Title: Abnormal mothers: Breastfeeding, governmentality and emotion amongst regional Australian women

Author: Dr Christina Malatzky

Address: Department of Rural Health
Melbourne Medical School
The University of Melbourne
49 Graham Street, Shepparton
Victoria AUSTRALIA 3630

Email: christina.malatzky@unimelb.edu.au

Phone: 060358234526

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Abstract Australia's apparently poor rates of breastfeeding are a frequent feature in mainstream news reports. Underpinning these discussions is the *breast is best* discourse, which implies that not breastfeeding is indicative of bad motherhood. Alongside this dominant discourse is the persisting construction of breastfeeding as a private, corporeal act. This article examines the governing gridlock formed by these two dominant discourses, analysing interview data gathered from mothers in regional Western Australia about their complex experiences with breastfeeding. I aim to highlight how the governance of these breastfeeding discourses disguises the various ways in which women's choices about breastfeeding are constrained. While these discourses may govern women in different ways, combined they represent a cultural paradigm clash which silences women about their difficulties with breastfeeding—the challenges women encounter in negotiating breastfeeding in contemporary daily life—both as a corporeal act and because of its corporeality. I argue that to avoid making women who

do not breastfeed feel abnormal, this clash needs to be challenged in—and by—the wider Australian populace.

Key words Breast is best, private corporeal act, governmentality, abnormality, cultural clash

Introduction

Breastfeeding is a frequent feature in mainstream Australian media, with news reports focusing on poor breastfeeding rates. Underpinning these discussions is the “breast is best” discourse, which implies that not breastfeeding is indicative of bad motherhood. The constraints under which women (attempt to) breastfeed are often ignored, reinforcing individual blame. For example, an article entitled *Only 1 in 7 breastfeeds for favoured six months* included the statement “women older than 35 or with a degree or higher income are more likely to breastfeed” [1], which assumes that such figures reflect women’s individual choices; the statement ignores the fact that older, more educated, and wealthier women have access to more services and cultural capital [2]. These kinds of statements draw on notions of social class to make value judgements about particular women’s mothering choices. However, the class discourse upon which these judgements rely is unacknowledged in public discussions; the criticism instead is directed at individual women and their (poor) decision-making. In this vein, calls such as that by supermodel Gisele Bundchen to “make breastfeeding compulsory” [3] capture a widespread insensitivity to the conditions under which women breastfeed, reinscribing outcomes from complex situations as simple choices.

When circumstantial factors are rarely acknowledged, however, they are trivialised through the proffering of simplistic solutions. For example, in a front page newspaper article entitled *Lack of support risk for newborns*, Western Australia’s Health Minister, Dr Kim Hames, claimed that child health nurses could refer women with more “complex problems” to lactation clinics [4]. These services may be helpful for some women and their infants. However, as the experiences of some participants in this study suggest, these kinds of interventions do not always result in the intended outcome because the techniques used can be traumatic for both mother and infant, limiting their effectiveness. Further, statements by medical professionals such as Professor Colin Binns from Australia’s National Health and Medical Research Council, that “if you’re not in there quickly, they can *easily* [emphasis added] give up and just feed on the bottle” [4] fail to appreciate the significant emotional and physical distress

many women experience when they have difficulties with breastfeeding. The decision to discontinue attempts to breastfeed was by no means *easy* for any of the participants in the study reported here.

This article analyses interview data gathered from women mothering in regional Western Australia to examine a gridlock formed between two dominant discourses governing women's emotions related to breastfeeding: the first that breast is best, and the second that breastfeeding is a private corporeal act. My intention is to highlight how women's choices about breastfeeding are constrained in various ways, a complexity that these two discourses work to disguise. Further, while these discourses singly may govern women in different ways, combined they represent a cultural paradigm clash which silences women about their difficulties with breastfeeding—the challenges women encounter in negotiating breastfeeding in contemporary daily life—both as a corporeal act and because of its corporeality. I argue that in order to prevent mothers being made to feel abnormal for not breastfeeding, this clash needs to be challenged in—and by—the wider Australian populace. It is, I suggest, the gridlock posed by these two dominant forms of governance that makes it difficult for many Australian women to be open about their difficulties with breastfeeding, and to avoid feelings of abnormality, guilt, and shame.

Governing perceptions of breastfeeding

The dominant message many women in the Western world receive about infant feeding is that the *breast is best* [5]. From my reading, three dominant societal discourses privilege this message: the discourses of risk, the *good mother*, and neoliberal understandings of human agency. The risks of not breastfeeding are part of wider risk cultures. Formula feeding is constructed as risking childhood, and indeed, lifelong health and wellbeing, because of the nutritional properties of breast milk [5, 6]. Moreover, the ongoing act of breastfeeding is seen as an essential element in establishing the mother-child relationship [6, 7, 2]. This construction is taken up in the discourse of the good mother. Good mothers do whatever is in the best interest of their child; they breastfeed. According to neoliberal understandings of human agency, accomplishing this mandate is fully within the personal power of individual women [8, 2]. Socio-ecological models challenge this focus on the individual in isolation from relational and social contexts. While there is feminist critique about how these models conceptualise and present social contexts as if they are independent from the individuals who create them [see 9], by emphasising the interactions between individuals, familial and/or community networks and broader societal contexts [10, 11], socio-ecological perspectives can be useful in contextualising

individual actions or circumstances to consider how individual women negotiate and contest dominant societal discourses [12, 9], including those related to good mothering and breastfeeding.

Women who cannot meet the expectations of the breast is best message are positioned as bad mothers, which impacts on self-perception and feelings about their performance as mothers [2]. Striley and Field-Springer [2] discuss how moral risks, “including feelings of disapproval from others through character attacks and judgemental discourse”, are internalised as guilt, shame, and doubt; in this case, in women’s mothering abilities. Women can experience tremendous guilt and deep feelings of failure when their mothering is judged as insufficient [2]. Consequently, when women cannot fulfil the expectations of the breast is best message, intense feelings of abnormality are triggered [13, 2, 7, 6].

Yet the breast is best discourse does not accommodate women’s diverse breastfeeding experiences [13]. It has been argued that the idealisation of breastfeeding narratives produces feelings of disappointment and failure in women whose experiences do not match these ideals [14, 15]. Consequently, women who are unable to breastfeed, or experience considerable difficulties with breastfeeding, can consider themselves to be bad mothers [14]. The interpretation that breastfeeding is a matter of individual choice is established through the exclusion of a range of complex experiences, and a lack of critical consideration of women’s individual contexts.

Simultaneously, breastfeeding remains predominantly understood as a private act within Australian society. There is a “general unease with the lactating body” [16] which positions breastfeeding as a public taboo in practice [17]. What is characterised as public space remains masculine space, defined by rationality and solid, “in control”, rather than “seeping” bodies [18]. The way in which these two dominant discourses combine to govern mainstream perceptions of breastfeeding precariously positions mothering women. Women can either be saintly, breastfeeding mothers in private, or participate in public life while hiding their visceral mothering practices. This article seeks to explore this governing gridlock, situated within a cultural paradigm clash between the breast is best discourse and the wider (un)acceptability of breastfeeding as a public, corporeal act.

Governmentality and emotion

From a Foucauldian-feminist perspective, what is learnt through discourse provides individuals with an understanding of themselves in the world [see 19]. The knowledge individuals acquire guides perceptions of “the kind of people we ought to be or become”, establishing what is considered normal or abnormal [19]. For Foucault [20], “to govern is to structure the possible field of action of others”; to

guide, in the context of my analysis here, women towards perceiving breastfeeding as the best way to feed an infant, if she wants to be a normal, *good* mother; and conversely, to constrain where, and in what context, women can (acceptably) breastfeed their infants. When it comes to breastfeeding, women's emotions are produced within the context of such governmentality. Discursive theories thus assist in examining the various ways in which women are positioned by, but also contest and push back against, dominant societal discourses related to good mothering and infant feeding practices, illuminating the constructed boundaries between individual experience and broader societal environments [see 9, 21].

In what follows, I draw on the concept of governmentality to examine how the knowledge women acquire about breastfeeding through the breast is best discourse, and the construction of breastfeeding as a private corporeal act, guides understandings of good infant feeding decisions and, by extension, good mothering, and how this normalises the stigmatisation of breastfeeding in public. The data presented shows what happens when women cannot act in the way that the breast is best discourse guides them to act—how women are made to feel when they have difficulties with breastfeeding, both as a corporeal act, and because of its corporeality. In the analysis, emotion is understood as a “cultural and interpersonal process of naming, justifying, and persuading by people in relationship to each other” [22]. Emotions are produced within a social context and, as Lutz [22] argues, “talk about emotions is simultaneously talk about society—about power and politics ... about normality and deviance”, and is thus, the “intensely meaningful”. As expressions of the wider social environment, emotions, such as feeling abnormal and ashamed, are operations of governmentality, of power [see 23].

Methodology

The data drawn on in this article was collected in a regional centre in Western Australia as part of a research project which aimed to examine how women living regionally reconcile with, negotiate, and/or resist different contemporary discourses of good femininity and maternity. Mothering women and those intending to mother sometime in the future were invited to participate via recruitment poster advertisements stationed at various local venues, including cafes, gyms, child health centres, child care centres, and playgroups. All organisations who hosted recruitment information also received a letter outlining the nature and possible outcomes of the study [24]. Women were also recruited via informal networks and referrals (snowballing) [25]. While no other selection criteria was included on recruitment information, all participants were White, and most would be considered middle class,

although they came from diverse educational and financial backgrounds, and had different outlooks and priorities in their lives and for their children. Twenty-nine women took part. However, this article draws on a subsample of 20 women who had given birth to live infants and were, thus, already directly subject to the pressure to breastfeed.

All participants took part in a semi-structured interview, usually conducted in the participant's home. Prior to commencing the interview, a discussion was had with each participant about the research project, particularly its aims and methodology, the dissemination of findings and issues, and safeguards protecting confidentiality and anonymity [26, 24, 27]. The study's plain language statement was used to guide this discussion to ensure that no areas of interest or potential concern were missed [26]. Each participant was given an opportunity to ask me (as the researcher) any questions pertaining to the research, after which written consent was explained and received from each participant [26, 24, 27].

The questions posed to participants in these interviews were wide-ranging and open-ended [27]. Each interview was audio-recorded and transcribed verbatim. Participants were offered a copy of the transcript to review prior to analysis. Once permission was granted by the participant, each transcript was coded manually using an iterative process of reading and re-reading, assigning descriptive phrases that captured my assigned meaning to particular sections of the conversation, then re-reading again and revising codes [27, 24, 28]. The resulting codes, detailed examples of which are illustrated in Table 1, were reviewed to determine which were most frequent and dominant. From this process, dominant and marginalised discourses were identified and the ways in which the identified discourses positioned participants—how women were made feel as a consequence of the structuring of their action/s—were then examined [29]. A Foucauldian-feminist conceptualisation of power, discourse, and subjectivity informed this analytical work and, in later stages of analysis, the Foucauldian concept of governmentality was used to theorise about the governance of women's emotions related to infant feeding practices, based on the data generated in this research [20, 19, 23].

While breastfeeding was not the explicit subject of this research, my attention was drawn to women's experiences of breastfeeding because of the significance breastfeeding held for the women I interviewed. All 20 women spoke unprompted about breastfeeding during their interview, and all expressed a desire to breastfeed their infants; it was evident in some of their accounts that they knew how to access information about breastfeeding. For 15 of these women, accounts of breastfeeding were

the source of intense emotionality, and were intricately connected to discourses of good versus bad mothering. Nine women had experienced specifically corporeal difficulties with breastfeeding, and a further six women had encountered difficulties because of the corporeal nature of breastfeeding and the regulation of socially-acceptable infant feeding practices, which had reproduced intense feelings such as guilt and/or shame. The subheadings used in the following findings section of this article represent the discourses and subject positions that were most dominant in the narratives of these women.

As a feminist researcher, I acknowledge and accept that my personal social location, history, values, and assumptions in conjunction with my philosophical and theoretical predispositions have necessarily informed every phase of the research process including, but not limited to, the analysis [30]. What is presented in this article is a particular reading of the data, not a simple representation of that data [30]. However, it is a thoughtful reading. I listened carefully to the experiences of my participants and have spent many hours enveloped within their narratives. My intention in presenting this data and my analysis of it is to complicate and challenge dominant understandings of Australian women's breastfeeding practices so that more women can feel empowered to talk openly about their experiences with breastfeeding, without fear of recrimination or shame.

Table 1 Examples of codes

Codes
Silence: There is a silence around difficulties with breastfeeding.
Hidden: The many intricacies related to breastfeeding represent aspects of mothering that are often hidden.
The missing "how"/practicalities: Discussions about the "how"/practicalities of breastfeeding are not had.
Devastation: Feelings of devastation when difficulties with breastfeeding experienced.
Not good enough: Feelings of abnormality, inadequacy, and as if one were a failure when one cannot breastfeed.
Ridiculous lengths: Persisting in going to extreme lengths to meet expectations of good mothering/to breastfeed.
Shame and humiliation: Feelings of shame and humiliation about being unable to breastfeed.
Guilt and trauma: Feeling guilty about not breastfeeding, and being traumatised by this experience/reality.
The pressure: There is a pressure to breastfeed that does not acknowledge the complex realities involved.

Stigma: There is a stigma surrounding not breastfeeding (bottlefeeding) akin to criminality.

No option!: The assumption is often made that breastfeeding/bottlefeeding is a choice; this is frustrating.

Not alone after all: An important, reassuring realisation that difficulties with breastfeeding are not unusual.

Medical censoring: Medical professionals withhold knowledge that difficulties with breastfeeding are common.

Each other: The knowledge that difficulties with breastfeeding are not unusual comes from own/other mothers.

Visual learning: There is a learning to be had through the visual of “seeing” breastfeeding in practice.

Public disgust: Breastfeeding in public is greeted with outrage and disgust, which stigmatises and shames.

Do it, invisibly: Breastfeeding is pushed as good mothering practice, but it must not be seen.

Workplace accommodations: Workplaces make few provisions for breastfeeding, making it difficult to continue.

Rights vs. practice: Legislation supporting the right to breastfeed is inconsistent with workplace cultures.

Findings

What no one tells you ...

Breastfeeding was described as one aspect of mothering that is not spoken about:

You don't see or hear of very many, I guess, negative elements of motherhood ... how difficult things are. I mean, you don't really hear a lot about breastfeeding. It's not something that's discussed a lot, whereas it's quite a difficult thing and most women try to do [it] and have issues with it. So yeah, there's different things that aren't discussed, I think, that are a bit more hidden (Ashley, aged 30, mother of one).

Beyond the message that they should breastfeed, women did not feel as though they heard much about the practicalities of breastfeeding. Like Ashley, Lena (aged 30, mother of two) characterised the exclusion of these kinds of discussions as a hidden aspect of mothering. Lena expressed that “what they don't tell you when you're pregnant is that breastfeeding is a learnt skill for the child and mother”.

Breast is best has been the central public message around infant feeding in Australia for many years [15]. Olivia's (aged 35, mother of one) account of attending a pre-natal breastfeeding course illustrates how the breast is best message impacts the information women receive from health professionals pre-birth.

I went to a breastfeeding course, run by the Breast Feeding Association, prior to having (her baby) but I didn't find that to be in hindsight effective. All they were doing was to try to get

you to breastfeed but you were there. You already intended to breastfeed, that's why you were there, and they would just, "if you take drugs during your labour your breastfeeding could be hindered". It was more like a scare tactic, I found. I was really sad because you were there to learn and you'd paid \$85 to sit there, yeah ... they just told you about how milk's created and all this factual stuff which you can read anywhere ... they didn't tell you how easy it is to get mastitis or how you should drain one boob first, and they didn't tell you the practical stuff.

Earlier in our interview, Olivia said that breastfeeding was a "huge topic of conversation, and I honestly don't think there is enough education about how that's meant to look and feel."

Breastfeeding may be a high-profile issue in Australian society, yet the focus is on the *act* of breastfeeding rather than on the ins and outs of *how* to do it. The naturalness of breastfeeding is assumed, and it is taken for granted that women will be able to breastfeed. Frank discussions about the complexities that can be involved in breastfeeding are excluded from public discourse [15], and as Olivia experienced, in the materials that women are offered before giving birth. As the following women's accounts suggest, these exclusions can lead women to struggle in seclusion, and to feel abnormal, guilty, and shameful.

Abnormal, guilty, and shameful mothers

Many participants recounted feeling abnormal and ashamed about having problems with breastfeeding which, for several women, led to bottlefeeding. All of these women talked about not realising in these early mothering phases that their experiences were and are common. In our interview, Vera (aged 34, mother of one) recounted hearing a woman in her social circle explain how:

It's been nine years since I've had a baby ... I can finally look at another woman breastfeeding without feeling like a complete failure. And I thought "oh my god, that's terrible" but I do think that there's a lot of pressure. I suppose it's supposed to be positive pressure but it doesn't come with any realistic figures attached because it wasn't until I was seeing my child health nurse and I was issuing with my child not putting weight on ... she was older ... she was from a different era where she wasn't caught up in political correctness. She was just quite straight and blunt with reality and statistics. She said 50% of women can't breastfeed, but unfortunately that was already after I'd been trying to breastfeed, nearly three months. She said unfortunately everyone looks at the mother but she said it's usually of that 50% half is the baby, half is the mother. And she said it's physiological, you can't do anything about it, but they don't tell you that before you have the baby, and I know quite a few women who've been absolutely devastated, or people look at you like "what's wrong with that woman, she's giving that baby a bottle", like you're a criminal.

This account captures the feelings of shame and abnormality experienced by women who cannot breastfeed.

Vera recounted her own experience of expressing milk and the lengths to which she would go to continue trying to breastfeed. Her account evidences complex feelings of inadequacy, along with anger, trauma, and humiliation:

I expressed milk for a ridiculous period of time—even though I was hardly getting anything—because it’s the other people saying “you can just express,” and it’s like “you don’t really know much about this process, do you?” Some people can express and it works and other people it doesn’t work, and for me it didn’t work. It wasn’t the same as her feeding. And I was doing dumb stuff like expressing 20 ml of milk and that’s all I’d be able to get out and that’s just, I realise now, stupid, and if I’d ... I’m sure if I went through the same experience with another child I would be saying to the doctors and the child health nurse that is completely unreasonable, “I will not do that, I’ll be putting her on formula”, you know. I was at one point told to feed her every two hours day and night.

Vera attended a lactation clinic. However, this service was described as exacerbating, rather than alleviating, the problem. She explained how:

The paediatrician wanted to observe her for two days, which meant no interference, which meant that she had uncontrolled pain for two days and trying to breastfeed her, so she was completely traumatised and didn’t want to breastfeed again.

Evidently, this scenario was significantly distressing for both mother and child, and contributed to, rather than aided, Vera’s problems with breastfeeding.

Ella (aged 32, mother of one) described how breastfeeding was used to categorise mothers as “good”, and correspondingly, associated negative stigma with bottlefeeding.

I always struggled to have enough milk and I always felt guilty, and there is a big bloody stigma about not breastfeeding ... people say “are you breastfeeding?” and they go “good girl”. It’s like, not good girl, if you can do it, you’re lucky.

Ella’s baby “wasn’t full and she’d be screaming and so I started giving her formula at night, but I didn’t like to do it in public.”

Freya (aged 30, mother of three) also encountered the stigma associated with bottlefeeding, even though the milk in the bottle was breast milk. She explained:

I had mastitis pretty much immediately with (baby), my first, but was told not to express any because that would stimulate the milk. My breasts were so massive (baby) could not attach so they suggested nipple shields. Then they are all the different nurses I saw, and none were consistent or helpful! After many tears and much pain I gave into my bleeding nipples to expressing. First baby thing is so hard! So in turmoil I expressed and bottlefed (baby) and felt absolutely pathetic. Even though he was still having breast milk the fact it was from a bottle carried a stigma. It’s funny, because I do feel breast is best, but if you can’t it does not matter—what matters is that baby is fed. When it came to me I felt useless and I doubted my mothering.

Freya’s account embodies the intense desire all the women in this study had to breastfeed. This suggests that the breast is best message has been, at least amongst these women, highly effective. However, the accounts above also capture the distress and feelings of bad mothering that can ensue when women’s realities cannot live up to the expectation that good mothers breastfeed.

These women's experiences challenge common perceptions of choice enmeshed in dominant portrayals of infant feeding options. Eva's (aged 25, mother of one) story captures a sense of no option, and feelings of guilt and inadequacy about her milk production.

I ran out at five weeks ... we wanted to breastfeed until he was at least six months, (partner) wanted him to be breastfed for 12 months, I wanted to only do it for six months, but we didn't even have that option because I just ran out. They gave me these pills to try and kick start it again but I just didn't have any milk.... People make comments about formula-fed babies, "you shouldn't be giving formula", "breastfeed's better", and then knowing it's not an option, you don't have that option.

As Eva's and other women's accounts shared above suggest, women feel judged by others for bottle rather than breastfeeding; bottlefeeding carries stigma and creates within women feelings of guilt, shame, and failure. Importantly, these women shared a frustration in the assumption that bottlefeeding is always a choice.

Knowledge gatekeepers and knowledge sharers

Most women's accounts of wrestling with the material situation that breastfeeding may not be an option for them included a moment when they realised their situation was not, in reality, abnormal. Leading up to these moments, most women spoke about how this knowledge was withheld from them by medical professionals. Usually, it was other women who shared this knowledge. For example, Peony (aged 29, mother of one) praised her female doctor's helpfulness in her transition to motherhood. However, the "exception" to this, both from the doctor and nursing staff, was with breastfeeding. Peony "couldn't breastfeed" and "at no point in that whole time I was there [in hospital for 12 days] did anyone say to me, 'some women just can't breastfeed'." If she had been told this she wouldn't have felt the need to "twist myself up" about it. Rather, Peony "would have appreciated it if one of the nurses had said 'some people just can't ... try as much as you can, but it's not the end of the world, formula's fine, you'll be fine'." But no one did. As Peony articulated, being reassured that she was not alone in her struggle to breastfeed would not have prevented her from trying; however it would have prevented her from experiencing such strong feelings of inadequacy and shame about her difficulties with breastfeeding. It would also have been a welcome source of reassurance that her baby would be okay without breast milk if efforts proved unsuccessful. It was a friend who eventually shared this knowledge with Peony, and enabled her to feel less guilty, since she now knew it was not "just her", but a common dilemma for many mothers.

Other women also reported receiving this knowledge not from medical professionals, but from their own mothers or other women. For example, Vera (aged 34, mother of one) described how she was:

Fortunate enough through my mothers' group to meet two women who had stopped breastfeeding because they had postnatal depression, and the frustrations they were having with breastfeeding were making them feel even worse, so they gave up for that reason. Well, I thought if they can give up for mental health reasons, you know it's not unreasonable.

These experiences suggest that the breast is best message may be encouraging what Vera described as a "political correctness" surrounding breastfeeding. This effective censorship is contributing to the hidden nature of breastfeeding practicalities and feelings of depression and anger amongst newly-mothering women.

(Un)Acceptability of breastfeeding as a public, corporeal act

Public rhetoric is focused on the message of breast is best [15]. However, participant experiences suggest that there is a disconnect between this message and the (un)acceptability of breastfeeding beyond the seclusion of the home. Following her description of breastfeeding as a learned rather than innate skill, Lena said "in years gone by, women would have learnt to breastfeed by seeing others. Now society tends to be outraged when they see people feeding in public." Lena shared her experience of being stigmatised and shamed for breastfeeding her 10-month-old son on a train in Perth, Western Australia:

A woman who was bottlefeeding said that it was disgusting that I was still breastfeeding my 10-month-old. My son wouldn't take a bottle and wouldn't eat solids until he was 11 months old!

This highlights the paradigm clash between the breast is best message, and the social (un)acceptability of breastfeeding as a corporeal, public act in many Australian communities. Breastfeeding is what good mothers do, but it must not be "seen".

Rachel (aged 33, mother of one) also spoke about how:

In Australia, we are behind closed doors, especially for breastfeeding, I thought like those other countries, like African women, they have their babies around them, they're holding them the whole time they're feeding, and it's so exposed and you could learn so much even from just that visual. We don't have that in ... well, I don't have that in my world, anyway.

When we hear statistics such as slightly more than half of 3-month-old infants are breastfed in Australia, and 14% of 6-month-old infants are still breastfeeding [see 31] we cannot assume that the corresponding proportion of children are not breastfed solely because mothers do not want to

breastfeed¹. Rather, as Rachel's observations suggest, critical attention needs to be given to the social contexts in which women are enacting infant feeding.

Returning to paid employment postnatal is also part of many Australian women's daily lives. Indeed, recent statements by the Federal Minister for Social Services about child care in Australia indicates that getting as many women as possible to return to paid employment as quickly as possible after giving birth is firmly on the Australian federal government's agenda [32]. The impact of workplace cultures on women's breastfeeding practices is especially relevant in Australia's current context, because the national paid parental leave scheme only offers financial support for 18 weeks, well shy of the 12-month recommended time period for breastfeeding [33]. Further, returning to paid employment after having a baby is known to be the point at which many Australian women discontinue breastfeeding [34]. Listening to women's accounts of how workplaces accommodate breastfeeding women provides context for these statistics. For Teal (aged 25, mother of one):

The hardest thing about returning to work was breastfeeding, because I had to express at work for about four months and, it was awful. I had to use my lunch break to express, and I had to go in the toilet, which I absolutely hated, or I had to go into the storeroom, and a couple of times I had people come in. Oh, it just wasn't nice.

Under these circumstances, the feasibility of breastfeeding for 6 months, let alone 12 months, is severely undermined. Similar experiences have been documented in the United Kingdom [see 35], indicating that this treatment is characteristic of Western, industrialised, workplace cultures.

In law, Australian workplaces are required to accommodate the needs of breastfeeding workers. However, as the recent Human Rights Commission report of pregnancy discrimination in Australian workplaces suggests, we cannot assume that legislative rights necessarily translate into everyday workplace practice [36]. As experiences such as Teal's demonstrate, there is rarely a synergy between women's legal rights to breastfeed and everyday workplace cultures. In the contemporary context, it is inescapable that the infant feeding practices of many Australian families are enacted within such environments.

Discussion

Accounts of breastfeeding experiences were central to most women's narratives about becoming mothers, and all of the mothering women who participated in this study expressed their desire to breastfeed. These women had certainly heard loudly and clearly the message that "good mother's breastfeed". However, the intense feelings of abnormality experienced by many of these women were

unexpected. This is particularly significant given that babies born today to White, middle class mothers are among the healthiest and most advantaged the world has ever seen [see 8]. It has led me to consider how the lives and bodies of women are regulated through the breast is best message, and how this marries with public perceptions of breastfeeding as a private act.

The discourse that the breast is best has a regulatory function. It uses a language of risk to the health of infants [6], and neoliberal understandings of individual maternal accountability for infant feeding and wellbeing [6, 7], to normalise breastfeeding as a natural, optimal, choice for women. In directing in this way women's perceptions of breastfeeding and their intended actions in regards to infant feeding, the breast is best message positions women who cannot breastfeed as abnormal, bad mothers. It does this by marginalising alternative breastfeeding discourses, ones that include the complexities—and sometimes corporeal challenges—of breastfeeding [14].

This study shows that the knowledge that complex breastfeeding experiences are, in reality, normal was often only received by women from their own mothers or other women, which is historically where this knowledge resides [see 37]. The medicalisation of childbirth and mothering led to doctors and other medical actors becoming powerful bearers of knowledge, who could privilege particular forms of knowledge [see 38]. Further, the body of knowledge about mothering produced through Western biomedicine can be used to assert disciplinary power upon the bodies of women [see 39]. From the accounts of women here, medical professionals can act as gatekeepers to knowledge about breastfeeding, and women's lactating bodies become (self)disciplined in often destructive and traumatic ways.

While doctors may be important informants, they are not women's sole source of information. Women who participated in this study used the knowledge they acquired from alternative sources to counter the one-dimensional nature of the breast is best discourse. By sharing this knowledge through social networks, women are providing each other with new "conditions of possibility" [21]; with an alternative discourse through which to understand their experiences. However, not all women necessarily receive this alternative knowledge, and judge one another based on the information they do receive.

Women's accounts suggest that there is a paradigm clash between the way breastfeeding is understood within the good mother discourse, and how it is understood as a corporeal act. In the first paradigm, good mothers' breastfeed; therefore, all mothers who want to be good breastfeed [see 5, 6, 7,

2]. The data presented earlier demonstrate how this paradigm governs women, and produces feelings of abnormality for those women who cannot conform to its logic. In the second paradigm, because of its corporeality, breastfeeding belongs to a private, secluded world; it is an act for home [see 18, 16, 17]. Therefore, breastfeeding should not be seen in public or semi-public places. This ideological clash creates real problems for mothering women living in Australia.

Regardless of whether they are engaged in paid employment, Australian women's lives are not lived in seclusion, or exclusively in the home. Mothering women who are breastfeeding encounter a cultural contradiction that, whichever way they play it, results in social sanctioning or unfair judgement. If women breastfeed outside of the home, they run the risk of being stigmatised, openly challenged, and shamed. If they do not breastfeed, they are positioned as bad mothers who are selfishly risking the health and future wellbeing of their child. Together, these governing relations work to regulate the lives and bodies of Australian women in ways that are difficult to escape.

In the workplace, legal rights are "embedded within existing practices, deeply-held beliefs and taken-for-granted expectations", particularly about gender, work, and what constitutes a good worker [40]. Providing Australian women with legal rights around breastfeeding gives them an "instrument for enforcement", and helps to frame breastfeeding as a "legitimate" and "important entitlement" [40]. However, cultural systems change slowly. Australian workplaces are still implicitly operating under the assumption that workers' bodies are male bodies, and that breastfeeding is considered a private rather than institutional concern [see 41]. Women have to negotiate their legal rights in the midst of much more powerful and ingrained social and institutional norms. The stigma women experience for breastfeeding in public and in the workplace disguises the way that these responses are normalised, which is embedded within a wider subjugation of women within Australian society.

The breast is best discourse can produce intense feelings of abnormality for women who experience difficulties with breastfeeding, because it constructs breastfeeding as a key requirement for good mothering. Yet conversely, women's accounts indicate that the understanding of breastfeeding as a central part of good motherhood clashes with the enduring perception that breastfeeding is a private corporeal act which should not be seen within (Australian) society. Where not breastfeeding opens women up to accusations of selfishness and bad mothering, breastfeeding in public exposes women to stigmatisation and shaming of a different kind. Within Australian workplaces, women continue to negotiate breastfeeding with much more powerful social norms that make it difficult for them to

breastfeed and, thus, to lay claim to good motherhood. To prevent women being made to feel abnormal for not breastfeeding, or for breastfeeding in public or in the workplace, the cultural paradigm clash between the discourse of the breast is best and the persisting construction of breastfeeding as a private corporeal act needs to be challenged in, and by, the wider Australian populace. Women's diverse experiences with breastfeeding need to be shared openly and included respectfully in public discussions.

Conclusion

In this article, I have argued that the breast is best discourse regulates women's perceptions of breastfeeding and their plans in regards to feeding their infants. The discourse normalises breastfeeding as the natural, optimal, choice for good mothers. How this discourse structures the "field of action" [20] available to women who are actively trying to be good mothers means that deep feelings of abnormality are experienced by women who cannot live up to expectations. Further, I have demonstrated how women are governed through the construction of breastfeeding as a private act, which assigns it to the home and, consequently, stigmatises and shames women who breastfeed in public. This construction is also normalised in workplaces, where women's legislative rights to breastfeed are dwarfed by powerful institutional cultures that ignore the validity of accommodating breastfeeding in the workplace in any serious way. Together, the governing relations formed between these two dominant discourses represent a cultural paradigm clash, which precariously positions mothering women. While an openness about women's diverse experiences of breastfeeding is needed to free women from feelings of abnormality, the governance of these two discourses combined make it difficult for Australian women to be frank about difficulties with breastfeeding; therein lies the quandary for women who are doing their best to be good mothers.

Notes

¹ However, I do not wish to undermine a woman's right to actively choose not to breastfeed, or to dismiss the powerful effects of contemporary bodily pressures that women encounter, which may play a role in these decisions.

Compliance with ethical standards

The author declares that they have no conflict of interest. All procedures involving human participants were in accordance with the ethical standards of X University's guidelines, the Australian National Statement on Ethical Conduct in Human Research, and with the 1964 Helsinki Declaration and its later amendments. Informed consent was obtained from all individual participants included in this study.

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