parents and mothers, especially, are caught up in a ceaseless attempt to meet good mothering standards that render them exhausted and frustrated. It is within these multiple contexts that contemporary breastfeeding practices are forged (see also Chapters 6, 7, and 9 in this volume).

In what follows, I show how the women who participated in my study respond to good mothering standards defined by the number of ounces of breast milk produced. Analysing how they prepare for breastfeeding, the advice they seek and the gadgets they purchase, I show how these women produce the lactating body as a carefully managed site and breastfeeding as a 'project' – a task to be researched, planned, implemented and assessed. Analysis of the breastfeeding project demonstrates that breastfeeding is far from a natural practice.

## 2.5 The Study and Methods

This study is based on interviews with twenty-five first-time, educated, work-force-experienced and class-privileged mothers in the San Francisco Bay Area in

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<sup>1</sup>Although the ILCA was formed by La Leche League, it quickly became an independent organisation.

1999–2000. I recruited half of the participants through a local virtual parents' organisation. Other women were recruited using a snowball technique that began with personal acquaintances, a mothers' groups' moderator and a lactation consultant. I also interviewed the latter two as informants. The focus on privileged women was motivated by data suggesting persistent racial, ethnic and class disparities in breastfeeding practices. I was interested in the experiences of women who from a statistical perspective achieved breastfeeding success.

Most of the women in my sample were in their thirties; they ranged in age from twenty-five to forty-one. Twenty were white, one was East-Indian, two were Latina and two were mixed-race (Asian/white). About one-half were native to the Bay Area or had local extended family support. All but one were in heterosexual marriages; one was a lesbian single mother who otherwise shared the group's cultural capital. All were college graduates and almost half held professional or graduate degrees. Before birth, they pursued careers in white-collar professions, such as law, medicine, accounting, engineering, management, nursing and teaching. Many of this group who returned to paid employment attempted to provide their babies with breast milk by pumping at work, with varying degrees of success (Avishai 2004). One-third decided not to return to paid employment for the time being. The babies' ages ranged from 6 months to 2 years. Interviews lasted between 2 and 3 h and were loosely structured, recorded and transcribed in full. Interview topics included pregnancy and birth experiences, childrearing ideologies, the breastfeeding decision process, breastfeeding and pumping practices, women's sources of breastfeeding information and advice, breastfeeding-related consumption, spousal and other support systems, perception of the maternal body and enjoyment of breastfeeding.

## 2.6 The Breastfeeding Project

### 2.6.1 *Consulting the Books and Asking the Experts*

Without exception, the women in my study subscribed to the 'breast is best' axiom (for similar findings in Britain and Australia see Murphy 2000; Schmied & Lupton 2001; see also Chapters 4, 6, and 7 in this volume). Therefore, 'breastfeeding wasn't much of a decision', one interviewee said, because 'the benefits are clear'. However, the effortless decision to breastfeed typically marks the beginning of a long, laborious and demanding process.

While study participants knew that their bodies were 'equipped' to breastfeed, many approached breastfeeding with awe: 'Is this going to work?' 'Is it supposed to be so painful?' 'Am I producing enough milk for him?' and 'Is she gaining enough weight?' Dykes (2005) notes similar anxieties among British women. They did not expect breastfeeding to just happen, nor did they trust their bodies to know intuitively what to do. Breastfeeding was both an art and a science, a skill to be learned and mastered by acquiring specialised knowledge and mobilising resources.

Diane, a 30-year-old engineer turned stay-at-home mom, was most fastidious in her preparation. Though she remarked that 'you didn't need to know much', she

referred to over a dozen childbirth, breastfeeding and childrearing books. She also took pre- and post-natal breastfeeding classes and met with a lactation consultant. In contrast, Lara, a 34-year-old administrator thought that little preparation was necessary. She assumed she would just know how to breastfeed. 'What's there to it? The baby sucks on your breasts'. However, she encountered a host of difficulties in the first few months, including sore nipples and insufficient weight gain. In hindsight, she said she wished she 'had learned how to breastfeed'. Knowledge, she assumed, would have prevented these difficulties.

Experiences like Lara's circulate among expectant mothers through books, classes, doctors' offices, websites and informal networks, serving as cautionary tales which underscore the importance of adequate preparation. Accordingly, study participants were proactive. Starting early in their pregnancies, most women sought some information about breastfeeding, and most mentioned books of the 'how to' genre such as *The Nursing Mothers' Companion* (Huggings 1995), *The Baby Book* (Sears & Sears 1993) and the *What to Expect Series* (Eisenberg, Murkoff, & Hathaway 1996). Some supplemented reading with hands-on training in the form of breastfeeding preparation classes; two also met privately with a lactation consultant pre-natally, *anticipating* difficulties. In these classes, offered as stand-alone or as part of a birth preparation series, mothers-to-be and their partners learn breastfeeding techniques and practice with life-size dolls. Not surprisingly, they attributed post-birth breastfeeding success to a pre-natal preparation:

I was extremely nervous, thinking, 'I am not going to get sore, I do not want to get sore.' I heard numerous stories from my girlfriends, how they were sore, how they were cracked, and stopped. I was so determined, 'I want the proper latch on'. That's the key, I heard. So I would start, and my husband would give directions: 'no, you're a little high, you probably want to do this direction.' That class was extremely useful. (Angela)

The quest for expert knowledge was more pronounced after childbirth, when many women felt insecure about breastfeeding techniques and breast milk production, or, in some cases, encountered significant difficulties. Most did not mobilise social networks to alleviate anxieties and problems (many accepted general advice from friends, but not hands-on instruction). It is important to remember that most of these women could not expect practical advice from older kin. As a result of the social history of breastfeeding in the United States, social, cultural and practical knowledge about breastfeeding had been lost over the past two generations (Gorham & Andrews 1990), eradicating the traditional role of older female kin as a resource for new mothers; geographical and emotional distance between family members exacerbates this process. Many women also felt that they could not expect much emotional support. The older generation of women were often critical of their daughters' or daughters'-in-law breastfeeding, and some balked at the sight of breastfeeding 'in public' (which, in many cases, referred to breastfeeding in front of family members at home!) and criticised the practice of breastfeeding 'older' babies. In this social setting, an expert – the lactation consultant – fills the need for expertise and support.

Almost half of study participants had met with a lactation consultant at least once. While lay lactation experts, associated with La Leche League (LLL), have served American women since the 1950s, certified lactation consultants, who are health professionals, are a recent phenomenon. The women in my sample considered these experts more professional than LLL volunteers, and preferred to pay rather than utilise LLL's free assistance (visits cost between \$50 and \$100; some insurance companies partially cover the cost). In addition, many women associated LLL with radicalism or conservatism, both unappealing.

By their own accounts, only four women turned to these experts for assistance with conditions that the medical profession defines as potentially dangerous conditions that require professional intervention, such as poor infant weight gain, unbearable soreness, or infected nipples. The others primarily sought a professional stamp of approval or emotional support. In Melanie's case, the lactation consultant alleviated anxieties about the milk she could not see:

I went twice to [a local lactation consultant]. When you're desperate, it's the obvious choice; it's like calling Jiffy Lube. I needed someone who knew a lot about breastfeeding to watch her breastfeed and say, 'yes, you're breastfeeding, it's working, she's doing fine.'

Melanie's insecurity highlights the ambivalence many women felt and which they thought could only be alleviated by an 'objective' professional. As in the case of pre-natal preparation, the aggregate message is that professional, quasi-scientific expertise is requisite in order to realise a 'natural' process – for those who can afford it.

Undoubtedly, lactation consultants are a vital resource for some breastfeeding mothers. Without their expert knowledge and practical advice, women who face painful or potentially life-threatening conditions, such as poor infant weight gain, would probably discontinue breastfeeding. Perceiving of the mother–infant unit as a patient, armed with clinical experience coupled with holistic and scientific approaches to lactation, these experts are better positioned to assist breastfeeding mothers than either paediatricians or obstetricians (medical professionals routinely refer their patients to lactation consultants). They teach women tricks of a newly rediscovered trade, and diagnose and treat a range of breastfeeding-related conditions. At the same time, these certified and paid professionals contribute to the construction of breastfeeding as a mothering project.

### ***2.6.2 Setting Goals and Assessing the Product***

The participants deployed other strategies to manage lactation: they set goals and strove to manage uncooperative lactating bodies. Both strategies emphasise the product, breast *milk*, over the process, *breastfeeding*.

In accordance with the American Academy of Pediatrics' then-recent recommendation concerning exclusive breastfeeding (1997), the participants established breastfeeding targets, stated in terms of duration and quantities to be produced, and sought to avoid commercial formula during their babies' first year of life. To achieve

exclusivity, a woman must supply *all* of her infant's nourishment needs until the age of 6 months, a period during which supplementation of any kind is discouraged, and all of her infants' milk requirements during at least the first year. (In 2003, 18% of American mothers met the first goal, and 11% met the second; Ross Mothers Survey 2003).<sup>2</sup>

My participants ceaselessly evaluated their 'success'. Employing the terms 'supply' and 'demand', they reported how much their infants drank each day and how this quantity measured against the amounts they were able to produce and/or pump (see Dykes 2005 for similar imagery among British women). Though more pronounced amongst women who pumped their breasts at work (Avishai 2004), the emphasis on 'making it' to the 1-year mark without introducing breast milk alternatives, and the focus on quantities pumped, was shared by most interviewees.

Consequently, while a handful viewed formula as liberation from full-time motherhood, formula feeding generated almost universal anxieties. Janine apologised to her baby when she first offered her a bottle of formula. Bridgett viewed formula as junk food – 'it's like feeding your baby potato chips'. Leslie, who suffers from severe migraines and occasionally could not nurse her daughter until her medication cleared out of her system, 'kept a backlog of milk in the freezer'. She felt nervous if she 'had fewer than eight 4-ounce bottles in the freezer. Because then what would I feed her?'

The emphasis on exclusivity resulted in constant monitoring and assessment of 'production' levels and the 'stash in the fridge', taking a heavy toll on many study participants. Stay-at-home mothers grappled with the '24/7 duty' entailed by their commitment to exclusivity, and resented the time spent at the pump (stay-at-home mothers often pump for emergencies, occasional breaks, and to mix with solid foods). Many experienced exclusivity as emotionally straining, and several were concerned that exclusivity would set in motion a gendered long-term family dynamic. For mothers who worked outside of their homes and were separated from their babies for several hours at a time, exclusivity entailed long hours of pumping at the work place; for these mothers, exclusivity was a physically draining enterprise. (Most of the working mothers in my sample were not able to pump sufficient amounts of milk; their babies' first birthday signified liberation from pumping; see Avishai 2004).

Many mothers remarked that exclusivity was irrational, ridiculous and unreasonable, insisting that 'formula fed babies do just fine'. Yet, in the context of breastfeeding as a middle-class mothering project, exclusivity makes rational sense: as goal-attaining individuals, these women were determined to meet a target, which happened to be stated in terms of ounces produced per day over a certain period of time. For these success-oriented, high-achieving women, a breastfeeding goal was no different than an educational, professional, or athletic goal. Accordingly, many mothers attributed 'success' to their mindsets and go-getter attitudes; 'failures' damaged their egos. Jennifer reflected:

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<sup>2</sup>The notion of exclusivity itself is a relatively new construction (Maher 1992; Law 2000).

We didn't supplement with formula until she was eight months old. I got the flu and it screwed up my production. I was bummed. It's irrational, but I felt like I failed. There was the ego thing. 'Oh look what I can do'. And I couldn't do it anymore.

Jennifer continued to spend an hour-and-a-half of her 9-h workday as an accountant at the pump until she reached the 1-year mark. She explained that pumping became 'like running a marathon. You just seem so close, why stop now? Then you can say, 'I did it for a year!' as opposed to wimping out at 8 months. I probably would have felt like I failed'.

Margaret, another working mother, did feel like a failure. Faced with a widening gap between supply and demand, Margaret described how she 'worked' on her milk production by increasing her food intake, adding late-night and early morning pumping sessions, and purchasing herbal supplements. The next section examines these and other strategies to increase production.

### ***2.6.3 Managing the (Uncooperative) Lactating Body***

In accordance with the breastfeeding goals they had set, the women in my study monitored their breast milk production. Melanie, a stay-at-home mother who pumped very little, was nevertheless anxious. She traced her anxieties to lactation experts' emphasis on 'numbers':

The books made me upset. *The Nursing Mother's Companion* made me particularly unhappy. It has this table on calculating how much your baby should be eating. It always freaked me out, because I just never seem to be producing that much. I don't read it anymore. Part of me realised, 'why am I worried about this book and these numbers, everything is OK on this end.' I feel it's best not to ask too many questions, just accept that it's a system that works. It's better that your breasts aren't clear. [Blum's 1999 book cover provides a jarring illustration of the image Melanie alludes to: a woman with one-ounce marks on her bare breasts].

Yet, Melanie did not accept her body as 'a system that works'. 'Lacking' the one-ounce marks, her breasts were a source of anxiety. For other women, concerns about 'the numbers' bred ceaseless attempts to increase breast milk production. Although this was especially characteristic of women who encountered difficulties, or women who pumped their breasts at work, I found that almost everyone engaged in some form of body assessment, management and control.

Breastfeeding plans devised by lactation consultants to deal with poor infant weight gain or maternal pain represent an extreme form of body management. In some cases, lactation consultants merely provide clients with objective tools to assess levels of production, easing anxieties about milk that mothers cannot see. Bridgett described the breastfeeding chart she filled out 'religiously' after meeting with a lactation consultant, who taught her 'to write down how many times I fed, what time of day, how many diapers, how long did I feed, left, right. If I had to pump, how much came out of the pump'. These charts bear a resemblance to infant feeding charts favoured by mid-twentieth century doctors.

Lactation consultants also help clients work through physiological impediments. Janine turned to a lactation consultant due to insufficient weight. The consultant determined that her daughter was an ‘inefficient nurser’, and devised a breastfeeding plan, which Janine compared to a gym workout program. For several weeks, Janine was overwhelmed by the plan that had her ‘nurse her for ten minutes, then pump and give her whatever was left. Then we would supplement with formula’. Heather’s workout plan was more elaborate, and included a supplemental nursing system consisting of milk bottles that deliver formula through tubes attached to the nipples. This system teaches babies to nurse and ‘jumpstarts milk production’, without jeopardising the baby’s health. This regimen was time-consuming.

I would make formula, clean the apparatus, tape tube, have him latch on with the tube in the mouth. And it’s hard, you keep having to adjust the apparatus. Then I would nurse for 15–20 minutes on each side, then pump again for 15 minutes, and clean. And by the time it was done, it was time to begin all over again!

These plans enabled Heather and Janine to supply their infants with *some* breast milk, though they were unable to breastfeed exclusively. However, their partial success came at a hefty price, as they were left drained, tired and upset about their failed bodies.

Though these are extreme cases, many interviewees had some qualms about their breast milk production which they attempted to increase, with varying degrees of success, by employing a variety of solutions, including drinking, eating and sleeping sufficiently and taking herbal supplements. Working mothers also added more pumping sessions and invested in a ‘workhorse’ of a pump.

The range of strategies deployed by the participants, including pre-marital preparation, ‘workout plans’ and ‘working’ on production, indicate that breastfeeding cannot be left up to nature. Breastfeeding can – and sometimes must – be actively assessed, controlled and managed. In addition, many women found that breastfeeding came with a hefty price tag.

### 2.6.4 Investing in Production Facilities

I got the Madella [breast pump], a Boppy [nursing pillow], and the glider [nursing rocking chair] (Eva, a 30-year-old corporate lawyer)

Though most of the women in this study suggested that breast milk is produced by their bodies ‘free of charge’, and contrasted breastfeeding’s ‘simplicity’ with the ‘bagfuls of paraphernalia’ associated with bottle-feeding, many of them were immersed in breastfeeding-related consumption, reflecting broader consumption trends that characterise privileged parenthood (Hays 1996; Lareau 2003; Taylor et al. 2004; Pugh 2005). Since the physiology of lactation assumes proper levels of nourishment and rest as well as maternal health – all stratified in the United States – the very construction of breast milk as ‘free’ by mothers and lactation experts masks social inequalities (Blum 1999; Law 2000). In addition, unlike the white, middle-class women in Blum’s (1999) and Bobel’s (2002) studies, whose understanding of breastfeeding as ‘natural’ entailed rejection of breastfeeding-related objects and

technologies, participants in my study embraced the expanding market of nursing gear, gadgets and accessories. They invested in nursing bras (~ \$40), nursing pads, breast pumps and related kits (\$200–400), nursing pillows (~ \$40) and nursing chairs (~\$200). Some purchased herbal supplements to enhance their milk supply or acquired breastfeeding outfits. Bridgett, who said she ‘didn’t go into a lot of expenses’, offered a list amounting to several hundred dollars.

People think breastfeeding is natural. But you do have to expect [to spend money]. It’s \$150 to have the lactation consultant come to the hospital, and it’s \$50 for half-hour consultation. And the breast pump is like \$200, and the nursing bras, and the lactation outfits are \$30 each. I only have one. . . Oh, also, when we got home, I couldn’t find the right chair in the house. We had an antique rocking chair, but the arms didn’t work. So we bought the glider. And then the pillow. . .

Margaret’s story about ‘the chair’ demonstrates the fetishised value that many study participants placed on specialty objects. Although she attributed her initial nursing difficulties to a variety of factors, including the physical conditions in a cold bedroom and her husband’s family’s breastfeeding purism, she associated alleviation of her difficulties with the purchase of a specialty breastfeeding glider:

When he was about four weeks old I nursed him in another woman’s rocking chair. I was like, ‘it doesn’t hurt! Is this what a chair could feel like?’ Because here I am in a room that’s too cold, with shrunken nipples, and a husband saying ‘go breastfeeding, go breastfeeding, you know my mom is La Leche.’ And my chair was too low! I thought: ‘I’ve got to get one of those chairs. I don’t care how much they cost’. . . I drove out to [a baby store]. I walked in the door and I said: ‘I want that chair, I want it now’. And the clerk said, ‘well, we’ll order it for you, it’ll take. . .’ ‘No, I want the floor model’. And she said ‘well, all right, what kind of car do you have?’ ‘Honda’. And she said ‘it won’t fit in your car, we’ll have it delivered.’ ‘Take it apart.’ She gets a screwdriver and takes the chair apart and puts it in the car. And I said ‘how much is it?’ ‘Oh, this one is on sale.’ ‘Thank god! You could have charged me \$5,000 for it, I would have paid it. . .’ Because I was distraught. I was getting two hours of sleep at a time at night. . . And that really changed things. After that it stopped hurting.

## 2.7 Conclusion

Public health and advocacy campaigns are based on the twin assumptions that ‘the breast is best’ and that breastfeeding is ‘natural’. From a sociological perspective, human decisions, practices and experiences – including those that pertain to reproduction, health and parenting in general and infant feeding in particular – arise within specific historical, cultural, economic and political contexts. ‘Best practices’ are also constructs shaped by specific conditions, norms and customs. These conditions, norms and customs govern infant feeding decisions – breast milk or breast milk alternatives; who may feed the child at the breast – the mother, a paid wet-nurse, other mothers in a network of childcare; where breastfeeding is to occur – in public, at the workplace, in the presence of family members, or only in the privacy of one’s home; how often breastfeeding should occur – according to a fixed

schedule or 'on demand', in response to infant cues; how long breastfeeding should last – through early infancy or well into toddlerhood; how breastfeeding is to be learned – within the mother's informal kin and social networks or through specialised professionals; and how breastfeeding is experienced – as pleasurable and empowering or as a burden.

To demonstrate that breastfeeding practices are social constructs, this chapter has focused on the experiences of one particular group of women – class privileged American mothers, who, from a statistical perspective, achieve breastfeeding success. The chapter demonstrates that these women construct breastfeeding as a mothering project – a task to be researched, planned, implemented and assessed, with reliance on expert knowledge, professional advice and consumption. They do so in the context of discourses of health promotion, good outcome childrearing, science, rationality and the market; breastfeeding is but one of many informed decisions they make daily about their health, lifestyle and parenting (Hays 1996; Rapp 1999; Lareau 2003). Significantly, these women have access to the resources and gadgets which assist them in materialising these choices, including high-quality pre-natal and paediatric care, household help and relatively long maternity leaves, all positively associated with 'successful' breastfeeding. In the process, these women draw on – and create a market for – commercial resources, including nursing and childrearing books, lactation consultants, pre-natal and breastfeeding classes and mothers' support groups.

Analysis of the mothering project sheds light on the obstacles encountered by women who cannot mobilise such resources, which are no longer considered optional. Viewed in this light, the twin constructs of 'the breast is best' and 'breastfeeding is natural' are impoverished slogans that do not capture the extent to which both the science and the imagery of breastfeeding are shaped by normative assumptions and middle-class experiences.

I expect that some feminists will find the project frame troubling, as it contrasts with emphases on pleasure, embodied subjectivity, relationality and empowerment that characterise much of the breastfeeding literature across the humanities and social sciences (Baumslag & Michels 1995; Giles 2003; Hausman 2003; Bartlett 2005; Dykes 2005; the November 2004 issue of *Australian Feminist Studies*). Elsewhere (Avishai 2007), I note that my study participants negotiated the project frame with notions of pleasure, intimacy, and, as one interviewee put it, a 'romantic image of breast-feeding that you would probably have if you didn't read anything'. However, the project frame dominated their narratives.

To be effective, I believe that feminist analyses of infant feeding must distinguish between normative/political agendas and empirical realities. Framing breastfeeding as an embodied, feminist-maternalist, empowering and post-modern response to corporate, gendered and medicalised regimes is a fine goal – but it insufficiently accounts for ethnographic data that point to the ambivalences and chaos associated with breastfeeding (Balsamo, Mari, Maher, & Serini 1992; Blum 1999; Schmied & Lupton 2001; Avishai 2004; Dykes 2005; Avishai 2007). I suggest that rather than criticising the project frame (and mothers who describe their breastfeeding experiences in consumerist, rational and scientific terms), feminists understand this frame

as a sensible solution to an otherwise potentially threatening, alien, or unintelligible practice. As Blum (1999) notes, privileging the sensual and relational aspects of breastfeeding may amount to coercive moralism (which is precisely the tone Kukla 2006 identifies in breastfeeding campaigns). Accordingly, my emphasis has been on how women approach breastfeeding within a specific social, cultural, political and historical context, with the understanding that breastfeeding is a cultural event shaped by institutional, historical, cultural, raced, gendered and sexualised arrangements.

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