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Practical Problems and Moral Discourses: an Ethnography of Breastfeeding

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PRACTICAL PROBLEMS AND MORAL DISCOURSES: AN ETHNOGRAPHY OF BREASTFEEDING

by

Tara A. Gallagher

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Partial Fulfillment of the
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ABSTRACT

PRACTICAL PROBLEMS AND MORAL DISCOURSES: AN ETHNOGRAPHY OF BREASTFEEDING

by

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The University of Wisconsin-Milwaukee, 2020
Under the Supervision of Professor Paul Brodwin

Universal and bioactive, breastfeeding is a burgeoning biocultural topic because it incorporates biological and social determinants of human behavior. The topic has amassed media attention framed as part of a bigger imagining of motherhood as an idealized state directed at the female body's performance. This paper questions media and public policy's role in the dissemination of culture and the symbolic value of breastmilk. This study examines breastfeeding discourses through the lens of an American, mostly white, Midwestern middle-class social structure. Using participant observation data of two postpartum support groups and semi-structured interviews with six primiparous mothers, my data suggests that women encounter an emotionally embodied process of learning when the biological demands and self- or socially-constructed ideals come in conflict with the practical realities of breastfeeding. Women will navigate a moral landscape when talking about breastfeeding, but do so through pedagogical and social strategies to 'survive the newborn'. Shame and guilt, therefore, a product of the politicized media and social marketing policy rhetoric that positions infant feeding as a matter of individual choice and responsibility rather than addressing the practical barriers women encounter.

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*In dedication to
love children
and single moms*

TABLE OF CONTENTS

List of Figures	vi
List of Tables	vii
List of Abbreviations	viii
CHAPTER	PAGE
I. Breastfeeding as a Biocultural Phenomenon	1
Framing Breastfeeding as Part of the Reproductive Body	4
Anthropological Perspectives	8
The History of a Controversy: Medicalization of Breastmilk	9
Breastfeeding as ‘Natural’ and Emergent Maternal Identities	15
Breastfeeding as a Choice	17
Methods	18
II. Parenting Strategies and Maternal Identity Work	28
The Need for a Strategy	29
Pedagogies of Breastfeeding and the Development of a Strategy	36
Parenting Ideologies: Routine and Attachment Philosophies	40
“Surviving the Newborn”: Parenting Strategies in Context	45
Expectations and Maternal Embodiment	47
III. Moral Authority in Social Support for Breastfeeding	56
Mom-to-Mom Community Building: A Function of Sociality	57
Mom-to-Mom Community Building: A Function of Pedagogy	61
Authority and the Role of the Lactation Consultant	65
Embodied Morality: Building a Maternal Support System	70
IV. “Breast is Best”: A Breastfeeding Narrative	81
A Brief Historical Review of Infant Feeding Alternatives	84
<i>Breast is Best</i> and the Breastfed Baby: Using Rhetoric as a Socio-Political Power	87
<i>Breast is Best</i> at the Intersection of Social Inequalities	94
Reflexivity and Rethinking Breastfeeding Promotion from an Anthropological Perspective	103
V. Conclusion	110
VI. References	120

LIST OF FIGURES

Figure 1. Diagram of a Breastfed Baby

92

LIST OF TABLES

Table 1. Detailed Information about Women Interviewed

27

LIST OF ABBREVIATIONS

AABN	African American Breastfeeding Network
AAP	American Academy of Pediatrics
AMA	American Medical Association
BFHI	Baby Friendly Hospital Initiative
BW	The City Babywearers
FMLA	Family and Medical Leave Act
HHS	United States Department of Health and Human Services
HP2020	Health People 2020 National Objectives
IBCLC	International Board Certified Lactation Consultant
ICCR	Interfaith Center for Corporate Responsibility
INFACT	Infant Formula Action Coalition
IVF	in-vitro fertilization
LLL	La Leche League
MBC	Midwest Breastfeeding Coalition
NBAC	National Breastfeeding Awareness Campaign
NPC	New Parenting Circle

NPN	New Parenting Network
PPD	postpartum depression
SIDS	Sudden Infant Death Syndrome
SNS	Supplemental Nursing System
TANF	Temporary Assistance for Needy Families
UNICEF	United Nations Children’s Fund
USBC	United States Breastfeeding Committee
USDA	United States Department of Agriculture
WHO	World Health Organization
WHO Code	Code of Marketing of Breastmilk Substitutes
WIC	Women, Infant, and Children Nutrition Program

Breastfeeding as a Biocultural Phenomenon

We are in a period of history when the medical science supports breastfeeding research and it seems as if there is no end in sight to what breast milk is capable of. Human milk is, biologically, our species' inherited form of infant food. There is a growing awareness about the significant benefits of breastfeeding as a source of infant nutrition, but not every mother breastfeeds. This study seeks to better understand the complexities of maternal decision making with regards to infant feeding.

The elemental argument in favor of a breastfeeding model for infant feeding is that it is part of the human evolutionary heritage. It is the original way humans, as mammals with mammary glands, fed their offspring (Stuart-Macadam 1995). The topic is extremely relevant in anthropology because breastfeeding is, “the ultimate biocultural phenomenon” (Stuart-Macadam 1995:7) where a common biological process meets a culturally variable behavior.

Currently, breastfeeding is a topic that is experiencing a burgeoning of interest in American culture, research, and anthropological literature. Breastfeeding moms seems to exist in a multi-vocal sphere of influence. The act of breastfeeding, as a biological exchange between mother and infant, occupies the interests of medical and public health domains. Other factors to maternal decision making include historical, economic, political, and social perspectives. These perspectives are more likely to suggest that breastfeeding goes beyond biology; that there is also a cultural exchange between caregiver and infant.

Within a Western media landscape, a depiction of motherhood as having moral consequence currently dominates the breastfeeding discourse. In what was most recently

depicted as "The Goddess Myth" (Howorth 2017), women in America are confronted with a growing perception of breastfeeding as part of mothering package where failure to do so will result in judgment from medical health professionals, public health workers, activists, or other moms. As breastfeeding research becomes more significant in public discourse, the disciplinary traditions of anthropology may be necessary to distinguish between social perceptions of breastfeeding and the experienced reality for new mothers.

Initially, I wanted to learn about how breastfeeding is perceived by new mothers regardless of how they fed their infant. How do women talk about infant feeding? How are expectations of motherhood articulated in infant feeding and how do women navigate these expectations through their experience? How do women decide to feed their infant given their maternal socio-political ecology? What is the symbolic value of breastmilk and how does this translate into a moral or ethical social code?

Through the trajectory of this project, it has transformed from a biocultural study about infant feeding practices to a larger discourse on the perceptions of maternal choice with breastfeeding as the focal point. The objective is to approach an emerging biocultural topic within the economic and political context of a Midwestern American city. Using standard anthropological methods of participant observation and semi-structured interviews, I examine how middle-class women experience breastfeeding through a perspective that acknowledges infant feeding alternatives. Some of the essential guiding questions include: Do mothers believe breastfeeding is a choice? How do they learn to breastfeed? Who or what influences their infant feeding practice? Is it a controversial subject for them? And if so, *why*?

My aim with this paper is to discuss the social issues surrounding infant feeding based on an analysis of data collected from women who attend postnatal support groups. Most of my participants began motherhood with the initial intention to breastfeed, though those were not necessarily the participants I originally sought out. As the women I met experienced challenges, changes, and confirmations to their maternal expectations, I allowed this study to be transformed by the open-endedness of participant observation. What follows is a women-centered analysis about the confrontation between ideals and practical realities.

In this chapter, I will further develop my research questions with an overview of the leading literature that has directed my own inquiry. This study is then further divided into three chapters. Each chapter takes on the emerging themes: the development of cultural ideologies, moral expectations and practical realities, maternal community support, and moral authorities. In my final approach to this complex biocultural subject, I detour into a discussion about breastfeeding as a public health ideal from an intersectional perspective. In the conclusion I discuss the potential for framing ethnographic data using policy analysis.

This project developed from a long process of self-discovery within and outside of academia. During the summer before my data collection, I became a doula and perinatal educator. I was trained to offer informational, physical, and emotional support through the pregnancy and birthing process. Perinatal training includes a working knowledge of postpartum issues and breastfeeding related support.

My reflexive role as a doula places me in a position to be an advocate for breastfeeding although much of my analysis conflicts with my own ideals and beliefs. Unlike many other breastfeeding scholars, I am not a mother with personal experience on the subject. Some of the

conceptual themes presented in this paper may be familiar to an audience dedicated to years of feminist-health activism, or breastfeeding advocacy and research. This project is a commitment to the addition of an intersectional approach to breastfeeding in an effort to promote progress towards public health initiatives that better recognize the constraints placed upon women following the birth of a baby.

Framing Breastfeeding as Part of the Reproductive Body

The research presented here represents an extension of some of the conceptual themes in Emily Martin's *The Woman in the Body* (1987). Martin's text explores how reproduction is perceived by women in America, and how scientific forms of thought can become socially and culturally embedded. Breastfeeding, like menstruation, pregnancy, and menopause, are part of the female reproductive system and, therefore, is subject to the same social complexities. However, Emily Martin rarely mentions breastfeeding in *The Woman in the Body*. That might be because breastfeeding is often considered outside the medical domain of reproduction even though the physiology of lactation is inextricably linked to reproduction. Investigation into the complex social issues begins by wondering why that is the case.

The Woman in the Body became a landmark text because it exposed cultural structures through a thorough examination of the language that perpetuates some of the thoughts women have about their bodies. Using language and metaphor within the context of the reproductive body to expose some of the cultural ideologies of 'womanhood' was a significant aspect of Martin's argument that influenced this study. Themes in *The Woman in the Body* such as medicalization and the 'biological body', cultural transmission of ideologies, and embodied subjective experience are essential to the creation of this text.

It is necessary to understand how Martin engages with these themes for my purpose of framing breastfeeding as part of the reproductive body. First, Martin argues that the medicalization of bodily processes mean that women often experience stages where women feel separate from their body. The result is a cultural system of reproduction that is mostly scientific. The “biological body” then reflects the language of science with implications of top-down/hierarchal control of reproduction, the creation of new norms with the invention of reproductive technologies, and new standards of conformity to those norms.

Secondly, Martin concludes that American women often experience a fragmented body image in a dominant biological model of the woman’s reproductive body. Therefore, American women embody oppositions or contradictions between their bodily functions and social expectations. Birth, for example, is seen as an involuntary act, independent of the woman’s will. Martin notes that the imagery of woman as laborer in birth means that the doctor is either the ‘foreman’ or ‘fixer’ of a uterine ‘machine’. She argues that this separation of mind and body is connected to the separation women experience between domestic work and marketplace work. Hormones are thought to play a role of causing strain between a woman’s bodily functions that can be internalized as a malfunction of efficiency, work discipline, and a dysfunction of the expected harmony within a family relationship. The consequence is the transmission of a cultural ideals that women are unable to resist: their body is for implantation and that reproduction can be controlled for efficiency.

I explore breastfeeding through a similar lens in which the history of scientific research and subsequent medical rhetoric surrounding the biological body has established normative “choices” for infant feeding practices. Knowing that breastmilk production is a top-down (milk

'let-down') function of oxytocin from the pituitary gland, breastfeeding is also subject to a process of pathologizing when things do not happen as expected. The persistence of economic metaphors that Martin confronts in *The Woman in the Body* should extend to breastmilk 'production' as well. Martin's interpretation of the biological body as a site that is "dedication to implantation" extends to dedication to motherhood after the baby is born.

The framing of this study relies on the interpretation of motherhood. Women are likely, if not forced by cultural expectations, to feel guilty when unable to conform to the expectations of a maternal caregiver. Within the dominant context of a fragmented self and body image, a woman who either does not or cannot perform a biological function such as breastfeeding will have to find another ideology to support her.

This study departs from the argument Emily Martin makes about the medicalization of reproduction because breastfeeding is usually considered outside of the medical domain. Breastfeeding does not perfectly align with the control of an institution because it was learned elsewhere. Therefore, I focus on different pedagogies of breastfeeding rather than emphasizing the medicalization of breastmilk, although such medicalization is a consistent context for how infant feeding norms are justified.

In a final, notable contribution, Martin's empirical data analysis demonstrates the extent to which the language and metaphors of the female body are made conscious or experienced by women from different social categories. Expectations of work, the significance of childbearing, and conceptualization of time, discipline, and human capacity vary between women of different racial and socioeconomic experience. While this study does

not approach the scope of Martin's ethnographic data, her analysis of the cultural perceptions of women's bodies is significant to this paper.

Enough time has passed between the first edition of *The Woman in the Body* in 1987 to consider how the reproductive body has been affected by the categorical divisions. It was my intention to have more socio-economic and racial representation in my data collection, compared to Martin. The empirical data given represents the experiences of women who were self-selected. Despite my best efforts to reach a more heterogeneous group of women, those who were willing to participate ended up being closer to my age, social status, education level, and race. Regardless, in this project I have spent a great amount of effort reflecting on social categories and how they are represented within the political and economic climate of my fieldwork.

The Woman in the Body provides a model of reference for the power of language in the transmission of cultural ideologies. This paper departs from Martin's analysis by moving beyond the scientific cultural systems to examine a spectrum of authority. Doctors are not trained to teach women how to breastfeed; instead, women rely on their interpersonal relationships, other women with children, and the lactation consultant. However, access to these resources are dependent upon social categories.

American female homogeneity is not adequate when considering the social and cultural constraints on breastfeeding. Therefore, this project frames breastfeeding as part of the reproductive body – breastfeeding decisions under ambit of reproductive freedom. Though rarely considered as a matter of punishment or civil liberties, breastfeeding occupies the nexus

of advocacy, dominant feminist ideologies, issues of gender equality and racial equity, and a history of public health policy.

Anthropological Perspectives

Breastfeeding may not have been explicitly considered part of the reproductive body in Emily Martin's *The Woman in the Body* because of the variability in who and how infant feeding is controlled. Martin's argument is focused on the scientific control of women's bodies – the 'biological body'—and doctors, scientists, and politicians appear to have less direct control on how a woman decides to feed their infant. However, if we go back to "The Goddess Myth", we see that there is thriving discourse in America that associates what happens in birth to a mother's infant feeding practice. A recent article in Time Magazine (Howorth 2017, 38) claims that women now feel especially pressured to breastfeed despite the complications they face or the lack of support. As problematic as that sounds, more alarming is how the article suggests that breastfeeding is the focal part of a *trend* dominated by a *myth* being perpetuated by popular culture, social media, hospital and public policy, and science.

"The Goddess Myth" raises three core issues: (1) How is it that breastfeeding is portrayed in media as a cyclical infant feeding trend in a culture of options? (2) Why is breastfeeding situated as part of a 'naturalist' canon in conflict with an 'anti-shame' canon? and (3) Why is breastfeeding characterized as a risk for regret, shame, guilt, or anger? Therefore, it is necessary to locate infant feeding research within the current theoretical contributions to breastfeeding research that recognizes the historical and conceptual implications of breastfeeding in a bottle-feeding culture. Central to the argument presented in this ethnography is *how* and *why* a biologically inspired action becomes moralized.

The History of a Controversy: Medicalization of Breastmilk

One of the priorities of this paper is to discuss how the historical trajectory of the breast-bottle feeding controversy shapes the current social landscape of maternal decision making. Also known as the breast vs. bottle 'debate', it implies that women either breastfeed or bottle feed their infant, presumably with a breastmilk substitute like a commercial formula. Of course, the reality is that the variables informing a woman's infant feeding decision are not recognized when the outcome is portrayed as dichotomous. Nonetheless, there is value in unpacking the historical and theoretical foundation of the breast-bottle debate to better understand how the controversy has become part of a moral discourse.

The History of Infant Feeding

Prior to the domestication of plants, there is no debate about whether prehistoric women were breastfeeding because there were no other effective options (Fildes 1995, 101; Stuart Macadam 1995). If a woman could not produce milk, another lactating woman would step in as a surrogate or the baby would die. Traditionally, paleoanthropologists are more interested in questions that consider the frequency and length of breastfeeding practices in prehistoric times. The use of paleodietary techniques including a comparative analysis of isotopic signature of skeletal remains from pre- (5500-2000 B.C.) and post- (A.D. 1650-1700) horticultural American populations (Fogel et al. 1989) suggests that infants were receiving alternative food sources by 18 to 20 months regardless of subsistence patterns.

By 7000-4000 B.C., historical evidence in the archeological record suggests that not all paleo infants were breastfed (Fildes 1986). Feeding vessels with traces of casein, the protein found in milk, have been found buried with infants in both Greek and Roman cemeteries, but

with little evidence as to whether they were used to supply artificial feeding at birth or supplement with breastfeeding (Fides 1989; Rosenthal 1936; Stuart-Macadam 1995; Wickes 1953). Milk from other animals was the most common form of a supplement (Barness 1987; Stevens, Patrick, and Pickler 2009). By the fifteenth and sixteenth centuries, other forms of artificial feeding known as “dry-nursing” became in fashion, especially in Europe (Davidson 1953; Fildes 1995).

The most dramatic divide in infant feeding practices occurred during and immediately after the Industrial Revolution in Great Britain when women who moved to urban areas to work and were more likely to supplement, but traditional breastfeeding practices mostly remained in rural areas (Fildes 1995). The changes in infant feeding practices at this time are considered evident with the rise and fall of childhood morbidity and mortality (Stuart-Macadam 1995). Although confounding variables cannot be controlled in the historical record, the pattern of infant mortality is especially in agreement with cross-cultural empirical data that indicates that the prevalence and duration of breastfeeding reduces death within the infant’s first year of life (Halcrow et al. 2018; Kramer 2010; Lithell 1981, Stuart-Macadam 1995; Wickes 1953).

The Politics of the Breast-Bottle Controversy in America

The use of breastmilk substitutes such as animal milk and some version of “dry-feeding” continue to be alternative feeding methods in the United States but have never been subject to a controversy quite like commercial formula. There have been alternatives to breastfeeding for as long as we can know. However, Penny Van Esterik has already pointed out that “these historical detours,” are necessary to understanding the controversy:

“This is, however, the first time in history when infants lived through these experiments long enough for others to measure the impacts on their health. This is also the first time that huge industries have promoted certain options for women and profited from mothers’ decisions not to breastfeed or to supplement breast milk with a commercial product,” (Van Esterik 1995, 148).

In the nineteenth century, advancements to food preservation brought about the invention of evaporated milk and the first powdered infant formulas (Stevens, Patrick, and Pickler 2009 2009). The first formula was developed and marketed in 1865 by Justus von Liebig, the “father of organic chemistry,” who sought to create the perfect infant food made of cow’s milk, flour, and potassium bicarbonate (Radbill 1981). Several patented brands with rudimentary formulas followed including Nestlé’s Food®.

Formula feeding as an infant feeding practice at that time was less successful than in Europe until the early twentieth century when improvements were made to the quality of milk supplies such as rubber nipples, and milk storage with the kitchen icebox (Fomon 2001). Also, sanitation, care for dairy cattle, and milk handling —acknowledged as part of public health— were emphasized as scientific breakthroughs were being made in areas of bacteriology (Bryder 2009; Fomon 2001; Stevens, Patrick, and Pickler 2009 2009).

It is possible the advancements in science, technology, and public health awareness helped paved the way for a conflict of interests. Prior to the invention of infant formula, the first chemical analyses were conducted by a French doctor on human and animal’s milk and concluded that human milk was the best source of infant nutrition based on chemical composition (from *Treatise of Physical Upbringing of Children* by Jean Charles Des-Essartz 1760

in Stevens, Patrick, and Pickler 2009 2009). The results, after all, are what chemical scientists sought after in a comparable alternative. By the end of the 1930's, the manufacturing of infant formula was considered effective enough to become regulated by institutions of power like the Food and Drug Administration (FDA) (Fomon 2001).

By 1930, a peculiar relationship between the medical establishment and the formula industry had developed. First, the American Medical Association (AMA) formed the Committee on Foods to approve the safety and quality of formula composition, giving them the power to accept or reject a brand of formula. Then, the AMA further imposed regulations on the infant formula manufacturers regarding the direct solicitation of information to no one outside of the medical profession (Stevens, Patrick, and Pickler 2009 2009). Overall, the marketing capacity of the formula companies was a perfect match for the medical establishment determined to have control on infant feeding (Van Esterik 1995).

A glimpse into the scientific research on infant feeding during the twentieth midcentury reveals how it has become medicalized. The state of breastfeeding research by the 1950s was characterized by incoherent data from animal studies and irrelevant research about minor differences in chemical composition between formula and breastmilk (Martucci 2015). Despite epidemiological data that clearly showed a contrast between breastfed and artificially fed infant morbidity and mortality rates (Grulee et al. 1934), the medical field relied more heavily upon the improving safety, convenience, and manageability of formula feeding. In general, physicians lacked knowledge about the physiology of lactation and the idea of a holistic body falls outside their scientific epistemology (Martucci 2015). The midcentury ideology of scientific motherhood failed to integrate breastfeeding into their practices at a time when many women

were more likely to accept medical technologies more generally (Martucci 2015). By the 1970s, only about 25% of American infants were breastfed (Fomon 2001; Van Esterik 1995).

Before there was the breast-bottle controversy, it was just the infant formula controversy. In the early 1970s, International publications such as the Third World Action Group's report titled *Nestlé Kills Babies* brought public awareness to the aggressive marketing practices by the infant formula companies in developing countries (Van Esterik 1989; 1995). In North America, advocacy groups such as the Interfaith Center for Corporate Responsibility (ICCR) and the Infant Formula Action Coalition (INFACT) revealed the infant formula controversy to American consumers through campaigns, demonstrations, and a very successful consumer boycott. By the time the boycott ended as a result of the advocacy, breastfeeding reached rates of 90% (Stevens, Patrick, and Pickler 2009 2009).

In response, the formula industry started advertising directly to the consumer, severing their relationship with the medical system. In 1990, the Academy of Pediatrics (AAP) released a statement that expressed opposition to such direct marketing because it caused confusion about infant nutrition (Stevens, Patrick, and Pickler 2009 2009). Since then, scientific research on breastfeeding has increased. Both the United States Department of Agriculture (USDA) and the World Health Organization (WHO) run promotional campaigns in favor of breastfeeding, and breastfeeding advocacy is ubiquitous. Regardless, the formula industry still has a thriving direct market to the American consumer and American physicians still provide formula as a resourceful "option" for when breastfeeding is not successful.

The Medicalization of Breastfeeding

The breast-bottle controversy has been well-analyzed (Cassidy 2015; Tomori 2015; Van Esterik 1989). Within the context of WEIRD (Western, Educated, Industrial, Rich, Democratic) America, infant feeding traditions appear to be more like a cyclical argument, analogous to American politics, rather than a dynamic movement. The breast-bottle controversy is still alive, especially in American media. Breastfeeding is seen as part of a universal persuasion—what doctors and fellow mothers *used* to do with formula.

Penny Van Esterik (1989) explains that the “shift” in infant feeding patterns that underlie the controversy over infant formula relies on the interpretation of infant feeding. In her earlier work, Penny Van Esterik argues for the distinct interpretation between a *process* model of breast feeding and *product* orientation of breastmilk. A product interpretation of infant feeding is compatible with the medicalization of infant feeding and the marketing of formula substitutes (Van Esterik 1989, 5). Breastmilk, even when considered the choice source of infant nutrition, is then interpreted as a product commodity.

Van Esterik describes the process orientation as, “the continuity between pregnancy, birth, and the process of lactation,” (Van Esterik 1989, 5). Lactation requires thinking about the milk as a source of sustenance beyond commodification.

Thirty years later, this dichotomy of interpretation is still used to support breastfeeding research in anthropology. The language of process, for example, is consistent with a model of breastfeeding as part of the reproductive body. To elaborate, breastfeeding as a process considers the circumstances in the action of feeding an infant: events that may require intuition or the development of skill. “Process language is better at capturing the embodied nature of

nurturing experiences like breastfeeding; the complex symbiotic relation between mother and infant has communication and co-regulation functions that extend far beyond nutrition,” (Van Esterik 2015).

Breastfeeding as ‘Natural’ and Emergent Maternal Identities

In her forward for *Ethnographies of Breastfeeding: Cultural Contexts and Confrontations* (2015) Van Esterik reviews the product and process model as a mesh rather than separate. Breastfeeding is not simply biological, nor social. This distinction is significant as breastfeeding scholars must confront how their rhetoric will be taken up by the media to promote or challenge the appearance of a burgeoning breastfeeding culture.

Breastfeeding scholars who are especially vocal in their advocacy for breastfeeding contribute to a discourse, the naturalist discourse, in the construction of a maternal identity based on the ideology of ‘natural motherhood’. The naturalist discourse is based on a model of motherhood in which natural instincts guides maternal behavior (Martucci 2015, 28). The ideology of ‘natural motherhood’ developed as an alternative to what was the prevailing ideological model of ‘scientific motherhood’.

Charlotte Faircloth discusses natural motherhood within the context of her argument for an anthropology of parenting—a form of ‘identity work’ —outside of traditional forms of kinship studies (2009; 2013). ‘Attachment’ mothers who subscribe to a philosophy of intensive parenting use the rhetoric of natural discourse as an accountability strategy for their non-conventional practice of breastfeeding on cue until the child outgrows the need and long-term co-sleeping: “The ‘natural’ to which women refer is multiple and elastic: known internally through ‘gut feelings’, revealed through ‘scientific findings’ and validated by the ‘evolutionary’

narratives [...],” (Faircloth 2013, 120). Faircloth concludes that accountability strategies are part of the narrative process of self-making through parenting practices.

Breastfeeding women are also even more likely to engage with identity work when living in cultures that have a low industry of parenting. In France, for example, where there is a salient distinction between motherhood and womanhood. Breastfeeding past the recommended amount of time can be considered a form of personal enslavement (Faircloth 2015). For French women, going back to work early is the norm and there is less anxiety over decisions about infant feeding. This reflects an ingrained attitude of humans as natural rather than the ‘need to get back to nature’ philosophy essential to the ‘back to breast’ movement (Faircloth 2015).

Faircloth and other social scientists who explore narratives of moral work (Ryan, Bissell, and Alexander 2010), as well as morally emergent identities (Marshall, Godfrey, and Renfrew 2007) have written about a local moral world of breastfeeding. These authors make it apparent that many women must negotiate between multiple and diverse concepts of ‘good mothering’. Moral work is when a woman adjusts to the differences between her mothering expectations and her mothering experience. The possibility of adaptation to change is a dominant theme in this literature regardless of the social, emotional, and practical contextual factors that inform their biographical identity as a mother.

Most of the authors I have discussed so far conducted their research in a European context. They demonstrate how narratives about breastfeeding are part of a dynamic relationship between moral integrity and a self-conceptualization. For this project, I examine these ideas in a Midwestern, urban American setting to consider how middle-class women

characterize breastmilk as a part of their identity as a mother. Specifically, I want to question the role of these ideas in the dissemination of culture and the symbolic value of breastmilk. What is in breastmilk that makes it favorable or replaceable? How do they know or learn this information?

Breastfeeding as a Choice

I am interested in how issues underlying the infant formula controversy, otherwise known as the 'breast-bottle controversy,' are still relevant in America. Historically, it was a controversy about the unethical marketing and sales of infant formula in developing countries which "ended" in 1984 with the lifting of the boycott against Nestlé (Van Esterik 1989). The survival of the controversy proceeds from the medicalization and commodification of breastmilk as a product when the process is an embodied commitment (Van Esterik 1989).

Cecilia Van Hollen's (2011) study on the breast or bottle debate is set in India where HIV-positive women are facing localized global health initiatives that are in opposition to the high cultural value of breastfeeding. Adding to the complexity of the issue, women must also negotiate mixed messaging between global and national advocacy for the nutritional benefits of breastmilk and HIV/AIDS (or any form of perceived milk 'contamination') prevention campaigns (Van Hollen 2011, 514). Van Hollen demonstrates the complexity of micro and macro politics that influence a transformative logic for how women make decisions regarding infant feeding practices. It is the mother who must take on the morally loaded responsibility of making infant feeding decisions based on personal and communal sociocultural values, economic realities, class identities, and top-down messaging from the Western biomedical community.

The overarching idea of the role of motherhood regarding ‘choice’ in infant feeding is problematic. ‘Mother’ and ‘woman’ are not mutually exclusive, but nor are they synonymous. One of the biggest critiques of modern ‘good motherhood’ is that it focuses on sociobiological fictions about parenting to the point where women undermine their own status (Badinter 2013). Furthermore, increasing pressure to follow idealized practices generates a subculture of judgement for and guilt among those who cannot: “Can we speak of the choice to breast-feed? The cultural imperative to breast-feed is so strong that it admits of no alternative,” (Balsamo, De Mari, Maher, and Serini 1992, 37).

When we take into account gender roles as a whole, reproduction and child-rearing are conditioned by cultural priorities (Maher 1992, 165). We can connect the breast-bottle controversy to present, liberal motherhood by examining how marketing, biomedicine, politics, economy, and gendered capitalist ideologies have transformed the rhetoric surrounding what it means to be a ‘good’ mother. Natural discourses are evidence of larger moral arguments about nature and the symbolic properties of breastmilk (purity vs. tainted, adaptive vs. inert, singular vs. standardized, and ‘symbiotic’ vs. ‘mechanical’) (Debusquet and Adt 2015). By examining what is ‘natural’ versus what is ‘artificial’ in competing discourses about fertility and breastfeeding, anthropology can reveal how the rhetorical structure of ‘choice’ is politicized (Hausman 2003).

Methods

My formal research and data collection takes place in a Midwestern city in the Great Lakes region on the coast of Lake Michigan. For this study, I chose to focus my ethnographic work on new moms who meet on a regular weekly basis without formal registration or financial

commitment to participate. It was important to me to seek out groups located at different areas within the city limits. I gained access to the new mom groups as a trained perinatal educator. By participating in a birthing network, I was able to provide additional support to the groups when needed.

Participant observation was conducted at two different sites where new moms meet with a facilitator for weekly, semi-structured gatherings. At both locations, the facilitator was certified as either a lactation consultant, perinatal educator, or both. Observation at the two sites took place over a three-month period. I began interviewing women during the last month of ethnographic data collection. Interviews continued for an additional month after participant observation was finished.

New Parenting Network (NPN) – This group had a designated location in a hospital on the North Shore within the city. NPN consists of three different subgroups depending on developmental age of the baby. The subgroup I observed was with mothers who had most recently given birth. When the infants begin walking, they are moved to the toddler subgroup which meets at the same time and within the same space located on the other side of the large room. Another subgroup of older toddlers, at or near the age of two, meets earlier in the morning on the same day. The large space is located on the main floor of the hospital. There is a large, visible sign and a waiting area outside of the room. The space is also used for childbirth and breastfeeding education classes.

The infant group consists of anywhere between fifteen to thirty-five mother/infant pairs, depending on the week. When the moms arrive, they sign in and receive a nametag. New members receive information about how to join a closed NPN group

on Facebook so that the other members of the group, and facilitator, are available to them outside of the meeting time. Many of the new members knew of the group because of information given to them when they gave birth at the hospital where the group is located. Other women come by word-of-mouth.

The cohort of new moms varied slightly in ages, ethnicities, and number of children. The dominant demographic at NPN were white, middle-class, first time mothers. I also want to note that occasionally a father or grandmother would attend NPN to accompany the new mom or take her place if she had gone back to work. There was a lot of diversity in the ages ranging from early twenties to mid-forties.

Most women did not know each other until they joined the group. The toddlers' mothers on the other side of the room were more familiar with each other because they had attended the group longer. It was not uncommon for a woman who previously came to the newborn group and moved to the toddler group with one baby, to go back to the newborn group after the birth of another child. In this instance, a woman spent most of her time with other women whose babies were the same age as her youngest.

Despite the noise and chaos of the toddler group in the room, the setting was structured by the clinical climate of the hospital. Huge mats covered the floor in the area where the NPN infants group met and toys cluttered the toddler area. In the back of the room is a station that functions like a small kitchen, a baby weighing scale, and several rocking chairs.

Upon arrival and signing in, the women would position themselves sitting on the floor in an in-ward facing circle with their infant placed on the floor space in front of them unless the baby was sleeping in a car seat. The formal group interactions begin about ten minutes after

the publicized start time when the lactation consultant asserts attention from the new moms. The women go around the circle and introduce themselves and their infants to the others. Next, the facilitating lactation consultant would make an announcement or talk about a scheduled topic. Sometimes a guest speaker would talk about a subject of specific concern for new mothers. After the beginning formalities, the lactation consultant would field specific questions for newer members while those who did not have questions would socialize with each other.

Unless she was sick or had an emergency requiring her to be somewhere else, there was only one facilitating lactation consultant who was present every week. Her attention to the problems of all the women, but especially the newest moms, was crucial to the success of the group. She was my gatekeeper to informants and a valuable source of support for many women who were meeting for the *New Parents Network*. In my time spent observing the new moms at NPN, the group got to be so large an additional perinatal educator was hired to assist the lactation consultant full time.

These meetings were structured but not formal enough to have an agenda for the full two hours of their duration. The NPN was part of a larger perinatal education program meant to provide support for mothers who gave birth at the location's hospital. The meetings were free, but the lactation consultant frequently requested a donation to be made for the continuation of a non-membership program. The routinization of the meetings and the consistency of the facilitator was suggestive of the institutional setting of the hospital.

New Parenting Circle (NPC) – In contrast to the hospital setting of NPN, the New Parenting Circle is located at a birth and learning center on the South Shore within the city. This group

consists of just one group of women with babies aged anywhere between two weeks to fourteen weeks. The space is not dedicated to the group, but also hosts groups such as La Leche League, City Babywearers, the Holistic Moms Network, and a cesarean support group for monthly meetings. The space is also used to teach prenatal yoga, childbirth education classes, hold doula training, and as the site of a midwifery school once a month.

NPC consists of anywhere between three to ten mothers and baby pairs. In contrast to NPN, there is no formal sign in nor a Facebook group. All the new moms were first time moms. The dominant demographic at NPC are white, middle-class mothers in their 30's. Some knew each other before joining and were there because they met during a yoga or prenatal class, and some were friends who had babies around the same time. There was no formal distribution of information about the meetings besides a spot on the birthing center's monthly meeting and events calendar. Although the location is a birthing center, most of the new moms had their baby in a hospital.

The setting was very casual and oftentimes the birthing center would provide refreshments and snacks. Although there was a scheduled meeting time, new moms would arrive throughout the first hour of the two-hour gathering. The room consisted of a circle of chairs for the women and "bobby" pillows on the floor. Bobby pillows can also be found at the NPN serving the purpose as a nursing support pillow. At the NPC they have a dual purpose to support the moms who nurse and to prop up the babies who can sit up with some support.

In contrast to the NPN's hospital setting, the birthing center was much more like a home ready to receive guests where the NPC took place in the main gathering room. The new moms introduced themselves and their infants to the others when they arrived. A late arrival halted

conversation long enough for the new mom to be greeted by the group. One of the most obvious differences between NPN and NPC is that there was a rotation of lactation consultants who facilitated the NPC group once a month. It was unusual for there to be a formal beginning to the meeting. The lactation consultant began by offering a variety of information depending on what the moms wanted to discuss. I had no formal gatekeeper to this group; on a couple of occasions, I was asked to step in as a facilitator when a lactation consultant was unavailable that week.

The informal setting allowed for the moms to have more control over the meeting although the lack of structure also meant that women were less likely to talk about concerns regarding the baby. The women seemed to float from topic to topic more often and the experience was overall more social. This made it more difficult to collect data. Furthermore, the rotation of different lactation consultants was unique to NPC as was the makeup of participants from week to week.

The location for these two groups is meaningful for this study. Their locations—one in a hospital, the other in a birthing center—immediately sets the tone of what mothering philosophies were most likely to be prescribed. A hospital and a birthing center are very different structural spaces. These differences warrant diverging mothering philosophies and, therefore, distinct objectives to their educational program.

Because I was also facilitating the NPC group, my role as a researcher was more participatory there. I also attended meetings of other groups at the birthing center to gain insight into how a philosophy develops in this space. I also did some supplemental fieldwork with the South Shore chapter of the Le Leche League (LLL). I began attending LLL meetings

because some of the women at NPC were members, and the lactation consultants who facilitated the NPC were suggesting literature to the group that was endorsed by the LLL. Some of the women I observed at the South Shore meetings also go to other LLL meetings in the city, depending on how much support they need or their level of breastfeeding advocacy.

I attended one meeting of the local Babywearers group upon recommendation by a woman who worked at the birthing center. Babywearing refers to the act of carrying a child at any age with the support of a sling or wrap as opposed to using a stroller to push a child around. Babywearing is thought to support breastfeeding because it allows for closer contact between the mother and baby. The City Babywearers (BW) are a group that specifically advocates for babywearing but within the same philosophy as the LLL who advocate for breastfeeding on demand. The City Babywears is the most popular postpartum group in the city. BW experts go from location to location across the city to do babywearing demonstrations, offer instructional support, and provide sample slings and wraps for women to try on.

In addition to my supplemental participant observation with the LLL and BW, I also participated in the events of two local breastfeeding advocacy groups within the city. I attended a planning meeting and breastfeeding week event with the County Breastfeeding Coalition as well as a breastfeeding week event with the African American Breastfeeding Network. It was my initial intention to spend more time observing these groups, but they did not meet often enough. Also, I wanted my data collection to be centered on new mom infant feeding experiences. I learned very quickly that breastfeeding advocacy has no age, no race, no specific reproductive capacity, or gender.

However, diversity of race and income are, admittedly, not adequately represented in this paper. My original intention was to include a wide range of women, but was unable to gain access to certain groups. I especially wanted to represent more women who did not breastfeed. I passed my information along to health and WIC centers across the city, I contacted other new mom's groups, and reached out to doulas working specifically within low income neighborhoods. In the short and limited scope of my data collection time, I was unable to hear from women with a different perspective. I consider this the biggest limitation in the study and inspiration for Chapter 4.

Given the context and socially tense climate during the time of my fieldwork, it was especially difficult finding participation within the African American community which represents 40% of the total population. This Midwestern city has a history of segregation, systemic gun violence, and tension with the police. In the summer of 2016, a young, black police officer shot and killed another young, black man who fled with a stolen gun. This particular incident incited three days of rioting in the neighborhood. To actively pursue was not appropriate action during that time and would have required a longer duration of relationship building.

I began recruiting women to interview during my time doing fieldwork. In the end, my interview data consisted of six, two-hour, semi-structured interviews: three are new moms I met at NPN and the other three are from NPC. They all identified as female between the ages of 27-40 with babies from six-43 weeks old at the time of the interview. *Table 1* includes detailed information about each one.

They represent first time *biological* moms who were eager to share their breastfeeding experience with me. Each one expressed an intention to breastfeed. And at the time of our interview, all were feeding their babies at least some breastmilk. Half of the women were either going back to work or working half time, the other half spent most of their time caring for their baby. Economically, they would be described as American middle-class.

As an anthropologist, breastfeeding was an obvious topic of choice for me because it connects evolutionary biology, reproductive physiology, and human development to an ambiguous location within American culture. On the one hand, it is celebrated as the biological way to nourish a child while promoting a better physical and emotional bond between mother and child. However, there are issues: biological complexities, necessary social support, access to maternal leave, mixed messages within the medical establishment and social media, the marketing of formula, fetishization of the female breasts, stigma associated with breastfeeding in public, and others beyond the scope of this paper. There is a sort of renaissance currently taking place in the literature with many people from different disciplines breaking down the intricacies of these issues. My construction is an ethnographic sketch of how breastfeeding represents an extension of cultural ideals, decision making processes, and systemic moral consequences.

Table 1: Detailed Information about Women Interviewed

ID	Age	Ethnic group	First baby age	Source of milk at time of interview	Details of feeding practice	Occupation	Relevant contextual details including living location
1.1 Valerie Jackson	27	Native American, White	Yes, 34 weeks	Breast	Exclusive, at beginning stages of baby-led-weaning.	Housewife, trained in infant massage	Suburban. Was adopted by her parents when she was 6 weeks old. Remains in contact with her biological mother.
1.2 Elizabeth Lawlor	34	White	Yes, 24 weeks	Breast and formula	Exclusively giving them pumped milk, began supplementing with formula at 9.5 weeks, giving solids in addition to milk.	Housewife	Suburban. Had In Vitro fertilization and gave birth to twins (one male, one female).
1.3 Maria Runyon	36	Hispanic	Yes, 43 weeks	Breast	Exclusively on demand, at beginning stages of baby-led-weaning.	Housewife	Suburban. Moved to Midwest from Miami when baby was 24 months; has previous parenting experience with foster children.
2.1 Melissa Groff	32	White	Yes, 27 weeks	Breast	Exclusive, unable to give breastmilk baby's first 3.5 days.	Social work, Spanish interpreter	Urban. Got pregnant after a period of reproductive difficulties; baby born with shoulder dystocia and almost died after birth.
2.2 Shelly Johnson	40	Hispanic, Serbian	Yes, 12 weeks	Breast and formula	Breastfeeds and pumps but always follows with supplemental formula.	Receptionist	Urban. Single parent; hospital staff introduced first formula, receives formula now through WIC; going back to work at 14 weeks which was extended from 12 because she needed more time.
2.3 Theresa Ward	36	White	Yes, 6 weeks	Breast	Exclusive. Pumping so that others can do breastmilk bottle feedings.	Lawyer	Urban. Demanding career as a partner at her law firm; planning to go back to work at 12 weeks.

Parenting Strategies and Maternal Identity Work

“I really think that it [breastmilk] is the best source of nutrition for a baby and if you don’t want to do it for whatever reason that is your choice and I’m totally fine with that,” (Valerie Jackson, 27, mixed-race housewife and part-time massage therapist).

“I remember that one of the benefits is that [breastfed] kids get sick less often. It was great for their immune system, besides the nutrition. So that was important,” (Shelly Johnson, 40, mixed-race single parent and receptionist).

“I know that if I had low supply, I would have fought hard to figure that out before [using] formula. I think that nothing created like that [formula] could ever match the amazingness of breastmilk in terms of nutrition and how breastmilk adapts to the baby’s needs,” (Melissa Groff, 32, white social worker).

“I thought breast milk would be better because it’s the natural progression of life. It’s for mammals; that’s what mammals do,” (Theresa Ward, 36, white lawyer).

“I thought it [breastfeeding] was the only option. I had the first [foster] kids and I was giving them formula...but it was because their mom wasn’t there. I never even knew that a woman can decide not to. I respect the ones that do [give formula], but for me it was like it’s there, why not? And it’s the best for her—everything I do is going to be the best thing for her.” (Maria Runyon, Columbia-born housewife).

This objective of this chapter is to demonstrate how breastfeeding moms navigate through a bottle-feeding culture. How do women respond to discourses that emphasize breastfeeding as the healthiest, natural, and obligatory form of nutrition? The language breastfeeding women use to talk about infant feeding reveals how they perceive the symbolic value of breastmilk.

Mothers must negotiate between the biological demands of breastfeeding and their parenting ideals. Often, new moms will discover and develop parenting strategies based on a cultural code that values breastmilk as a product. The practice of breastfeeding is learned

through various pedagogical sources. However, the practical problems women encounter in the process of learning *what is*, often acquire moral implications of *what ought to be*.

New moms must come up with a strategy based on what they need to get by during the first year of a newborn's life. Different women subscribe to different parenting philosophies depending on their parenting ideals about what moms provide for infants in relation to nutrition. However, their infant feeding practice can often create personal tension through self and socially constructed expectations. How mothers manage this internal crisis results in a new, embodied identity.

When the biological processes of motherhood present themselves, finding a strategy becomes a dominant part of that process. Everything else seems to fall into place depending on how a woman identifies with her newfound role as the provider of nutrition. Recognizing that the struggles of motherhood and infant feeding are varied, this chapter illustrates how new mothers will re-evaluate their moral expectations based on the practical problems they encounter.

The Need for a Strategy

The ethnographic data of this study reflects the need for some women to seek breastfeeding support in the first few months after giving birth. Though not all mothers who attend the meetings such as those provided by NPN and NPC are first time new moms, the primary focus of new mom groups consisted of giving them support through the dissemination of information about how to "survive the newborn".

A typical meeting at the NPN begins with introductions while the group sits in a circle: Newborns are on one side of the room while the crawling and walking toddlers play on the other side. The room is very loud with this arrangement, so the lactation consultant must ask

for attention to facilitate the beginning of introductions. As the sixteen moms begin to go around the circle and introduce themselves and their baby, some late new moms arrive and join in. To sign in and be present is to be included in the group. All women are asked to wear a name tag that includes both their name and the name of their baby. They are also instructed to say how old their baby is. Today the ages range between 10 days to 7 months.

The lactation consultant tells me that most of the women who come to the meeting can breastfeed, even if they don't, and are here mostly to ask questions. She explains to them the importance of tummy time for motor development, shows them variations of how to hold a baby for breastfeeding, and provides them with tips, remedies, and books on breastfeeding and sleeping. For example, today the lactation consultant gives a woman some mother's milk tea. There is no fee for joining the NPN though donations are encouraged. The lactation consultant stresses that donations are the only way the group will survive without a required fee.

The tone at NPN reflects the nature of the institutional setting of a hospital: busy, structured, resource rich, and conducted by a certified professional. The lactation consultant provides support for the various needs of the members of the group. She is, in this case, the first in a line of authoritative contacts the new moms will have for the development of a feeding strategy. The NPN is part of a larger perinatal education program and the lactation consultant is one of a few that offers support for women who especially need help with breastfeeding during the first few days of postpartum. Most women are encouraged to seek breastfeeding counsel with her when they give birth at the hospital.

In contrast, the mood at NPC reflects one of a smaller, collective, more informal introductions to newborn care:

This session starts with the group assembling on the floor with rugs and pillows in a room designated for prenatal yoga, birthing classes, as well as the Babywearers, Le Leche League, and New Parenting Circle cycle of gatherings. There is no one person to facilitate again this week. Some babies are on their tummy and one does not like it. According to one participant in the group, infants do not like "tummy time" at first.

A new mom arrives to join the group for the first time with a three-week-year-old and another woman says, "I applaud you for being here." The newcomer has come because her concern right now is the trouble she is having with burping. Her baby has been crying a lot and she does

not understand what is wrong except that her baby has not been easily passing gas after feedings. Someone recommends Mylicon gas drops and explains how they bind to the gas molecules to break them up. The discussion prompts another mom to talk about how she discovered that her baby was intolerant of some foods. She shares her experience with finding out that genetic intolerances usually develop between six and nine months. All agree that a baby will generally show signs of “unhappiness” when unable to pass gas or if constipated. The newcomer remarks that it is nice to have alternatives out there when a change is necessary to make a difference.

In the context of a birth center setting where there is no single facilitator, the conversation tends to flow into information seeking based on age of the baby and experience of the mother. The themes that emerge in these discourses range from developmental milestones and infant health, prenatal and birth experiences, stories about going out in public with a newborn, and inherent issues or pressure they experience regarding infant feeding and sleeping. Some of the women do appear to come for peer advice on topics covered at the NPN by a lactation consultant. In this smaller group setting, the women interact with more familiarity. Some are here based on the recommendation of a friend.

A lactation consultant comes to join the meetings at the NPC twice a month to provide a more informational setting. It is not always the same lactation consultant, and depending on the individual providing the support, the discussion of strategies can vary from formal instruction on the six month “ideal” breastfeeding trajectory to the more informal setting of passing around dark chocolates to stimulate the release of oxytocin. In this setting, the presence of a lactation consultant is there to step in where institutional authority is lacking. For example, one lactation consultant tells the group that, “People do it (breastfeed), but most don’t know how to do it. You can never have enough breastfeeding support. You should address your questions to your doctor, but no one does.”

Scientific rhetoric— “research discourse”—influenced the cultural code of breastfeeding that values breastmilk as a product (Van Esterik 1989). Obstetricians and pediatricians are more likely to highlight the benefits of breastmilk because of compelling evidence-based research and statistical studies that suggest breastmilk is the superior form of infant nutrition. Bernice Hausman outlines the three general principles that champion the scientific case for breastfeeding: (1) the species specificity of human breastmilk, (2) individual and unique immunological properties that pass from mother to infant, and (3) the social relationship that develops between mother and infant through breastfeeding (2003, 16).

The current recommendation from the American Academy of Pediatrics and the World Health Organization is to feed human breastmilk exclusively for the first six months postpartum and continue breastfeeding for twelve months as supplemental foods are added into the diet (US Department of Health and Human Services 2017). However, it is observed within academic discourse, medical authority, public policy, and personal experience that most American women do not follow this recommendation and will supplement with formula at some point. In 2015, 85% of American women were breastfeeding immediately after birth, 58% were breastfeeding at six months postpartum, and only 38% were still breastfeeding at twelve months after giving birth (Oliveira, Prell and Cheng 2019). Therefore, American infant feeding is collectively referred to as a bottle-feeding culture.

To consider breast milk only as a source of nutrition and immunity suggests a product-oriented discourse aligning with a market model where human milk is in competition with formula and other milk substitutes. More recently, there has been considerable push by some medical experts and breastfeeding advocates against the product-oriented narrative about

breastmilk and breastfeeding. They agree about the superiority of the product; however, their message is that breastfeeding is already the normal way to feed an infant and the language used should reflect this fact. Health care providers, childbirth educators, and others often talk about the 'advantages' of breastfeeding. But to describe the differences between breastfeeding and artificial feeding this way includes the underlying assumption that artificial feeding is what is normal and acceptable, even though there may be some 'fringe benefits' to breastfeeding (Newman and Pitman 2003).

In contrast, a process model of breastfeeding takes into consideration the continuity between pregnancy, birth, and lactation (Van Esterik 1989). The biological and cultural complexities inherent in human milk extend to a process-oriented model of breastfeeding. Instead of comparing breast milk to formula substitutes, the action of breastfeeding is inseparable from the benefits of the product.

Discrepancies in the research discourse have been highlighted by counter-research claiming that the authoritative, medicalization of infant feeding induces a 'risk culture' of parenting (Wolf 2010). The risk of not parenting the way science deems best overlaps with moralizing attitudes about infant feeding. Subsequent media attention on opposing opinions in breastfeeding discourse is considered dangerous to the overall message of the benefits of breastfeeding (Van Esterik 2015). There were inherent moral perceptions women have about infant feeding in my own research, but the stimulating aspect of this anthropological study is in the way that women make a meaningful construction of the problematic, research-oriented discourse with their own observations and experiences.

What was it about breastfeeding that made you decide to do it?

“I don't have a problem with the people that formula feed or people doing it [action of bottle feeding], it's just not something that I wanted to do. There's no recall on breastmilk, but there will be recalls on formula. I don't know all the chemicals in it [formula] and it smells awful so I'm sure it tastes bad. If you do formula you have to wash and sterilize bottles all the time. You always have to make sure you are mixing things and keeping it with you wherever you go. There's more to it in a way. Also, I think breast milk has so many advantages that formula doesn't have, like he [her son] got a cold before and so my body customizes to whatever he needs and I was even told that when he was so congested, your body knows to thin down your milk so it's easier for them to drink. I was still pumping at that time and it was a completely different color and consistency. Your milk changes to whatever your baby needs at that exact feeding and no formula can do that,” (Valerie 1.1).

“I haven't noticed any strong difference between formula and breastmilk fed children. I know there's medical research and anecdotal things out there, but I don't see it in my own family members. I research everything. For as much work as breastfeeding is, it would have been more work to supplement because I would have had to find the right supplement. I would have to get the right bottles ready and figure out how to do them right. Breastfeeding was kind of like, 'You seem hungry, here's a boob.' As much work as it has been, and as hard as it has been, I thought that formula feeding would have been more difficult,” (Theresa 2.3).

In a bottle-feeding culture, women talk about the value of breastmilk's nutrition and antibody properties by comparing breastfeeding to formula feeding. Many women in the new mom groups make an effort to resist a judgmental attitude towards those who formula feed. Some women recognize the medicinal potential of breastmilk as a substance that adapts to their baby's needs. Breastfeeding is also a source of security; it is a “go to” if the baby is upset. Having the option to nurse is, as shown here, an accessible resource that provides comfort for the baby, and convenience for the mother. As an alternative to the uncertainty about what and how a supplemental product should be used, breastfeeding is the biological substitute in a world of options.

Moral attitudes in infant feeding discourses reflect the experience of first-time biological mothers and their desire to 'give what is best' to their baby. The breastfeeding process is

instrumental to their maternal education and what will ultimately define their parenting philosophy. There is a common emphasis is on the biological assertion of 'My body, my breastmilk comes from *me*'. A moral dilemma arises when women must negotiate between their desire to satisfy the expectations they set for their biological selves, and the realities of that demand.

For this social milieu, it is possible to assert that the breastfeeding process is the ideal form of infant feeding, though not necessarily what is most practical for the mother. Formula is an option when the biological demand is no longer sustainable.

"We had to supplement [with formula] early. They were getting as much breastmilk as I could produce, and I was happy about that. My body was nourishing two other people. I was damn impressed with that fact and not upset about needing to give them a little bit more because at the end of the day, I wanted them to be healthy more than I needed to be fulfilled because every single piece of their nutrition came from me. Formula is fine. It's absolutely fine, and they were still getting 80% breastmilk throughout that process. I think it might have been a more emotional transition for me if we had to go exclusively with formula," (Elizabeth 1.2).

Prominent in this study the ability to articulate an emotional connection to breastfeeding as a biological process they could provide. This teeters into a more complicated moral landscape where breastfeeding is romanticized as something that implies a simple solution to infant nutrition and compliance to a gendered role (Martucci 2015, 157). The development of a strategy, therefore, is necessary when the biological and ideological construct of breastfeeding as *natural* contrasts with the experience.

Interestingly, women avoid explicitly saying that breastfeeding is natural, although half of the women interviewed for this study said that breastfeeding came natural to *them*. Women who engage with moral attitudes about human milk, do so through a cautious position about the process of breastfeeding. The language used reflects their own experience with the realities

of breastfeeding. This is also true for the women I encountered at the new mom groups who must negotiate preconceived perceptions about breastfeeding prior to giving birth, the biological demand of providing infant nutrition, and the social expectations to breastfeed provided by the group.

First time biological mothers are, perhaps, more susceptible to the moral social discourses because they are more objective, but less experienced. The development of a strategy arises from one's ability to adapt to the unpredictable biological changes of motherhood. A new mother navigates on a continuum of perception where on one end of the spectrum is that breastfeeding is the most natural way to feed her infant and the other end where 'ownership' of her infant feeding decision is based completely on pragmatic realities.

Pedagogies of Breastfeeding and the Development of a Strategy

Tanya is a first-time mom at New Parenting Network who supplements her occasional breastfeeding with Enfamil formula:

Tanya considers breastfeeding a real good thing for the baby: it prevents allergies. It is also good for her too. She is 44 years old and everyone else she knows is her age or older. Her husband's sister gave her tips on how to breastfeed, but made it sound so easy. What she *did* know (in advance) about breastfeeding she learned from classes taken at The Women's Center. That's where she learned about colostrum and how to prevent SIDS (Sudden Infant Death Syndrome). She also attended a breastfeeding class at WIC (the Women, Infants, and Children Nutrition Program). They said that breastfeeding babies are happier which led her to learn more about the Mother Friendly Childbirth Initiative's 'Smart Babies University' counsel on breastfeeding. She is starting to change her diet, knowing he eats what she eats. She wishes she was more prepared for the complications, however, originally thinking that it is "all natural." In her child development class, she was told breastfeeding was best for the baby, but she doesn't know how people did it before bottles. In the end, her breastfeeding problems caused her guilt—"I felt like it was all me."

Like Tanya, many women move beyond the simplicity of breastmilk as a preferred option over formula towards a comprehensive practice that is beneficial for both the mother

and the baby. Whether they decide to breastfeed or not, most women do recognize that breastmilk is biologically better for a baby's development. However, the process involves the biology of the mother as well. Her time and energy are in demand to make it possible. In this example, Tanya's diet—and her body— is subject to making the practice of breastfeeding work. For new moms, the process of learning how to breastfeed is inseparable from the process of negotiating how to accept biological demands on their body.

Most mothers do not consider breastfeeding *natural* for them unless it has become easier for them. To get to that place, they must develop strategies that make it possible to overcome potential obstacles in the first few months related to breastfeeding. I consider these 'surviving the newborn' strategies based on how mothers talk about their first few months with an infant.

This 'survival' mentality played out in a group setting when the facilitator at New Parents Network prompted the new moms sitting in a circle to each express something about what their baby has done lately that surprised them. One mom discovers that her baby "can be delightful" by sleeping longer, thereby allowing her to get more sleep or be more social. Other answers were about developmental milestones: babies who were moving, tracking (with their eyes), and reaching with intention. Some women expressed excitement about their babies having more sociable qualities: laughing, smiling, and making facial expressions. Finally, some discussed the changes taking place that required an element of adaptation like their baby's teeth coming in, a transition to solid foods, or going back to work and the shift into a daycare. Most were things they knew their baby would do eventually, but they were still *surprised*.

'Surviving the newborn' requires human support but also material resources which often becomes a topic in conversation at these new mom's groups. There is an emphasis on "finding something that works." This often requires a discussion about bottles, sleeping aids, and teething remedies. Consistent with the idea that breastfeeding is part of a bigger network of parenting ideologies surrounding what it means to be a "good" parent, mothers seek out resources that support their ideal way to meet developmental milestones.

Most mothers do not just discover a parenting strategy. They will locate experts in breastfeeding while navigating physiological complications. A tactic lactation consultants and breastfeeding advocates use to educate and support breastfeeding is largely based on the mother's learning process. When they are given instruction about how to breastfeed, the biological complexities characteristically emerge. The official role of the lactation consultant is to help navigate these complexities through hands-on demonstration.

Instruction on how to breastfeed with a new mom:

A newborn sits next to me while the lactation consultant instructs the new mom on how to hold her baby while breastfeeding. She shows her how to do the "cradle hold". The lactation consultant gives her a footrest and a pillow that wraps around her waist (a "bobby") for breastfeeding to brace the baby.

"Tickle, tickle," the baby opens her mouth and the new mother gets her nipple in. The lactation consultant tells her to "push her on it." They witness her baby 'suck and swallow'. Once mom's milk supply has been established, the baby needs to learn good sucking skills. The new mom is instructed to squeeze milk and force a suck mechanism until her baby bobs. Forced expulsion is necessary when the milk comes in slower. It also depends on how much her baby is getting and how rich the milk is. The lactation consultant says, "The right breast is like the appetizer and main meal while the left breast is dessert." She instructs the new mom to breastfeed ten minutes on one side then change to the other breast. When doing this in the middle of the night, it doesn't matter if the infant has a dirty diaper: "They need the milk." The lactation consultant then shows her the "C-hold" around the neck which helps control getting her on until the baby is bigger. "The nipple should come out rounded, not flat." The new mom is also advised to pump about 20 minutes by leaning forward and emptying the breasts. Pumping is sometimes necessary to get on the baby's cycle.

If a commitment to the energy and time demand is a characteristic of motherhood (and successful breastfeeding), it is necessary to discuss what that means. It's not only that there is a necessary energy requirement on behalf of the mother to provide the means for development for an infant, but there is also a learning curve that demands mental and emotional energy.

Other biological mechanisms are at play including the physical mechanisms of a baby's latch and 'suck and swallow'; oxytocin and the milk let-down reflex; the fat content in hindmilk—"richness" of breastmilk—having more caloric value than the lactose sugar foremilk; and the body posture or ergonomics that support the mother's comfort while also preventing a baby's natural reaction to what feels like falling. In order to meet the energy demands for continued development of the baby, a mother *and* baby must meet the biological requirements that make breastfeeding possible in the first place.

While most of these basic techniques are taught in a prenatal breastfeeding class, they are often a "foreign concept" until put into practice. One new mom retrospectively explained how to her the information was overwhelming and too different from her pre-baby experience to understand without practice. Also, not every mother has access to a breastfeeding class because of the time or financial commitment it requires, especially when a mother's energy is mostly consumed by the development of a fetus and the mental/emotional preparation of the birth experience. Continuous with prenatal practice, the postnatal experience is often about the developing of a maternal strategy contingent upon access to resources and support.

In her own ethnographic research on the middle-class American dilemma of nighttime breastfeeding, Cecília Tomori (2015) explores childbirth education courses as a site for transformative middle-class American parenting as part of a larger consumption of medical and

moral ideologies surrounding childbirth. She concludes that separate models of parental personhood are consumed and depend on how they seek out or purchase resources that provide a basic knowledge to enhance success. In a similar vein with my own research, Tomori has found that consumer choices in parenting models relies heavily on privilege within the stratification of “consumer choices,” (2015, 114-118).

When I asked my informants about what advice they would give a mother who was having trouble breastfeeding, all of them recommended they seek support. ‘Support’ refers to anyone who would support their choices which ranged from seeking advice from the Le Leche League, a lactation consultant, a pediatrician, or other mothers with similar experiences. The pedagogical influences women encounter include homespun wisdom at the birthing center, institutionalized public health information, media-inspired websites, “real moms” with blogs, and communal sharing of educational resources.

The dissemination of information varies based on the intended audience. Although most medical authorities support breastfeeding as a superior form of infant feeding, the use of cautionary language is prevalent in mom-to-mom interactions and secular pedagogies are less informed by research discourse. Meeting developmental milestones becomes the biological force that drives new moms to adopt a pedagogy that suits their needs, but it is characterized by the type of human support and learning resources available to them.

Parenting Ideologies: Routine and Attachment Philosophies

Feeding, sleeping, and weaning methods involve ‘surviving the newborn’ strategies that illustrate how mothers construct a parenting philosophy based on their maternal ideals. For sleeping, there are two methods that were most prominent in my research: sleep training

represented by *The Happy Sleeper: The Science-Backed Guide to Helping Your Baby Get a Good Night's Sleep--Newborn to School Age* (Turgeon and Wright 2014) and co-sleeping represented by *Sweet Sleep: Nighttime and Naptime Strategies For the Breastfeeding Family* (Wiessinger et al. 2014). These books are recommended to new moms when the issue of lack of sleep arises. For a new breastfeeding mom, it inevitably does.

Sleeping strategies are inextricably linked to how a new mom works with her system of support and resources to develop a strategy that supports her breastfeeding practice. Within the context of my data, most women chose breastfeeding as the preferred practice of infant feeding. Sleep training was encouraged at the New Parenting Network by a lactation consultant who also teaches a “Working Women and Breastfeeding” class. Co-sleeping was more likely to be encouraged at the New Parenting Circle where there is a closer spatial connection to La Leche League. Both are strategies of survival that emerge from a research discourse, but vary based on what social ideals a mother values most.

Routine Training –

Sleep training is a practical strategy for women going back to work who are also pumping and/or supplementing with formula. It usually involves the partners who must learn how to give a bottle. The timing of this process is what is referred to as ‘paced feeding’ at New Parenting Circle and ‘bottle training’ at New Parents Network. By introducing a bottle, this expands her community of support and reliance on additional material resources.

New moms will subscribe to bottle training when there is a significant demand on their energy external to the mothering experience. For example, when I asked about the subject of

co-sleeping with her baby, Theresa preferentially discussed her need for a routine because she is looking forward to going back to her demanding full-time job as a partner in a law firm.

“We introduced the bottle because I had a lot of friends that said if you introduce the bottle then Andy [her spouse] can do a night feeding, and I can sleep longer. We moved his bassinet from right next to our bed to the other side of our room, and now there is some distance. I'm hoping we can drop down to one nursing at night, hopefully in the next week or so. Then we will move his bassinet into his nursery, and eventually just put him right into the crib. I would really like him in the crib before I go back to work because I don't want to have him in my room then, but we will see. I know every baby is different. Right now, I'm trying to implement the way I do things to get him to adapt. Like at bedtime, we wash him. And you know the first couple times, he would scream and fuss. Now he's kind of like, 'I know what this is.' He's starting to realize, 'If I do this, then I get to eat',” (Theresa 2.3).

This method trains the baby to adapt to the mother's schedule. The intended long-term result is for more sleep which makes for a more rested, happier mom but also a baby that is learning about social cues such as proximity and social values like privacy and routine.

The cultural expectations that influence Theresa, and many other women who chose to develop a strategy based on a routine parenting philosophy, have to do with their role as a financial provider. Maternal caretaker and provider are two very different roles, but both require a significant amount of energy and time. For Theresa who is used to long nights working as a lawyer, her exhaustion with breastfeeding the first six weeks of her son's life is, “not maintainable...It's like a lifelong trial.”

The narrative of independence over domesticity or practicality over idealism and unrealistic expectations influences the development of a strategy that works for the 'working woman'. Breastfeeding becomes the reinforcing stimulus to train the baby's behavior into a routine. The biological outcome (development) and transmission of culture (social ideals) keeps a mother breastfeeding despite the energy and time demand.

When prompted, Theresa will explain that her parenting philosophy is grounded in developmental milestones that lead to a self-sustaining individual.

What's the most important thing about being a mother?

“Right now, the immediate focus is making sure that he's thriving, which is nutrition. It's making sure you're eating, making sure that what you're eating is translating into multiple wet diapers and, you know, a few dirty diapers every day, and making sure that we are seeing growth, and that you are hitting like the mile markers of development. My whole life focus revolves around that. But I think my long-term my goal would be independence. Raising a child that's not dependent on me, that can function on their own,” (Theresa 2.3).

Attachment Parenting –

The mothers who co-sleep every night are participating in an alternative strategy to bottle training to manage their nighttime feedings. Co-sleeping means that the mother will sleep near their infant, and in most cases, bring their babies into bed with them. This strategy includes breastfeeding on demand for the first six months. For others it includes long-term breastfeeding that extends beyond the recommended breastfeeding for one year. Co-sleeping is part of a larger parenting philosophy of ‘attachment parenting’ coined by the pediatrician William Sears (1987). This parenting philosophy is advocated by the Le Leche League (LLL) which recommends maximum maternal response through physical comfort.

When discussing breastfeeding and sleep, nearly every mother who is nursing will admit to napping with their baby at some point. Attachment parenting requires full nights of co-sleeping until the baby is completely weaned from the breast, or when the child chooses to initiate their own independence. For new moms who co-sleep through the night, it is a way to feel more connected to their breastfeeding practice at a level of convenience compatible with what they consider *natural* for them.

For Valerie, who was a consistent co-sleeper, having her baby sleep with her was preferred for reasons coinciding with why she avoided using formula. She needed a strategy that made her feel safe because it aligned with avoiding the unknown outcomes of not being in control. Eventually, her personal expectations became part of her baby's developmental needs.

"It [having her baby sleep in a crib] just felt very unnatural to me, to have my child in a different room. I would end up stalking the baby monitor all night and going in to check on him like, 'Are you alive?' When he's with me, I tune in and hear his breathing and so it doesn't worry me. He did sleep in there [the crib] off and on, but then started to flat out refuse it. I didn't like him being in there, so I was just like, 'Sorry Will [her spouse], you lose.' (Laughs) So now he's in bed with us and it gets everyone the most amount of sleep. I'll wake up and he will be eating. Then it's like, 'Well that's convenient'," (Valerie 1.1).

Not all mothers who co-sleep will breastfeed, but mothers who nurse on demand will most likely co-sleep because it allows for longer periods of sleep. 'Dream feeding' is when a baby will nurse while mother and baby are sleeping. As mothers develop their parenting strategy, co-sleeping reinforces a mother's choice to breastfeed on demand because it alleviates some of the work and energy requirements while also assuaging some of the uncertainty in the mothering experience.

Whereas the role of the partner for sleep training might include feeding the infant with a bottle in the middle of the night, for co-sleeping it is maintenance of diapers. Community support and resources are not absent with this parenting strategy. They are, however, modified to where the new mom optimizes her emotional connection to the infant as the primary provider of nutrition. This symbiotic relationship is almost like a continuation of fetal developmental, though instead of being a purely biological and environmental, there is an added level of social and cognitive exchange.

How do you feel like you influence your baby's development?

“In every way (laughs). Obviously, I know I do when I am taking care of him. I think the things you do with them, impacts them. I think it's the things that you do, and how you handle yourself because they are like sponges. They are always learning, and I know it was like really important, or it is really important to me that I'm setting an example,” (Valerie 1.1).

The idealism behind co-sleeping as part of a nighttime breastfeeding strategy preserves the emotional bond between mother and baby above anything else. Women who breastfeed on demand identify the energy and time difficulties as a characteristic of motherhood. Co-sleeping, then, is part of a larger philosophy and parenting practice that supports the commitment to having a baby and being “good parents” (Tomori 2015).

'Surviving the Newborn': Parenting Strategies in Context

Routine training and attachment/co-sleeping are the two dominant strategies that the white, middle-class, married/partnered, and heterosexual women in my study use to 'survive the infant.' They are also most likely to be encouraged by the dominant forms of maternal authority at the NPC and NPN. They require varying levels of physical comfort measures for a crying baby. Because physical comfort and maternal support is very much valued within the construction of motherhood in this social context, having more than one option creates on-going criticism between proponents of different parenting philosophies. The more symbolic the value of breastmilk, the more likely moralizing attitudes will emerge. How the information is presented to women in these new mom circles depends on social ideals of the group. What I have found to be the most likely objective for either strategy is that ultimately all mothers want more sleep and to raise a baby who will be independent adult one day.

Although Theresa and Valerie have subscribed to different parenting strategies for ‘surviving the newborn’, they share some anxiety about being a new mom. Theresa who “researches everything” built a routine into her parenting style so that she could feel more in control. For Valerie, being able to have her son in bed with her eased much of her anxiety while demonstrating her maternal ideals about always being there for your child “no matter what.” The result for both parenting strategies is a happier mom which, in theory, should produce a happier baby.

The biggest contrast between routine training and attachment parenting as strategies of ‘surviving the newborn’ are the cultural expectations of “maternal instinct.” Routine training implies that the infant must learn to plan. By contrast, attachment parenting implies that a mother must automatically know what her baby wants, and her actions will be held accountable as such. Both strategies require some awareness of normative hetero-patriarchal expectations about women as having a universal, biological ‘drive’ towards motherhood over other pleasures including other social relationships, hobbies, and a career (Ragsdale 2013). The difference is how one defines parenting: something that can be controlled or something that is intuitively unfolding as it happens.

Attachment parenting has elsewhere been criticized as a form of “total motherhood” that advocates for a philosophy and logic of the “the natural” that is somehow without consequence and impenetrable from cultural risks and rhythms (Wolf 2011, 85-98). Based on my own data collection and elsewhere in the research, attachment parenting is incompatible with maternal employment and, therefore, will reproduce gendered capitalist systems that reproduce racial and class inequalities (Tomori 2015).

To counter Wolf, the premise behind attachment theory originally proposed by psychiatrist John Bowlby was based on the impression that separation between infant and mother would result in psychic damage for the infant (Blum 1999, 33). This psychoanalytic theory was based on wartime work with orphans and refugee children. However, it is not without influence in this urban community which has experienced a great deal of social violence. Since the original conception, attachment theory has become the hallmark of La Leche League International's approach to a dominant maternalist narrative in which breastfeeding on demand gives preference to the child's developmental timeline (Blum 1999, 37-38; Tomori 2015, 78-80).

Routine training and attachment parenting are both parenting strategies that allow for parental control of the baby's development. Routine training may seem less 'natural' to the attachment theory advocates because it requires the infant to adapt to the mom's routine instead of vice versa. Rather, nursing on demand trains the mother by modifying her behavior (diet, for example), based on the perception that it will be passed on to her baby. Just like how Valerie's baby begins taking on his personality by "refusing the crib" when she had already established her own objection to having him away from her bed— both strategies reproduce cultural values through modification in order to achieve maternal convenience.

Expectations and Maternal Embodiment

Regardless of where a mother falls on a naturalist-pragmatist continuum, and despite how she modifies her or baby's behavior to reproduce cultural values, she is still susceptible to conflict between the biological demands of her infant feeding practice. To breastfeed in a bottle-feeding culture requires personal and/or social expectations that must be negotiated in

times of struggle. How new moms chose to manage these conflicts can result in a new, embodied identity of motherhood.

Breastfeeding relies on the hormones oxytocin and prolactin to establish a milk supply, allow for a milk let-down, and keep the milk coming – what is commonly referred to as supply and demand. This is the bio-social relationship a mother establishes with her infant’s feeding demands: her breasts will supply more milk as long as they are being continuously stimulated by a suckling mechanism and emptied. This is after she has already established a milk supply. Mothers have two options to keep up with the supply and demand: their infant must be able to empty their breasts while nursing or they pump. Otherwise, their milk supply will go down and a mother might have to supplement with formula. Estrogen levels rise with time postpartum, causing the milk supply to further diminish.

The hormonal connection between mother and baby is important in keeping the biological process of breastfeeding going and is involved in the maternal-infant bond. The maternal-infant bond, from a biological standpoint, is maintained by the hormone oxytocin, otherwise known as “the love hormone,” because it is released during all forms of pair bonding. Oxytocin is, perhaps, the hormonal representation of breastfeeding as a biodynamic process. The hormone does not simply act as a top-down feedback mechanism for the production of breastmilk; oxytocin has also been shown to change the neural structure of the brain regulating social cognition and affiliative behavior (Ross and Young 2009).

Supply and demand may require mothers to negotiate between hormonal changes in the ‘supply and demand’ and their new identity as a breastfeeding mother. Biological new

moms especially encounter new self-awareness when confronted with the biology of milk supply and the functionality of their breasts as sole provider of nutrition.

“If I had not nursed. If I had said, 'I'm too selfish,' because to me that's the biggest part is, I've basically lost my person. I've lost me. Like I'm gone because all I am is a Dairy Queen. I'm constantly like, 'Are you hungry? Do you need to eat?' My whole life revolves around nursing and I'm a very selfish person, so it's been a very difficult thing to do. But apparently, I'm not so selfish that I've done it. There was a lot of pressure from that family from day one that you need to breastfeed and so it's done. Even now I'm still thinking, 'Maybe we should just switch to formula,' but I don't know. I enjoy nursing so I go back and forth,” (Theresa 2.3).

Theresa displays an example of what women in her social milieu are likely to experience when breastfeeding for the first time. Like many new moms I encountered over the course of my research and perinatal training, she questions the value of breastmilk when confronted with her own self-perceptions as well as the opinions of members in her maternal community. Family values and personal beliefs can cause tension, but most of the pressure is embodied by the new mom and does not result in any external conflict. Theresa feels disconnected from her ‘person’—her identity. However, breastfeeding is allowing her to see herself as a new, ‘un-selfish’ person and she has discovered that she enjoys doing it.

Interestingly, Theresa’s planned for a ‘natural’ birth but went two weeks past her due date which led to her being induced. She was nursing on demand but now she is trying to get her baby on a routine schedule so that she can begin thinking about work again. Her social expectations are mostly self-produced. This was very common with other women in this study who experienced deviations from their ‘birth plan’ and the birth experience. If the birth experience was traumatic or ‘out of their control’, especially in the hands of medical personnel, meeting the biological demands of breastfeeding becomes part of a healing process when the expectations about their labor were not upheld.

The maternal-infant bond, usually the symbolic force behind moral attitudes in breastfeeding, is downplayed in routine training even though it is still recognized as an enjoyable part of the feeding experience. However, the bond has produced some compulsion over the body's performance. Symbolically, Theresa has embodied a parenting strategy by re-directing her cultural ideals of independence and self-service towards a display of integrity in her infant feeding practice. For mothers who do follow a routinized schedule, usually because they are working, conflict with their infant feeding practice and their socio-political ecology is more internalized than critiqued.

A crisis also emerges when women value the maternal-infant bond in breastfeeding but then are unable to breastfeed on demand. Establishing a feeding routine becomes a cathartic way to overcome disappointment when their initial intentions cannot be met. For example, Elizabeth who had in-vitro fertilization then carried and labored twins, embodies a routine to negotiate between past and present expectations.

"Before I got pregnant, my thought was that I would have one baby and I would try to breastfeed them for a year. That was my plan. When I moved to exclusive pumping, very early on, I just had to throw my expectations out the window. I'm giving them as much [breastmilk] as I can, formula will supplement whatever else they need. It's also important to me to reclaim my freedom, a little bit. I talk a good game; it's [pumping less often] a very emotional process, no matter how I can rationalize it," (Elizabeth 1.2).

Theresa and Elizabeth both follow feeding and sleeping routines, but for different reasons. Elizabeth does not work, but instead is managing a household with two babies. Also, she has much more family support for her infant feeding practice although she has witnessed much more external criticism on social media sites. Her sensitivity to moralizing attitudes and judgmental behaviors is recognized through her "emotional process" of letting go unmet personal expectations.

In some other cases, the mother can breastfeed and does, but cannot meet social expectations of a happy wife or a happy mother. For example, Maria is the only new mom I talked to who had a completely 'natural' birth that was not followed by a traumatic experience or complications. Maria is dedicated to attachment parenting: she only nurses on demand, she co-sleeps, and she takes her daughter everywhere. Her oxytocin levels should be very high. Although she is meeting her parenting ideals, she still struggles to meet personal and social expectations.

"What has been not so natural is the relationship with my husband; that has been hard. Everyone said so that you are not to let the baby be the most important thing in your life and know that he is also there, but for me it has been difficult. All the time, the baby wants things, and the co-sleeping so it's everywhere...It's difficult for me when he comes home. I'm very tired and if I'm a little bit frustrated. And I just want to go to sleep. I don't know if it's also because we moved and I don't know anybody here so I got more attached to her, or if it's actually because I've been a foster mom and have had kids removed from my house that I really want to keep something. I don't know if that affects the attachment I've got with this one," (Maria 1.3).

Maternal ideals in attachment parenting styles can conflict with social expectations surrounding a mother's other social relationships. Oxytocin has been shown to promote in-group favoritism and out-group derogation (De Dreu et al. 2011). This means that her feelings of connectedness with her baby can dampen her connectedness to her spouse on a chemical level.

The tension she is experiencing is not directed towards her spouse, but is guilt resulting from unmet social expectations. Memory of her experience as a foster mom intensifies her attachment behavior. Though it is presented as an afterthought, Maria's previous identity as a foster mom reinforces her personal expectations as a first-time biological mom. It serves as the focal point for her new embodied identity as one who is co-dependent on the maternal-infant bond.

Maria may have unique circumstances that intensify the connection between her breastfeeding strategy and self-determined expectations. However, similar sentiments are expressed by other attachment parents. In comparison to how Theresa and Elizabeth use a routine strategy to parent, the mothers who embrace the theory of attachment parenting must also negotiate between a former and present identity based on the biological demands of breastfeeding. The difference is that their negotiations take place on a heightened ideological level that that very much conflicts with the norms of bottle culture.

Rae, a Le Leche League leader and a mother who breastfed her son for an extended period, describes some of the internal negotiations she faced to normalize the societal expectations that stay-at-home attachment parents face:

Rae goes on to refer to societal expectations at home with the baby and how women think they are going to do other things [like home projects] but they are taking care of someone who is, "completely dependent on you." She argues that a baby's needs are not the same as a 2-year old's wants: "Women need to trust in their instincts and feel more confident. Trust your gut, know you aren't perfect, and be gentle with yourself. Being a mom is the most important, most challenging job you will have." She tells us that the hardest part, especially as a stay at home mom, is the 'Martha Stewart fantasy'. She got nothing done. "I had to see parenting as just enough." Rae also expressed suspicion with what she considers "rigid" social expectations surrounding sleep training and when to wean a baby on to solids. She chose to breastfeed her son until he was four and half years old, and self identifies as a "social odd ball."

Despite their commitment to the attachment parenting strategy, new mothers will demonstrate frustration in the experience as the primary caretaker. All mothers probably experience this frustration to a certain degree, but it is enhanced by the moral pressure mothers endure when nursing on demand. The narrative of "sacred motherhood" (Tomori 2015, 79) requires women to embody the maternalist domestic role. By taking on a larger portion of the biological demand than one who might supplement with formula or allow

her spouse to bottle feed, the socio-political ecology of a mother becomes a point of dissention when it does not recognize mothering as legitimate work.

All the women who attended the Le Leche League meeting were already breastfeeding and seeking support for a variation of parenting that matched their positive embodied experience with breastfeeding. Breastfeeding is believed to produce more confident, secure independent adults. For Rae, “If you don’t baby your babies, you will baby your adult kids.” In other words, to not breastfeed is not loving your baby less, it is parenting less.

In all its ‘naturalness’, nursing on demand is not accepted as the standard way of parenting in American culture. Therefore, mothers who do nurse on demand, and especially long-term, often direct a great deal of their energy towards dismantling social criticism or with advocacy for their beliefs. This can be very complicated when they know their formal identity had values that were once aligned with more ‘normative’ parenting practices.

How do you feel as if motherhood has changed you?

“Sometimes it's weird. I love her with all my heart... but it’s the *women* that get pregnant, it's the *women* that breastfeed, it is the *women* that have to leave their job. At the end of the day, my husband is great. He helps a lot. But I'm the one that is looking out for her. Everything goes by me and [yet] they also expect you to be good with your husband and maintain good [social] relationships. Are you kidding?! I think that that's kind of unfair. And then when you meet people now, they never ask, ‘What do you do?’ because you’re a mother; you have a baby,” (Maria 1.3).

In another scenario, an embodied conflict might mean that a mother is no longer able to bond with her baby. What happens when a mother values breastfeeding, but can no longer sustain the social expectations of physical and emotional balance, independence, and the maternal-infant bond? The recommended method is seeking out a form of maternal community building for “long and loving support.” Another suggestion is to normalize

postpartum depression (PPD). The third option is to request anti-depressants. It all depends on the new mom's socio-political ecology. Postpartum depression, though well understood as common for women to experience because of the biological and social demands of caring for a newborn, still retains the stigma of a mental disorder.

On several occasions, postpartum depression was a topic that was discussed at the New Parents Network:

Today a therapist has come to the formally address postpartum depression with the group. As a therapist she knew stuff about anxiety, but it is very different to experiencing postpartum depression. One often asks, "Is it wrong to feel it (depressed)?" She goes on to blame the hormones, the lack of estrogen in breastfeeding moms, when they can't make serotonin. She tells the new moms, "Breast-feeding makes you more susceptible to depression." The experience is the symptomatic feeling of withdrawals; the chemical reason for PPD that has been documented as far back as 1800. However, there is been no research until much later. Everyone will feel overwhelmed at some point, and the therapist is here to tell these women when to recognize when it has become "too much" or when they "become lost." She says, some women start telling themselves, "I don't want to be a mom anymore": this is when the depression has gotten to a level that needs to be addressed.

The embodiment of a new maternal identity does not necessarily mean a new mom has to have a cathartic experience or PPD, but it often does require a crisis between a parenting ideal and her personal or socio-cultural expectations. Based on my interviews and observations with NPN and NPN, the embodiment of a new maternal identity does not appear to happen more often to moms who develop one parenting strategy over another.

The conflict between maternal ideals and realities becomes embodied through the act of breastfeeding. The scientific basis for breastfeeding in a bottle-feeding culture contributes to moral attitudes made implicit by how mothers talk about their breastfeeding practice. First time biological mothers are especially susceptible to a contrast between the research discourse and the process of breastfeeding. The often-cited desire to be "a good parent" with reference

to their infant feeding practice suggests that women are driven by both biological and social influences.

Faced with biological complexities that complicate the breastfeeding process, women learn how to navigate through infant feeding based on what resources and support are available to them. The strategies of routine training and attachment parenting are made available to new moms in the postpartum parenting groups. To 'survive the newborn' means that a woman faces certain energy/time demands as well as hormonal challenges during the first months of an infant's life. Though meant to strategically alleviate some of the initial difficulties, parenting strategies are founded on larger parenting philosophical ideals.

Breastfeeding, then, becomes a fulcrum to other parenting decisions and life choices. The symbolic value of the milk is consistent with the cultural exchange of ideals. Complicating this process are personal and social expectations surrounding gender norms, capitalist values, and the socio-political ecology of the mother. Therefore, the reality will almost never align with the expectation and negotiations are made between her original expectations and her new identity as a mother.

Moral Authority in Social Support for Breastfeeding

Whereas my objective in Chapter 2 was to show how women negotiate a new maternal identity in response to scientifically-based discourses that emphasize breastfeeding as the healthiest, most natural, and therefore, moral form of infant nutrition, my objective in Chapter 3 is to better illuminate the social dimensions within this process. Building a community of support is the most significant strategy a new mom must develop and deserves a richer analysis. Not all women who choose to breastfeed encounter problems, but many will at some point. Specific breastfeeding problems sometimes require pragmatic solutions, but there is also a much more emotional process of embodiment.

A support system of family, friends, and other women provide social assistance for lactation counsel and domestic support (Van Esterik 1989). A support system is purposely built by a mother. As expectations, trials, and tribulations in the first year often guide the mother's emotional development, what expands for her is a meaningful network of people who have helped her work through and process those experiences.

I argue here that the value women place on their system of support reflects the moral authority inherent in the social discourse surrounding infant feeding practices. Given that it is a system involving many parts, I prefer to refer to their support system as a support community. A support community includes the new mother as an autonomous individual, her baby, who is defined by an absence of autonomy, and whoever the mother chooses to allow into their network.

This chapter will examine community support within an instructional setting to highlight the main themes of maternal community building, expert and lay discourses, and the role of teaching through emotional support. I end the chapter with three case studies to illustrate how new moms build a community of support that aligns with their parenting ideals.

Mom-to-Mom Community Building: A Function of Sociality

I sit with a new mom at the New Parents Network. She is not a first-time biological mother, so I am curious and ask her why she was here today. Tanya also has a four-year-old and she tells me she nursed him until he was eight months old. The first time she came to the New Parents Network was when her first son was two months old. She delivered him at the hospital (Marymount, where group is located) and heard about the group through delivering there. Now she comes for the social support, because the first time she had a baby, "It was easy to bond with the other moms and I remain in contact with some I met here [at the New Parenting Network]." This second time with the group, she has specific questions. For a long time, she wasn't confident about going out on her own with a new baby. However, she comes here to socialize the baby, and for help with her own questions that come up.

Though she was able to feed her first baby, she still struggles to breastfeed. Currently, she is able to breastfeed her new baby when he wants which is about every two hours, though it's not regular. She also supplements 4-6 oz. of formula every day. No one explained to her what a process it is to breastfeed: the baby screams when milk didn't come in at first, the positions are uncomfortable, and she contends with the labor of it. Therefore, she supplements with Enfamil.

My initial conversation with Tanya suggests that women need the support of these new mothering groups for various reasons including a connection with other mothers and help for specific questions. She does not specify to whom her questions are directed for but highlighted here is the desire for mom-to-mom relationships. Given the physiological changes a body goes through during the process of pregnancy and birth, the body after is marked by an experience new mothers can share. Additionally, Tanya notes that building a community with other moms is not separate from the baby's first act of socialization.

Tanya makes an explicit point about the location of this group. It is important to recognize that the New Parenting Network is located at a hospital, unlike the New Parenting Circle located at a birthing center across town. The hospital setting itself is an advantage, in this case, because it is a site for women to transition from the birth to a social setting of support.

When prompted to talk about how they discovered this group of new moms, some of the women told me they were given direct information about NPN at the hospital following their labor. This distinction is relevant because the NPN group was much larger than the NPC. It was here that I most often encountered women supplementing with formula even though they had prior access to breastfeeding support. In contrast, it is more likely a woman hears about the group through her established social network at the NPC.

When asked to describe the neighborhood in a formal interview, one mother tells me: “I think North Shore is a very progressive and liberal and it’s a hugely into more natural [ideals]. Not as hippie as South Shore (where NPC is located), but pretty close. And so there’s a whole vibe of the community that would probably support, you know, breastfeeding,” (Theresa 2.3). Although NPN is advertised as an infant feeding neutral place to go for new parent socialization, it is acknowledged that these groups are a valuable resource to support breastfeeding, specifically, given their location within the city.

Though what brings new moms to the group may initially differ, it is important to point out that the women who go to these groups are A) either not working, working part time, or have not gone back to work yet and B) have managed to physically remove themselves with a baby in tow to show up, often not an easy accomplishment. Mothers, like Tanya, seek these groups because when they lack confidence in their parenting, it is worth the energy to leave the

domestic space in order to be receptive to social support. The decision to go can be very practical: they seek answers to their questions. However, women will keep coming back week-after-week or baby-after-baby for the sociality of mom-to-mom community building.

I first encountered Theresa at the New Parenting Circle when she came with her son three weeks after giving birth at Marymount which promotes the New Parenting Network. Her ability to leave the house when her son was still quite new and to attend both groups (NPC and NPN) is recognized by the other moms as a ‘wonder woman’ mentality for her bravery in leaving the domestic sphere with her baby so early on. Given the prominent representation of mothers with newborn infants in social media, as dirty, tired, and socially absent, new moms are searching for a reason to interact with others like them. On the topic of ‘getting out’ (of the house), which came up very explicitly one day at NPC, one mom mentioned she would “go stir crazy [if she didn’t ever leave the house].” Most moms agreed it was hard at first but that they considered the NPC “a safe place” where “watching moms and babies is a good way to learn because it is crazy how quickly the time passes.” It is often the first public place a new mom visits after giving birth.

For maternal community building to be sustainable, new moms have to make a conscious effort to meet each other with the perception that their practical inquiries will be met without judgement, regardless of their infant feeding practices. That is not every mother’s experience. It is well established that these groups, the New Parenting Network and the New Parenting Circle, provide lactation support. Breastfeeding is recognized as the most difficult challenge postpartum, whereas accessibility to infant nutrition appears to be effortless.

Many mothers, like Tanya, feel forced to supplement with formula despite initial attempts to breastfeed. Mom-to-mom community building begins through a very common scenario: A woman has a baby, and with every intention to breastfeed something happens to indicate that it will not be simple. No matter how minor or major the breastfeeding problem, most mothers need to discuss it regardless of whether they will pursue a strict breastfeeding only practice.

For many mothers who are supplementing, mom-to-mom community building is a strategy to overcome their disappointment of not being able to do something that they had assumed would be enjoyable. New moms often discussed barriers to their breastfeeding practice. Sometimes, they would prefer to share their struggle with another new mom, rather than consult an authoritative figure for support.

Mom (A) is telling me her breastfeeding story and goes back to the subject of support groups. They would ask her if she was supplementing and she lied, telling them "no." However, she was only getting 1 oz. total pumping for 40 minutes every day. She told me that she felt inadequate, like she couldn't provide the baby's first food. Then another mom (B) joins in the conversation and says that her second child was easy, there was an oversupply, and she donated eight gallons of milk. But this third baby was difficult, especially at night. (A) Insists that every baby is different and that there are complex issues: "If it's not their [baby's] way, it is wrong—to feed the baby is most important but people make it seem like it [breastfeeding] is what you are supposed to do.

(B) Agrees, "Yeah, but it's not easy; nothing is easy about it. If a mom has to use formula, don't make her feel like it's bad."

(A) "People don't realize how much work it is: there is little pain when latched but realistically it's unpleasant 8-10 times per day."

(B) "It [supplementing with formula] a good system."

(A) "A system that works."

They talk about how they want to breastfeed, but they would "lose their mind" if feeding 24 hours a day. For them, it doesn't matter in the end if the babies are gaining weight and "meeting [developmental] milestones."

This is an example of a mother who acknowledges her negative emotions such as the perceived shaming she felt at a breastfeeding support group and inadequacy of her own body,

but then minimizes her guilt through mom-to-mom support. At the onset of the conversation, the first mom approached me to talk about all the problems she had encountered with breastfeeding. Her argument included the statement, “The shame is real,” and followed with supporting evidence of why she was having difficulties in the breastfeeding process. In the conversation with the other mom, her problems with breastfeeding are irrelevant compared to the inadvertent shaming she encountered in another breastfeeding support when other people were so eager to help her through the problems.

This scenario demonstrates that new mom groups do contain an element of established social expectations: a mom should continue try to breastfeed despite the energy demands it requires. Conflict with these social ideals can lead to a new mom to find a social solution to the challenges they face. Mothers often join a support group when it appears to be a judgement free zone, but when those expectations are not met, they explore other options. The ‘best fit’ for these mothers is not just based on how they decide to feed their babies, but mostly the social support for their decisions, often articulated as the “baby’s way,” i.e., the compromise they make between their guilt and the needs of their supposedly non-autonomous offspring.

Mom-to-Mom Community Building: A Function of Pedagogy

New moms have varied emotional experiences connected to breastfeeding. There is the often-heard mantra, “To each their own,” intended to mitigate ideological conflicts while maintaining a posture of encouragement. It is somewhat ambiguous, however, as to whether “their own” refers to the mother or the baby. Therefore, ‘crisis’ is contained within the new mom who must decide how she will identify as a mother. Will she remain self-autonomous and

separate from the baby or assume her new role within a maternal-infant unit? The 'crisis' is the moral loading about what is natural and social expectations about what makes a good mother. In selecting a maternal support system, mothers are subject to advice, solicited and unsolicited that recreates this tension.

In my time with NPN and NPC, I observed several occasions when a new mother came to the group visibly emotional because she is experiencing problems associated with breastfeeding.

Tracy, week one: A new mom (Tracy) comes into the group for the first time and she is crying. She seems shy as she approaches the facilitator who is filling in for the lactation consultant this week and does not immediately take her baby out of the carseat. She needs advice on breastfeeding her two-week-old because right now she can't without a nipple shield. The facilitator just listens, mostly, then gives the crying mom advice by telling her to use the cross-cradle position if the baby could latch. Another mom—Bea—whose baby was only ten days at her first visit, and is now at four weeks, tells her that she experienced the same problem. The lactation consultant taught her the football hold. Now her baby has no problems with latching.

A few other moms become involved in the conversation and assure Tracy that she has at least ten days to get her infant off the nipple shield. Her baby has already been checked a couple of times for tongue-tie, but the mom is very concerned. One woman tells her, "It's not a big deal," if she must supplement at first. Tracy tells them that breastfeeding leads to pain and she starts sobbing again. She says she knows she is hormonal. Still, Tracy doesn't know why she can't breastfeed, and is crying about how hard it is. She is pumping and using bottles of breastmilk already.

This story continues and an entire scene emerges as several women offer their support which ranges from giving Tracy advice ("Continuously try different positions"), assuring her that it is a common problem ("People don't talk about it...we are still struggling"), sympathizing with her emotional reaction ("It was a very dark period of my life [when unable to breastfeed]"), offering encouragement to continue ("It does get better"), and minimizing the negative affect associated with the alternative ("It's fine, it's not a big deal. The baby won't die on formula").

In this vignette, Tracy, who is experiencing extreme physical and emotional distress, makes the decision to go to NPN for help getting her baby to latch onto her breast without a nipple shield. A nipple shield is often given to women to help a newborn latch during the first breastfeeding, especially when the baby is stressed or sedated due to anesthetics used during labor. She does not attribute all her distress to the breastfeeding problem, nor does she show any signs of guilt or self-doubt; it's just another thing that is contributing to her exhaustion. However varied, even contradictory, the other moms' responses are, they demonstrate the affective power breastfeeding has to elicit shared experience and knowledge. There are practical problems new moms face when their bodies change to meet the biological demands of breastfeeding.

Pedagogical influence also shows up in the form of unsolicited advice. Internal conflict based on moral attitudes surrounding infant feeding practices produces opinionated moms, not experts. Everyone wants an opportunity to share their experiences. It is up to the new mom to decide to who she will listen, and which strategy most embodies her values as a mother, or the mother she wants to be. Tracy may have come to the group with specific questions, but now she has the opportunity and options to build a mom-to-mom community of support.

Not all mom-to-mom interactions are this emotional or overwhelming. More often, the function of experienced, older mothers is to participate in material sharing, rather than offering solicited or unsolicited advice. Material sharing refers to discussion and recommendations surrounding consumer items mothers purchase or acquire through hand-me-downs for their baby. New moms share informal information about breastfeeding when they talk about Baltic amber necklaces as a "natural analgesia" for teething babies, creams they recommend

for broken skin around the nipple, the cost of adaptors for their breast pumps, which bottles their baby prefers, and what ‘baby led weaning’ books they recommend. By sharing information about material items, women are connecting to a market of parenting ideology.

Mothers may or may not be conscious of this but considering the value of maternal community building for mothers with emotional needs, material sharing is the *least* morally loaded form of sharing. In the previous vignette, for example, Bea engages Tracy with information she learned from the lactation consultant and talks about material items that made her situation better. By revealing a similar breastfeeding problem, Bea legitimizes Tracy’s struggle. Also, her baby is only a couple weeks older than Tracy’s baby which sets up a convenient social relationship between the two moms and a commonality between their babies. This dynamic establishes Bea up as a perfect candidate for mom-to-mom support, and in the weeks to follow, I witnessed them become friends.

Mom-to-mom socialization is a constructive way woman build their communities of support, but it does not consider the other social actors who either directly or indirectly support their infant feeding practices. Moral authority is often implied through a collective effort to troubleshoot breastfeeding problems, and most women lack expert knowledge. I do not wish to suggest that their rich emotional experiences are devoid of intelligence and undeserving of recognition. On the contrary, I argue here that mothers must navigate through diverse levels of authority in their community of support in order to emerge more confident in their breastfeeding journey.

Authority and the Role of the Lactation Consultant

Those who go to NPN and NPC with a real desire discover solutions to their breastfeeding problem are there to speak with an International Board Certified Lactation Consultant (IBCLC)—one who is a designated expert based on 2,500 contact hours of postpartum lactation counseling. The lactation consultant is the pedagogical expert. Her function in mom-to-mom community building is to facilitate the pedagogy.

It is difficult to underestimate the role of the IBCLC in the life of a new mom regardless of how her first year with a child goes. In both the New Parenting Network and the New Parenting Circle groups, a lactation consultant is a resource: one to whom a mother with a pressing breastfeeding question or problem can go to for practical advice or solutions. However, she is not neutral about infant feeding practices. It is clearly her role to support, educate, and advocate for breastfeeding. This does not discourage women who are supplementing with formula from engaging with the IBCLC the way they might if she were another new mom.

The lactation consultant's status as facilitator makes her the expert on more than just lactation. One mom from NPN tells me she considers the IBCLC the "resident doctor": a calm counselor for new moms on a personal/friendship level and a welcome contrast to the obstetricians and pediatricians—the "business people." There is a moral authority inherent in the role. In her ethnographic observation of multiple lactation consultants, Jennifer Torres concludes,

"When lactation consultants challenge the construction of breastfeeding pathology and limit intervention, they also challenge the construction of women's bodies as suspect and prone to disorder. Emphasizing the nutritional properties and health benefits of breast milk can also serve this function, celebrating women's ability to nourish their babies. However, it also

contributes to the moral imperative to breastfeed, especially when even small amounts of milk are presented as making a difference in babies' health. This creates a fine line that lactation consultants must walk between supporting breastfeeding women, who may be lacking support from those around them, and reinforcing total motherhood," (2014, 165).

At NPN, the lactation consultant was available to assist both an infant group and a toddler group. She was much more accessible to the infant group due to "new mom neediness." The IBCLC will be the first person to point out that having more children does not make any mom an expert on breastfeeding. To demonstrate how lay and expert narratives can sometimes be in conflict during these new mom groups, I consider the lactation consultant's point of view for a moment to demonstrate how her authority is both validated by a first time new mom, and unintentionally undermined by a 'new' mom with older children.

Tracy, week two: I speak with Tracy who came in crying about a latch problem last week and she tells me she got some new advice, "It's not the short sucks but that the 'suck/swallows' with the long strokes that equal a milk letdown." Another mom (B: who also has two older children and a newborn) explains to us what a milk letdown felt like for her: "It's not painful. There's tingling and then a lot of pressure. (To Tracy) I don't know if that helps." The lactation consultant talks to Tracy about how she needs to wean her baby off the nipple shield by four weeks. She advises, "You can breastfeed on the shield for one breast, and then breastfeed off the shield with the other." She also suggests that Tracy might need to see someone about the baby's jaw because it could be off. Tracy has no desire to take her baby to the chiropractor, but she has TMJ (temporomandibular joint dysfunction) herself and asks the lactation consultant, "Is this inherited tension?" Mom B quickly chimes in, "Breastfeeding is hard. It's not rainbows and butterflies." The lactation consultant responds to B but is addressing Tracy, "The more you do it, the easier it gets." She then offers more advice by suggesting 'tummy time' for 15 minutes every day, finding an App that to track her feedings, and discourages the use of a pacifier.

Tracy comes back to NPN so that she can get professional support from the lactation consultant who was absent the previous week. She has been building a repertoire of advice on how to troubleshoot her latch issues. This is her opportunity to solicit advice from an expert but gets additional, unsolicited support from another mom with older children. The two levels of authority are not equal, nevertheless, they are in conflict. The lactation consultant is telling

Tracy something she doesn't want to hear ("take baby to a chiropractor") and the other new mom, in an attempt to rebut common misconceptions about breastfeeding, solicits negative reinforcement. In response, the lactation consultant reaffirms her position as an advocate for breastfeeding with positive reinforcement and authoritative advice:

Tracy becomes visibly worried again about weaning her baby off the nipple shield. The lactation consultant recommends again that Tracy call a chiropractor for work because of the emotional distress it's causing, then to wait and evaluate next week. She also suggests popping her baby off the nipple halfway through a letdown, making sure the baby wakes and asks for more comfort. This will help her daughter not take a pacifier over the nipple. "But for now, relax and enjoy her! Nothing, including marriage, is more uprooting and can turn you upside down than a new baby."

The other mom B whose infant is having gastrointestinal induced colic which is complicating her own breastfeeding tells us, "You are your own worst judge... By the third kid you should have it together." She admits that in her frustration, she is currently not the mom she wants to be to her oldest two children. The lactation consultant says to mom B, "Someone needs to keep it together," and recommends Rescue Remedy (a homeopathic stress relief) but not necessarily for her infant's colic; they both can use it.

As the lactation consultant offers practical advice and remedies for both mothers though through her dialogue, a more nuanced moral authority emerges. She recognizes how easy it is for new moms to pathologize their struggles with breastfeeding and this is what separates her from other forms of medical authority. However, by making note that increased frustration will make the problems worse, she is normalizing the situation.

This is a very effective method to encourage continued breastfeeding, but it involves the dissemination of subtle socio-political ideologies surrounding motherhood. Through the recommendation of holistic methods, the lactation consultant moves away from the practice of promoting pharmaceuticals. She still imparts knowledge about these social expectations though they conflict with the new moms' current experience. Her role as an advocate for new moms is

to communicate practical solutions given a demanding socio-political context that they all must endure as women and as mothers.

The desperation new moms experience to solve their breastfeeding problems stem from conflict between differing forms of moral authority. It's as if being a mother isn't enough because they must also manage opinions and social expectations about how to best raise their infant to be an independent adult, but what that means is highly contested. The lactation consultant urges her to enjoy her infant now to distract her from her present distress. It's beyond a practical solution; it's recognition that time will continue no matter how embodied the emotions are.

The first-time mothers I interviewed all shared their experience of pregnancy as a time when their body would often get tired because of the developing fetus. However, most of these women still enjoyed pregnancy. It's as if they set their expectations about pregnancy based on the fetus' fragile state of dependency. Therefore, it was easier to navigate through those physical and physiological changes. After the baby comes into the world, their confidence is now met with the harsh reality that this child has entered into a socio-political context that promotes a surrendering of maternal self-autonomy (through breastfeeding, for example), while encouraging the parenting skills needed to foster new, autonomous humans. A shared sense of defeat was perhaps best articulated by Theresa in group one day, "Everyone fucks up their kind in a special way. Some [moms] just don't like breastfeeding," giving the impression that she understands why.

Not all lactation consultants attempt neutral moral authority. Another lactation consultant I encountered in my research very much favored breastfeeding education over

practical knowledge. My doula client (a low-income African American woman, 23, with her second child) initiated breastfeeding, most likely due to my encouragement, but experienced constant frustration when feedings took a long time. Her infant was only a week old when I accompanied her to NPN for help.

My client had practical questions about the baby's gas and how to use her new breast pump. The lactation consultant certainly answered her questions. However, she went beyond practical solutions to teach my client everything from work laws regarding breastfeeding, diet, establishing a routine, to how to best manage her frustration. She even gave advice on constructive verbal praise/criticisms to avoid potential negative behaviors of the baby. Finally, the lactation consultant demonstrated this form of constructive praise by telling my client she has "gorgeous nipples" and "creamy looking milk packed with protein and antibodies," to reinforce her breastfeeding practice.

Variations of lactation authority produce a range of discourses surrounding breastfeeding that can become increasingly more about how to parent the 'right way' than about helping women work through their breastfeeding problems and maternal crises. Moralizing attitudes in lactation authority implicitly demonstrates how mothers are expected to be cognizant of how their actions translate into the moral development of their children. It's not as if the mother herself must learn these moral and ethical values; it's about the baby being born free from the burden of these values, and the level to which the mother feels accountable for the product of her mothering. Depending on the type of moral authority to which she subscribes, her role can go from absolute caretaker to one of many 'in the village' (from the often heard saying, "It takes a village to raise a child.")

Support groups differ in their philosophies and it is up to the new mom to decide which philosophy on parenting she is going to go with (Chapter 2). Based on her emotional experience with breastfeeding, a mom re-examines and possibly revises her initial expectations about breastfeeding. This may lead her to adopt a different philosophy. And there are variations of authority to turn to: lactation consultants are only a small fraction of the maternal social community.

Certainly not every mother has trouble breastfeeding. It is far more likely that they will experience tension between different levels of authority. Unlike the lactation consultants who facilitate the NPN and NPC groups, I had no direct experience with the medical authority personnel: midwives, obstetricians, pediatricians, pediatric specialists, and postpartum RNs, but I heard about them. Tanya, the mother whose reasons for coming back to NPN included a previous positive experience with her first child and practical questions with her new baby, tells me about how the nurses get frustrated with postpartum questions: “No one said that it’s normal [to have breastfeeding problems] or that it [milk production] is coming. It’s not warm up in postpartum.” Tanya and other mothers often expressed frustration with either the lack of knowledge about breastfeeding in the medical community or the separation between the medical authorities’ expectations and the new mom’s experience. This is often the impetus for a new mom to discover another source of authority.

Embodied Morality: Building a Maternal Support System

In new mom support groups, moral authority is intrinsic to discourses surrounding breastfeeding. I have relied heavily upon the social dynamics of the group to illustrate the role of lay and expert breastfeeding discourses in navigating through breastfeeding

problems. Though my ethnographic observations of these new mom groups show how women interact with each other, the creation of a maternal support system is far more varied, and beyond the scope of what I can contain here.

Before I conclude this chapter, I include here four case studies that depict concrete examples of how mothers to transform, create, or uphold their expectations as a mother because of conflict within their maternal community of support.

Bodily Competence and Alternatives—

Milk share, or what is known as breastmilk donation and milk banking, is a unique form of material sharing that is morally and ethically loaded. It may or may not, result in mom-to-mom community building through friendship. Donor milk sharing has a controversial placement in American culture. Lactation over- ('donor') and under- ('recipient') sufficiency itself will drive milk sharing among white, middle class American women who are highly motivated to breastfeed (Palmquist and Doehler 2014). Internet milk sharing, as a form of 'local milk banking', is a particularly complex and embodied practice that intersects structural inequalities, bio-cultural dimensions, and differences in social support (Palmquist and Doehler 2014, 145).

My experience is limited to one recipient of donor milk though I was aware of milk donation exchange taking place through contact with other mothers in NPN and NPC. Fiona, the mother recipient of donor milk in my research, has an incredible background story for searching out donor milk.

The lactation consultant suggests I talk to Fiona, a new mom who is in the toddler group and currently pregnant after a history of miscarriages. She has a story about using donor milk. Fiona was a lawyer and public defender in bioethics and public health. She attempted in-vitro fertilization (IVF) multiple times, and finally got pregnant in Barbados using an English donor egg. This process complicated her birth. She also had issues with milk coming in, and by day three postpartum, she still had no colostrum. Eventually, they gave her daughter donor

breastmilk via the Supplemental Nursing System (SNS) after two days of pumping but to no avail. She tells me, "I never felt discriminated against. A mom will feed no matter what, it's a necessity and you have to make it work."

She was finally able to breastfeed on her own, but by seven months postpartum, she got pregnant without IVF. Unknowingly, Fiona was already about two months pregnant with her second "miracle baby" when advised to wean immediately by her obstetrician. She had to stop right away so that the hormones produced by lactation wouldn't complicate the new pregnancy. When she could pump, she stored it in freezer bags but would feed with a bottle. Her frozen supply of breastmilk was rationed to 1-2 bottles per day until it was gone. Now her daughter is becoming more independent and doesn't look back for her as much. She thinks it is because that connection is lost now without feeding her on her breast.

Many problems women initially encounter with breastfeeding follow previous decisions they made before heightened awareness of breastfeeding as dependent on the state of their body. These are the more complicated situations a mother must navigate. For the sake of brevity, I omit the many complications Fiona experienced in pregnancy and through her birth process. Nevertheless, she continued to adjust, meeting the needs of her baby first, and then her personal values as a mother. Fiona represents, "an exceptional group of middle-income women," (Palmquist and Doehler 2014, 145) driven to give her baby what she considers the best. For Fiona, it is to have that bond and her baby depend upon her for nutrition. However, no matter how much symbolic value she attributes to the maternal-infant dyad, when the baby's health is considered critical, shame and guilt are no longer applicable. Fiona describes her complications through pregnancy, birth, and postpartum as if they were things that she went through to get to a certain point: being able to *finally* breastfeed.

Although her experience is miraculous in a way, she also laments some over having to give up breastfeeding her daughter so early. This was not easy for her because she loved to breastfeed when she finally could. Unable to provide breastmilk herself, she has made the choice to receive donor breastmilk. We talk about what is referred to as "milk moms" or oversuppliers of breastmilk. If you go through the National Milk Bank, it is \$5/oz. of breastmilk. She thinks that there needs to be stronger acceptance of donor milk through a local milk bank. Formula is expensive which is why it's hard on some people. With the milk donors, she would just give

them her address and they would stop by, often nameless. There is a trust issue, but all she cared to know was that they were drug free, what their prenatal experience was like, and their diet. She didn't really ask about alcohol because it's ok to have a beer here or there, it's even considered good because of the B-Vitamins. I ask if there is any truth to when a baby cries, all moms have a milk let down and she tells me that it's true. "A baby cries and everyone feels it."

When a mother to gives or receives donor milk, she is participating in a form of material sharing with another mom that carries far more moral loading than the passive expression of mothering ideologies. More is at stake. First, the concept of "oversupplier" inherently separates mothers into categories that emphasize the capabilities of their body functioning. This translates into an embodied pressure for a donor milk recipient to negotiate between feelings of body incompetency and moral principles surrounding how best to feed their baby. For Fiona, being able to finally breastfeed her daughter was a marked victory over her body that was first unable to conceive but then was also unable to provide her preferred method of infant nutrition.

Furthermore, Fiona is making an ethical decision because she is choosing to participate in milk sharing with local milk moms rather than the National Milk Bank. The National Milk Bank has a rigorous qualification and screening process for milk sharing whereas most local milk banks, internet milk sharing, and local milk donations rely on an informal relationship between the donor and recipient. The screening process involves internal negotiation by the recipient who must weigh out the unknown risks with the valued benefits. This leads to an agreement in accepting donor breastmilk based on a system of trust between donor and recipient.

Additionally, this unique form of maternal cooperation demonstrates the potential for tension between maternal agency and interpersonal support systems. Apprehension felt by 'the

husbands' may be due to their position in the decision-making process. For Fiona, this was an influence that drove her to explore other material items to help bring in her own breastmilk. Therefore, Milk sharing is not easily perceived as the practical solution to breastfeeding problems. For a mom who is not getting enough sleep or who is going back to work but cannot meet the nutritional needs of her baby through pumped breastmilk, donor breastmilk may be a considerable option to *them* but not necessarily the others in her community of support. Upon reflection, Fiona's decision to turn to alternative methods when her milk did not come in created a different dilemma for her husband who was apprehensive of accepting breastmilk from a local milk donor. During the first year of a baby's life, the mother is subject to constant reexamination and revision of her moral ideals in parenting or, like Fiona, methods to meet those demands. Mothers not only have to negotiate between their breastfeeding problems and an emotional embodied experience; sometimes they must manage competing support systems.

Compliance and Practicality—

Elizabeth is a 34-year-old, upper middle-class, Caucasian first time mom. After years of infertility, Elizabeth got pregnant through IVF with twins, putting her in a 'high risk' category: "So we were seeing a lot of doctors from the beginning...I know some people who get thrown by that and rattled but for me it was actually license to go, 'hey, professionals got this.'"

It turns out, she was right, and Elizabeth had to have a 'split birth' where her son was born vaginally, and her daughter born in via emergency cesarean section. She was able to have immediate skin-to-skin with her son, but not her daughter who was in NICU for 36 hours.

She recalls skin-to-skin as a hazy experience coming out of general anesthesia from her surgery, “It didn’t feel like the intentional, purposeful moment that I imagined it to be.”

At the time of our interview, Elizabeth’s feeding style was exclusively pumping for breastmilk though she went through a long period of attempting to nurse on the breast and supplement with formula. She never had supply issues, but both had to use nipple shields at first when she was breastfeeding. When one twin wasn’t gaining weight and the other lost two ounces, she began to pump her breastmilk only. She tells me that she found it emotionally challenging to nurse and it was a bonus for her that they started taking bottles early. Tandem feeding was not in her comfort zone though she says that many people were fighting to keep her breastfeeding, but their perception of breastfeeding was much easier than the actual challenge she faced. “Breastfeeding could take like an unexpectedly long amount of time...Like that’s not reasonable for managing this household. I had to remind myself that it’s okay, it’s not a failure, working moms do this [give bottles] all the time.”

Elizabeth was feeding her twin infants bottled breastmilk, *mostly*, until she also had to supplement based on her pediatrician’s recommendations and a “no nonsense” attitude for what weight her babies had to be at for health. “We will follow our doctor’s recommendations for nutrition and if I don’t make it [enough milk] ...they’ll probably get formula.”

The financial burden of formula was never an issue because her pediatrician’s office was able to give her a case of free samples through Enfamil’s Twin Program. She can pump enough now that her babies are also eating baby food. However, she also recognizes that different developmental stages require varying levels of independence and looks forward to a time when

feeding them is no longer an “Olympic event.” Overall, her expectations changed based on what was practical for her and her family:

“Having twins relaxed my expectations in a positive sense in that... it’s still an emotional process and decision I think, but it allowed me to forgive myself in advance... ‘ok, if this doesn’t go perfectly, smoothly, according to my plan, it’s ok...there’s two of them.’ That was the license I needed to forgive myself and that ended up being really important when I was making choices like adding in formula to supplement and you, moving to exclusively pumping and bottle feeding.”

Limitations and Knowledge—

Shelly is a 40-year-old, working middle-class, bi-racial first-time mom. Because of her ‘older’ age, she was also considered ‘high risk’ so her obstetrician scheduled her to be induced early:

“I ended up having an emergency C-section but she [her daughter] was supposed to be a vaginal birth. The nurses ended up being the ones to make the call for when it was time for what drug because the way they described the contractions was terrible period cramps, well mine are like death, so that’s what I was waiting for. (Do you know why you ended up having an emergency C-section?) Because my water broke, well 12 hours went past...and I wasn’t dilating past six [centimeters]...so you know, so much time had passed that for her, for her well-being.”

Shelly never mentions skin-to-skin contact after her labor, so when I ask about it she tells me that she was never encouraged to put her infant to her breast at the hospital.

“I found all that out way after. I was discharged and then I was disappointed when, you know, what I missed out on. They were giving her the liquid Gerber gentle, yeah, so that’s what she was started on.”

Shelly began her breastfeeding journey at home by herself after leaving the hospital. She found out later her positions were wrong, but she tells me with pride that her daughter, “never complained, she nursed really easy, actually.” Her milk supply began to reduce by the third week.

At the time of our interview, Shelly was breastfeeding some but mostly giving her daughter bottles of formula, which was covered by the Women, Infants, and Children (WIC) program. She tells me she would breastfeed because, "Health and bonding and then the more I learned about the other benefit. Initially it was for the nutrition (*So initially for the nutrition and then it became about the bonding?*) Uh huh...And then it became about more." She says she never had any breastfeeding traditions and she thinks her mother (who died when she was 19) fed her bottles of formula. She also has very little in terms of support from the baby's father and his family. Her persistence to attempt breastfeeding has been met with some opposition from her stepmom, however, who questions why Shelly feels so strongly about nursing. "She asked me, 'Why is it so important...What's wrong with formula feeding?' And what not, well there's a whole lot of reasons...Not only the nutrition but there's the comfort and the bonding... [stepmom says], 'Well you get that anyways,'...'Sharon, you don't understand. You've never been a mother; you've never been there...' she hasn't said anything since then."

Through the multiple times I have met with Shelly, her main concern has always been about going back to work. She tells me her biggest regret is not knowing how to breastfeed and pump prior to giving birth, "If I would have known then what I know now, I wouldn't be in this position." She insists that her classes through the hospital were "stupid" and about what drugs you could get and the procedures. They didn't prepare her for going back to work.

She tells me later that she was offered classes specifically for breastfeeding but already had to miss work for doctor's appointments. Her co-workers originally told her that she would just figure out how to breastfeed on her own, and her workplace was supportive of her

needing to take an additional time off to be with her baby. Overall, Shelly had to learn to create her own expectations of motherhood based on a positive emotional experience with breastfeeding. Only then did she start making demands that were aligned with her values.

Resistance and Perseverance—

Valerie is a 27-year-old, middle class, first time mom. She experienced a delightful pregnancy and with every intention of having a drug-free birth opted for an epidural when the medical staff recommended that they rupture her bag of waters. The pregnancy still lasted longer than anticipated. Valerie now breastfeeds on demand. Much of her opinions regarding breastfeeding is supported by the fact that she was adopted by her parents and her occupation prior to giving birth was in infant massage; “I just had really strong feelings about breastfeeding exclusively. I don’t really know where it came from, like crazy pregnancy hormones maybe, I don’t know. Everyone has pretty much been supportive. My parents are really supportive.”

However, her expectations of being able to breastfeed on demand was met with opposition in the beginning from medical authorities at the hospital where she gave birth. She suffered a traumatic loss of blood after the birth and had a difficult time getting her milk to come in.

“There was a nurse and his doctor really pushing it and being like, ‘you need to supplement with formula because of this, this, and that.’ [They were] really trying to intimidate me is what it came off like. My husband went into caveman, I-have-to-protect-my-family mode and yelled at the doctor and was like, ‘I don’t want you around my wife; we are not doing that.’ And he ran out and got one of the lactation consultants. She was leaving for the day, and he dragged her up to my room and was like, ‘You have to talk some sense into this doctor.’ And she did.”

Her husband had taken the breastfeeding class at the hospital and was important for her as a constant source of reassurance about her body’s capabilities. She began pumping in the hospital because the medical staff thought she didn’t have an adequate supply of

breastmilk, and it turned into an issue of oversupply. This began another round of complications because her son had learned to latch and swallow, but not suck due to her forceful letdown. After about a month and a half her baby was constantly fussy and the pediatrician told her she probably had lost her supply; “I just got really frustrated that they weren’t helpful at all. It was just like any time I called there it was like, ‘Oh well, maybe you should just do formula,’ and I was just like, ‘no’.”

They called on the lactation consultant to troubleshoot for a solution to her breastfeeding problem, and they discovered that he wasn’t sucking. Her son needed to see a pediatric speech therapist to correct the issue. Looking back on her experience she tells me:

“I think I’m a really strong-willed person and I can make up my mind even if a doctor is saying ‘no, do this.’ I ultimately feel like it’s my body, my child, I’m the one that knows what’s best regardless of someone else’s credentials. But I think there are a lot of women that don’t feel that way, or don’t have the confidence to pursue something else so...We did that, and that was our major breakthrough...They [doctors] are so attached to their growth chart.”

The women in these stories share the experience of conflict in their maternal community leading them to identify who they are as a mother. It is important for new moms to discover who belongs in their system of support. For Elizabeth, who had genuinely wanted to nurse her babies, it was impractical given what she calls the “twin factor.” She had many levels of support for her decision despite having to work through her own guilt. Shelly, also labeled as ‘high risk’, was not taught about her choices before giving birth and, consequently, was initially compliant with medical authority. However, her confidence built up through a positive experience breastfeeding her daughter. Only then was she able to move towards a more independent role as a mother. In contrast, Valerie was very resistant of authority, opting for her own values. The role of her partner was crucial through her struggle with breastfeeding

issues that could have easily moved her to give her baby formula. Her story is like Fiona's story; despite a traumatic experience, through perseverance and an embodied confidence, they find a way to meet their valued ideal.

In the end, a mother will evolve as the baby develops. Building a community of support is crucial to self-discovery. Tension between opposing forms of authority or philosophies are inherent given the moral loading of breastfeeding and social expectations to produce independent humans. It is too simplistic to consider breastfeeding problems 'practical' because the mothers with them truly embody guilt and frustration. To what extent a woman is going to continue trying to breastfeed depends on the strength of those values *before* the problem arises, how much self-autonomy she desires, and the strength of her community of support. Mom-to-mom community building and other forms of moral authority may not actually be as influential as the embodied experience itself, but the commitment offers opportunities to work through that experience, to experiment with other philosophies, and to ultimately feel connected with each other through the pressure of expectation.

“Breast is Best”: A Breastfeeding Narrative

In 2007, The Agency for Healthcare Research and Quality linked the practice of not breastfeeding to an excess of health risks. In the culmination of evidence to support the superior nutritional and immunological properties of breastmilk, the Surgeon General issued the first *Call to Action*. This is a comprehensive outline of the sociological barriers to breastfeeding and the necessary commitment needed from clinicians, employers, communities, researchers, and government leaders to bolster national attention of breastfeeding as a public health issue (US Department of Agriculture 2011).

Public discourse surrounding infant feeding is growing and the formal recognition of the role medical anthropology plays in public policy and breastfeeding comes as no surprise (Van Esterik 2012). In this chapter, I detour some from the description of how new moms unpack their individual and social expectations to discuss the systemic constraints to breastfeeding. By taking a critical stance, I recognize the context of my result as being a very specific subset of middle-class, white, married/partnered, heterosexual women. However, even within this subset, I encountered variations in systemic roadblocks to breastfeeding such as confusing medical rhetoric, unsupportive workplace policies, and some institutional and interpersonal forms of racism. Thus, I hope to generate a better understanding of how new moms grapple with the idea of breastfeeding as a ‘choice’ when there are deeper layers of power that go unrecognized on the surface (social “norms”), and insight into what grassroots level advocacy looks like.

It has been established elsewhere that ethnography already has an impact on social change, especially regarding public perceptions of health (Hansen, Holmes, and Lindemann 2013). For better or worse, anthropological perspectives are already being packaged as part of a rhetorical argument in favor of breastfeeding. Anthropology research that emphasizes the normalcy of long-term breastfeeding (i.e. Katherine Dettwyler) as well as patterns of lactation and care by contemporary foraging societies like the !Kung of the Kalahari (i.e. Konner and Worthman) have contributed to the evolutionary discourse used in favor of Pleistocene-esque “stone age mothering,” (Hausman 2003). Given concerns about specific narratives that “cherry pick” from anthropological literature to promote a rhetorical message (Faircloth 2013; 2017), breastfeeding scholars are confronted with questions about their relevancy (Pigg 2013).

The specific discourse I would like to address exists at the nexus between media messaging and public health promotional efforts of breastfeeding. I offer an intersectional-informed critique of the national public policy origins that inform the motto *breast is best*. Intersectionality is an analytic framework that examines social groups, relations, and contexts by which policy is informed from multiple positions (Dhamoon 2011). My analysis seeks to understand how breastfeeding is being framed by media, healthcare, and even public health through *breast is best* without adequate attention to various issues of marginality and privilege.

Intersectionality is an expanding research paradigm in political and social sciences that treats social positions as relational, multiple, and visible to the power relations central to them (Dhamoon 2011). *Intersectionality* was originally coined in the 1980s to refer to intersecting

relations of marginality and vocality of women-centered struggles surrounding racial and gender discrimination. Even though the concept and language of intersectionality is still contested within feminist scholarship, it is meant to denaturalize narratives that are taken as given and separate subject formation and identities from institutional factors (Dhamoon 2011).

Intersectional work is an examination of the complexity of subject formation by focusing on the multiple processes and systems that inform differing forms of penalty and privilege. My critique of *breast is best* is meant to evaluate the socio-political context that informs maternal experience and “individual choice” as a matrix of processes (discourses and practices of doing or making differences) and systems (racism, patriarchy, sexism, and capitalization) (Dhamoon 2011).

I am using this detour to argue that *breast is best* is overused and outdated in breastfeeding literature. I hope this argument will help allow space for a better conceptual basis for breastfeeding policy change to develop. The 2020 national objectives set by Healthy People (HP2020), a wide-ranging national health promotion and disease prevention initiative, has targets for breastfeeding that have yet to be met. How and to what extent current policy is effectively making a difference is beyond the scope of this paper. What I offer here is a critique that will inform an intersectional approach to defining the barriers to breastfeeding. An examination of public policy from an anthropological perspective is not only relevant to my research questions, but is necessary to the process of undoing the “boxification of culture” inherent in public health research:

“Measurement in public health programs and research requires bounded categories and must remove confounding variables. But what public health calls confounding variables, ethnographers call thick description. Public health is heir to the biomedical factory analogy of the individual as a discrete bounded body,” (Van Esterik 2012,56).

The intersectional methodology assumes the stance that breastfeeding, as a component of social life, cannot be decontextualized from categories of social position (Dodgson 2012). By critiquing public policy from a position that is inspired by my role as an ethnographer, rather than as a mother or staunch breastfeeding advocate, I hope to contribute to the body of literature that resists the reduction of cultural differences to measurable traits.

Current public policy is in alignment with the media inspired framing of *breast is best*. In this chapter, I briefly address local breastfeeding coalition building as a potential source of resistance against *breast is best* advocacy. Groups like the Midwest Breastfeeding Coalition and African American Breastfeeding Network have their own framing of breastfeeding. According to the *Call to Action*, local coalitions are recognized as having an important role for community advocacy although I argue here a local context is far more sensitive to inequalities that may inhibit the larger, national campaigns from reaching HP2020 set goals.

A Brief Historical Review of Infant Feeding Alternatives

Infant nutrition is assumed to be a choice that confronts the modern mother only (Stuart-Macadam 1995). Prehistoric mothers had no choice but to breastfeed although wet nursing, the practice of a woman breastfeeding another's child, was an ancient and accepted social custom (Fildes 1995). Wet nursing evolved from a necessary alternative to breastfeeding in 2000 BC into an "alternative of choice" used by women of high social status in Greece by 950 BC (Stevens, Patrick, and Pickler 2009, 32). A few publications surface in the historical record that favor the mother over the wet nurse as a preferred method for infant feeding (Stevens, Patrick, and Pickler 2009). Breastfeeding was considered a saintly duty: it increased affection between child and nurse, but also led to the transfer of physical and psychological

characteristics through breastmilk. Regardless, wet nursing became a popular, organized, and well-paid profession for poor women during the Renaissance (Stevens, Patrick, and Pickler 2009).

During the Industrial Revolution in Great Britain, women were more likely seek alternatives to breastfeeding while living and working in spaces that made them subject to environmental toxins. By the 19th Century, the supplementation of artificial feeding practices (cereal, cow's or goat's milk) became more practical than wet nursing (Fildes 1995; Stevens, Patrick, and Pickler 2009). With the 1851 invention of the glass bottle in France, artificial feeding developed to replace wet nursing as the accepted alternative to breastfeeding. However, immigrants with strong breastfeeding customs who moved to American urban spaces continued to breastfeed and use wet nurses despite impoverished and unsanitary living conditions (Fildes 1995).

Infant feeding supplementation became a common practice in the urban landscape while breastfeeding was associated with poor families, and women living in rural areas. This was particularly significant in the United States context during the Antebellum Period. In Northern manufacturing cities, having an alternative to breastfeeding was matter of social nobility and class distinction. In the South, wet nursing was associated with the institutionalized separation of enslaved women from their children (Boswell-Penc 2006). Furthermore, wet nursing was a duty of slave mammies, the women who would suckle the white masters' babies (and their future master). This allowed aristocratic wives to avoid lactation amenorrhea and have more children. By 1900, attitudes toward wet nursing had completely shifted to reflect changing attitudes towards immigrants and former slaves while the feeding bottle and

availability breastmilk alternatives advanced (Boswell-Penc 2006; Stevens, Patrick, and Pickler 2009).

The commodification of infant feeding began in the late 19th-early 20th century along with increased pediatric specialization. Biomedical journals were particularly important to the increased awareness of public health standards of sanitation and dairying practices (Fomon 2001). Linda Bryder's historical research on modern infant feeding demonstrates how the Social Darwinist movement and the burgeoning science of bacteriology "demand that babies be breastfed for the sake of 'national efficiency'," (2009, 1). However, the trend in breastfeeding declined as substitutes to breastmilk and cow's milk were being manufactured, regulated by the FDA, and, therefore, producing scientific, marketable research that deemed them safe and perfectly adequate replacements for breastmilk (Bryder 2009; Foman 2001). Consequently, breastmilk substitutes steadily increased in urban markets abroad, especially in developing countries.

Breastfeeding came back to be *en vogue* during the 1970s and 1980s as part of a woman's health movement. Breastfeeding awareness increased as infant feeding became a public debate with grass-roots consumer movements in North America and Europe (Van Esterik 1989). Global recognition of the questionable ethics involved in commercial promotion of artificial feeding developed as a result of public trial between Nestlé infant formula manufacturers and the Third World Action Group (in Germany). The libel suit between the Third World Action Group and Nestlé resulted in thorough monitoring of multinational corporate interests by groups such as the Infant Formula Action Coalition (INFACT) (Van Esterik 1989).

In the later 20th Century up to our current time, public health policy initiatives developed more evidence-based biomedical research promoting breastfeeding. Although the 1970s wave of feminist social action was a push back against the established institutions and patriarchal control of the female body, it also was meant to re-normalize breastfeeding and frame the mother-infant bond as one of empowerment through a process, rather than a product (Van Esterik 1989, 5).

In sum, a historical review of alternative infant feeding practices indicates factors such as class status, geography, political context, and theoretical paradigm having an impact on the individual circumstances that influence a mother's 'choice' to breastfeed. The current framing of *breast is best* is assuming that breastfeeding is easy and free for every mother, ignoring a history where alternatives were necessary prior to the formula industry.

Breast is Best and the Breastfed Baby: Using Rhetoric as a Socio-Political Power

"I think *breast is best* is a very simplistic way of looking at breastfeeding. I think it can be a good thing, just in terms of the very basic way of letting families know, and maybe particularly targeting lower educated families to know that even though WIC gives you free formula, it is better to breastfeed for your baby. I do think that some of the messaging about breastfeeding, while I obviously believe that breastfeeding is a good thing, it can create some judgment. It doesn't leave an opening to acknowledge that some people can't breastfeed for one reason or another. I think the simplicity of some of the messaging doesn't allow women to prepare for some of the challenges that could arise. I've seen some of my friends struggle: 'The world's telling me I need to breastfeed, but I'm not making enough milk for my baby. Now I feel like the worst person in the world for supplementing with formula'," (Melissa 2.1).

In public discourse, the mantra *breast is best* is the phrase used in government and healthcare institutional policies promoting the nutritional and long-term health benefits of breastmilk. Though not a policy itself, *breast is best* is consistently referred to as the fuel behind the breast is best /'fed is best' (formerly the 'breast vs. bottle') debate. This debate is most often framed by various news publications and social media outlets as having breastfeeding

believers and preachers — "bullies" — on one side versus the 'not best', guilt-ridden women who push back (Roussey 2017).

Given American media's role in exacerbating the conflicting discourses surrounding breastfeeding, it is not entirely ironic that *breast is best* slogan originates from a 1988 article "Is Breast is Best?" recommending the supplementation of formula for premature babies (Foss 2017:72). However, the actual slogan *breast is best* didn't appear as part of the middle-class American vernacular until the 1990s when it was used as part of the WHO-UNICEF Baby Friendly Hospital Initiative to foster media and medical adaptation of breastfeeding as the "norm."

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) worked in tandem to develop global breastfeeding policies that addressed corporate advertising and marketing of formula in developing nations, specifically the boycott against Nestlé. Based on public health statistics regarding infant mortality and morbidity, the 1981 Code of Marketing of Breastmilk Substitutes (the WHO Code) was the first major political enterprise to counter the "dangers" of formula milk substitutions (Baumslag and Michels 1995). *Breast is best* global "policy", from a historical perspective, came about when UNICEF began to publish materials that both warned against bottle-feeding and promoted breastfeeding for health workers in rural areas of Zimbabwe (Baumslag and Michels 1995, 165).

The official "Baby Friendly" effort was initiated in 1991 when WHO and UNICEF implemented a slew of policies known as the Baby Friendly Hospital Initiative (BFHI). In response to the growing awareness that doctors and hospitals are targets for formula

consumerism, the BFHI initiative is a global effort to, “encourage and recognize hospitals that have implemented optimal lactational management,” (Baumslag and Michels 1995, 175). To claim status as a “Baby Friendly” hospital, maternity services must be trained and adhere to the *Ten Steps to Successful Breastfeeding*. Hospitals around the world adopted the BFHI status and some countries including Latin American countries and Kenya adopted the Code or a model of it as law.

The global policies were put into place based on global needs for a closer examination of the medical case for breastfeeding in developing countries. Breastfeeding scholars are often conflicted by the *who, where, why, and how's* of breastfeeding advocacy (see Hausman 2003 on Pam Carter 1995, Linda Blum 1999, and Jules Law 2000), but all agree that like most global health problems, infant disease and death contains larger social issues: “Promoting breastfeeding as a panacea for poverty is ethically questionable; educating women about what they can do in the face of state neglect is not,” (Hausman 2003, 203).

Unlike the 118 countries who approved the Code in 1981, the United States did not adopt the Code until 1994. The lag has been attributed to the political debate and conflict within the American Academy of Pediatrics (AAP) (Baumslag and Michels 1995; Koerber 2013). Although there was a consistent push to adopt formal recognition of pro-breastfeeding policies from groups like the Le Leche League, breastfeeding focus groups, and AAP task forces, the pivotal moment in American policy occurred when the AAP issued a policy statement in 1997 that referenced breastfeeding as the “normative model” of infant feeding. Prior to this stance, the AAP used more neutral language citing breastfeeding as “optimal” compared to formula in preceding statements (Koerber 2013). By formally recognizing how much the formula industry

influenced U.S. infant feeding practice, the 1997 statement issued in an emergent sense of urgency to promote breastfeeding for at least the first year of an infant's life.

Of critical concern is not the adoption of global pro-breastfeeding policies by the AAP; it is the rhetorical and political marketing of *breast is best* ideals. The 1997 policy statement and subsequent statements focus on the dominant expertise of medical authority. Congruent with this topos is the June 2004–April 2006 National Breastfeeding Awareness Campaign (NBAC) that influenced the national circulation of the idea that formula use was “risky” while breastfeeding resulted in a healthier, more intelligent baby based on scientific evidence (Koerber 2013).

Critical of breastfeeding advocacy, Joan Wolf (2011) attributes “Risk Culture” in breastfeeding promotion as part of a larger scientific paradigm. She argues that breastfeeding vs. formula feeding comparison research as risk-factor epidemiology is driven by larger, neoliberal political and professional agendas. The NBAC campaign's messaging is based on funded research by the National Ad Council and McKinney & Silver LLC advertising to determine what would be the most compelling ways to persuade U.S. mothers to breastfeed (Koerber 2013, 23). At the heart of the campaign are governmentally funded messaging regarding the risks of not breastfeeding which prompts Wolf's ethical critique of public health framing in breastfeeding advocacy.

“The NBAC was marked by overcharged rhetoric and disingenuous and morally dubious comparisons. [...] Nowhere was the absence of women more striking than in the campaign's exclusive emphasis on babies, in its choice *not* to address breastfeeding's potential health advantages for mothers. [...] Indeed, they often expressed a certain incredulity that women could be told that ‘breast is best’ and still choose formula, and they assumed that bottle-feeding mothers did not hear or understand the message,” (Wolf 2011, 118-120).

In her thorough analysis on how the media has influenced public discourses about breastfeeding, Katherine Foss (2017) points out that increases in the rates of American

breastfeeding mirrors domestic breastfeeding tips, stories, and articles that convey guilt for women who cannot or chose not to breastfeed. Since the implementation of WHO-UNICEF programs, breastfeeding success has had mixed results. Though it is well known by now that media influences the public perception of infant feeding, academic scholars like Foss and Miriam Lobbok recognize that the role of media as part of larger institutional and cultural barriers—

“While the phrase *breast is best* is accurate, it is also dripping with insinuation of a mother’s inferiority and attributions of blame for not breastfeeding. [...] This focus on individual responsibility for breastfeeding reflects the tradition of individualism as an American value. In the United States, we love to blame people, not organizations, businesses, fractured systems, or institutions,” (Foss 2017, 2).

The argument for the normalization of breastfeeding depends on the growing evidence of breastmilk as the ‘perfect’ food and medicine. In the United States, it is common to encounter very specific narratives that highlight certain biological advantages. ‘The Breastfed Baby’ in *Figure 1* is an image that comes from a parenting blog featuring a white woman with an angel’s halo breastfeeding while sitting in front of her computer with a cup of coffee and a breast pump. It is a visual representation of what is disseminated through other forms of new media including WebMD.com, *Fit Pregnancy and Baby* (a website and a magazine that can be picked up at a local OB/GYN office), Kellymom.com, and BabyCenter.com. All are sources I have come to know about through the new moms I encountered while doing my research. Women in previous studies have also reported a perception that the *breast is best* based on the dominance of a particular breastfeeding rhetoric based on health messaging. This discourse is consistent with a health promotion approach that favored the benefits of breastfeeding over the realities of infant feeding (Lagan et al. 2014).

The Breastfed Baby

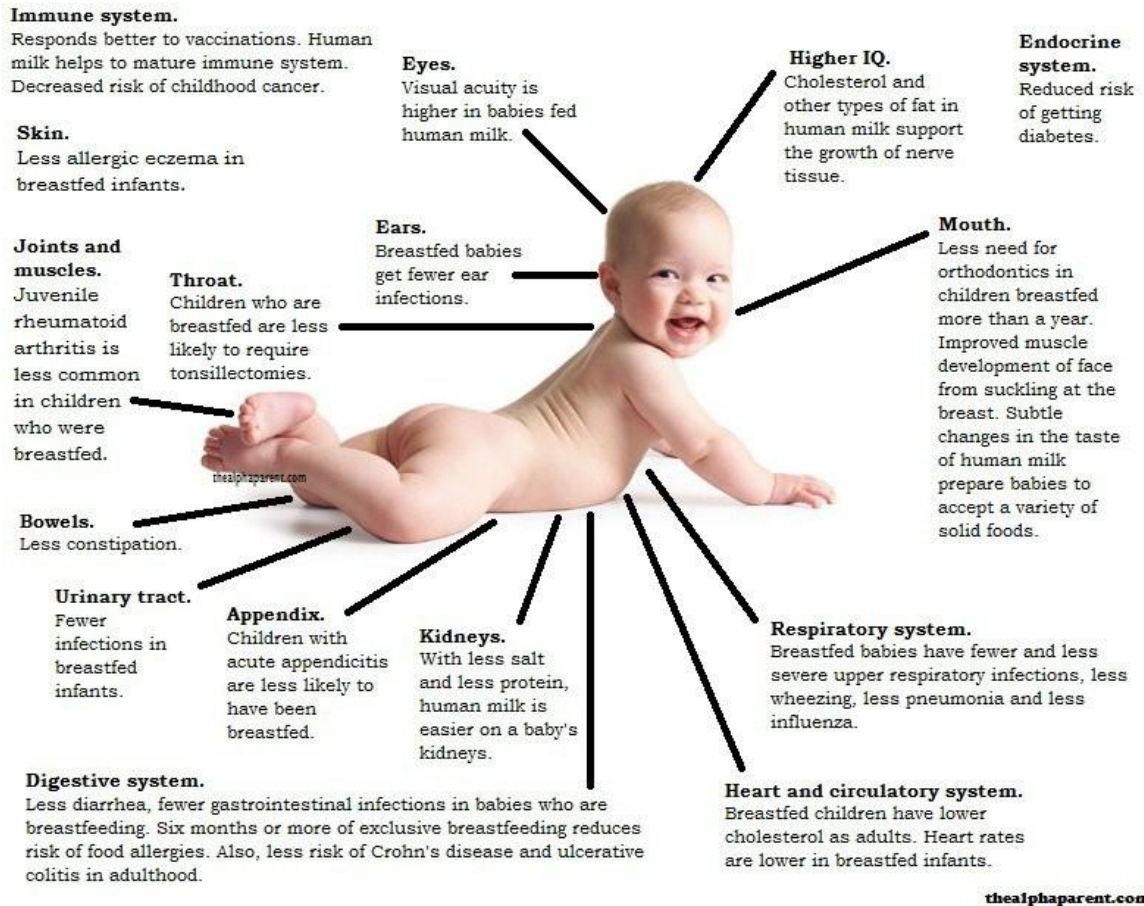


Figure 2.1: Diagram of a Breastfed Baby from The Alpha Parent: The Politics of Parenting Blog (<http://www.thealphaparent.com/2011/12/diagram-of-breastfed-baby.html>). Dec 16, 2011.)

Philosophically, a critical analysis of *breast is best* is reminiscent of a Michel Foucauldian discourse on the techniques of power. *Breast is best* is based on the commodification of breastmilk. Economic value combined with scientific discourse as evidence suggests that human milk can be commodified through ubiquitous information that comes from authoritative knowledge. Situated within the “Western ethos of individualism”, public health messaging that emphasizes breast milk over the provider (medical model) or bonding as dependent on breastfeeding (maternalist model) reduces breastfeeding to a moral imperative emphasizing

“good motherhood” (Groleau and Sibeko 2012). The result is an institutionalized form of power, one devoid of any context for the constraints of breastfeeding, especially for marginalized women: “The implied morality becomes a mechanism of surveillance, used to control mothers’ actions, creating difficult power relations between mothers and health providers,” (Groleau and Sibeko 2012).

Although *breast is best* is not a policy itself, the current framing demonstrates the influence of scientific inquiry on ideologies of neoliberal economies (Farmer 2004) giving rise to neoliberal policies. Again, within the historical context of the Industrial Revolution in the United States, the varying socio-political response to infant feeding practices has been determined by what will make the United States “the fittest” through international competition with other Western countries. Competition for biological efficiencies of a breastmilk replacement and market product produced changes in infant feeding patterns that supported artificial feeding mechanisms. The framing of breast is best vs. ‘fed is best’ as a debate could not be established until infant feeding became a set of products you could sell.

The very nature of the mantra implies what Susan Draper has considered mothering in postmodern America as “an isolated enterprise in which children are seen as commodities that mothers are expected to produce perfectly,” (1996, 260) further strengthening the current social ‘problem’ having more to do with a practice of ideological state apparatuses than a ‘breast vs. bottle’ debate. The public push towards exclusive breastfeeding implies a gendered ideology about the role of women as unwaged laborers. Furthermore, the simplicity of the message *breast is best* implies a class ideology. Women who educate themselves about breastfeeding are likely to be more regulated by ideologies of freedom, morality, and

responsibility. Instead, *breast is best* ignores breastfeeding as a culturally-embedded process (Martucci 2015). It also ignores the environmental and social effects of structural violence on the “less privileged” who are blamed for producing the cultural norms surrounding infant feeding *and* dismissed as socially, culturally, or biologically flawed when unable to nurse (Bowell-Penc 2006). To know and experience the breast being best is to acquire a level of self-awareness of one’s social placement.

The policy ‘problem’ is that the debate is currently framed as an issue concerning public value of a simplistic phrase used to represent a complex socio-biological experience. *Breast is best* breastfeeding advocacy assumes that infant feeding decisions are a matter of individual choice, and that choice is an equal opportunity for everyone. The social issue under consideration contains moral implications regarding how an individual chooses to mother and the potential consequences are possible long-term health problems or delayed cognitive development for the baby. Formula-feeding mothers are at risk of being labeled as 'lazy' or 'unfit' based on an ideology of motherhood that overstates the actual benefits of breastfeeding (Groskop 2013) while formula-fed babies are at risk of being labeled as ‘poor’. *Breast is best* appears to be a moral debate regarding the responsibility of the mother but it develops from and rewrites underlying structural socio-economic and racial inequities that have been around far longer than the debate itself.

Breast is Best at the Intersection of Social Inequalities

Inherent to a controversy is a difference of voices, exemplified here by rhetoric linked to differences in power and knowledge (Van Esterik 1989). The corporate structure of the formula companies and the biomedical healthcare authorities are the two institutions involved with

framing the 'problem'. Both of their tactics include the use of biomedical research and "randomized trials" to justify their respective claims. So far, the science suggests that breastfeeding reduces infant morbidity and mortality from GI and respiratory infections, Sudden Infant Death Syndrome (SIDS), and necrotizing enterocolitis in preterm infants as well as the *possibility* of protecting infants long-term against obesity, hyperlipidemia, hypertension, Type-2 diabetes, and atopic disease while promoting neurocognitive development (Kramer 2010). However, the reproduction of *breast is best* recreates the assumption that every woman's experience is equal while erasing structural inequalities such as access to adequate biomedical healthcare, waged labor, and healthy living conditions. Therefore, knowledge and power are limited to those who are privileged enough to be consumed by the debate.

Perhaps the most oppressive assumption underlying *breast is best* is one regarding racial reproductive equity. A literature review of the research on factors that influence breastfeeding to six months indicate that the woman's intention, social support, and self-efficacy are the biggest predictors (Meedy, Fahy, and Kable 2010). However, when racial and ethnic differences in breastfeeding are considered, African American mothers were far less likely to initiate and show intention to breastfeed (McKinney et al. 2016). Furthermore, McKinney et al. concludes that African American mothers are significantly *more* likely to experience in-hospital formula introduction. Early introduction of supplementation is the biggest predictor of shorter breastfeeding duration despite indications of poverty (McKinney et al. 2016). Therefore, regardless of the other factors (poverty, college education, age, and marital status) that predict infant feeding practices, African American mothers are far more likely to experience racial prejudices in the hospital.

The public assumption that all African American mothers are unwilling to initiate or sustain the practice of exclusively breastfeeding their babies is the essence of what Dorothy Roberts considers the dominant social message of compulsory motherhood under patriarchy as it is complicated by racism:

“Procreation by Black mothers, on the other hand, is devalued and discouraged. The devaluation of Black motherhood is a way of disregarding Black humanity. The value society places on individuals determines whether it sees them as entitled to perpetuate themselves in their children,” (1998, 11).

It is the medical community that upholds the *breast is best* campaign. Black women commonly experience institutional forms of racism that prohibit or devalue them as moral or virtuous and denies them mothers’ parental rights. Current public policy systemically targets African American women with *breast is best*, but then they are far less likely than white women to discuss breastfeeding with their healthcare provider prior to giving birth (Gross et al. 2014). Furthermore, oppressed populations are even less likely to receive consistent support through the breastfeeding process.

I have already established that characteristics of race and socioeconomic status are not considered a part of the dialogue when framing public policy. The social sciences and even some news sources are beginning to recognize this disparity (Grayson 2016). Perhaps the real debate is between white patriarchal institutions that normalize judgment and put knowledge on a hierarchy and the real, everyday experience of motherhood. The current representation of the public health campaign overlooks inherent forms of structural inequities.

Exclusive breastfeeding is recognized as the normative model to feed an infant by both U.S. federal public policy and international public health policy. The public health impact is based on the recognition of breastfeeding as species-specific source of infant nutrition that

confers beneficial health, psychosocial, economic, and environmental effects (U.S. Department of Health and Human Services 2011). Following in the footsteps of NBAC, in 2007, The Agency for Healthcare Research and Quality has linked the practice of not breastfeeding to an excess of health risks. In the culmination of evidence to support the superior nutritional and immunological properties of breastmilk, the Surgeon General issued the first *Call to Action*; a comprehensive outline of the sociological “barriers” to breastfeeding including lack of knowledge, social norms, poor social supports, embarrassment, lactation problems/health care, and employment (U.S. Department of Health and Human Services 2011). Interestingly, the United States Department of Agriculture (USDA) is perhaps the most identifiable player in the creation of the *breast is best* debate while also being the source of current policy response.

The Women, Infants, and Children (WIC) program was established by Congress in 1975 as a source of supplemental nutrition for women who meet the income guidelines and are also at nutritional risk. As of March 2017, WIC eligibility requires applicants’ gross income to be at or below 185% of the U.S. Poverty Income Guidelines (in 48 contiguous states, D.C., Guam, and territories) (U.S. Department of Agriculture 2017). The USDA began breastfeeding promotion and support first through WIC in 1989 (U.S. Department of Agriculture 2015). Then, in 1992, the Secretary of Agriculture established the first national breastfeeding promotional campaign, “...to promote breastfeeding as the *best* [emphasis added] method of infant nutrition, foster wider public acceptance of breastfeeding in the United States, and assist in the distribution of breastfeeding equipment to breastfeeding women,” (U.S. Department of Agriculture 2015).

WIC state agencies began collecting data on the incidence and duration of breastfeeding of their participants beginning in 1994 (U.S. Department of Agriculture 2015) coinciding with

welfare reform limiting Temporary Assistance for Needy Families (TANF) benefits. Three years later, the USDA began using a social marketing approach to encourage breastfeeding through the campaign “Loving Support Makes Breastfeeding Work” and “Breastfeeding: A Magical Bond of Love,” which was specifically designated for Hispanic mothers (U.S. Department of Health and Human Services 2011). These programs are meant to apply a social marketing approach to support breastfeeding mothers enrolled in the WIC program. This was the first USDA effort to encourage low-income mothers to breastfeed by overcoming the lack of knowledge as a barrier to breastfeeding.

This application of a social marketing model has been an effective way to get WIC moms to initiate breastfeeding as there has also been a rise of overall continued breastfeeding in the U.S. (Pérez-Escamilla 2012). However, exclusive breastfeeding rates have remained low for most WIC participants. Although using commercial marketing principles has increased overall awareness of the benefits of breastfeeding, it has divided WIC participants into women who *only* perceive the benefits of breastfeeding from women who are more likely to report the social barriers (McCann, Bayder, and Williams 2007).

The USDA has targeted low-income women by using WIC breastfeeding intervention as a precursor to a much larger national breastfeeding campaign, but the public perceptions on breastfeeding constraints are consistently divided by ethnicity, race, and education levels. Based on the results of a 2000 Lifestyle survey of people who represent a cross-section of all US adults, “non-whites,” and those with less income and education are more likely to have negative perceptions of breastfeeding (Li, Fridinger, and Grummer-Strawn 2002). Within a sample of low-income women only, breastfeeding initiation rates were lower for African

Americans, unmarried women, those with no college education, those with a full-time job, and those who were WIC certified (Khoury et al. 2005). The initial governmental policies to close the knowledge gap were based on an assumed homogeneity of social norms. Furthermore, programs like “Loving Support Makes Breastfeeding Work” downplays infant feeding decisions made within the constraints of lived experience.

With due critical attention to how the USDA uses WIC to inform a larger population of women, I argue here that the moralization inherent in *breast is best* emerges from moralizing attitudes regarding employment and waged vs. unwaged labor inherent in the welfare state. Economic programs, like WIC, are meant to be amoral—lacking moral messaging (King 1999). They are, however, political. The “programme of morality” reproduces the failure of welfare state policies as individual failings in order to keep control of who and how one gains access to the necessary resources of reproduction and childcare:

“The coincidence that occurs from time to time of a system’s values with those of morality, is sufficient to convince moralizers of the possibility of a permanent or long-term coupling between the two codes so that the terms good, moral and virtuous will eventually become congruent with the terms legal, profitable, politically expedient, scientifically true, healthy, academically successful, etc., so that moral agendas may also become legal, political, economic, scientific, medical and educational agendas,” (King 1999, 12).

It is not surprising, then, that women who encounter problems while breastfeeding feel a sense of stigmatization because low-income women are categorically deemed morally disadvantaged from the onset. The roots of this stigmatization in policy can be traced to the cultural politics of the late 19th Century maternalist social program that stressed prescribed gender roles. For women, it was keeping cultural standards of domesticity and motherhood. Maternalist welfare policies, however, proscribed African American mothers (“defined by society not as women but as workers”) from the maternal ideal through racial

discrimination. Their assumed immorality and lack of knowledge was incompatible with maternalist domesticity (Mink 1995, 51).

Additionally, Guttman and Zimmerman found that many low-income women suggested that they would have liked to breastfeed but chose not to because it was discouraged in certain economic contexts, suggesting that more privileged women could do so more easily (2000, 1468). Tensions between perceptions about breastfeeding's social context and practice elicit negative emotional states for low-income multiethnic mothers in the U.S., thereby maintaining class-based disadvantages.

Federal regulations require WIC to make decisions about how breastfeeding should be encouraged. For example, WIC participants who are breastfeeding may receive benefits for up to one year after their baby is born. Non-breastfeeding moms can only receive benefits for up to six months after their baby is born (U.S. Department of Health and Human Services 2011). In 2009, a nationwide training for all local WIC agencies was implemented to ensure all WIC peer staff could promote and support breastfeeding despite the fact that WIC provides half of the infant formula in the United States at no cost to low-income families (but for a limited time).

The funds for breastfeeding promotion are still far less than those spent on obtaining formula (Kent 2006). In 2004, nutritional services and administrative costs were US\$1.3 billion compared to the formula rebates providing US\$1.5 billion additional to the WIC budget (Kent 2006). Externally, the USDA is pushing for prenatal peer-counseling programs to increase breastfeeding rates postpartum. This is a positive policy based on research that concludes that access to early prenatal care is an important indicator for breastfeeding exclusivity (Tenfelde, Finnegan, and Hill 2011).

Internally, WIC negotiates contracts with formula companies on rebates for a product manufactured at a very low price but sold at an inflated retail prices determined by market forces. It has been argued elsewhere that the WIC formula rebate program is an incentive to drive more women to formula feed (Kent 2006). In the very least, it has certainly been acknowledged that the formula manufacturers who win the formula contract with WIC are providing substantial financial incentives to them in the form of rebates, ultimately diluting the breastfeeding message (Tuttle 2000).

From a critical perspective, WIC is producing conflicting options for low-income women and reproducing racial capitalism (Melamed 2015). The neoliberal funding logic of WIC has negative consequences for families when they are either no longer eligible for free formula because: (A) they are no longer in need of supplemental foods or at nutritional risk, or (B) they meet income standards; receiving other welfare program benefits. The other option WIC participants have is to avoid being ineligible for WIC benefits.

African American women are affected the most by these governmental policies. Among all WIC participants, African American mothers are most likely to not initiate breastfeeding, express postnatal intent to breastfeed, or breastfeed longer because they are much more likely to perceive the barriers of breastfeeding in their everyday lives (McCann et al. 2007). The attempts that WIC has made to target African American fathers is one route to reaching an influence on women. However, it is also problematic because it perpetuates “powerful negative images of African American ‘female loaferism’” (Mink 1995, 51), and ignorance as the key barrier to breastfeeding instead of structures of low-wage work in racial capitalism.

The 2009 appropriations for the WIC program contained additional provisions for women who breastfeed and expanded the scope of WIC's activities to include peer counseling for WIC participants who breastfeed (U.S. Department of Health and Human Services 2011). It may be meant to provide incentive for breastfeeding. However, it also drives competition and division within the WIC program while ignoring the multiple reasons why African American, young, unmarried, and working mothers may not have the community support needed to sustain breastfeeding.

WIC peer counselors have found that historical (generational gaps in breastfeeding as a result of slavery, formula as a sign of wealth, a history of abuse) and socio-cultural (concerns of body image, sexualization of the breasts, and a "strong, hardcore, callous...empowered" image of Black motherhood) are some of the specific perceptions of breastfeeding for African American women enrolled in the WIC program (Gross et al. 2014). WIC may be able to reach out to some women in need of the education as well as social support, but it does not change the negative social norms and perceived embarrassment of breastfeeding in public.

Furthermore, to say that public embarrassment is an equal concern for every breastfeeding or bottle feeding mother ignores the racist and sexist tropes about black women, especially black mothers as either being a controlling matriarch or bad mother "Jezebel" or a "Welfare Queen" (Tang 2015, 149).

For African American women, there is nationwide perception that they exhibit negative social norms that interferes with their ability to breastfeed long term and the misogynoir that low-income Black families "don't know" or "need the education." However, given that African American women have a completely different historical experience, this "disparity" of African

American breastfeeding rates seems unreasonable when measured with white “self-imposed social, political, and biological yardsticks” (Stanford 2017). The incongruent messages that low-income African American mothers encounter between breastfeeding and the racial-capitalist reality: their hospital experience, WIC, and in their community, suggests that breastfeeding might be another symptom of racial population control; it is certainly another indication of white supremacy inherent in reproductive rights (Ross 2006).

Reflexivity and Rethinking Breastfeeding Promotion from an Anthropological Perspective

There are several barriers to breastfeeding that national programs are attempting to dispel through USDA operated WIC interventions and United States Department of Health and Human Services (HHS) breastfeeding initiatives. Historically, the public health messaging used by these agencies has deepened inequalities between economic class and race. The 2011 Surgeon General’s *Call to Action* statement makes a conclusive note that coordination and collaboration across federal agencies is insufficient, mostly because there is no formal structure to coordinate breastfeeding initiatives. There is no one agency to blame, nor is there a coordinated effort to improve public health because the governmental agenda in breastfeeding has and never will be about anything except the commodification of ideals, specifically medical progress in this case.

Instead, the United States Breastfeeding Committee (USBC), an independent, nonprofit coalition, spearheads the mission of bringing together governmental, educational, and educational agendas together. When you consider the national efforts to bring breastfeeding programs to the state level, what you find is that there is no infrastructure and most breastfeeding support comes from small, localized, unfunded coalitions.

In a more formal review of current policies that address breastfeeding, Jennifer Lucas and Deborah McCarter-Spaulling mention the lack of current workplace policies that protect breastfeeding mothers. Under the Family and Medical Leave Act (FMLA), women are allowed twelve weeks of unpaid maternity leave; this represents yet another policy that restricts breastfeeding options for those who cannot afford unpaid time off or who would rather avoid breaking organizational norms (Lucas and McCarter-Spaulling 2012, 153).

Admittedly, women who are working, who have decided to formula feed immediately after birth, and those who may be really straining with the means or time to breastfeed are not adequately represented in this study. The context of my research is based primarily on middle-class, white women—many who were able to take adequate time off or refrain from working completely or partially during their breastfeeding journey. I am certainly not the first researcher to identify this discrepancy. Martucci (2015) has noted that there is a consistent disconnect between African American motherhood and breastfeeding given a salient tradition of racist scientific and medical discourse that has fueled maintenance of a racial hierarchy. What does this mean to me? For one, I have just dedicated a great deal of energy dissecting the public health discourses of *breast is best* knowing that for a very large population of mothers, this messaging is inconsequential to their frame of reference.

On a reflexive level, I have struggled with this. Deborah, who was one of my only African-American informants, once told me I will consistently have a difficult time finding low-income, formula feeding, or African-American participants because I (A) offer no incentives for participation, (B) would have to consistently reach out, sometimes in excess to gain some level of interest, and (C) am simply not a part their community. Even if I had established all three of

Deborah's criteria for my doula client, I was unable to successfully gain her participation without some form of coercion of power. It was in that personal defeat, I put my own interests aside and have decided to let the lack of data *be* the data.

Deborah was able to inform these specific constraints because of her ongoing work for the African American Breastfeeding Network (AABN). The AABN is a local coalition meant to normalize breastfeeding in the African American community by raising awareness of breastmilk's benefits, addressing breastfeeding disparities, and forming allies with other organizations in the community. This conversation took place while we greeted members of the AABN during the first annual "Lift Every Baby" event: a gathering to take place during August (National Breastfeeding Awareness Month) to celebrate new life, health, wellness, and breastfeeding promotion.

This event was staged as a ritual ceremony with the burning of sage meant to cleanse the space and make room for healing within the community and a pouring of libations to honor young children and babies who have died. The group gathered in a circle, explained by the father (dispelling the racist myth undergirding policy suggesting that Black fathers are "not as involved", and also "need education") leading the ceremony as "A symbol of the village filled with youth and elders." Affirmations are made specifically as a call for healing within the African American community in this city but also for children everywhere living in the face of violence. Then at noon, the babies are 'lifted' by their parents in a symbolic gesture meant to show community support for their good health. Finally, the pregnant mothers are embraced.

After the ceremony, the participants sit down to eat and discuss the connection between ritual ceremony and the violent context that precedes their gathering. Earlier in the

month, the community witnessed an uprising when a 23-year-old, African American male was shot fleeing a police officer who was also African American. This city, defined by residential segregation and “broken windows” policing, has a history of police shootings but this particular incident incited a backlash of rioting and continuous protesting that lasted a few weeks. The participants in this ceremony did not condone or condemn the actions of either young man, but instead talked about the significant link between guns, violence, and abuse particular to this community and their desire to generate actions that promote healing.

For this group, breastfeeding is “the first pipeline” of healing; it is considered a part of the “chain” that links an individual to the community, and a developmental solution to the root of the community’s problems. The language used at the AABN network suggests that they frame breastfeeding as an alternate to the school-to-prison pipeline. Breastfeeding is meant to be transformative for the community, not the individual baby nor the individual mother. I suggest that the *breast is best* adage is not a problematic issue given the socio-political context of their experience.

The AABN is part of a larger community of breastfeeding advocates in the city trying to change local policies that restrict access to breastfeeding for new moms. The local chapter of the Midwest Breastfeeding Coalition (MBC), for example, was able to extend paid maternal leave for government employees. Consisting of members that include nurses, public health workers, WIC employees, and mothers, the local MBC seeks to represent multi-vocality within a framework that advocates for increased breastfeeding awareness for the communities they represent. They frame breastfeeding promotional efforts based on long- and short-term objectives that are relevant to the local governmental administration.

The mission of the local MBC is to reach out directly to a culturally diverse set of people to promote, support, and protect breastfeeding. By offering bi-monthly educational events and newsletters, they approach their community through social awareness rather than policy-informed practices. Some of this work includes advising healthcare practitioners so that they are more likely to meet larger national goals like the HP2020. Part of their work is writing grants, hosting the World Breastfeeding Annual Walk/Latch, and advocating for breastfeeding rights by working with local county legislatures.

My time with them was spent during the biggest event of their year: the 2016 World Breastfeeding Week walk and “The Big Latch On”. The event included a large gathering of women in the coalition but also non-members who have gathered with signs and babies. The coalition was set up for registration at the meeting point. At their coalition meeting prior to the walk, I learned that this event was the best way they could become more visible to the community to promote membership. Then the women walked to a nearby farmer’s market where the event was to take place. Groups of breastfeeding women all “latched” at the same time in solidarity for breastfeeding awareness.

The flyers for the big breastfeeding event read: *Breastfeeding: A Key to Sustainable Development*. The Midwest Breastfeeding Coalition and African American Breastfeeding Coalition, backed with the support of other local non-profit projects, reference breastfeeding within the context of wider objectives aimed towards ending poverty and hunger, good health and well-being, quality education, gender equality, clean water and sanitation, and affordable and clean energy. By framing breastfeeding as part of a

larger demonstration of sustainable public health practices, the policy ‘problem’ becomes rooted in community solutions rather than individual requirement.

To conclude, the lack of significant data on mothers who formula feed, women from low-income families, and women of racial and ethnic diversity—while it presents a problematic under-representation of experience, also provides a reflexive image of my journey through the research process. I realize now that even if I had found women willing to participate in my study, my research questions may not resonate with their experience. It is worth acknowledging these gaps because they pose additional fields of inquiry; they pose a real conundrum for us who want more women to breastfeed. Certainly, there is a way to frame the *breast is best* logic in a way that does not reproduce social inequalities, oppression, and moralizing attitudes surrounding motherhood.

Currently there is a slippage between top-down public health messaging and everyday survival for all mothers, but especially those who are marginalized by race or class. *Breast is best* is meant to promote a simple motto for breastfeeding advocacy, but my research suggests the motto exists in the minds of a very specific social milieu who use it to help define their mothering philosophy. There is all too often a dissonance between practical realities and the *breast is best* messaging that is shaping the moral context of motherhood. Therefore, these women have to navigate through their experience and then decide to accept, ignore, consume, or avoid breastfeeding policy.

Finally, it is worth mentioning that Intersectional Based Policy Analysis is a framework that could improve public health promotion and breastfeeding advocacy because it provides an innovative structure for equity-driven public health policy (Hankivsky et al. 2014). There is a

great deal of complexity when approaching “the problem” of constructing infant feeding social norms that adequately represent the interests of all mothers. Within the breastfeeding scholarly community, there is growing awareness that the discussion of breastfeeding discourses needs to be recognized within a larger context of reproductive justice (Martucci 2015). The most lucid approach would be to adopt a paradigm shift that recognizes the agency of women, rather than “empty vessels to be filled by biomedical knowledge, an underlying ontological postulate that has been ineffective in public health action,” (Groleu and Sibeko 2012, 210).

Conclusion

The previous chapters consider the cultural complexities of breastfeeding from individual, social, and systemic contexts. In Chapter 2, I consider how women embody the experience of breastfeeding by developing strategies to “survive the newborn”. In Chapter 3, I discuss the role of parenting groups in the formation of a maternal community that will support the new mom regardless of the inherent moral authorities that arise. And in Chapter 4, I detour into an intersectional based critical analysis of public health breastfeeding initiatives that promote the idea that *breast is best*. My research analysis is based on focused interviews, participant observation at two select parenting group sites, and participation in two local coalition groups to answer the main research questions I have about how women articulate personal and social expectations, navigate through the breastfeeding biological experience, give symbolic value to breast milk, and grapple with the ‘decision’ to breastfeed given a complex socio-political ecology that supports bottle feeding.

Consistent throughout the previous chapters is an emphasis on how women talk about breastfeeding given historically conflicting dialogues. The evolutionary and scientific model for infant feeding, collectively known as the resource discourse, support breastfeeding as the superior way to feed an infant. New moms recognize breastfeeding as such regardless of how they feed their infant. Women make the rhetoric they encounter personally meaningful by recognizing breastfeeding as an accessible resource of comfort for their infant. In addition, new moms use caution when discussing formula to not imply that breastfeeding is easy for everyone. On the contrary, women talk about breastfeeding as only *natural* when it has

become easy for them. The personal experience of breastfeeding, therefore, is discussed within a framework that upholds ideals surrounding practicality (safety, adaptability, accessibility) in a larger culture that prefers more than one infant feeding option.

This study especially draws upon the experience of first-time, biological mothers. Within this homogenous social milieu, I found that they are emotionally responsive to the breastfeeding process. They need to develop a strategy when biological demands and/or ideological construct of breastfeeding as *natural* conflicts with their breastfeeding trajectory. Women confront and navigate these practical realities by developing strategies to “survive the newborn.” New moms use strategy to adapt to biological unpredictability within breastfeeding practice while engaging with socio-biological norms surrounding how a newborn meets developmental milestones.

The personal and social expectations of these socio-biological norms are articulated through the consumption of maternalist ideals. Two parenting philosophies stood out in my data: routine training and attachment-style parenting. Depending on how the “work” of mothering is valued relative to expectations for the mother to remain a self-autonomous individual, a family will decide on a philosophy that *works for them*. By embracing a parenting philosophy, a new mom occupies a moral landscape where expectations of mom as provider and maternal figure come in conflict. Furthermore, where emphasis on modifying the child (routine training) contrasts with behavioral modification of the mother (attachment parenting), there is a space for criticism, allowing for media related rhetoric to turn practical commitments into a moral and ethical debate over ideals.

Symbolically, the value of breastmilk is in the exchange of cultural ideals surrounding self-autonomy. The most poignant ideal is independence which will either happen sooner (routine training) or later (attachment parenting). A bottle feeding culture relies on these ideals to separate postpartum breastfeeding from the pregnancy and labor portion of reproduction. By framing breastfeeding as part of the reproductive body, new moms move through a process of learning how to breastfeed that is connected to the whole experience. Management of this process requires the embodiment of a new mothering identity. The biological and energetic demands of the breastfeeding process are negotiated as part of this new, embodied identity. Given influence of the research discourse on the new mothers within my study, a moral code to “give my baby what is best” is also embodied in the role provider of nutrition.

Significant to this study is the strategy of mom-to-mom community building. Within a maternal community, an ethical code of non-judgement develops regardless of the moral authorities that emerge. Maternal community building is an external process of self-discovery based on who will offer the best support for their own maternal development. New moms encounter conflict in this process when confronted with inconsistent expert and lay discourses. How new moms look for a community of support will determine the type of support they will get. Institutional settings like the New Parenting Network, for example, rely on more pedagogical resourced support than the less structured community of the New Parenting Circle.

The NPN and NPC differed less in their social homogeneity than they did in the pedagogical and ideological tone. Both groups reflect mom-to-mom community building as a function of sociality to overcome expectations that breastfeeding is supposed to be

enjoyed. Through the process of social interaction with other new moms, lay discourses emerge that acknowledge perceptions of shame in emotional crisis and a necessary compromise of maternal identity given the ‘baby’s way’. Women used mom-to-mom community building as a function of pedagogy to mitigate negative emotions associated with the biological demands of breastfeeding. The role of the lactation consultant is to de-pathologize the demands when they arise. At NPN, the continuous presence of a lactation consultant and formal advertising of the group reflects an institutionalized setting that requires authoritative knowledge over the body.

At NPC, where the social cohort was more ideologically uniform from the beginning, the pedagogical influence of the group was in the discussion—maternal sharing of information and materials. Expert discourses at NPC relied less on moralizing attitudes about how to breastfeed because most new moms were already seeking expert advice outside of the NPC, especially the members of La Leche League. Compatible with what is seen statistically regarding breastfeeding initiation and duration, new moms who come to new mom groups seeking advice because they are pre-determined to breastfeed are more successful in finding the lay or expert support they need to overcome the challenges of the process. However, most new moms (with more frequency at the NPN) were seeking expert support in the form resourceful advice to normalize the emotional experience of breastfeeding when going back to work. Therefore, new moms relied more heavily on the expert help at the NPN for practical solutions to navigate a socio-political context of their breastfeeding practice.

Medical and naturalist discourses in pedagogies, solicited and unsolicited breastfeeding or mothering advice, and policy/media rhetoric that supports a specific socio-political message illuminates on how the idea of ‘choice’ is shaped by culturally embedded ideals that reinforce a

normative message. Although new moms in this study are certainly conscious of the media inspired “Goddess Myth” and *Breast is Best* political influence, there is an inherent rejection of the controversies of the issues when processing emotions through practical realities. To what extent new moms believe that breastfeeding is a choice, still feels unanswered, but I do not think the limitations of this dataset allows for that research question to be truly answered.

Due to my reflexive limitations, a growing concern about breastfeeding policy in the literature, and insight into grassroots framing of breastfeeding, I decided to take a critical stance using intersectional based policy analysis to demonstrate the socio-political structure of ‘choice’ as a matrix of processes and systems. In this analysis, I have found that feeding alternatives have a history with systemic roots including class statuses, geography, political context, and enslavement. The breast vs. bottle debate is part of a larger socio-political power that uses research based and scientific rhetoric to promote policies that contribute to a ‘risk culture’ based individual responsibility, commodified children, and classist ideologies that ignores structural violence. Policy implementations at the state level (WIC for example) normalize judgement by placing breastfeeding knowledge at the top of a hierarchy. Meanwhile, a national program of morality limits access to breastfeeding resources, access to childcare, and jobs that allow for longer maternal leave to low-income women. African American women, with a history of reproductive control, are hit the hardest with disadvantages to include systemic racism with a higher prevalence of early introduction of formula, indicating another system of racial and population control.

Using an ethnography of local coalitions, breastfeeding advocacy is framed more closely as a transformative practice for the community, rather than a medically researched

decision based on individual responsibility. Used as part of a ritual healing, the African American Breastfeeding Coalition frames breastfeeding as part of a larger, localized need for social healing in an urban landscape known for segregation and violence within their community. Breastfeeding advocacy is also framed by the local coalition chapter to bring larger social awareness about public health initiatives that promote sustainable health practices. In contrast to a national program of breastfeeding awareness, local advocacy deviates from emphasis of knowledge and relies on small actions.

My study especially draws on the management of individual and social expectations that are sometimes unavailable to women until they place constraints upon the lives of the participants. In the end, women influence and learn from one another. Many of the themes presented here are not new to breastfeeding scholars. However, my research considers *how* breastfeeding should be promoted in the future. The extent to which I assume the role of an ethnographer with a personal agenda to get more women to breastfeed longer is irrelevant when considering that most women would breastfeed longer if given the opportunity. Therefore, the way we talk about breastfeeding and the way it is supported locally and nationally is crucial to encouraging women to breastfeed longer.

I very deliberately push the framing of breastfeeding as part of the reproductive body. There is already a collective understanding that breastfeeding is a subjective, embodied experience for women and that too much emphasis is placed on breastmilk as a product. Part of accepting the reproductive aspect of breastfeeding is to acknowledge that there is nothing passive about the immunological properties of the milk, the hormonal control of oxytocin and prolactin in the milk “let down”, nor are the way social ideals “passed on” from mother to

infant. Additionally, the product/process dichotomy is becoming antiquated, but the reality is that breastmilk is a living, active bio-substance with a process of becoming optimal to formula.

One cultural implication of my research findings is that development in the first year of an infant's life is dependent on how the mom "mothers". The way women talk about how they "survive" the infant suggests practicality when faced with the emotional demands of breastfeeding in the process. My ethnography gives more voice to the women when so much of the medical and natural discourses favor the perspective of the infant. To balance this, I propose that when consideration is given to breastfeeding as part of the reproductive body, we think of it in terms of reciprocal relationship between mother and infant. Instead of focusing exclusively on the 'maternal-infant bond', I believe we need to recognize that physiology is not devoid of the environmental and social conditions of the maternal experience.

What was and remains intrinsically a biocultural piece of work requires elaboration of the term 'biocultural'. By invoking biocultural analysis here, I want to use one of the most common proscriptive uses of biocultural to evaluate how sociocultural influences biological outcomes and evolutionary processes while biology is also being evaluated by culture (Wiley and Cullin 2016, 565). As a complex topic of interest, breastfeeding is the perfect biocultural subject. I can remove myself from making bold assertions that humans can and should breastfeed, but I cannot deny having an interest in contextualizing human breastfeeding as an important site for political-ecology biosynthesis (Goodman and Leatherman 1998).

This paper contributes to a body of biocultural anthropology on breastfeeding by examining the separation of public health policy and medical recommendations from socio-cultural normative beliefs. Considerable attention is given to how the access to health and

nutrition (through WIC, for example) can influence the human biology of breastfeeding. I suggest future work to determine to what extent the microbiome has shifted over the course of infant feeding trends and access to immunity or environmental toxins. An interest in how the microbiome can evolve with our personal perceptions of identity (Benezra, DeStefano, and Gordon 2012) was inspiration through the course of this project. Much work still needs to be done to understand better of how nutrition shifts the genomic and metabolic symbiotic relationship with our microbiota and susceptibility to disease and its implications for breastfeeding.

In addition, it is important to consider how the physiological mechanisms of breastfeeding influence social relations. Specifically, the balance of oxytocin and estrogen in lactation amenorrhea and child spacing, post-partum depression, and ingroup/outgroup favoritism are points of interest through the development of this study. The naturalist perspective puts emphasis on the ideals of a mother/infant body. However, there needs to be a closer examination of how the physiology of the mother-infant dyad has larger social influence on kinship, maternal community building, and workplace policies surrounding maternal leave.

One way to access breastfeeding as being both biological and cultural is to consider reproduction as part the development of extended memory. This bio-cultural approach frames early physiological childhood memory formation as a derivative of changing experience (Nelson 2008). I recommend this potential framework for thinking about the reproductive body as an extension of memory so that there is more emphasis on socio-cultural impressions on physiological development. Such a discourse is still medical but gives far more recognition to the variability of individual experience. Counter to moral obligation in risk narratives,

promotional efforts could allow for more transparency regarding socio-cultural factors that influence physiological mechanisms. Imagine what breastfeeding promotion would look like if there was less emphasis on women “surviving” the infant; rather, they were “thriving” as co-creator of physiological memory!

There are numerous situations where women cannot or will not breastfeed an infant. With breastfeeding framed as part of the reproductive body, however, intersectionality can extend more fluidly to breastfeeding policy that acknowledges bodily autonomy. The momentum of reproductive justice is evident in breastfeeding literature already (Smith, Hausman, and Labbok 2012). So, what does it have to do with medical anthropology? It is a matter of theoretical perspective. Elsewhere, medical anthropologists argue that social anthropological analysis has the impetus in post-colonial social change (Frankenberg 1980; Hanson, Holmes, and Lindemann 2013). I argue with my intersectional based critic of breastfeeding public policy, that it is imperative for social science data to be recognized as another narrative within an already complex history of rhetorical discourses. Therefore, I am theoretically in favor of a position where medical anthropology is more actively engaged with the outcome, especially when it comes to the language we use (Pigg 2013).

Moving forward, I hope to see more ethnographic work being done on local breastfeeding coalitions through an intersectional lens. Anthropology works in this area to avoid the temptation of romanticizing grassroots movements, while allowing for a richer depth of awareness of how morality can function as a form of cultural inheritance that is passed, preserved, or challenged by values of individuals, groups, and social institutions (King 1999). The public health breastfeeding agenda could benefit from understanding to what

degree local advocacy groups carries hierarchy, creates an identity for themselves and marginalized peoples.

An ethnographic approach to a public health discourse is not only about breastfeeding advocacy; it carries the opportunity to inspire both local and global change by addressing the inequalities within each system. By considering breastfeeding as part of the reproductive body, rather than breastmilk as a by-product, the socio-political control over the messaging will have to become more transparent. Breastfeeding advocacy has traditionally been about the exploitation of formula companies abroad. An intersectional perspective moves away from demonizing formula in favor of breaking down the systemic, oftentimes local, barriers preventing women from having access to breastfeeding as a practical option.

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