



Medicalized mothering: experiences with breastfeeding in Canada and Norway

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Abstract

This paper explores infant feeding practices and experiences of mothers in Canada and Norway, two countries where breastfeeding rates are relatively high. Based on interviews with 33 Canadian mothers and 27 Norwegian mothers, we also examine how mothers feel, think and talk about their infant feeding decisions and experiences, and examine similarities and divergences across their stories. Our findings reveal that infant feeding is very much organized according to the logic of the broader medical discourse, a finding which lends support to arguments that contemporary parenthood is characterized by a process of increasing medicalization. Our findings also reveal the existence of a broader culture of pressure, competition, judgement and surveillance regarding breastfeeding, suggesting that the high breastfeeding rates in these two countries are not merely a result of favourable structural conditions, but also of strong cultural expectations towards breastfeeding. We discuss our findings in connection with the broader argument that medical discourses and health professionals are becoming the primary authorities and moral gatekeepers of contemporary parenthood.

Keywords: infant feeding experiences, breastfeeding Norway, breastfeeding Canada, breastfeeding discourse, medicalized mothering, intensive mothering

Introduction

Pro-breastfeeding health and maternity discourses have been an important transmission vehicle for educating mothers (and others) about the health and nutritional benefits of breastfeeding, and have certainly played a significant role in reversing the once-dominant trend of formula-feeding as the majority feeding practice (Apple, 1987, 1997; Wolf, 2007; Wright, 2001). In many ways, these trends can be viewed as positive changes, not only for the overall health of infants and mothers, but also for the recognition and protection of breastfeeding as a basic reproductive right (Blum, 1999; Maher, 1992; Palmer, 1988; Van Esterik, 1989, 2002).

However, there is also a growing body of literature that highlights some of the more problematic aspects of contemporary pro-breastfeeding discourse, including the argument that the structure of current discourse places new

restrictions on mothers' choices and strengthens the moral connections made to them and to the practice of mothering (eg, Blum, 1999; Hausman, 2003; Knaak, 2005, 2009; Murphy, 1999, 2000, 2003; Wall, 2001; Wolf, 2007). Some, for example, have brought attention to the medicalization of infant feeding, pointing out how breastfeeding, while considered a 'natural' event, must nevertheless be taught to mothers through scientifically based, professional intervention (Carter, 1995; Law, 2000; Lee and Bristow, 2009; Wall, 2001). This literature has also raised issue with the increasing pressure and moral burden put on mothers through the discourse itself, including the problematic assumptions that failure to breastfeed may contribute to less-than-optimal bonding and/or to having a child whose brain potential may not be maximized (Law, 2000; Wall, 2001).

Further, it has been pointed out how professional pro-breastfeeding discourses not only prescribe the appropriate length of time women should breastfeed, but also how, where and in front of whom they should expose their breasts to do so, further adding to the regulation, surveillance, and disciplining of maternal bodies (Avishai, 2007; Murphy, 2003; Schmied and Lupton, 2001; Stearns, 1999; Wallace and Chason, 2007). In short, the content and tone of various breastfeeding 'facts', guidelines, and pieces of advice have been shown to intersect and intertwine with broader discourses on motherhood, contributing to the formation of a collective understanding of what is 'normal', socially desirable, and taken-for-granted as appropriate and expected mothering behaviour (Ellingsæter, 2005, 2010; Knaak, 2009; Moi, 2007; Wall, 2001).

These issues are further compounded by a general discursive presumption that the ability to exercise a 'choice' to breastfeed is as simple as making the decision to do so, a presumption which has been heavily critiqued as inadequate for properly understanding mothering decisions. Yet, in our current discursive environment the demands of mothers' everyday lives – the actualities of labour, time and energy involved in exclusive breastfeeding, and the competing demands on mothers' time and energy – tend to be denied or downplayed, and infant feeding is assumed to exist largely in isolation of the many other practices of which it is actually a part (Carter, 1995; Law, 2000). This obscures the fact that some mothers are more able to viably 'choose' breastfeeding – especially prolonged, exclusive breastfeeding – than others.

In this context, a number of researchers have brought attention to the tensions that exist between the dominant discourse – which tends to frame breastfeeding as inherently pleasurable and convenient – and mothers' actual breastfeeding experiences – which are more likely to be characterized by pleasure *and/or* disruption/displeasure, as well as a high degree of physical labour, emotional intensity, and ambivalence (Avishai, 2007; Blum, 1999; Carter, 1995; Davies, 2004; Schmied and Lupton, 2001; Stearns, 1999; Wallace and Chason, 2007). Others again have examined the experiences of mothers who formula-feed, highlighting how these mothers – well aware of the fact that they are engaging in behaviour deemed culturally deviant – must engage in 'moral repair work' (Blum, 1999; Lee, 2007, 2008; Murphy, 1999, 2000, 2003).

It is our intention to add to this body of literature by exploring infant feeding experiences of mothers in Canada and Norway. Much of the current research on this issue is based on interviews with mothers living in the US (eg, Avishai, 2007; Blum, 1999; Wallace and Chason, 2007) or Britain (eg, Carter, 1995; Lee, 2007, 2008; Murphy, 1999, 2000, 2003), where overall breastfeeding rates are still quite a bit lower than they are in Canada¹ and, most especially, Norway where nearly all mothers initiate breastfeeding (see details below). If we adhere to the central sociological premise that experience is mediated in both smaller and greater ways by broader social contexts, we can suggest that mothers living in regions where breastfeeding rates are higher might have different infant feeding experiences than mothers in regions where rates are lower. Our intention is thus to examine mothers' infant feeding experiences in these two currently under-explored contexts.

Our analysis explores infant feeding practices and experiences. We also examine how mothers feel, think and talk about their decisions and experiences, and look for similarities and divergences across their experiences. It is our position that such explorations are crucial to the emergence of new knowledge, particularly because they allow for the generation of valuable theoretical questions about the 'whats', 'hows' and 'whys' regarding the various similarities and/or differences in infant feeding practices, perceptions, experiences and decisions. We are especially interested in exploring what mothers' experiences and decisions reveal about the social organization of contemporary motherhood and examining how mothers' infant feeding beliefs, feelings, decisions and experiences may be organized and coordinated by the broader cultural and discursive environments in which they live (see Smith, 1987, 1992, 1999, 2005).

Study context

The two countries, Canada and Norway, are similar in many important respects. Both countries strongly promote breastfeeding, and they promote it in similar ways. Official breastfeeding recommendations follow the World Health Organization (WHO) declaration of 2001 stating that the child should be given mother's milk for at least the first year of life, and should be exclusively breastfed (or given mother's milk) for the first six months (Health Canada, 2004; Statens råd for ernæring, 2001; WHO, 2002, 2003). All mothers in these countries are entitled to 'free of charge' access to various forms of professional assistance, including lactation consultants, 'help-lines' and community nurses or public health nurses. Further, Norway and Canada both adhere to the WHO's International Code of Marketing of Breast-milk Substitutes which places a restriction on the marketing of formula products, and a number of hospitals are officially recognized as 'breastfeeding friendly' according to UNICEF's Baby Friendly Hospital Initiative guidelines. The two countries also both have relatively comprehensive maternity-leave policies.²

In both Canada and Norway, breastfeeding is the established norm. Recent data suggest that 88 per cent of Canadian mothers breastfeed initially, 54 per cent of them breastfeed for six months or more, and approximately 24 per cent meet the WHO target of exclusive breastfeeding for the first six months of a child's life (Statistics Canada, 2010).³ Rates for Norway indicate that 98 per cent of all children are fed breast milk initially, 80 per cent are breastfed at the age of six months, while 9 per cent of them are exclusively breastfed at this age (Øverby *et al.*, 2008).⁴ In Canada, both initiation and duration rates are higher for mothers with higher-status occupations or higher levels of education (Millar and Maclean, 2005). In Norway, only duration rates vary by social background, with well-educated mothers breastfeeding for a longer period than mothers with lower levels of education (Lande and Andersen, 2005; Øverby *et al.*, 2009).⁵

Methods and data

Our research is based on qualitative interviews with 33 Canadian mothers living in and around the city of Edmonton, in the province of Alberta,⁶ and 27 Norwegian mothers living in and around Bergen, the country's second biggest city.

For most of the mothers in the Norwegian study, their youngest child was 18 months of age or younger at the time of the interview. Nearly all were still breastfeeding.⁷ In the Canadian study, approximately two-thirds had a child under the age of 18 months at the time of the interview, most of whom were breastfeeding. For a third of the mothers in the Canadian study, their youngest child ranged from approximately two to four years of age. These mothers were no longer breastfeeding, and, as such, their stories were more retrospective in nature and required more recall than the stories of the other mothers in our studies.

Both samples contained considerable socio-demographic variation in terms of the mothers' ages, parity, educational attainment, income levels, and employment status.⁸ In the Norwegian study, all but one of the mothers were married or in stable partnerships. In the Canadian study, all but four of the mothers were married or in partnerships. None of the Norwegian mothers were of non-Western immigrant origin, and despite recruiting efforts, the Canadian study captured only one story from a mother of non Euro-Canadian origin.

For the Norwegian study, the mothers were recruited mainly through snow-ball sampling, beginning with personal acquaintances and one member of a mothers' group (see Andrews and Vassenden, 2007). For the Canadian study, mothers were recruited via posters and presentations at various locales, including day-care centres, community health centres, activity and community centres, and university campuses. Interviews were conducted with the Norwegian mothers between 2005 and 2007 by the first author and with the Canadian

mothers between 2004 and 2005 by the second author. All interviews were conducted in person, tape recorded and transcribed.

Neither of the two studies in their original form was undertaken with infant feeding as the main focus of investigation. The Canadian study was concerned with the process of postnatal adjustment while the Norwegian study was set up to explore lay discourses and practices on child health promotion where infant feeding was but one of a number of issues. In our conversations with mothers around these broader issues, infant feeding emerged as central to their narratives. Mothers from the Norwegian study were, however, asked to give detailed accounts of their infant feeding practices and experiences and also elaborate on experiences in different settings.⁹ To investigate the mothers' stories more closely, we extracted from our interviews accounts on this issue.

In our analysis we draw on Smith's (1987, 1992, 1999, 2005) interest in a sociology that begins from everyday experience, and which uses such experience as the starting point for investigating how women's 'everyday worlds are hooked into and shaped by social relations, organizations, and powers beyond the scope of direct experience' (Smith, 1992: 89). It is a method of inquiry that is always ongoing, looking to uncover and explicate the institutional processes organizing people's everyday experiences. Participants are approached as knowledgeable individuals. As Smith (1992: 91) articulates:

Inquiry starts with the knower who is actually located; she is active; she is at work; she is connected with particular other people in actual ways . . . Activities, feelings, experiences, hook her into extended social relations linking her activities to those of other people and in ways beyond her knowing . . . inquiry is directed towards exploring and explicating what she does not know – the social relations and organizations pervading her world but invisible to it.

Smith recognizes two sites of interest: the everyday local setting of experience; and the extralocal, which exists outside the boundaries of one's local world. The actualities of people's everyday local worlds – their circumstances, thoughts, actions, feelings, experiences – are permeated by and coordinated through this larger, extralocal social organization known as 'ruling relations'. Ruling relations, in turn, are known variously as discourse (academic or professional), bureaucracy, institutions, management, mass media, etc., and are based in various forms of text (see, eg, Smith, 1999: 73f, 2005: 10). Further, through a treatment of discourse as active and as inherently relational, the interest is to map how people's everyday worlds are organized by the broader institutional relations of which they are a part.

While methodological positions that emphasize actors' subjective interpretations are often criticized for subjectivism, Smith (1987, 1992) shows us that an inquiry that *begins with* women's experience is not the same as a sociology *of* women's subjective experience. Our analytical interest is thus to begin with mother's everyday experiences as a way to open up a window to the

institutional relations through which breastfeeding (as a key aspect of early mothering) is experienced and accomplished.

Our analysis proceeds on the assumption of intersubjectivity; that there are commonly created meanings and realities between ourselves, as researchers, and the mothers we have interviewed (see, eg, Schütz, 1971; Smith, 1987). We share language and culture, and also gender and the experience of infant feeding. We consider this a strength, both to the data gathering and analysis phases of our studies. Nevertheless, we have access to the experiences of the mothers who participated only through the stories they told us.¹⁰ Their stories may be affected by any number of factors, such as their perception of the interview situation and the power dynamics in the interviewer-interviewee interaction, for example.

Our interview designs allowed participants to reveal as much or as little about their practices, feelings and experiences as they wished to. While we captured a variety of experiences, none of the mothers told an exclusively glorified story. Several of the Norwegian mothers even worried that they had talked too much about negative aspects. Perhaps the mothers who participated in our studies felt at ease in the interview situation (and seemed to speak openly and honestly) because we were sociologists interested in exploring their experiences, and not health professionals or researchers studying breastfeeding rates (see our analysis section below on mothers' hesitations about disclosing certain infant feeding decisions). Although the mothers seemed to talk freely about their experiences, there could still be elements of their feeding experiences or feelings that we were not made privy to, either because of our role as researchers, or because they did not feel comfortable disclosing such experiences or feelings more generally.

Prenatal decision-making and the discourse of choice

With only two exceptions, one from each study, all the mothers we interviewed initiated breastfeeding or pumped breast milk from the beginning.¹¹ Mothers across the studies articulated breastfeeding as an obvious decision. They differed, however, in how they talked about their choice to breastfeed.

For the vast majority of the Canadian mothers, there was little to no uncertainty regarding the question of feeding method. They never entertained the notion that they *wouldn't* breastfeed. Even so, they talked about their decision to breastfeed *in relation to* the alternative (formula feeding). Their narratives pointed to the existence of a broader cultural discourse in which the notion of choice plays an active role formally but not personally. In their mind, the 'choice' to formula feed may well apply to other mothers, but not to them. This is illustrated in the following comment by Suzanne:¹²

I don't think negatively of people who make that choice [to formula-feed]. I think that's an individual choice, you know. I mean, I think breast milk is

better than formula. So for them, that's fine. But for me, I had decided I was going to do the breastfeeding no matter what . . . So, yeah, I was very stubborn about that. (Suzanne, Canadian study)

Canadian mothers also indicated that a formal discourse of choice still exists within the health care community. Penny, for example, recalls the following:

the nurses [in my prenatal class] asked people if they were planning on bottle feeding or breastfeeding . . . and then when I was in the hospital, they asked me right off the bat, 'are you breast or bottle?' (Penny, Canadian study)

Mothers from the Norwegian study, by contrast, had never been asked questions about how they intended to feed their child, neither by health professionals nor by lay people. In the Norwegian context, breastfeeding is presumed to be the *only* option, unless the mother for certain extraneous reasons cannot breastfeed. In fact, the Norwegian mothers could not recall making any conscious choice on feeding method. Virtually all of the Norwegian mothers responded to the interviewer's query about their decision to breastfeed with a response similar to that of Karin, who, somewhat ironically, states: 'Sure, I intended to breastfeed. That's the way infants are fed in this country, isn't it?'

While the Norwegian mothers did not describe the notion of choice to be operable in the context of breastfeeding itself, some of them activated the language of choice in regards to certain breastfeeding specifics; namely expectations for duration and exclusivity. Even though most mothers in both studies were committed to doing 'whatever it takes' to reach established breastfeeding targets (ie, exclusive breastfeeding for six months, with continued breastfeeding after that for up to one year or more), some did express a desire to take a more pragmatic, 'one step at a time' approach with breastfeeding.

In general, the mothers who adopted a more flexible manner towards exclusivity and duration said they knew women who had struggled with breastfeeding. For this reason, they did not take for granted that breastfeeding would go smoothly and wanted, therefore, to remain open to the unexpected.

Meeting breastfeeding targets

For most mothers in our studies, breastfeeding did not go smoothly. While difficulties ranged from the minor to the more severe,¹³ nearly all the mothers spoke of experiencing physical pain (with the use of expressions such as *unbearable* or *torture*), lack of sleep, and/or the devotion of (often extraordinary amounts of) additional effort and time towards on-demand breastfeeding. Yet, all the mothers in our studies – including the three who eventually

switched to exclusive formula feeding because of their difficulties – were committed to persevering through whatever challenges they encountered, as expressed by Suzanne and Solveig in the following extracts:¹⁴

I don't care how much it hurts or anything . . . for me, I felt like I have to do this naturally. I have to. And I don't know, I just – in my head I thought I'll wait for six or eight weeks but I knew even if that time came and went, I'd probably give it another two weeks, and another two weeks. And I would keep doing it. I just thought, I have to . . . I had to do it. No question. (Suzanne, Canadian study)

After a week and a half, or maybe two weeks, I asked my husband to buy breast milk substitute. I thought I couldn't take it any longer. I had read everything about all kinds of cures, creams, techniques, breastfeeding pillows, and asked just about everyone, neighbors, different public health nurses, and . . . After four weeks one particular ointment seemed to work to ease the pain and cure the nipples . . . I still worried because the child didn't seem satisfied after being fed . . . I never used the substitute, but it felt good, though, to know that it was within reach. (Solveig, Norwegian study)

In addition to a high level of commitment, a number of mothers across the two samples also indicated that a big part of what enabled them to work through various breastfeeding difficulties was that they *could* make working through breastfeeding problems a priority because they had only the one child, for example, were on full maternity leave, had few competing demands on their time and energy, had an extensive social support network, and had easy access to professional assistance.

While the emotional and physical toll of experiencing breastfeeding difficulties was significant, so too was the ultimate sense of accomplishment when difficulties were resolved. Mothers spoke of feeling proud, even empowered, once breastfeeding started to go smoothly. By contrast, mothers who were not able to overcome their difficulties described quite the opposite; their stories were typically marked by feelings of failure and disappointment. This contrast can be seen in the stories of Beth, who gave up breastfeeding after three months of struggle, and Jill, who was able to continue:

I felt so horrible about myself that I couldn't do this for my child. I don't know. Even though I was doing everything I could, I mean, everything, I just could not. It just wouldn't happen for us, you know? It was so, I don't know. You feel like less of a person, less of a mother, less of a woman even, you know, that you can't do this for your child . . . I feel like I'm always questioning my abilities as a mother. I think you do, anyhow. But when you – when this happened, you know, it multiplies it, you know. (Beth, Canadian study)

Breastfeeding didn't get started well, and there were lots of terrible things about this postpartum experience. Except that I was really determined . . . I guess that was very empowering because I knew lots of people would have decided it wasn't worth it . . . and it was one of my first experiences where I had a strong conviction about what was right and what I wanted to do. And I really backed it up with action. And so despite all the problems it was very empowering. (Jill, Canadian study)

In general, most mothers in our studies considered the medical discourse¹⁵ on infant feeding the most trusted, most correct, and most up-to-date source of information about how a child ought to be fed. As Marianne states:

If they [public health authorities] recommend breastfeeding for two years, for the health benefits of my children, I'd certainly go for two years. (Marianne, Norwegian study)

Yet, the two groups of mothers presented somewhat different arguments for *why* it was important for them to be successful with breastfeeding. The Norwegian mothers spoke almost exclusively about the health benefits and discussed the importance of breastfeeding mainly in medical terms, with an emphasis on fatty acids and other immunological and allergy-preventing properties in breast milk.¹⁶ By contrast, the Canadian mothers – in addition to breast milk's nutritional benefits – emphasized 'bonding' as well as the fact that they felt it was a core component of 'good mothering':

[breastfeeding] wasn't ever something I questioned . . . I wanted to develop a bond with her, especially given that I had never been around kids. I wanted to kind of make the most of what I could offer as a mom. I wanted to develop a bond. (Fran, Canadian study)

This difference between the two groups of mothers could, at least in part, be connected to differences in the character of the broader medical discourses in these two countries. In the health literature in Canada, a connection between breastfeeding and 'bonding' is often made (see Knaak, 2006; Wall, 2001), while similar literature in Norway (eg, Nylander, 1999, 2002), mostly emphasizes the nutritional aspects associated with breastfeeding.

Most of the mothers in our studies were generally committed to following health authorities' prescriptions regarding various breastfeeding 'how tos', and to meeting established targets for breastfeeding exclusivity and duration. However, striving to reach the specific goal of six months exclusive breastfeeding was a stronger focus among the Norwegian mothers than it was among the Canadian mothers. Many of the Norwegian mothers talked about how they struggled with decisions about whether or not to introduce solid foods or formula milk before the six months benchmark – even if their child seemed to need it, and even if they themselves were experiencing exhaustion from frequent feeds and disturbed sleep.

Women from the Canadian study were somewhat less concerned with strict adherence to the ‘six months exclusive breastfeeding’ target, which means that no other substances are to be fed to the child prior to that time. In general, the Canadian mothers were less likely to express hesitation about the idea of introducing solid foods prior to the six-month mark. They were, however, quite likely to express strong feelings against use of formula as a food supplement in the first half year:

I’ve heard all these things about how horrible [formula] is, and you know, I always said, ‘I’m only going to nurse . . .’ and my husband was trying to convince me, saying ‘well, maybe we could give him some formula, it would give you a break.’ You know. But no way in hell was I going to do that. I’m going, ‘you’re not going to introduce that stuff to my baby!’ (Raeanne, Canadian study)

Once again, this difference between the two groups of mothers could be related to differences in the character of the medical discourse in these two countries. In Canada, for example, there is still a fair bit of public health emphasis on dissuading mothers from considering formula as a comparable alternative to breast milk, often through a strategy that positions formula as the more ‘risky’ alternative (Knaak, 2006). By contrast, the current public health emphasis in Norway is less on getting mothers to choose breastfeeding (Norway has close to 99 per cent initiation rate for breastfeeding), and more on encouraging them to breastfeed exclusively for six full months.

Pressure and the ‘breastfeeding police’

In both studies, mothers talked about there being considerable pressure with respect to breastfeeding:

Virtually everyone I know breastfed their child even if they struggled tremendously in the early weeks . . . The pressure is so strong that it is easier to breastfeed than not to breastfeed. (Karin, Norwegian study)

I knew that breastfeeding was the best thing for [my baby], but there’s also a lot of pressure . . . I felt really pressured. (Beth, Canadian study)

The pressure the mothers spoke of was experienced in two main ways: directly (in specific interactions) and indirectly (existing within the culture at large). A number of mothers described feeling direct forms of pressure from health care professionals – often in regards to the specifics of their practice and in terms of the importance of *continuing* with breastfeeding. For example, mothers who had difficulties with breastfeeding spoke about how their health care professionals rarely (if ever) suggested supplementation or weaning be

undertaken in order to ease suffering. Bettina, from the Canadian study, recalls her lactation consultant specifically telling her that ‘giving up [breastfeeding] is not an option’. Even though close others – such as their own mothers, grandmothers, or spouses/partners – often suggested supplementing or weaning, it was the opinions and advice of health professionals that the mothers in our studies tended to privilege.

Many of the mothers also felt that the questions asked by health professionals during routine infant health checkups were often made more in a spirit of control than in a spirit of support. The result, we learned, was that for a number of mothers in our studies, this led to a breakdown of openness between themselves and their health professionals. Mothers who decided to wean early and/or do combined feeding (breastfeeding with formula supplementation), for example, often hid their decision from their health care professionals.

The pressure the mothers felt regarding breastfeeding – that it was important for them to breastfeed ‘correctly’, according to established guidelines – contributed to mothers feeling fearful and worried about the consequences of not being successful with breastfeeding:

What sort of kept us going in those first weeks [when I was having problems with breastfeeding] was that at least he would take a bottle. But I was so worried, because you read and hear things, and those nurses – they are mothers’ best friends and worst enemies sometimes because they’re like, ‘oh, nipple confusions and nah-nah-nah, never give them a bottle if you’re going to breastfeed,’ and they got me so worried about that . . . but it all got worked out eventually. (Natasha, Canadian study)

While all the mothers in our studies said they felt considerable pressure from the health community, for many this pressure existed more as a general sensation or *feeling* than as a result of specific interactions. In fact, a number of mothers said that, much to their relief and appreciation, certain specific interactions with health care professionals were not rigid or dogmatic, but flexible, understanding and supportive. Rita, from the Norwegian study, for example, started using formula as a feeding supplement because of difficulties with breastfeeding. She worried about what the public health nurse would say about her practice, and in the interview, she relayed how she was not in the mood for taking critique or getting into any discussion on the issue, so she had decided not to tell the public health nurse about the formula. On the day of the public health nurse’s home visit, a few weeks after the child was born, Rita ensured that nothing could reveal her mixed feeding regime. During the visit, however, she changed her mind and decided to be honest about her decision to supplement. To Rita’s surprise, the public health nurse supported her practice.¹⁷

Many mothers, both Norwegian and Canadian, also talked about how pressure to breastfeed (exclusively, and for a certain length of time) existed *outside*

the health community, in their interactions with friends, coworkers, and others, as Penny, from the Canadian study, articulates:

I never felt comfortable breastfeeding, but when I got pregnant you get the pressure from everybody around you to breastfeed . . . but the nurses never pressured me. They never pressured me . . . believe it or not, the people who did give me some harsh things about [my decision to not breastfeed] were men. Like my boss and the guys at work. You know, who were fathers. ‘You should breastfeed.’ And I’m thinking, why does a guy have the right to tell me that I have to breastfeed? . . . and I started to debate it, and I started to think, ‘well, maybe I should,’ and then I thought, ‘no, I still don’t feel comfortable about this.’ . . . but you still feel guilty if you don’t breastfeed at first.

As well, mothers who fed via bottle (whether the bottle contained formula or breast milk) often talked about how they had to field comments about their practice, and/or received disapproving gazes when feeding in public. This theme was more prominent in the stories of the Norwegian mothers, and is probably due, at least in part, to the fact that public breastfeeding is more widely accepted in Norway than in Canada.

While the mothers in our studies agreed about the existence of a general culture of pressure around breastfeeding, the *appropriateness* of this pressure was somewhat a point of debate. Some, for example, thought the pressure acceptable because they believed that breastfeeding’s importance needed to be stressed, and that a certain amount of pressure helped to ensure that mothers did not give up too easily. This was Vibeke’s (Norwegian study) opinion. She believed that that pressure surrounding breastfeeding helps to keep mothers motivated in the face of difficulties and helps ‘to ensure all children a perfect start of life’. Most mothers, however, did believe that the pressure was too strong and intense:

I can see [breastfeeding] being a real issue I think for a lot of women. Because there is some – I don’t know if it’s real outwardly pressure or if it’s just more subtleties – . . . but I think it could be a very serious situation if somebody feels like [they want to breastfeed] and then if they have to give it up, or just feel too overwhelmed to really keep going with it . . . [for me] it got to that point where I could not imagine not being successful with [breastfeeding]. And, I just thought, I can’t even go there with it, because it truly, I think, would have spiralled me into a serious probably state of depression. (Natasha, Canadian study)

It was in this context that mothers (many Norwegian and some Canadian) used the ‘breastfeeding police’ as a term when they referred to the intensity of the pressure they experienced both from the health care community and the lay community.¹⁸ In fact, many mothers (especially in the Norwegian

study) became agitated or upset when they started to talk about the general pressure surrounding breastfeeding. As such, they used the term ‘breastfeeding police’ to communicate the extent to which they felt their and other mothers’ breastfeeding practices were being monitored and judged, and the negative impacts this had on their feeding experiences.¹⁹

Also, a number of interviews – in both studies – contained stories of mothers judging other mothers for weaning early or for not breastfeeding at all. In general, mothers tended to express this kind of judgement mainly when they felt that another mother had not given breastfeeding sufficient effort:

A friend of mine who works fulltime, she chose not to breastfeed, and I thought, ‘oh she’s horrible, how could she not do that?’ . . . For me personally, it wouldn’t ever occur to me that I wouldn’t try to breastfeed. (Beth, Canadian study).

One of my friends decided not to breastfeed her second child because of the difficulties she experienced with nursing her first . . . I, personally, tried to encourage or even persuade her to breastfeed but that didn’t help, and I’m sure she also has heard elsewhere that her decision not to breastfeed was not a wise decision . . . Today, there is no reason not to breastfeed you’ll get all the support you need. (Vibeke, Norwegian study).

As indicated in these mothers’ comments, the judgement of another mother for not breastfeeding did not seem to be primarily about whether she was necessarily ‘successful’ with breastfeeding. It was, rather about whether or not she ‘tried hard enough’.

Competition and the ‘supergirl syndrome’

Mothers also talked about the existence of a culture of competition. Ragnhild, a mother of three from the Norwegian study described how in recent years many of her friends and other mothers she knows, have ‘become desperate in their efforts to fully breastfeed for six months’. In Ragnhild’s perception, the intensity with which mothers strive to adhere to the prescription of six months exclusive breastfeeding has increased dramatically. Although the intensity with which the mothers in the Canadian study drove to meet the ‘six months exclusive breastfeeding’ target was not as strong as it was among the Norwegian mothers, there was nevertheless still a strong commitment among them to ‘do everything right and not make any mistakes’, as Emily stated.

This intense commitment among many mothers to ‘doing everything right’, was described by mothers, who participated in the interviews, as a kind of ‘strive towards perfection’, a motherhood version of ‘the super girl syndrome’. The super girl syndrome in motherhood, as Bente from the Norwegian study

explains, comes from the need that many modern women feel to relay an impression of themselves as smart and fit and highly capable; thus, when they become mothers, they continue to be high achieving and success oriented, wanting to mother 'perfectly'. Mothering perfectly, in this context, largely means 'following the book to the "t"' (Penny, Canadian study).

As indicated by the mothers in our studies, success in motherhood is marked or signalled by breastfeeding; even more, by managing to breastfeed according to guidelines established by the medical community. These guidelines emerged as a shared cultural benchmark which mothers used to compare and evaluate their own and other mothers' feeding practices. Many of the mothers we interviewed activated a language of comparison, whereby mothers noticed the practices of other mothers, ranked themselves (and others) against other mothers, and also often strove to be 'best in class'.

This culture of comparison and competition in breastfeeding appears to be made possible, at least in part, by characteristics central to the practice itself; namely the fact that few mothers actually succeed in their efforts to exclusively breastfeed for six months (ie, the guideline itself still remains out of reach for many mothers as a population-level prescription), that breastfeeding is a labour-intensive activity, and is also a practice often characterized by the need to endure pain. In other words, breastfeeding, for many mothers, takes a considerable amount of effort, perseverance and commitment.

Elisabeth (from the Norwegian study), for example, was well aware that she was a member of an exclusive group of mothers, and she described how proud she felt when she managed to fully breastfeed her first child for the prescribed number of months.²⁰ Mothers who did not accomplish this goal or experienced a feeling of *not* being 'best in class', described feelings of failure. We provide two stories from our studies to illustrate.

Sigrid, a mother of two from the Norwegian study, suffered from postpartum depression after her first child was born. During the early weeks following birth, Sigrid was breastfeeding exclusively and she described how breastfeeding was her 'bright light' – the one thing she was feeling good about, a task she had mastered. Unfortunately, her six-week-old son was gaining weight slowly, and it was recommended that his diet be supplemented with formula. Sigrid, thus, changed to a practice of combined breastfeeding and formula supplementation until her child was approximately six months old, at which point she stopped breastfeeding altogether. Although Sigrid said her child thrived on this combined diet, she still felt 'like such a failure', as a mother, for not being able to exclusively breastfeed for the prescribed number of months. Sigrid further described how she avoided public outings with her child because she could not bear bottle-feeding him in public – that doing so would have made her 'feel even more of a failure'.

Sigrid wanted so badly a feeling of success (as a mother) that she planned to have her second child as soon as possible after her first was born. When it came to breastfeeding this second child, she again experienced problems. At the time of the interview, the distress Sigrid felt by 'failing' at both her attempts

to exclusively breastfeed had not faded. She told her story through tears, and described how, years later, she still experienced intense grief because she felt she had ‘failed’ with breastfeeding.

In contrast to Sigrid, Marianne (also from the Norwegian study) succeeded in her attempts to follow medical-expert guidelines on infant feeding for each of her three children. Nevertheless, she spoke of feeling ‘deeply depressed’ after every group consultation with the public health nurse because her children did not grow as fast as other children in the group. All her children were healthy, but that did not seem to be the key marker for Marianne, at least while in these consultations with other mothers and the public health nurse. Rather, it was the fact that her children’s weight was visibly lower than other mothers’ children – despite the fact that that she had been a ‘successful’ breastfeeding mother – that spawned these feelings of failure. She said her husband recommended her not to participate in these group consultations, as he believed they had an unhealthy impact on her well-being.

Both Sigrid and Marianne are well-educated women in their mid-thirties, and several women from the Norwegian study opined ‘the super girl syndrome’ to be particularly noticeable among this demographic. Karin, for example, expressed the opinion that the higher up on the educational ladder mothers are, the stronger they feel the pressure to breastfeed. She underscored her point by referring to her sister-in-law, a 22 year old with little post-secondary education, who weaned her child at the age of two months: ‘She didn’t bother to continue, [and] apparently, she doesn’t feel guilty at all.’²¹

Muted resistance

As described above, most mothers in our studies strove to meet established targets and guidelines regarding breastfeeding ‘how tos’. This finding was not universal, however. It is in the stories of the mothers who challenged certain specifics within the official guidelines where we can see some indications of resistance towards the hegemony of the medical breastfeeding discourse.

Some mothers, for example, said they did not worry so much about strictly adhering to the rules about how to ensure the avoidance of nipple confusion and/or how to properly engage in on-demand feeding.²² We also noticed that not all mothers felt as strongly about the need to strictly adhere to the current target of ‘six months exclusive breastfeeding’ and/or ‘total breastfeeding duration of one year or longer’. Hanne, Turid and Vibeke (from the Norwegian study), and mothers such as Bettina and Paige (from the Canadian study) said that they occasionally supplemented with formula to better allow themselves to drink alcohol, to keep up sporting activities, to encourage their child to sleep through the night, or for other reasons. Also, some of the mothers introduced solids earlier than the current six-month benchmark because they wanted to let their child experience something new; to encourage progress in the child’s development; or because they felt that their child was ready for it.

While these mothers still expressed a commitment to breastfeeding, their narratives differed from those of mothers with stronger commitments to 'doing everything right' in that they did not talk about feeling 'guilty' or 'disappointed' about following a practice somewhat modified from that which is officially prescribed. Some of these mothers expressed dissatisfaction towards the rigidity of current breastfeeding rules, and indicated that breastfeeding targets and 'how tos' should be viewed with more flexibility; that basically 'one size does *not* fit all'. Some stated that a more flexible approach in regard to feeding better allowed them to keep things manageable:

My philosophy has become whatever works is the approach I take. Whatever makes my life – whatever works, whatever makes it manageable . . . And when I get into a rut where I put myself down I just try to remind myself . . . as long as he is a happy child who develops normally, there's really no major concern and it's not my goal to have a 'super baby.' (Paige, Canadian study)

Line, a mother from the Norwegian study, also tells a story illustrative of this theme. Her only child was born prematurely and hospitalized because of jaundice. Line attempted to breastfeed, but the child was unable to latch onto the breast properly. Therefore, Line pumped breast milk and fed her child via bottle. After approximately three months, she switched to formula because her milk supply had dwindled.

In contrast to the other mothers who said they 'felt like failures' if they had stopped breastfeeding earlier than hoped or expected, Line did not speak about her experience in terms of failing. She said she had done the best she could under the circumstances, and that switching to formula was the best decision for both her child and herself, although, as she added, her decision to stop pumping 'was also an egoistic decision or sort of'. Her husband, who was present during the interview, indicated that he had encouraged her to continue with the pump, but Line did not think it was worth the struggle. She explained how she had been in a state of severe sleep deprivation because of around-the-clock pumping and feeding demands, and she believed that securing herself more sleep would have a positive impact on both herself and the child. Line also figured the child would be well nourished on formula.

Despite the mothers' beliefs and feelings, and despite the fact that they said they were *personally* confident about their own feeding decisions and practices, many of them still tended *not* to volunteer information about their modified practices to health care professionals. These mothers worried about receiving criticism for their altered practices vis-à-vis established breastfeeding targets and/or 'how tos'. Some also compensated for not breastfeeding exclusively during the first six months by continuing to breastfeed past the one-year mark. This suggests that they are well aware that their decisions are instances of institutionally defined deviance, and as such, potentially subject to moral sanctions. It further suggests that, in as much as these mothers' actions

and opinions might be considered indications of resistance, their reservations about to whom and how they disclose such information limits the extent to which such action is taken up in the broader network of institutional relations as resistance or counter-discourse.

Discussion and conclusions

With only two exceptions, breastfeeding for the mothers in our studies was a taken-for-granted decision. A main difference between their narratives in this regard had to do with the notion of choice. While the Canadian mothers indicated that in some sense ‘choice’ still exists both within the Canadian culture at large and within the health care community, this notion was not present in the Norwegian context.

While mothers across the two studies supported the notion that ‘breast is best’, they described a tremendous sense of pressure to accomplish the prescriptions contained in the medical discourse on breastfeeding. As such, they often hesitated to discuss modified feeding practices with their health care professionals, out of fear of judgement or criticism. Many mothers – particularly from the Norwegian study – employed the term ‘breastfeeding police’ as a pejorative term to describe the intensity of the pressure they felt. In this context, health care professionals, as the legitimized agents of the dominant medical discourse, emerged as highly powerful institutional representatives, whereby the authority to ‘establish the rules’ and also to monitor adherence to such rules, seemed to lie very much within their jurisdiction.

As well, a number of mothers expressed frustration with the rigidity of the dominant infant feeding discourse; that ‘one size does not necessarily always fit all’, and that there is sometimes good merit in having flexibility in one’s approach to feeding. In this context, we heard a kind of ‘talking back’ to the dominant (medical) breastfeeding discourse, whereby mothers themselves questioned the assumption that the medical community is always right. However, the frequency with which we heard these mothers speak about a fear of criticism – and the measures they took to ensure they maintained a certain alignment with the medical discourse – suggest a rather half-hearted form of resistance. The caution mothers took in terms of positioning themselves in any way tangential to the medical discourse reveal the difficulties mothers have trying to establish themselves as authoritative experts in their own right.

For the most part, mothers did not seek validation or knowledge from their own mothers or mothers-in-law about the ‘how tos’ of infant feeding, nor did they tend to privilege experiential-based knowledge over the expert discourse. In other words, the women we interviewed did not seem to worry about the fact that expert discourses often are detached from actual experiences (see, eg, Smith, 2005), or that, in the case of infant feeding, the WHO formulated target of six months exclusive breastfeeding – which added to mothers’ difficulties and struggles – could be argued to be a ‘medical construction’ of recent times.

In this sense, our findings are in keeping with the premise that the institution of modern mothering is not only an expert-guided undertaking, but also an increasingly expert-endorsed one. It is the voices and opinions of health professionals – and fellow mothers who are similarly fluent in the dominant medical discourse – that come to matter most to mothers; it is they who are perceived to have the most ‘correct’ knowledge, and also the authority to endorse and judge ‘proper’ parenting practices.

Many mothers also spoke of a culture of competition – where mothers often strive to be ‘best in class’ at breastfeeding, where they compare themselves and each other against established breastfeeding benchmarks/targets, and where they use such comparisons as a basis for evaluating both themselves and others.²³ Our analysis thus shows how mothers are *hooked into*, as Smith (1992) puts it, hierarchically flavoured social relations with one another. Mothers are connected across space and place through the tenets of the dominant medical discourse, which they use as a culturally shared evaluative tool. Mothers employ the medical breastfeeding discourse as a barometer for measuring, comparing and evaluating both themselves and other mothers against the prescribed ideal. Mothers make decisions, voice (or not voice) opinions, watch each other, talk (or not talk) about their breastfeeding experiences through the tenets of the dominant medical discourse, bringing it constantly into being in the process. The medical discourse of breastfeeding is therefore not something that fully ‘stands over’ mothers, demanding adherence. Rather, it is something that is embedded in their everyday lives, being continually activated and legitimized through its use as a shared cultural script and evaluative tool.

Our findings also lend support to arguments that contemporary parenthood is characterized by a process of increasing medicalization, which means that the institution of medicine also plays a powerful part in social control of mothers. By prescribing how and for how long mothers should breastfeed – and by mothers deferring so strongly to such prescriptions – our analysis demonstrates the ways in which the medical discourse is working to govern maternal bodies (Foucault, 1991a, 1991b) as well as how it is working to define what modern ‘good’ parenting is or is not (see also Blum, 1999; Lee, 2008; Wallace and Chason, 2007).

Findings from previous studies conducted by Blum (1999), Lee (2007) and Murphy (2003) point to counter-discourses that materialize in practice, reflecting Foucault’s (1991a) argument that attempts to govern or discipline individual bodies tend to evoke resistance. Our analysis shows how mothers, instead of weaning early or choosing formula from the outset, negotiated certain tenets *within* the dominant medical discourse, such as length of breastfeeding exclusivity and duration. At the same time, however, they tended to reinforce both the authority and legitimacy of the discourse as a whole. In this sense, mothers in our studies seemed to be following a pattern which fits more into Beck and Beck-Gernsheim’s (1995) reasoning.

Beck and Beck-Gernsheim argue that in today’s risk-averse parenting culture, parental autonomy is becoming increasingly less relevant. They argue

that parents attempt to do their best for their children, while simultaneously seeking to minimize personal responsibility for their parenting decisions and actions. In other words, by deferring to professional authority and expertise – parents do not have to carry the entire weight of the responsibility for their child's health and well-being. As a parent, it is thus 'safer' to follow expert advice, even if this prescribes practice in almost every detail. Our findings suggest that in the arena of infant feeding, this deeper process is very much at play in terms of how mothers' practices and experiences are being organized and coordinated.

There are many consequences to this larger trend, a number of which can be gleaned from our interviews. For one, mothers are faced with an increasing dependency on, and vulnerability to, the advice and assistance of medical experts in navigating day-to-day feeding processes and other parenting concerns. Secondly, the increasing power of medical discourses to determine correct parenting behaviour leads to an undermining of mothers' own confidence about the appropriateness of any decision that might be tangential and/or somewhat contrary to tenets of the dominant (medical-based) discourse.

Third, it leads to an increasing disregard towards advice and/or knowledge offered by those deemed to exist outside and/or tangential to the dominant medical discourse, such as the transmission of intergenerational mother-to-mother knowledge, experiential and/or lay knowledge, or other philosophical paradigms, for example. This potentially cripples the validity and legitimacy of other forms of knowledge and ways of thinking about parenting and child care (see also Andrews, 1999, 2003, 2006).

In as much as the world of modern parenting, and especially the domain of infant feeding, is increasingly becoming a pact between mother and state, a relationship between mothers and medical authorities, further research and understanding is needed. As such, questions aimed at understanding more about the character and consequences – positive and negative, intended and unintended – of the increasing medicalization of modern parenting, not only with respect to infant feeding, but also for the broader institution and practice of mothering will be particularly important as topics for future research and investigation.

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Notes

- 1 Canadian breastfeeding rates vary by province, with lower rates in Canada's eastern provinces and higher rates in the more western and central provinces (Statistics Canada, 2010).
- 2 In Canada, mothers who meet the basic eligibility requirements are entitled to 55 per cent of their salary for a total of 50 weeks. Many large organizations also provide 'top-ups' to this programme, enabling mothers to receive near to all of their full salary for the time they are on

- leave. In Norway, mothers who meet the requirements are entitled to 100 per cent of their salary (up to a certain amount) for 38 weeks or 80 per cent of their salary for 46 weeks, and then another five weeks of paid annual holidays. Norwegian mothers are also entitled to paid lactation breaks during work hours.
- 3 In an earlier Statistics Canada report on breastfeeding rates (see Millar and Maclean, 2005), the authors note that 'there were some discrepancies between stated duration of exclusive breastfeeding and the time when other foods were introduced' (2005: 24). It is thus possible that the current figures could also be affected similarly, where some mothers defined exclusive breastfeeding as 'not feeding formula' as opposed to the 'not feeding any other sources of food'.
 - 4 According to figures presented by Lande (2005), Lande and Andersen (2005), and Øverby *et al.* (2008, 2009) the changes of recommendation on breastfeeding in Norway, from 2001, have not led to significant changes of practice, except for at the age of 12 months where breastfeeding rates have increased.
 - 5 Up until the late 1970s breastfeeding rates were higher among mothers with lower levels of education than among mothers with higher levels of education (Listøl *et al.*, 1988).
 - 6 In Alberta, the breastfeeding initiation rate is 92.4 per cent (Statistics Canada, 2010).
 - 7 One mother, Sigrid, had her youngest child four years prior to the interview. She approached the researcher and asked if she could participate in the study because she wanted her experiences and feelings of anger and frustration around the general breastfeeding pressure to be captured.
 - 8 Mothers' ages ranged from 24 to 44 in the Norwegian study, and 20 to 45 in the Canadian study. Mothers in the Norwegian study had between one and five children, while the Canadian mothers had between one and four children. Educational attainment ranged from uncompleted high school to doctoral candidates in both studies, but more than half of the participants had either a college or university degree. Income levels in both studies ranged from dependence on social assistance to a household income of over \$100,000 per year.
 - 9 Spradley's (1979) ethnographic approach is a main source of inspiration for the interview design and the ways in which questions were asked.
 - 10 In some cases we also observed mothers' practices as they were breastfeeding during the interview.
 - 11 Penny, from the Canadian study, decided against breastfeeding from the outset, citing strong personal aversion as the main reason behind her decision. Kristine, from the Norwegian study, practised exclusive formula-feeding for her second child because of problems that occurred when she breastfed her first child. This case is pursued in Andrews (in prep.).
 - 12 All names are pseudonyms.
 - 13 Breastfeeding difficulties were related to complications of labour, previous medical treatment or surgery; insufficient milk supply (or worries about the adequacy of the supply because the child either appeared unsatisfied after feeding, or was not growing satisfactorily according to the established guidelines), difficulties in getting the child to latch properly onto the breast, and/or problems such as plugged breast ducts, bleeding and cracked nipples, or breast infections.
 - 14 In total, three mothers (one from the Norwegian study, two from the Canadian study) stopped breastfeeding as a result of the difficulties they experienced. Except for one mother (from the Norwegian study), all other mothers eventually managed to establish a breastfeeding practice they were satisfied with. For some, this meant a practice involving formula supplementation, for most it meant maintaining (or returning to) a practice of exclusive breastfeeding.
 - 15 By the 'medical discourse on breastfeeding' we refer to ideas involved in WHO's recommendations on breastfeeding exclusivity and duration (for details, cf. Study context).
 - 16 Two mothers spoke of how sad they were because their children, at around eight months, were beginning to lose interest in breastfeeding. Both mothers more or less 'forced' their child to continue, as they wanted to breastfeed until at least the one-year mark because of the health benefits.

- 17 Three mothers from the Norwegian study believed that their public health nurse's supportive approach contributed to the problems they experienced. They ended up shock feeding their children with formula (due to low weight gain) because they, as they said, followed advice about not breastfeeding constantly on demand.
- 18 Internet search for the Norwegian expression equivalent to 'breastfeeding police' (*amme-politi*), gives close to 6,000 hits (10 June 2010).
- 19 The extremely strong pressure that has surrounded breastfeeding in Norway over the last decade has triggered responses probably leading to a decrease in breastfeeding rates.
- 20 Elisabeth shared the experience of exclusive breastfeeding for six months with only three other mothers from the Norwegian study.
- 21 Karin herself did not express any kind of judgement in regard to her sister-in-law's decision.
- 22 Being more flexible with these breastfeeding details was more common among mothers who did not experience significant difficulties getting breastfeeding established.
- 23 Kukla (2008) also talks about mothers using breastfeeding as an important measure of mothering (or as a 'signal moment').

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