BLURRING THE BOUNDARIES

BREASTFEEDING AS DISCURSIVE CONSTRUCTION AND EMBODIED EXPERIENCE

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CERTIFICATE

I hereby certify that this thesis has not already been submitted for any degree and is not being submitted as part of a candidature for any other degree.

I also certify that the thesis has been written by me and that any help I have received in preparing this thesis, and all sources used, have been acknowledged in this thesis.

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ABSTRACT

This thesis studies maternal subjectivity in a group of 25 Australian women in the 1990s. The research uses a poststructuralist perspective to answer the question: How do women create a maternal subjectivity and give meaning to their lives when they become mothers for the first time? Discourse analysis is used to analyse data collected through a series of interviews with women, from late pregnancy to six months after birth. The early finding that breastfeeding was central to women's experience as mothers focused this research on the place of breastfeeding and the maternal body in the construction of contemporary motherhood.

The majority of participating women constructed breastfeeding as crucial to their maternal identity. They were committed to breastfeeding. In their accounts, breastfeeding was 'natural' and 'taken for granted', pivotal to their relationship with their baby, 'best for the baby', and something that a 'good' mother does. Personal accounts of success and achievement were particularly prominent. Breastfeeding required 'perseverance' and became an 'identity project'.

Breastfeeding, however, was not only constructed in Foucauldian terms through varying discourses, but was simultaneously an 'embodied' experience, sensed and perceived by women in diverse ways. This embodied or 'non-discursive' dimension of breastfeeding was difficult for these women to articulate and is poorly understood by health professionals. For some, breastfeeding fostered a connected, intimate and sensual relationship with the baby. These women were comfortable with or tolerated the 'blurred' boundaries of self and 'other', mother and child. Other women, however, found breastfeeding to be disruptive of body boundaries and routines, and distorting of their known experience of their breasts and body. At times, they felt disconnected or desired 'separation' from their infants. This difficult and distressing breastfeeding experience challenges the public and professional discourses that persuade women to breastfeed. The connected and intimate embodied experience of breastfeeding, however, presents a threat to a woman's sense of rational autonomy and independence.

This thesis uses feminist and other poststructuralist and phenomenological theories, to explore the complexity of the relationship between personal embodied experiences and the public and professional discourses and practices of breastfeeding. The findings of this study challenge midwives, nurses and lactation consultants to understand the diversity of women's personal experience of breastfeeding. Health professionals need to reflect upon their role in producing and reproducing the contradictions and tensions of motherhood and breastfeeding in the late 1990s.

INTRODUCTION

> As a mother holds her new baby in her arms, she also experiences a sensation of emotional and physical fulfillment that here at last is what she has been waiting to see and she is also emotionally fulfilled by producing a child for the man she loves. (Bourne, 1979: 8)

> ... once a woman becomes a mother, her life will never again be quite her own. It's something few of us want to believe, let alone discuss, let alone - dare I say it - celebrate. But it remains, nevertheless, the single defining feature of a woman's life on the far side of the great divide. (Maushart, 1997: 17)

This study is about motherhood and breastfeeding among a group of 25 Australian women who gave birth to their first child between 1994 and 1997. Motherhood continues to be a topic of debate and contention in the late 1990s. These quotes represent the polarized and contested public discourses of motherhood that women must negotiate when becoming mothers for the first time. As an academic subject, motherhood has been extensively studied by health professionals and across the social sciences and humanities. The interests and concerns of these disciplines also reflect the contradictions and tensions around motherhood. Psychoanalysis, developmental psychology and medical science traditionally take a child-centred approach, and individual mothers are the focus of diagnosis and treatment. Feminism, critical sociology and at times anthropology, claim alternatively to take a women-centred approach, describing the personal experience of motherhood as well as theorising the subordinate position of women as mothers in a patriarchal society. In the current sociocultural context there remains, however, a powerful imperative to be a mother. Crouch and Manderson (1993) believe that many women perceive a strong relationship between self-identity and child bearing. In the 1990s most women who become mothers invest enormously in motherhood - they want to be 'good mothers (Hays, 1996). The persuasion to mother, however, continually contradicts the rational, autonomous and independent lifestyle of women in the 1990s.

I embarked on this study of motherhood as a midwife, nurse, feminist scholar and mother, with a particular interest in understanding the way in which women negotiate or make sense of the complexities, innumerable contradictions and tensions that surround

motherhood in contemporary Australia. Taking a poststructuralist perspective, I wanted to understand how women draw upon the diverse discourses surrounding motherhood in order to create meaning in their lives as first time mothers. The decision to have a child is typically constructed as a matter of personal choice. Yet women and their partners are influenced in their decision by such questions as: What is the appropriate time and age to have a child? Should they be married? Have they bought a house? Is the partner in secure employment? Is the woman ready to have some time out from paid work? Can the couple afford to pay the bills if she is not working? If the woman's income is needed or she wishes to return to work soon after the birth, how will this impact upon her relationship with the baby? Equally, there are questions and tensions that shape the woman's experience of pregnancy and birth. How do women make sense of prenatal diagnosis, where should the baby be born, what is their commitment to 'natural birth', and how can their partner be actively involved in the pregnancy and birth? Once the baby is born, questions persist: How should the woman behave as a mother? How should the man behave as a father? What defines a 'good' baby? Interestingly, in the study reported here, the majority of women did not deliberate about whether they should breastfeed. Without exception, all the women in this study planned on breastfeeding their babies. Some of these issues of contemporary motherhood have been examined in recent feminist and sociological writings (see Doucett, 1995; Everingham, 1994; Hays, 1996; McMahon, 1995; Ribbens, 1994). I was also interested, however, in exploring the importance of these questions surrounding motherhood for midwifery and nursing practice and theory.

Like the research and writing of most theses and indeed much qualitative research, this endeavour represents a journey, a time of challenge, learning and change. Originally I set out to study the meanings and practices of motherhood in the 1990s in Australia. Using discourse analysis, I wanted to explore the personal, public and professional discourses that women draw upon to construct their experience as new mothers. My purpose in doing this was to further develop nursing and midwifery theories of maternal identity. The title of this study, however, indicates that what follows is more specifically about breastfeeding rather than the broader topic of motherhood. As the interview schedule (see Appendix B) indicates, the majority of questions used in the interviews focused on the meanings women attributed to motherhood and mothering and their

personal experience of becoming a mother. These 25 women described in depth their experience of pregnancy, birth and motherhood and the volume of transcribed data is testimony to this. Surprisingly, however, over the first six months following the birth, it was the experience of breastfeeding that dominated many interviews. Breastfeeding was talked about as the women described their baby and their relationship with her/him, discussed infant care tasks, talked of the 'good' mother and the father's position in relation to the baby and finally, when speaking of returning to paid work. Breastfeeding was central to their experience as first time mothers in the six months following the birth. While not a representative sample, all of the women participating in this study breastfed their babies for a period of time. At three months following birth, 20 of the 25 women continued to breastfeed and at six months, 18 women were still feeding.

During the analysis of the transcribed interview data, it became evident that breastfeeding was both a discursive practice and an embodied experience. Breastfeeding represented, indeed amplified, many of the tensions and contradictions of new motherhood. Thus, in exploring maternal subjectivity, I have developed a particular focus on the maternal body and the experience of breastfeeding. This focus is consistent with a poststructuralist approach to exploring subjectivity (see Bordo, 1986; Jacobus, Fox Keller & Shuttleworth, 1990; Weedon, 1997). I wanted to understand the place of the maternal body and breastfeeding in constituting maternal subjectivity, the thoughts, actions, feelings and emotions of a first time mother.

The Imperative to Mother

The notion that motherhood is crucial to women's identity has dominated 19th and 20th century discourses. Historically our understandings of women, women's nature and women's bodies are closely linked to their reproductive function and the prescribed nurturing role (Ehrenreich & English, 1979; Martin, 1987; Usher, 1992). It is often assumed that women receive gratification and a sense of purpose in their reproductive capacity. In contemporary society there remains an overwhelming imperative for women to become mothers. Recently I spoke with a man who was attending antenatal classes I was facilitating. His partner had given birth prematurely and they came to the class to tell us their news. The man told me proudly, 'Having the baby has really completed her (his partner)'. There was no mention of his 'completion' as a man. Motherhood is

considered to be an essential part or stage of a woman's development, as well as crucial to her identity (Marshall, 1991; Phoenix & Woollett, 1991; Rich, 1976). There is a 'normative or mandatory quality of motherhood' (Woollett, 1991: 51). Motherhood is an archetype, 'an enduring ideal with images that cut across cultures, historical periods, social conditions and cultural boundaries' (Stearney, 1994: 146).

The premise underlying nursing and midwifery theories of maternal identity and the transition to motherhood embrace this account of the normative and mandatory nature of motherhood. This thesis challenges the notions of maternal subjectivity that underpin nursing and midwifery theories.

A World Apart: Nursing/Midwifery and Feminist Understandings of Motherhood

In order to locate this current study, I want to highlight the polarisation of nursing and feminist theoretical and empirical work on motherhood. An extensive literature pertaining to parent-infant nursing and parental development informs current nursing practice (Walker, 1992). Walker (1992: 179) adds, 'At its essence is the formation of the parent-infant relationship and emphasises the parent's tie to the infant'. Although Walker uses the term parent, she acknowledges that the majority of research has focused on mothers and their adaptation to the maternal role. Within this work there is an assumption that the maternal role is an inevitable and necessary component of adult female development. It is rare that the decision to mother is ever questioned, and more importantly, the social context within which mothering occurs is examined inadequately. Nursing research draws heavily on psychological accounts, focusing on the individual woman and her personal and social characteristics. There is a tendency among nurses to identify 'maladaption' and to look for pathology in the individual.

Guided by this professional account, nurses and midwives both overtly and covertly make assessments of a woman's progress in assuming a maternal identity. We assess a woman's acceptance of the pregnancy, her developing relationship with her infant and observe her ability to perform the tasks of infant care. Ultimately many midwifery and nursing practices are infant-centred. It is the wellbeing of the infant that appears to motivate many of our practices. For example, Koniak-Griffin (1993: 257) stresses, 'The

process of maternal role attainment is important because it directly influences parenting behaviours in care giving and social interaction and the infant's emotional wellbeing'.

The contributions from nursing and midwifery accounts are discussed in more detail in Chapter Two. However, what is noticeably absent from this literature is any discussion of the meanings of mothering. The rich debate that has occurred over the 70s, 80s and 90s in the sociological and feminist literature, exposing the powerful ideologies and institutions that constrain women in a subservient role, has not been incorporated into nursing literature or even influenced the direction that this work has taken.

While nursing and midwifery theorists, researchers and commentators have pursued an understanding of maternal role attainment, the second wave feminism of the late 60s and 70s challenged the notion of the archetypal mother. Initiated by the writings of de Beauvoir, feminist debates cast mothering, childbearing and childrearing as the source of oppression for women, a form of patriarchal social control (Friedan, 1963; Firestone, 1970; Millett, 1970). Sociologists and feminists such as Oakley (1974), Harper and Richards (1979), Treblicot (1984), and Wearing (1984), all exposed the constraints of motherhood in patriarchal societies, the low status of women's domestic role, their limited economic power, and the unrealistic demands of the dominant account of the 'good' mother. It was argued that women mothered alone in nuclear households with little social support or respite. These studies stressed that the 'institution' of motherhood (Rich, 1976) had to be dismantled in order for women to achieve equity and status in public life. Throughout these debates women were urged to take control over their bodies and to insist they were the ones who knew their bodies and their babies best. Not surprisingly such feminist arguments, if known, were not taken seriously either by nurses or midwives who cared for mothers and babies.

During the 80s and early 90s, while nursing accounts persisted in examining maternal role attainment and the transition to motherhood, feminist debate took an important turn. The early feminist writings held little appeal for many women. It was not a choice for most women to abandon heterosexual relationships and the development of families. For some women, motherhood provides a sense of identity, giving meaning and purpose in their lives (Boulton, 1983; Doucett, 1995; Everingham, 1994; Ribbens, 1994). As an

occupation motherhood is often considered preferable to outside paid employment, providing more control and autonomy in women's lives than other occupations (Baker, 1989; Oakley, 1992; Ribbens, 1994; Treblicot, 1984). These feminist accounts that honour mothers by espousing a woman-centred perspective have been more publicly appealing. Rich (1976) initiated efforts to separate the 'experience of mothering' from the 'institution of motherhood'. Motherhood as 'experience' could be a source of great joy and creativity (Rich, 1976). Within much contemporary feminism there has been a move to re-value mothering and embrace intimacy and nurturing as a feminist ethic. For example, object-relations theorist Nancy Chodorow (1978) highlights women's connectedness to others and the positive impact this has on women's mothering abilities. Carol Gilligan (1982) believes women have a capacity for relationality, a responsive, caring and empathetic connection to others. Ruddick (1982) also praises the creative work of mothers, theorising that motherhood is associated with an ethic of care, where nurturing others comprises a particular way of thinking, a 'maternal thinking'.

More recent feminist analysis positions women as active or agential in giving meaning to their experience of motherhood. Everingham (1994) believes previous sociological and feminist work excludes the contributions that mothers make to the creation of value systems and forms of subjectivity through their nurturing activity. Authors such as Everingham (1994), Blum (1993), Scott (1988) and Alcoff (1988) believe the equality debate obscures the woman as an agent active in creating her subjectivity and in recreating social relations. As McMahon (1995: 16) emphasises, mothering is 'both socially determined and personally contingent in women's lives'. Recently, sociologists (Hays, 1996; McMahon, 1995; Ribbens, 1994) have drawn attention to the tensions and contradictions of contemporary motherhood. Today women are encouraged to establish mothering as a successful personal endeavour, carried out in a sensitive, creative and child-centred way, while at the same time participating in the paid work force with increasing demands for productivity.

It seems extraordinary to me that none of this rich and diverse feminist debate has entered into the nursing literature. In this thesis I wanted to introduce a broader sociopolitical perspective of motherhood into nursing and midwifery understandings of maternal identity. In taking a poststructuralist approach I wanted to focus on maternal

subjectivity, examining the way in which women draw upon the personal, public and professional discourses of motherhood to create meaning in their lives as mothers.

Consistent with this perspective I was also interested in the maternal body. Feminist applications of poststructuralist work, particularly the work of Foucault, focus on the body (Barky, 1988; Bordo, 1986; Carter, 1995; Dickson, 1990). My interest in the maternal body became central to the analysis when it became evident that the experience of breastfeeding was crucial to maternal subjectivity amongst these 25 Australian women.

The Maternal Body

Over the past three decades, feminist analyses have articulated the centrality of the body in the constitution of female subjectivity. The body is central to our lives as women. For example, Usher (1992: 31) explains that the body is also at the centre of the discourses which define and control women. Young (1990) notes that ever since Western thought has separated mind and body, women have been identified with the body. As bodies, women have been feared, devalued and seen as 'other', yet simultaneously they are desired in terms of sexual pleasure and as mothers. Feminist endeavours have exposed the marginality of women's bodies (Douglas, 1966; Ehrenreich & English, 1979; Jacobus, Fox Keller & Shuttleworth, 1990; Martin, 1987).

Prior to the 1990s it was rare that the body, other than the biological body, was of interest to nurse theorists or researchers. More recently a number of nurse researchers, particularly in Australia, are showing a greater interest in theorising and researching the body within nursing (see Lawler, 1991; edited volume by Lawler, 1997; articles published in the *Nursing Inquiry* journal). This work, however, tends to focus on the ill or diseased body. The study of the maternal body is arguably about the 'well' body. Nurse theorist, Reva Rubin (discussed in detail in Chapters Two and Four) has made the most important contribution to nursing theories of maternal identity and the maternal body. Rubin locates the body and body image as pivotal to the maternal self, developing a detailed understanding of the embodied experience of pregnancy and the postpartum. Her theorising, however, does not incorporate or explore the place of breastfeeding in the construction of maternal subjectivity. In this study I am interested in exploring the

relevance of the maternal body, particularly the embodied experience of breastfeeding for nursing/midwifery theory and practice.

The women who participated in this study also discussed bodies. At various times throughout the interviews, the women talked about their bodies and in particular, their breasts. They talked of their bodies as natural, designed to bear and nurture an infant, as machines under the control of hormones, as property, often unclear about the ownership of their bodies and they described their bodies as having sensations and feelings that they were not aware of before. There were some key phrases and statements they used that made me aware of the non-discursive dimension of the maternity experience. The women frequently stated 'I don't know how to explain it', 'I don't have the words to describe it', 'I can't describe it', 'You know what I mean'. One of the women elaborated, 'Until I was a mother I never knew I had those feelings inside me'. Through pregnancy, birth, breastfeeding and nurturing activities, many women become very much more aware of their embodied selves. For these women maternal subjectivity was an embodied subjectivity, constructed particularly through the experience of lactation and breastfeeding.

The Current Study

This thesis examines maternal subjectivity in a group of 25 Australian women in the 1990s. The study began with two questions:

1. How do women create a maternal subjectivity and give meaning to their lives when they become mothers for the first time?
2. How do these contemporary representations of maternal subjectivity contrast with the understandings of maternity articulated by theoretical frameworks that guide the practice of nurses and midwives?

In taking a poststructuralist approach to this study, I started by exploring the personal, public and professional discourses that women draw upon to make sense of their lives as mothers. In an attempt to transcend the dualities of mind and body, individual and society that are inherent in most accounts of maternal identity, I was interested in exploring the place of the maternal body in the women's experience of new motherhood. The early finding that breastfeeding was central to women's experience as

mothers prompted the focus on the place of breastfeeding and the maternal body in the construction of a maternal subjectivity in the 1990s.

The interview data collected for this study is part of a larger study entitled '*Discourses of Parenting: A Longitudinal Study*', and is funded through the Australian Research Council. This project, undertaken by Professor Lesley Barclay, Associate Professor Deborah Lupton and myself, is conducting interviews with men and women as they become parents for the first time. The women and men are interviewed separately, up to nine times following the birth of their first child. The final interview occurs when the first child turns three. As a researcher on this project, I have conducted all the interviews with the women in this study. For this thesis, I have analysed data collected in the first six months following the birth.

In Chapter One I detail a poststructuralist understanding of subjectivity. I argue that this theoretical perspective allows an exploration of the dynamic and changing nature of subjectivity and can help to account for diverse and competing realities. In other words, poststructuralism helps account for why people think, act and feel differently. A poststructuralist approach also allows the possibility to transcend the common dualisms of individual-society and mind-body that persist in western humanist thought and in our understandings of maternal identity. Through the analysis of language and discourse, this approach can account for the diversity, complexity and contradictions in the experience and meanings of motherhood and breastfeeding. In this chapter I detail what is meant by discourse and the central place of language in the constitution of subjectivity. Despite current concerns about the disregard for human agency in poststructuralist thought, I argue that the individual as an active, social agent is visible in more recent theorising. In this study subjectivity is seen as not only being constituted through language and discourse but as shaped by unconscious and emotional responses and embodied experiences (Grosz, 1994; Lupton, 1995; Young, 1990).

While much poststructuralist debate has concerned the dualist divide between individual and society, voluntarism and determinism (see Holloway, 1989), I also highlight the need to deconstruct the dualism of mind and body. Following Grosz (1994), this study focuses upon corporeality in the constitution of subjectivity. In this study, the body is

afforded a central place in understanding women's experience of motherhood and in particular the experience of breastfeeding. In Chapter One I also link a poststructuralist perspective to the methodological approach of discourse analysis. In recent times discourse analysis has been considered an important method for understanding social organisation, power relations and social change.

The 25 women in this study participated in a series of five interviews. Each woman was interviewed once prior to the birth of the baby and four times during the six months after birth. The approach to data collection is discussed in detail in Chapter One. In this study women were asked to 'talk' about their experience of pregnancy, birth and in particular the early mothering experience. As Young (1990: 13) notes, '(t)alk about experience expresses subjectivity, describes the feelings, motives and reactions of subjects as they affect and are affected by the context in which they are situated'. In poststructuralism, 'experience' is not seen as a true or authentic representation of the self but rather as something constituted through language and discourse.

From the outset this study has been approached as a feminist endeavour, seeking to know more about women and their lives in the early months of motherhood. With this in mind, the methods used in this study are discussed in relation to the feminist debate about the conduct of interviews, the nature of the relationship that develops between researcher and participants and important ethical considerations. Reconciling a feminist approach to research with the highly interpretative tradition of discourse analysis is not always easy. On the one hand feminist approaches want to affirm women's experience and to retell this experience as women describe it. Yet in a poststructuralist approach, these personal stories are treated simply as accounts that are culturally constructed. It is important to acknowledge that the analysis of data presented in this thesis represents my interpretation of the experience of these 25 women.

In Chapter Two I examine the construction of maternal subjectivity within nursing and midwifery texts, the theoretical and empirical work that guides practice. I begin by examining the psychoanalytic discourses of feminine identity that underpin the conceptual work on maternal subjectivity. This account directs the child-centred focus on the relationship between the mother and her infant within the discourses of

attachment and bonding. Secondly, I examine the sociological discourses of the '50s and '60s, where motherhood is identified as a role characterised by particular behaviours and actions. I then focus on the discourse of maternal role attainment in the work of Reva Rubin. This chapter highlights the continuing presence of the humanist notion of the rational, autonomous and non-contradictory individual in current maternity nursing and midwifery perspectives. What is also particularly evident in the analysis of nursing and midwifery theories is the lack of discussion about infant feeding in theoretical terms. Breastfeeding is simply a source of nutrition and another nurturing activity that a mother undertakes.

In Chapter Three I analyse some of the diverse professional and public literature around breastfeeding. The majority of writings about breastfeeding present a pro breastfeeding stance. The professional accounts of nursing, midwifery, public health, nutrition, anthropology and public policy continually emphasise that breast is best for the baby, the environment and global economy, breastfeeding is essential for bonding or securing the relationship between a mother and child, and more recently, particularly in public accounts, breastfeeding provides a source of personal satisfaction and achievement. It is rare in these accounts, including work from feminists, that women's personal experience of breastfeeding is described.

Chapter Four develops a theoretical understanding of embodied subjectivity based on the premise that it is through our bodies that we come to know and understand our world. In this chapter I detail a number of theoretical perspectives that contribute to an understanding of maternal subjectivity and the maternal body. Rather than drawing upon one grand theory to theorise embodied subjectivity, I utilise or 'merge' concepts from a variety of disciplines such as phenomenology, neurophysiology and poststructuralist approaches from sociology, philosophy and feminism. In taking a dialectical approach to the body, I attempt to redress the dualisms of individual-society and mind-body, examining the relationship between discourse and lived experience. The work of Reva Rubin, and her application of Paul Schilder's work on body image and body boundaries, introduces theorising of the maternal body. I also draw upon some of the important phenomenological concepts developed by Merleau-Ponty. Merleau-Ponty's philosophical perspectives of the lived and active body provide an understanding of the

'embodied' nature of the self and attempt to link mind and body in a non-dualistic manner. Secondly, this chapter presents a range of theoretical approaches within contemporary poststructuralism. Here the body is not only something biological or natural. It is also constructed or made (Lupton, 1994b). Drawing on the work of Foucault, Elias, Shilling, Lupton, Rose, Freund and Hochschild, I outline important concepts such as power-knowledge and the body, technologies of discipline, governmentality, practices of the self, 'identity projects', the 'civilized' body, and 'emotion' work. Finally I draw upon feminist developments in understanding embodied subjectivity. This work of Kristeva (1982, 1986), Douglas (1966, 1970) and Grosz (1994) argues that women's bodies, as the 'other' and different to the masculine 'norm', have been constructed as polluting, dangerous and uncontained. As such, pregnancy and birth are the 'abject', things that pose a threat to order and control. These and other feminist authors offer various 'reconstructions' from which to view the female body and its connection to other bodies particularly through pregnancy and breastfeeding.

In Chapter Five I commence my discussion of the findings of this study. Using a case study approach I describe three different accounts of motherhood and breastfeeding. Each case study creates a story (albeit my interpretation) of an individual woman's experience and provides a sense of continuity for the reader about the lives of three women participating in this study. The case studies outline the experience of pregnancy and birth and demonstrate the complexity and contradictions of motherhood and breastfeeding. Chapters Six and Seven explore the nature of breastfeeding as both a discursive construction and as an embodied experience, and draw on all data generated by the interviews. The women in this study described their beliefs about breastfeeding easily. The majority expressed a strong commitment to the pro breastfeeding discourses and were prepared to persist with breastfeeding despite any difficulty that might arise. On the other hand, it was often difficult for the women to articulate the sensed and perceived bodily experience of breastfeeding. The embodied experience of breastfeeding described in Chapter Six provided a source of personal pleasure, intimacy and satisfaction for some women. In Chapter Seven I continue the discussion of the embodied experience of breastfeeding, describing the more distressing and dissatisfying

experiences. Here breastfeeding as an embodied experience challenges women's understanding of the mother-infant relationship.

In Chapter Eight breastfeeding is examined as a 'practice of the self'. It describes the varying personal 'practices' women participated in to establish and maintain an identity as both a breastfeeding mother and as a 'good' mother who is relaxed, calm and in control. Practices of exclusion and perseverance demonstrate the commitment some women gave to breastfeeding. Alternatively, practices of regulation demonstrate the need for some women to 'work' at re-establishing control, order and boundaries in their life.

In the final chapter I synthesise theories of embodied subjectivity with the personal accounts of motherhood and breastfeeding articulated by the women participating in this study. I explore what the embodied experiences of breastfeeding reveal about notions of maternal subjectivity. Here it becomes clear that breastfeeding challenges or threatens personal boundaries and public notions of order and control. In the Conclusion to this thesis, I discuss the implications of the findings for the practice of midwives, nurses and lactation consultants.

Some Personal Reflections

I need to explain my frequent use of the term 'nurse' rather than 'midwife' and my reliance on 'nursing' research undertaken in North America. As an Australian midwife, I am conscious of the current professional debate surrounding the categories of nurse and midwife and know that my concurrent use of the terms nurse and midwife may not be popular. This study, however, seeks to further our theoretical understandings of maternal subjectivity and is primarily about women's personal identity as mothers, how women go about creating a maternal subjectivity and what meanings they attribute to motherhood and breastfeeding. The nature of women's identity as mothers has not been theorised by midwives with the exception of Jean Ball (1987). The writings and research of midwives focuses more specifically on midwives' relationship with women and principles underlying midwifery practice (Bryar, 1995). Most of the theoretical developments and research on maternal identity have been developed by North

American nurse theorists and researchers and hence my reliance upon 'nursing' rather than 'midwifery' theorising.

It is important to recognise my position within this study and also to acknowledge the many women who are not represented in this research. This study of motherhood has been conducted with white, in the main Anglo-Australian, able-bodied, heterosexual women, who are in 'stable' relationships, who have generally healthy babies. This narrow and exclusive group of participants means the analysis cannot speak for mothers from other cultures, mothers who are in lesbian relationships, mothers who have babies that are ill or disabled or for single mothers. As a white, Australian born, middle class, educated, heterosexual woman, I also know that I come to this research with particular values, and these values may have influenced the discussions with women and my interpretation of the data. I am also a mother of two children, both born in a birth centre and each child breastfed for two years. These practices reflect particular beliefs and the women I interviewed knew some of my background. This positioned me as an 'experienced' mother, and although I may doubt my own experience at times, in the eyes of the women I interviewed, I was more experienced. This created a difference between us. In addition, I am a midwife and facilitate antenatal classes. A number of women in the study attended classes that I led. This positioned me as an 'expert' or at least someone knowledgeable in the area.

So I began this challenging journey. Informed by professional and personal experience, I held certain expectations of what I might learn. With the generosity of the 25 women who shared their experiences with me, I have come to a surprising, and at times professionally and personally confronting, destination or conclusion. These 25 women have shown me aspects of contemporary Australian motherhood that I had thought little about and are poorly understood, yet, have important consequences for the practice of midwives and nurses.

CHAPTER ONE

STUDYING MATERNAL SUBJECTIVITY

This thesis examines maternal subjectivity in the 1990s and asks the question: How do women create a maternal subjectivity and give meaning to their lives when they become mothers for the first time? In this chapter I begin by outlining the way in which subjectivity is to be understood in this study of motherhood. I use a poststructuralist understanding of subjectivity in an attempt to transcend the common dualisms of individual-society and mind-body that persist in nursing and midwifery understandings of maternal identity. The chapter then links a poststructuralist understanding of subjectivity to discourse analysis, the method used here to analyse the nursing and midwifery theoretical and empirical work on maternal identity and to examine women's personal constructions of motherhood and breastfeeding. Finally, this chapter describes the way in which data were collected or the way in which 'text' was created for undertaking discourse analysis. Here I address feminist and ethical issues associated with researching the lives of women.

1.1 SUBJECTIVITY - A POSTSTRUCTURALIST APPROACH

The study draws upon a range of poststructuralist perspectives of subjectivity. Informed by the writings of numerous theorists such as Derrida, Freud, Lacan, Marx, Althusser and Foucault, poststructuralist works link language, subjectivity, power and social organisation. More recent poststructuralist endeavours have placed greater emphasis upon understanding subjectivity as embodied and emotional, accounting for corporeal existence (Grosz, 1994; Young, 1990) and for unconscious thought and emotions (Henriques, Hollway, Urwin, Venn, et al., 1984; Hollway, 1989; Lupton, 1995; Lupton & Barclay, 1997). In this thesis concepts from Michel Foucault and Norbert Elias are used together with some of the more recent developments of poststructuralism and subjectivity (Shilling, 1995; Lupton, 1995), particularly the feminist approaches in the work of Kristeva (1982, 1986), Grosz (1994) and Young (1990). In this thesis there is no commitment to a universal theory of subjectivity or to the production of a theory of

maternal subjectivity. Rather, the theoretical approaches and concepts used here attempt to extend thinking about maternal subjectivity and to encourage reflexivity in midwives and nurses in their work with new mothers.

Why Poststructuralism?

Motherhood in the 1990s continues to be a vexing and contradictory issue, particularly within feminist debates. As highlighted in the Introduction, it is within these opposing accounts that one can most clearly see the need to understand diversity, ambiguity and contradictions in the experience and meanings of motherhood. In our practice as nurses and midwives, how can we make sense of the many competing realities of mothers and maternal subjectivities? This question has interested feminists who theorise subjectivity. Feminists have argued that theory must take account of the plurality and diversity of women's situation, 'account(ing) for competing subjective realities' rather than searching for universal explanations (Weedon, 1997: 8). Feminists have also called for a theory of the subject that addresses the divisions of individual and society and mind and body (Hollway, 1989; Grosz, 1994). Finally, a theory useful to feminism must have political application, account for power and power relations, open the arena for change and also account for resistance to change (Scott, 1988; Weedon, 1997). In placing such demands upon a theoretical framework, various feminists have turned to poststructuralist theory (Bordo, 1986; Carter, 1995; Dickson, 1990; Walkerdine, 1986). Poststructuralism is believed to offer a way to conceptualise social organisation, power and the individual, as well as explaining the diversity of experiences amongst women (Weedon, 1997).

The Central Place of Language and Subjectivity

The crucial element in all poststructuralist theory is language. Weedon (1997: 21) states, 'For all forms of poststructuralism the common factor in the analysis of social organisation, social meaning, power and individual consciousness is language'. Language, rather than referring to vocabulary or grammar, is a system through which meaning is constructed and cultural practices organised (Scott, 1988). Through language people come to represent and understand their world. In this way language constitutes social reality for us (Weedon, 1997). We do not come to know our social world without language. It is the place not only where social forces are defined and contested, but also

'where our sense of ourselves, our subjectivity is constructed' (Weedon, 1997: 21). Of crucial importance here is the notion that language is not the expression of unique individuality, but rather constructs subjectivity in ways which are historically and socially specific (Weedon, 1997).

For Foucault, human beings in all their aspects are historically located and historically specific. Foucault believes that humanist discourses that place the subject at the centre of reality or history have failed to grasp the extent to which the subject is fragmented in the social field (Savicki, 1988). Foucault insists that our subjectivity, our identity and our sexuality are interrelated and do not exist outside language, but are brought into play by discursive practices (Martin, 1988). Following Foucault, Weedon (1997: 31) suggests, 'It is language in the form of conflicting discourses which constitute us as conscious thinking subjects and enable us to give meaning to the world and act to transform it'. This approach contrasts markedly with a humanist approach to understanding the individual and social relations. The humanist position sees the individual as the source of social phenomena and production of social reality including knowledge. The individual is seen as a unitary, non-contradictory and rational being (Henriques, et al., 1984). The humanist subject, the rational individual, is most frequently described as the Cartesian subject, composed of separate mind and body and the agent of social phenomena. This is the subject that predominantly features in nursing theories of maternal identity.

Poststructuralism considers that we do not construct our experience of life nor are we rational, unified beings (Weedon, 1997). In this understanding of the social world and individual consciousness, the ideas and values associated with motherhood are diverse, constantly changing and do not represent any authentic or true experience as a mother or of mothering. This approach questions the belief that the decision to become a mother is a matter of individual choice. In a poststructuralist approach, the decision to have a child is constructed through a range of competing discourses. Today, while many women recognise and are critical of the constraints and demands of childbearing, they are still drawn to mothering as part of their lifestyle. Others, although conscious of the prevailing incitement to motherhood, may resist this discourse.

Language and Discourse

The concept of discourse is an important part of poststructuralist theory. Discourse, however, is a difficult concept with varying definitions, many of which conflict and overlap. Broadly speaking, a discourse refers to 'systematically organised sets of statements' (Kress, 1985: 6) that provide 'a coherent way of describing and categorising the social and physical worlds' (Lupton, 1994a: 28). Scott (1988: 35) states that a discourse is a historically, socially and institutionally specific structure of statements, terms, categories and beliefs. Discourses exist in both written and oral forms and in social practices, give expression to the meanings and values of an institution (Kress, 1985). Generally discourses differ within and between the institutions and social practices in which they take shape, according to the positions of those who are speaking and those who are addressed (Macdonell, 1986). Lupton (1994a: 28) states, 'Discourses gather around an object, person, social group or event, providing a means of making sense of that object, person and so on'. A clear and useful example of discourse is seen in the current, popular understandings of a 'natural' discourse of childbirth as opposed to a 'medical' discourse of childbirth. When a person supports the 'natural' model of birth, they use words such as 'choice', 'control', 'women-centred' and are more likely to support practices in labour that represent less medical intervention and the non use of medicated pain relief and so on. Those supportive of a 'medical' model of birth often talk in terms of 'risk', 'ensuring a healthy mother and baby', 'active management' of birth and support practices such as epidural anaesthesia and artificial rupture of membranes, stressing 'the experts know best'.

In some instances a discourse may be recognised only in its opposition to another discourse (Macdonell, 1986). In any institution there will be a distribution and hierarchy of discourses reflecting certain values, class, gender and racial interests. Some discourses will be privileged, some more readily accepted and some considered to be knowledge while others not.

Discourses are dynamic and changing. It is important to emphasise that discourses are not neutral but operate powerfully in the construction of social realities. Kress (1985: 6) describes how discourses '... define, describe and delimit what it is possible to say and not possible to say (and by extension - what it is possible to do and not possible to do)'.

Parker (1992) highlights the powerful and ideological nature of discourse. Firstly, discourses support institutions. Many powerful discourses have strong institutional bases and through language they are able to control the meaning of health, justice, spirituality and so on. Secondly, discourses reproduce power relations, with some subjects 'gaining' and some 'losing'. Finally, discourses have ideological effects. As Lupton (1994a: 29) states, 'Because discourses attempt to persuade audiences to accept a particular version of reality they are ideological'. The ideological nature of discourses allow dominant groups to tell their stories about the past in order to justify the present (Parker, 1992).

The work of Foucault had a major influence on developing an understanding of discourse and describing the constituting effects of discourses. For Foucault it is discourse that makes and unmakes our world. Weedon abstracts succinctly Foucault's notion of discourse:

> Discourses... are ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledge. Discourses are more than ways of thinking and producing meaning. They constitute the nature of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern. (1997: 105)

This understanding of discourse highlights its place in the constitution of the minds and bodies of individuals, locating subjectivity within a wider network of power relations. In Foucault's understanding, discourse also functions as a means of struggle, opening up the possibility for resistance and change or reversal of dominant discourses (Weedon, 1997).

Foucault has, however, been criticised across a variety of disciplines for his overemphasis upon the constituting effects of discourse (Fairclough, 1992a; Henriques, et al., 1984; Parker, 1992; Shilling, 1993). Critics believe that Foucault's notion of discourse does not pay enough attention to contestations of practices and struggles between social forces and ignores the way in which social practices actively structure discourses (Fairclough, 1992a). In addition, it excludes active social agency (Fairclough, 1992a; Henriques, et al., 1984; Hollway, 1989). Thus some of Foucault's theorising and

analysis, at times, appears similar to the more structural approaches to power, inequality and the subject. Parker (1992: 5) asks, 'Is all reducible to discourse?' We are warned about overemphasising the social determinants of discourse as well as the construction of the social in discourse (Fairclough, 1992a).

Foucault's notion of discourse, however, is still of value and has been further developed. For example, Lupton (1994a: 29) describes a symbiotic relationship between discourse and social practices with 'discourses producing the types of practices that are adopted and the practices themselves reinforce and contribute to discourses'. Fairclough (1992a) describes a dialectical relationship between discourse and social structure. He argues that on one side, discourse is shaped and constrained by broad social structures, social relations such as class and gender, relations specific to particular institutions such as law, education, health and by various norms and conventions. On the other hand discourse is socially constitutive as emphasised in Foucault's work. 'Discourse contributes to the constitution of all those dimensions of social structure which directly or indirectly shape and constrain it' (Fairclough, 1992a: 64).

Yet in these reformulations of the relationship between discourse and social practice, the subject as agent, actively constructing a continuous sense of self and positioning in the world, remains hidden. For many feminists advancing the notion of human agency, the poststructuralist idea that as individuals we are constituted and have very little choice in who we are is particularly abhorrent (Alcoff, 1988; Young, 1990). Young (1990: 13) warns, 'In efforts to expose the unitary, rational subject as mythical, much poststructuralist work has completely eclipsed the subject'. Henriques, et al. (1984: 204) also ask the following important question regarding the discursive construction of subjectivity:

> (If) the subject is composed of or exists as, a set of multiple and contradictory positionings or subjectivities(,)... how are such fragments held together?...What accounts for the continuity of the subject and the subject's experience of identity? What accounts for the predictability of people's actions, as they repeatedly position themselves within particular discourses? Can people's wishes and desires be encompassed in an account of discursive relations?

Despite these concerns, Young (1990) believes that we need not reject all poststructuralist work. She maintains that many pragmatic concerns such as issues of oppression, resistance and emancipation can be addressed through a poststructuralist perspective of subjectivity. In redressing the over-determinist position of Foucauldian thought, Young (1990) and Henriques, et al. (1984) understand subjectivity to be simultaneously constituted in discourse and shaped by the self. Young (1990: 13) describes subjectivity in this way:

> Subjectivity is constituted in language and interaction, a contradictory and shifting product of social processes in which a person discovers her or himself already positioned. But however much we are constituted, we also have purposes and projects that we initiate; the concept of the subject retains this aspect of agency as creative, as the life activity that takes up the given and acts upon it.

In a similar way, Henriques, et al. (1984) use subjectivity:

> ... to refer to individuality and self awareness - the condition of being a subject - but understand in this usage that subjects are dynamic and multiple, always positioned in relation to particular discourses and practices and produced by these - the condition of being subject.

In this study of motherhood, subjectivity is understood to be socially constructed through interactions with others. Lupton (1995: 7) states, 'We are not born with subjectivity but acquire it from infancy'. In this approach, language and discourse are believed to constitute subjectivity but importantly, Lupton (1995: 7) adds, this occurs 'in a complex relation with other sources such as sensual embodied experience and the unconscious'.

Deconstructing Boundaries and Dualisms

It is important to return to a discussion of the poststructuralist endeavour to 'deconstruct' dualist thought. Hollway (1989: 31) states, 'A critique of individual-society dualism lies at the basis of most poststructuralist thought'. As mentioned above, poststructuralism deconstructs the humanist notion of the subject-as-agent and the unitary individual. The view that the individual is self-contained and unitary has created one of the major dualisms in western society - a division between individual and society. This is

highlighted by Henriques, et al. (1984) and Hollway (1989), in their strong critiques of psychology and its focus on the individual. At best they argue the two dimensions of individual and society are examined by social psychologists for how they interact and the way in which one affects the other. These authors also identify the tendency of social sciences and politics to search for answers for change purely in social theory thus maintaining the other side of the individual-society dualism (Hollway, 1989). This dualist approach is frequently seen in analyses of health care. For example, when attempting to explain women's attendance for antenatal care, some commentators rely upon explanations that reside within the individual, their personality and life circumstances, whereas others search for answers in the structural provision of antenatal care.

Hollway (1989: 27) states, 'Poststructuralism is about trying to transcend this hopeless dualism, by rejecting both voluntarism and determinism'. As discussed in the Introduction and Chapter Two, the dominant approach in empirical research of the postpartum period concentrates on identifying individual characteristics and the social circumstances that are related to poor parenting outcomes. Those who differ from established 'norms' or 'roles' are described as 'unsuccessful' in or 'maladapting' to the parental role. The majority of interventions focus upon the individual and changing perceptions or behaviour. It is rare that the premises underlying these established 'norms' are questioned. In contrast, the sociological and feminist work on motherhood highlights the social context within which mothering occurs and the dominant ideologies that surround motherhood. It advocates that a change in the public and social construction of motherhood is necessary for individual women to have a more positive experience of motherhood. These analyses tend to privilege the social understanding of experience at the expense of personal agency.

The writings of Henriques, et al. (1984) and Hollway (1989) on the individual-society dualism are important in exposing the way in which various disciplinary endeavours have fragmented our understandings of self or subjectivity. Burkitt (1991) identifies that this split between individual and society is not the only issue of division. People not only feel divided from each other but within themselves. The connection between our thoughts and actions on one hand and our emotions on the other causes concern and

discomfort for many individuals. We are not only separated from others but we are also separated from ourselves (Burkitt, 1991). This reflects the core dualism, that of the mind and body.

Grosz (1994: vii) describes the mind-body dualism as the 'belief that there are two mutually exclusive types of 'things', physical and mental, body and mind, that compose the universe in general and subjectivity in particular'. Each of these, the psychic interior and the body, are constructed as separate and self-contained with incompatible characteristics (Grosz, 1994). Many attribute this mind and body split to Cartesian thought (Grosz, 1994), however, this has been disputed (Lawler, 1991). Regardless of its origins, the dualist interpretation of mind and body persists and makes it impossible to answer many questions of everyday occurrence that demonstrate a connection between mind and body. For example, Grosz asks, 'How can consciousness ensure the body's movements and how does the body inform the mind of its needs and wishes?' (1994: 6-7).

Modern subjectivity or notions of self have been predominantly explored in terms of the mind, the psyche or consciousness and to a much lesser extent in terms of the body. Approaches to the body have varied. Predominantly the body has been studied as an object and understood in natural, biological and medical sciences as an object of organic functioning. In the social sciences, emotions, perceptions and cultural practices are similarly viewed as objects of study. The body is merely an extension of the conscious mind and psyche (Grosz, 1994). Other dualist understandings of the mind and body position the mind as transcendent over the body. Here in traditional philosophical thought, the willful and powerful mind has possession over the body, the body as machine or tool is inert and controlled by the mind, requiring training and discipline (Grosz, 1994). Importantly Grosz (1994) notes here that many feminist analyses of patriarchal power have used this understanding of the body in their critique of male appropriation of the female body, the powerful male having control over the passive female body.

Yet another approach positions the body as a 'signifying medium, a vehicle of expression, a mode of rendering public and communicable what is essentially private

(ideas, thoughts, beliefs, feelings, effects)' (Grosz, 1994: 9). Through the body, a subject is able to express or communicate interior experiences of the conscious and unconscious mind and alternatively the subject receives input from the 'external' world. The body becomes a transparent surface that mediates between interior and exterior, individual and society. In this understanding the body continues to be passive and pliable. In Foucauldian thought, the body is something that is shaped by discourse in order to position a subject in particular ways. In more recent poststructuralist thought it is something that is also worked upon by the subject in order to represent the inner self (Lupton, 1995; Rose, 1996; Shilling, 1993).

In each of these understandings of the body, the mind-body dualism persists and the experience of having a body or being embodied is denied. Grosz (1994: 10) states, 'The place of the body in constituting or forming thoughts, feelings, emotions, and psyches is ignored'. In this study of maternal subjectivity, the body is afforded a central place in understanding women's experience of motherhood and in particular the experience of breastfeeding.

1.2 STUDYING SUBJECTIVITY THROUGH DISCOURSE ANALYSIS

What is Discourse Analysis?

The study of discourse originated from diverse linguistic and philosophical traditions that privilege the place of language. In recent times, discourse analysis has developed as a multidisciplinary endeavour and is seen by certain groups of philosophers, sociologists, social psychologists, feminists and cultural theorists as an important method for studying social organisation, power relations and social change. The application of discourse analysis is recent in the context of health research, but is, however, producing significant analyses of the sociocultural context in which illness and disease are experienced and understood (e.g. Lupton, 1994a,b, 1995; Marshall, 1991; Rudge, 1997). Discourse analysis has rarely been employed within nursing/midwifery research (Cheek & Rudge, 1994) but is a useful endeavour for such research as it can highlight the use of language and related practices in which both the researcher and the reader of the analysis are involved. Importantly, discourse analysis highlights the

'constraints upon our practices and the possibilities for individuals and groups challenging those constraints' (Fairclough, 1992a: 240).

As a method, discourse analysis deliberately systematises statements or different ways of talking so that we understand them better (Parker, 1992). Discourse analysis involves both a focus on the micro aspects of language and a macro interest in the historical, social and political context in which language is used (Lupton, 1992). While there are a number of varying approaches to discourse analysis, all emphasise the examination of linguistic processes and thus differ from other techniques of textual analysis (Lupton, 1994a). Overall, discourse analysis seeks to answer questions that are sociological in origin rather than linguistic (Potter & Wetherall, 1994).

The emphasis of discourse analysis is upon identifying the discourses that exist, examining how these discourses are manufactured or constructed by individuals and groups out of a range of styles, linguistic resources and rhetorical devices (Potter & Wetherall, 1994). This differs from a content analysis of interview transcripts or media reports in that discourse analysis is not trying to recover or relate events from a participant's story and is not treating language as a reflection of other things (Potter & Wetherall, 1987). Rather, it is focused on the ways in which people represent their experiences or feelings, the repertoires of discourse that they draw upon to present themselves. Discourse analysis examines the tensions or contradictions within and between discourses, asking how a particular discourse competes successfully or otherwise with an alternative discourse. Finally, the analysis examines how such discourses 'reproduce and transform the world' (Parker, 1992: 5).

Undertaking discourse analysis requires a degree of reflexivity of both the researcher and reader (Parker, 1992; Lupton, 1994a). The analyst continually needs to ask why was this said and not that, why this choice of words and not others? (Parker, 1992) It requires an awareness that all knowledge is socially produced and that one is producing a discourse by analysing another discourse. As such the research takes a certain political position (Lupton, 1994a).

The examination of texts is central to discourse analysis. Text analysis is becoming important in many areas of social research and as Fairclough (1992b: 211) notes, 'Texts constitute a major source of evidence for grounding claims about social structure, relations and processes... texts are sensitive barometers of social processes, movement and diversity, and textual analysis can provide particularly good indicators of social change'. Text refers to any form of communication that can be produced in a written form such as advertisements, photographs, hospital records, medical consultations, books and newspapers as well as everyday conversations, speeches and interviews transcribed to become text (Lupton, 1994a). In this study, transcribed audio tape recordings of unstructured interviews with parents have become textual data.

Approaches to Data Collection and Transcription

Recently a number of commentators working in the field of discourse analysis have provided an outline of approaches to data collection and analysis (Fairclough, 1992a; Parker, 1992; Potter & Wetherall, 1987). However, Fairclough (1992a: 225) warns that there is no 'blueprint' for doing discourse analysis. Such an analysis will be approached in many ways according to the nature of the project as well as the views of the researcher. For this study, the work of these various authors has guided the decisions made regarding the nature of the data to be collected, the sample size and the transcription and analysis of data.

Traditionally discourse analysis has relied upon records and documents of interaction as data sources. For example, transcripts of everyday conversations, news reports, letters and so on are all features of social relations and structures and allow the researcher to capture a wide variation in accounts (Potter & Wetherall, 1987). As interviews between the mothers and researcher comprise the major source of data for this study, it was important to conduct the interviews in a way that would draw out the diversity of participants' discourses. It was important to allow participants to talk freely around a subject to ensure a wide range of discourses was addressed. Potter and Wetherall (1987: 165) suggest that the interviewer should try to generate 'interpretative contexts' in the interview. This may be facilitated by returning to the same issue more than once in the interview or series of interviews and at times offering alternative views to the one

presented in order to prompt the participant to elaborate on their views (Potter & Wetherall, 1987).

Transcription of data to produce the text for analysis is difficult and time consuming yet it is essential for the analysis that the transcripts are accurate. In this study, all verbal utterances have been recorded and inaudible speech noted. Pauses, emphasis, laughs and other non-verbal forms of communication have been recorded by the transcribers. Interruptions by interviewer and places where two people speak at once were also noted. These non-verbal data have been recorded on the transcripts and form part of the analysis.

Approaches to Data Analysis

Analytic approaches to discourse analysis are not well defined and vary according to the type of 'text' that is being analysed and upon the research question or interests of the researcher. Potter and Wetherall (1987: 169) describe analysis as occurring 'within a broad theoretical framework, focusing attention upon the constructive and functional dimensions of discourse'. They believe that analysis comprises a search for pattern in the data, examining the similarities and differences in either the context or form and is also concerned with the function and consequences of various accounts or discourses (Potter & Wetherall, 1987).

This description, while providing the essence of discourse analysis, gives little guidance for researchers wanting to undertake discourse analysis. The analysis for this study has also been guided by some of the techniques outlined by Fairclough (1992a). In his work, Fairclough (1992a: 62) aims to 'draw together linguistically oriented discourse analysis and social and political thought into a framework that specifically studies social change'. While seeking to combine a micro-linguistic approach with a sociopolitical analysis, Fairclough's approach continually favours a sociopolitical focus as he draws attention to discourse as a social and political practice. In this regard, Fairclough's approach is consistent with the aim and objective of this study.

For Fairclough, social practice and text are both dimensions of a discursive event or discourse (Fairclough, 1992a). These two dimensions are mediated by a third that

emphasises discourse as a specifically discursive practice. Fairclough (1992a: 71) states, 'Analysis of a particular discourse as a piece of discursive practice focuses upon processes of text production, distribution and consumption. All of these processes are social and require reference to the particular economic, political and institutional settings within which discourse is generated'.

Fairclough (1992a: 72) brings together three analytical traditions in discourse analysis:

1. close textual analysis in linguistics
2. the macro-sociological approach to analysing social practice in relation to social structures
3. the interpretivist tradition or micro-sociological approach of seeing social practice as something which people actively produce and make sense of on the basis of shared understandings.

While this model conceptualises analysis in three dimensions, in practice Fairclough clearly states that these three dimensions will overlap. For example, there are many instances where the distinction between what is text and what is discursive practice is not great. Fairclough (1992a) explains that the parts of the analysis that deal with text are descriptive and the parts that deal with discourse and social practice analysis are interpretive.

In undertaking the analysis, Fairclough (1992a) suggests beginning with the dimension of discursive practice, moving to analysis of text and then to analysis of social practice. In this way analysis proceeds from some interpretation to description and back to interpretation. Overall, analysis should be directed at identifying features, patterns and structures that are typical of certain types of discourse. As analysis proceeds, Parker (1992) adds, it is necessary to step back a number of times to make sense of the statements that have been singled out.

The analysis in this study consisted of an initial coding of data into groupings of discourse types, such as 'public discourses of the good mother' and 'professional discourses of breastfeeding'. Particular samples of text, for example segments of text that discuss 'what is a good mother', were highlighted. These pieces of selected text were

then examined more closely, looking at the words, phrases, figures of speech and metaphors used. The final part of analysis then examined the social relations, practices and institutions that these discourses were part of and had also influenced. The data was also examined to ascertain what other texts parents drew upon to express their notions of reality: for example, self help books, the news media, medical explanations, conversations with family and friends.

The table presented in Appendix C was developed as a guide to data analysis for this study. Important points or moments in the text useful for detailed analysis have been identified using the framework developed by Fairclough (1992a: 232-238). References made to the work of others are cited within the table.

1.3 CREATING THE TEXT

In the following section I describe the way in which 'text' or data was created for the purpose of undertaking a discourse analysis. As in a traditional research report, this section includes a discussion of data collection techniques, selection and recruitment of participants, conduction of interviews and ethical considerations in undertaking the research. It differs from the traditional research report in its emphasis upon the nature of the relationship between the participants and myself, the researcher in this study.

How 'Text' was Produced

In order to capture the diversity and changing nature of women's experience during the first few months of motherhood, I spoke with women on a number of occasions over a six-month period. The longitudinal interviews allowed me to explore how these women constructed their lives as mothers and the way in which a variety of discourses of motherhood, particularly breastfeeding, shaped their experience in the first few months with a new baby. These transcribed interviews provided the major source of 'text' for analysis. The first interview with each mother (and father) was held in late pregnancy and subsequent interviews were conducted after the birth of the baby, when the baby was approximately one week old, four to six weeks, ten to twelve weeks and six months old. These time periods have been identified in the literature as marking significant

changes in women's experience (Crnic, Greenberg, Robinson & Ragozin, 1984; Mercer, 1985a; Rubin, 1984). The interviews varied in length, from 45 minutes to one and a half hours. In general the interviews with the women took up to 15 to 30 minutes longer than the interviews conducted with the men.

Twenty-five women and their partners participated in this study of parenthood. The participants were recruited in two ways. First, couples attending antenatal classes that I facilitated at a Sydney metropolitan hospital were invited to participate in the study. Towards the end of the series of antenatal classes, they were provided with information about the study and a contact telephone number. This recruitment approach maintained participants' confidentiality and was successful with between one and three couples willing to participate from any one antenatal class. Recruitment was spaced over a period of 18 months and a total of 17 couples were recruited in this way. A further four couples were approached on the antenatal ward of the same hospital. These women were either attending the Pregnancy Day Assessment Program or had been hospitalised for hypertension. Recruiting women who had been hospitalised for a period during pregnancy increased the diversity of the study. A further four couples were known to different members of the larger research team and expressed an interest in participating in the study. Particular consideration was given to maintaining the anonymity of these couples and is discussed further under 'Ethical Considerations'.

In planning the study, participation was limited to women who were expecting their first baby, fluent in English and over 18 years of age. The larger study required both women and their partners to participate and thus it was important that the women were in a stable relationship with the father of the baby. It was also considered important that the newborn infant be generally healthy with no congenital abnormalities. If the infant arrived prematurely, it should be well other than minor complications associated with prematurity. (The issue of recruiting or excluding particular women is discussed further under 'Ethical Considerations'.)

Who Participated

Of the 25 women participating in this study, the average age was 28.2 years, ranging from 23 to 35 years at the time of the first interview. The majority of these women were

Australian born or had lived here since a young age. Four of the women had moved to Australia in their late teens or twenties, two coming from the United Kingdom, one from Zimbabwe and one from Northern Europe. Twenty-three women were married and two were in long term de facto relationships. On average the women had been in their relationships for seven years (range 18 months to 12 years).

As the majority of the women were recruited through antenatal classes at a hospital in Sydney's south, most lived within this general geographical area. This area spanned a 25km radius from inner southern suburbs to suburbs on the outskirts of Sydney's south. An additional six women lived in other areas, two were from Newcastle (150kms north of Sydney) and the other four women lived in Sydney's west, south west, inner west and northern beaches. Fifteen women and their partners lived in houses or units that they were purchasing. Nine women lived in rented accommodation and one woman and her partner lived with her parents.

Twelve of the women held tertiary degrees or diplomas and prior to the birth of their baby they had worked in a variety of occupations such as teaching, speech therapy, nursing, podiatry, health promotion, management and business. Of the remaining 13 women, four held trade certificates, four had completed year 12 and five had completed year 10 at school. These women were employed as administrative assistants, bank officers and customer service operators. A number of women did secretarial and clerical work.

Eleven of the 25 women planned to give birth in an alternative birth centre environment. They had chosen this predominantly on the recommendation of friends, believing it to be a nice home-like environment, a place where birth could be as 'natural' as possible. During pregnancy, two women were transferred from the birth centre program to receive care for hypertension. The remaining 14 women were all booked for conventional delivery suite birth. These women had based their decision on having medical technology available and were prepared to use medicated pain relief.

Six of the women had emergency caesarean section, usually after very long labours or for fetal distress. Three women had planned caesarean sections for breech presentation

and for maternal hypertension. Six of the 16 women who had vaginal deliveries had an epidural anaesthetic.

Orchestrating the Interviews

Organising a series of interviews with 25 women and their partners required much time and energy. To organise one interview with a woman and her partner would generally require at least five telephone calls making contact with the couple and the male interviewer. Whenever I spoke with the woman or her partner, I always needed to ensure that I had time available to 'chat'. I would always inquire as to how they were and how things were going with the baby. Sometimes these calls entailed talking with other family members where I was told about recent illnesses or deaths in the family, parenting experiences and particular beliefs about breastfeeding or where a baby should sleep.

After agreeing to participate in the study, the woman and her partner were first interviewed one to six weeks prior to the due date of the birth. The interviews were held in a variety of locations, although predominantly in participants' homes. Antenatal interviews were conducted with 22 of the women. Three antenatal interviews were not conducted because the baby was born before the interview was undertaken. In addition, two of the 22 antenatal interviews had problems with tape quality, which prevented transcription, so data were only available in the form of field notes.

Written consent to participate in the study and to tape record the interviews was obtained from each person at this first interview. Demographic details were documented and at the completion of this first interview. I provided my home and work telephone numbers so participants could let me know when the baby was born.

Each participant and her partner were asked to contact me following the birth of the baby. It was stressed that I did not expect to be the first person contacted after the birth but that we would like to speak with them again within the first week following the birth. After the woman or her partner let us know of the birth, further contact was made to arrange the next interview. These interviews were conducted between day four and day 12 following the birth. In one instance the second interview was missed due to

Christmas commitments. These interviews were conducted in the hospital with nine women and at home with 15 women. Eight women went home on early discharge programs.

Subsequent interviews occurred at four to six weeks, ten to 12 weeks and six months following the birth. Again the time frame of the third, fourth and fifth interviews varied as family and work commitments of both the participants and the interviewers had to be taken into consideration. As discussed in 'The nature of the relationship', it was important that interviews be arranged at a time and place convenient to the participants. In one instance I had to arrange my visit for the third interview at least half an hour after the baby had been fed or an hour or so before as breastfeeding for this woman had been so painful she would be in tears during and just after feeding the baby.

Creating 'Text' - Interview Questions

A set of open-ended questions and prompts were formulated to guide the interviews. In the early phase of the study several broad areas of discussion were identified, such as women's ideas and feelings about becoming mothers, how women described their baby during pregnancy and after the birth, pictures or images they had of motherhood, what they believed a mother was and their common sources of help or advice. These areas were discussed within the larger research group as the same interview prompts were used for the fathers' interviews. After the first four couples had been interviewed for the third time the questions were reviewed, difficulties and gaps identified and a revised set of questions formulated (see Appendix B). It became very evident in these early interviews that the feeding and settling of an infant were focal areas of concern for these parents. These issues were also influenced by others and presented many contradictions for the parents. Specific questions were designed in order to discover the discursive practices surrounding feeding and settling an infant.

Overall the interviews reflected a combination of genres (Fairclough, 1992a). The interviews were designed to be semi-structured, using prompts to encourage women to present and account for their version of this new world. This research interview genre is characterised by an informal style that allows women to talk freely around a topic and engages them as active participants in this interaction. I did not follow the interview

questions strictly and parts of the transcribed text represent a more conversational genre where we 'chatted', sharing ideas on infant care and so on. There were many occasions in which I did not look at the interview schedule at all until the very end of the interview to check if there was anything in particular that I needed to follow up. At times the interview transcripts clearly indicate the presence of a counselling genre where my colleagues involved in the fatherhood research and I used questioning and responding techniques that subtly encourage a participant to open up, to elaborate or talk more about an issue.

In order to draw out the diversity of participants' discourses, we employed Potter and Wetherall's (1987) technique of generating interpretative contexts in the interview. This occurred by returning to the same issue more than once in the interview or series of interviews and at times offering alternative views to the one presented in order to prompt women and men to elaborate on their views (Potter & Wetherall, 1987).

Ethical Considerations

Ethics approval was obtained from the Southern Sydney Area Health Service, the Hunter Area Health Service and the University of Technology, Sydney Ethics Committees. Information and consent forms (see Appendix D) were given to participants when they were informed about the study and consent forms were signed when I met with the women and men for their first interview prior to the birth. However, following the granting of approval to conduct the study, there were a number of ethical issues that required further consideration.

The exclusion criteria for this study of parenting stated that couples would be excluded if a full-term baby was born unwell or if a pre-term infant was born with any problems or complications other than those associated with prematurity. The study was thus concerned with parents who had healthy full-term or generally healthy pre-term infants. A sick infant was initially considered an additional factor that would impact on the parenting experience making these women and men different from the others in the study. While this may be so, my colleagues and I expressed discomfort at terminating a couple's participation in the study after the first interview. We firmly believed that participation was likely to benefit most participants and after establishing initial rapport, it would have been callous if not unethical to terminate participation without at least

spending time speaking with them following the birth of their infant. We resolved to visit the couple at the planned time and to offer them the opportunity to continue in the study if they so desired. At this time, the condition of the infant would be discussed, moving away from the interview schedule to allow these parents to discuss their fears, concerns or experience. If the parents wished to continue in the study then the other planned interviews would proceed. In a qualitative study, particularly where diversity is sought, we believed that these data would increase the diversity of experience and broaden the range of discourses drawn upon, particularly in relation to images of the 'perfect baby'.

Women and men were recruited into the study through convenience sampling. I was working as an antenatal educator in the hospital where the study was conducted. This position provided easy access to many couples expecting their first baby. I was also in a powerful position. Couples were informed about the study towards the end of their series of classes by which time they were very familiar with me and were told that I would be conducting the interviews with a male colleague. This made recruitment easy, with no shortage of people wishing to participate. The fact that it was the midwife facilitating their classes who would conduct the interviews did not appear to restrict any areas for discussion by the women or men. They appeared to feel free to comment at interview upon the value of the classes they attended.

Further convenience sampling occurred through the recruitment of two work colleagues and a friend of two of the male interviewers. Conducting interviews with people who were known to some of us led me to examine whether the strategies for maintaining confidentiality and anonymity were sufficient to completely protect the anonymity of those known to us. The recorded data have been marked only by codes and are kept in a locked filing cabinet, the key retained by two of the researchers. Consent forms and demographic details are kept in a separate locked cabinet from the tape data and transcripts. None of the transcripts contain identifying names and all participants were given a pseudonym that appears in the transcripts. As some of the clerical staff transcribing the tapes may have been aware of the identity of colleagues participating in the study, the interviewers who undertook those interviews transcribed these tapes.

This study conducted interviews with female and male partners. Mothers and fathers were interviewed separately. This raised issues of confidentiality between the female and male partners who were encouraged to share their thoughts and feelings with the interviewer. My colleagues and I frequently travelled together to the participants' homes and following the interview we would discuss various aspects of the interviews and provide each other with the perspective of the mother and father. At times women and men commented about their respective partner and expressed dissatisfaction with the words or actions of the other. During recruitment it was important that couples be told that what they said to the interviewer would not be later discussed with the respective partner.

Further Ethical Considerations - the Nature of the Interview Relationship

At the outset of this project, my colleagues and I felt very comfortable with the notion that the interviews with both women and men would be guided by broad feminist principles that emphasised authenticity, reciprocity and intersubjectivity (Maynard & Purvis, 1994; Stacey, 1988). The work of feminist scholars (Oakley, 1981; Reinhartz, 1983, 1992; Stanley & Wise, 1983) has argued that meaningful and feminist research depends upon empathy and mutuality, with a resulting egalitarian, reciprocal relationship. Further considerations of the nature of the relationship that develops during interviews, however, led me to examine some of the apparent contradictions that exist in this feminist rhetoric.

Oakley (1981) is well known for her critique of the tenets of empiricist research, in particular the protocols that govern the conduct of interviews. Oakley's work on the transition to motherhood is particularly relevant to this study. Oakley (1981) sees the one way process in which the interviewer elicits and receives but does not give information as inappropriate, even absurd. She convincingly states her position using illustrations of questions that her respondents asked of her during interviews about the transition to motherhood. Women participating in Oakley's study asked questions in relation to caring for the baby, for example, 'Do you think my baby has too many clothes on?' or 'Why is it dangerous to leave a small baby alone in the house?' They also asked questions about Oakley's personal experience such as 'Do you have children?' 'Did you breast feed?' Finding it impossible to ignore such questions, Oakley (1981) describes

interviewing women as a 'contradiction in terms', believing that interviewees cannot be simply objectified to data and that the interview situation is not devoid of social and personal meaning. As Ribbens (1989: 579) states, 'Interviews are a very complex social encounter'.

In her work, Oakley (1981) describes the friendships that she developed with many of the women in her study. The women frequently took the initiative in moving the relationship beyond the boundaries of a traditional interview by offering tea, coffee or a meal, showing interest in the life of the interviewer (what sort of person she was and why she was interested in this subject) and what the goals of the research were. Some women took the initiative to ring Oakley to arrange subsequent interviews and others rang between interview times to let her know about things that had happened. As final evidence of the reciprocity that developed in the research, Oakley (1981) states that a number of women are now her close friends and there are others who contact her when something happens in their life, such as the birth of another child. To emphasise the non-exploitative nature of the research relationship, Oakley (1981) stresses that the interviews were always conducted at a time and place convenient to the mother. If there were chores to be done before the interview could take place, Oakley offered and often did help with the work. Crouch and Manderson (1993) and Brown, Lumley, Small and Astbury (1994) in their recent work with new mothers also describe the development of a similar relationship with their research participants. They talked, laughed and cried together about their experiences of motherhood. They shared their experiences and would frequently hold babies, change nappies or hang out washing.

Such work has been convincing and my colleagues and I were similarly influenced by feminist approaches to interview relationships. We worked at establishing a very informal and comfortable environment to enable both women and men in the study to talk freely about their experience of early parenting. Key questions and prompts, as described, were developed to guide the discussion and were modified in response to participants' ease or difficulty with the question. During the study we appear to have been very successful in creating this informal environment. Upon arrival at the participant's home we always spent time talking about things that have been happening, for example, how things were going with the baby and what was happening at work.

Frequently we were offered tea, coffee, beer or wine and sometimes something to eat. In a couple of instances the woman and her partner had prepared afternoon tea or supper and on subsequent visits we reciprocated by bringing something to eat.

After a period of 15 to 30 minutes we commenced the separate interviews in different rooms in the house or unit. At the end of the interview we came together again and picked up on general chat. We were often shown the baby's room, had a cuddle of the baby or looked at recent photos. While the recorded interviews lasted from 30 to 90 minutes, our visit to the home was between one and a half to three hours. In general the interview with the mother lasted 15 to 30 minutes longer than the interview with the father, but this was not always the case. In between the interviews there were times when I rang the women to see how things were going, particularly if they had been experiencing difficulties.

Initially we favoured the notion of reciprocity and believed that this was occurring in our encounters with new parents. The participants in our study showed hospitality, gave much of their precious time and shared the intimate details of their personal experience. We had to ask what we were giving them in return. We considered that we were giving them time - time to talk about experiences very dear to them and an opportunity to express their feelings and thoughts to a sympathetic listener (Cotterill, 1992). Many of the couples commented that the questions prompted them to think about issues they had not spoken of before and that following our time with them they often spoke about the interview and what they were thinking and feeling. In this sense we considered that we were contributing to their relationship. While we were not in a clinical role, we believed that we should answer participants' questions about their birth experience or about caring for their baby. If we were unable to answer their question or the matter required professional opinion, we referred them to appropriate sources of help. In addition we offered the participants the original tapes, once the data had been transcribed, so that they had their recorded thoughts and feelings as a form of a diary.

What we did not give these couples in return was the same detail about our own personal lives. All participants knew that I was a mother of two young boys and many had met me in my capacity as an antenatal educator. We shared some of our ideas about

young babies and men as fathers and we shared some experiences. Most know that I had breast fed my children and that as young infants and toddlers they had slept with me. When mothers asked me what I did in particular situations, such as when a baby wakes very soon after settling, I answered them.

Is it possible to achieve a relationship between interviewer and interviewee that is reciprocal, completely free from power, non-hierarchical and non-exploitative? Stacey (1988: 24) in her ethnographic fieldwork found that contrary to the belief ethnographic methods are well suited to feminist endeavour, 'the ethnographic method exposes subjects to far greater danger and exploitation than do more positivist, abstract and 'masculinist' research methods'. Stacey (1988) describes the way in which the human engagement and attachment necessitated by ethnographic research actually places participants at grave risk of manipulation and betrayal by the ethnographer, particularly in the writing and presentation of the final product of the research.

Ribbens (1989: 580) identifies a range of difficulties or 'knotty problems' that must be considered when conducting depth interviews, such as power and control, listening and caring, involvement and motivation. Ribbens (1989) describes a number of issues of power that concern her in undertaking in-depth interviews. She highlights the way in which convenience sampling, where participants actively volunteer to take part in a study, may actually place them at greater risk of manipulation than those recruited as part of a random sample. When someone volunteers to participate, their motivation in participating is more assured, placing the researcher ironically in a more powerful position (Ribbens, 1989). If participants feel that the interviewer is imposing upon and controlling the interview situation, then it is difficult to maintain their motivation. Oakley (1981) has described the way in which a participant may sabotage an interview where they do not feel comfortable and wish to get their point across. It appears therefore to be in the researcher's interest to foster a relationship where participants feel comfortable and will part more easily with information and willingly co-operate in the research process. Cotterill (1992), however, does not believe that the research participants are always in a vulnerable position. She highlights the complexities of power and control in the interview situation, providing numerous examples that demonstrate the 'fluid' nature of the interview encounter. For Cotterill (1992), balances

shift between and during different interview situations and sometimes the researcher is as vulnerable as those being studied. Ultimately for Cotterill (1992), it is in the final analysis and writing of the research report that the researched become vulnerable and the researcher powerful. Ribbens (1989) described this as defining people's realities for them and for a wider audience.

Ribbens (1989) also questions how far in practice researchers take the call for reciprocity. She takes issue with Oakley in her claim for reciprocity. Ribbens (1989) states that the majority of questions Oakley answered were calls for information and less frequently was she asked to disclose personal and sensitive issues about herself. How much do we let someone know about ourselves? Ribbens (1989) suggests that the next level of reciprocity would be to volunteer information about ourselves without waiting to be asked and sharing our views in response to a situation. Ribbens (1989) adds, however, that perhaps openly talking about oneself in an interview may significantly shift the direction of the interview. We must ask ourselves whether part of what we give to participants in in-depth interviews is the opportunity to have someone listen to their story, the chance to talk about themselves, a practice not readily accepted in our society - the 'sympathetic listener'. As Ribbens (1989) comments, if I start talking about myself, this may be seen as breaking the research contract rather than sharing myself with the participant. The readiness to share information may also be interpreted differently by different women. Some may see my willingness to share my experience as being open while others may believe that I am making demands of them to be equally as intimate (Ribbens, 1989). Cotterill (1992) considers that these issues of reciprocity are moral issues. Similarly, Oakley's (1981) description of the friendships that she formed with women participating in her study should also be viewed as a moral issue (Cotterill, 1992). Is the development of friendships through the interview process a form of manipulation? Are participants more likely to disclose personal experiences to someone who they feel is interested in them?

The nature of the relationships that I had with these 25 women varied. In the main our relationships felt comfortable and friendly. As our relationship continued over the six-month period, many of the women shifted in their discussions from the more acceptable 'public' account to disclosing their 'personal' account (Cornwell, 1984) of their

experiences as a mother and their relationship with their partner. In presenting the findings of this study, however, I acknowledge that the analysis presented here represents my interpretation of the experiences of these 25 women.

CONCLUSION

In this chapter I have described the way in which subjectivity is to be understood and studied in this thesis on motherhood and breastfeeding. Taking a poststructuralist perspective, I emphasised the central place of language and discourse in constituting social organisation, social relations, power and individual consciousness. Subjectivity is seen as being precarious and constantly changing as it is constituted through discourse, as well as embodied experience. In this approach, a mother is not a fixed, given or authentic entity, rather, a particular product of historically specific practices of social regulation and changing personal experience and perception. In using this understanding of subjectivity, however, I do not deny that individuals have agency and creativity in the constitution of the self. As Lupton (1995: 137) argues, there remains a 'tension between understandings of the body and subjectivity as discursively constructed and notions of subjectivity and projects of the self as agential, the point of resistance'. It is accepted that this 'dialectic can never be resolved... (instead)... there is a continuing struggle over meaning' (Lupton, 1995: 137).

It is the tensions and contradictions in the meaning of motherhood and experience of breastfeeding that this thesis explores. I commence this study of motherhood, subjectivity and the body by examining the way in which maternal subjectivity has been constructed within nursing and midwifery theoretical and empirical work.

CHAPTER TWO

THE MATERNAL SUBJECT IN NURSING AND MIDWIFERY THEORY AND RESEARCH: CONSTRUCTING THE BOUNDARIES

This chapter examines the construction of maternal subjectivity within nursing and midwifery theory and research. Here I ask the question: how do nurses and midwives interpret, write about and theorise maternal subjectivity? An understanding of the construction of maternal subjectivity within professional texts is important because it can provide the opportunity for nurses and midwives to become more aware of their practices and the purposes they serve (Fairclough, 1992a). In some respects, this chapter acts as a traditional literature review, setting the direction for this particular study of motherhood. The approach taken, however, in examining the literature is in the form of a discourse analysis, examining the historical context of current theories of maternal subjectivity. Consequently the theoretical perspectives and related research discussed here have been treated as 'data'.

2.1 ROLES, TRANSITION AND ATTACHMENT: AN OVERVIEW OF NURSING RESEARCH

Transition to the Maternal Role

In the following section I provide an overview of the nursing and midwifery empirical work that guides our practice as midwives and nurses. As noted in the Introduction, the area of parental development has been studied extensively. In studying maternal identity, nurses and midwives have tended to adapt frameworks from developmental and social psychology as well as functionalist sociology. Drawing upon these frameworks, becoming a mother has been examined as a crisis or stress (Avant, 1988; Mercer, 1986a), psychosocial adaptation (Ball, 1987; Lederman, Lederman, Work & McCann, 1979; Lederman, 1996; Ventura, 1986) and transition (Foss, 1996; Majewski, 1986; Meisenhelder & Meservey, 1987; Pridham & Chang, 1992; Roberts, 1983; Tomlinson, 1987, 1996). Theoretical work developed within nursing has focused on describing maternal identity and identifying and testing components in the process of maternal role attainment (Chao, 1979; Curry, 1983; Koniak-Griffin, 1993; Mercer,

1981, 1985a, 1986a; Rubin, 1967a,b, 1975, 1977, 1984; Walker, Crain & Thompson, 1986a,b; Zabielski, 1994). What is immediately striking about this focus is the assumption that there is 'a' defined maternal role and an identity as a mother, that is acquired in developmental stages and is measurable in quantitative terms.

Taking this positivist approach, questions of maternal role identity are coupled with questions regarding the characteristics and variables that influence or indeed hinder the individual's 'maternal role attainment' or transition to parenthood. Concerned with maladaptation and pathology, nursing studies examine the impact of maternal 'variables' such as age (Gottesman, 1992; Mercer, 1985a,b, 1986a; Reece, 1995), parity (Mercer & Ferkeitch, 1995; Pridham & Chang, 1992; Waters & Lee, 1996), marital status and relationship with partner (Barclay, MacDonald & O'Laughlan, 1994; Ellis & Hewat, 1985; Majewski, 1986; Mercer, Ferkeitch & DeJoseph, 1993), individual personality characteristics (Ball, 1987; Leifer, 1980; Mercer, 1986a), degree and type of social support (Chalmers & Meyer, 1994; Crnic, Greenberg, Robinson & Ragozin, 1984; Cronenwett, 1985; Jordan, 1989; Levitt, Coffman, Guacci-Franco & Loveless, 1993; Pridham, Egan, Chang & Hansen, 1986), perception of birth experience (Pridham, Lytton, Chang & Rutledge, 1991), role conflict or strain (Majewski, 1986; Simon, 1992) and employment status (Jordan, 1987; Lee & DeJoseph, 1992). Added to these psychosocial variables, nurses have studied the stressors (Ferkeitch & Mercer, 1990; Pridham, et al., 1986; Walker, 1989) or situations of adversity such as high risk pregnancy (Mercer & Ferkeitch, 1994) and prematurity (McGrath & Meyer, 1992; McKim, 1993; McNeil, 1992). In a number of studies the impact of the infant and its characteristics, such as temperament, have also been examined, particularly in relation to the mother's confidence (Bullock & Pridham, 1988; Mayberry & Affonso, 1993; Roberts, 1983; Zahr, 1991).

Assuming the existence of a maternal role, nurses in clinical practice have focused more descriptively on identifying the concerns of new mothers asking, 'What does a new mother need to know to enable her to enact this role and what are her information priorities?' These studies are specific in their descriptions indicating, for example, that during the first postpartum week to ten days women want information about postpartum complications, infant illnesses (Davis, Brucker & MacMullen, 1988; Martell, Imle,

Horwitz & Wheeler, 1989) and baby care, particularly infant feeding and behaviour (Bull & Lawrence, 1985; Graef, McGee, Roxycki, Fecina-Jones, et al., 1989; Martell, et al., 1989; Pridham, 1982). Studies focusing on women's needs six weeks or later following the birth have found that women want information on social and emotional changes and are concerned with balancing demands of husband and other family members as well as finding time for themselves and 'being a good mother' (Gruis, 1977; Harrison & Hicks, 1983; Hiser, 1987; Pridham, et al., 1986; Smith, 1989).

Nursing work often focuses upon the confidence of individual women as mothers as both a dependent and independent variable (Mercer, 1986a; Mercer & Ferkeitch, 1995; Pridham & Chang, 1992; Walker, Crun & Thompson, 1986a,b). A woman's confidence in her parenting is considered to play a central role in adaptation to motherhood. Further emphasis is placed on a woman's cognitive thought processes, with interest in the way a mother thinks about or formulates 'knowing' issues and seeks action on problems (Pridham, Chang & Hansen, 1987). Pridham and Chang's (1992) work indicates the greater the number of 'knowing' issues or concerns expressed by a woman, the easier her transition to motherhood. Following this track, nurses have also been concerned to intervene in the transition to motherhood, testing a range of postpartum interventions to increase a new mother's knowledge and confidence such as teaching interventions relating to infant care (Brouse, 1988; Flagler, 1988; Golas & Parkes, 1986) and encouraging attendance at postnatal support groups in the community (Buckley & Kemsley, 1995).

Much of this research has been undertaken employing a quantitative approach using survey questionnaires or structured interviews for data collection. Women are frequently asked to rank, prioritise or select options for care from a predetermined 'list' based most commonly on the professional literature or the expert opinion of professionals working with women. Rarely are such tools derived from what women have said (Schmied & Everitt, 1996). Interestingly, when the priorities of new mothers are compared with those of health professionals, discrepancies are found (Blackburn, Lyons, Stein, Tribotti, et al., 1988; Laryea, 1989; Morales-Mann, 1989). Nurses and midwives tend to prioritise the physical care activities, with a concern for 'maladaptation', while mothers

are concerned with their new role and perceive teaching and psychosocial care as important postnatally.

Attachment and Bonding

The relationship that a mother forms with her infant has concerned many nurses. As with the work on maternal role and the transition to motherhood, much of this work is descriptive, with a concern for poor attachment and the development of interventions to reduce 'pathology'. This research is based on the work of John Bowlby, Mary Ainsworth, Marshall Klaus, John Kennell and Reva Rubin. The maternity nursing and midwifery textbooks most commonly refer to definitions of attachment and bonding articulated by these researchers (Coffman, 1992). Crouch and Manderson (1995) note a 'dogmatic' tone in the medical texts in relation to attachment and bonding. Similarly it can be said that the guidelines provided for nurses and midwives have tended to focus upon assessing and monitoring particular attachment behaviours demonstrated by mothers, such as en-face gazing, finger-palm touching of the infant and encompassing of and talking to the infant (Avant, 1979; Lobar & Phillips, 1992; Millot, Filiare & Montagner, 1988; Tulman, 1985, 1986).

Nurses have also been interested in intervention that will enhance the mother-infant attachment, conducting studies, for example, that measure the effect of prenatal interventions on postpartum attachment, teaching women how to palpate the fetus and massage their abdomen during pregnancy (Carson & Virden, 1984; Carter-Jessop, 1981; Davis & Aldridge, 1987). In the postnatal period, programs that provide information or 'teach' parents about the abilities of their newborn babies and ways of caring and interacting with infants have also been tested (Dean, Morgan & Towle, 1982; Furr & Kirgis, 1982; Perry, 1983; Roberts, 1983; Tedder, 1991). In the main, these interventions were not found to enhance attachment to the fetus or baby (Coffman, 1992). Often this type of intervention is somewhat patronising in its assumptions about the type of relationship a mother may develop with the fetus or her infant.

Still focusing on pathology of mother-infant attachment, others have studied the variations of attachment behaviours in different groups. For example, those who breastfeed or bottle feed (Martone & Nash, 1988), adolescents (Mercer, 1985b), women

classed as medical risk (Kemp & Page, 1987; Mercer & Ferkeitch, 1994), mothers of preterm infants (Huckabay, 1987), mothers with disabled infants (Capuzzi, 1989) and mothers who had a caesarean section (Hillam, 1992; Tulman, 1986).

Drawing upon the well-known work of paediatricians Klaus and Kennell and associates, much maternity nursing and midwifery practice embraces the notion of both a 'sensitive' period and the importance of extended contact of mother and infant following the birth. Despite extensive criticism of the work on bonding (Eyer, 1992; Goldberg, 1983; Lamb, 1982; Myers, 1984), nurses have been concerned to further test the impact of skin-to-skin contact at birth and extended postpartum contact or 'rooming-in' (Brodish, 1982; Curry, 1983; Norr, Roberts & Freese, 1989; Prodromidis, et al., 1995; Winkelstein & Carson, 1987). The results of these and other studies are equivocal in terms of the impact that skin-to-skin contact following birth and/or 'rooming-in' has on maternal attachment. Checklists of maternal behaviours are also commonly used in studies of mothers. In 1982, Rhone produced a bonding inventory consisting of seven behaviours. It is worthwhile highlighting three or four of the behaviours that interest nurses. A woman scores 0 on the scale if she verbalises concern for herself, has no questions about the baby, expresses anger or dissatisfaction at the outcome of the labour and refuses to hold baby.

In summary, within the nursing literature there has been a preoccupation with how a woman attains a maternal identity, her relationship with her baby and the factors that hinder this transition (see Walker, 1992; Mercer, 1995, for a more extensive review). While this work is valuable, there are some underlying assumptions that are rarely questioned. First, the transition to motherhood is almost always framed from the perspective of an individual woman whose personal characteristics or social circumstances may facilitate or hinder the role transition. The notion that there is a maternal role, however, is rarely questioned and the related maternal behaviours appear to be somewhat prescriptive. In these studies the women's personal experience or view are rarely mentioned. Rather there is a concern for ‘pathology’ or ‘maladaptation’. Second, becoming a mother is presented as a 'natural' progression, an expected stage of adult feminine development. The mother's central place in child rearing is privileged and the nature of the love that a mother has for her child is romanticised. There are a

few studies that examine women's identification with the feminine role as a variable that may influence the transition to motherhood. Ironically, in a number of these studies hypotheses relating to feminine characteristics and role identity have not been supported (Barnes, Leggett & Durham, 1993; Brouse, 1985). Within nursing theory and research there is little challenge or even questioning of this dominant account of femininity.

Theoretical Perspectives Informing Maternity Nursing Research

Traditionally the nursing profession has drawn upon many disciplines to construct its knowledge and practices. Theoretical perspectives prominent in the above writings around maternal-infant nursing have their basis in mainstream psychology, interactionist sociology and Freudian psychoanalysis. There are three theoretical frameworks that have primarily formed the basis for these nursing research interests and practice concerns in the postpartum and early parenting period (Walker, 1992). Firstly, transition theories based on sociological theory of the 1950s and 60s have emphasised the behavioural and psychosocial accounts of new parenthood. Secondly, theories of maternal-infant attachment based on the work of Bowlby and Ainsworth have emphasised the affective element of the relationship of mother and infant. Along with theories of attachment, nurses and midwives have paid particular attention to the concept of 'bonding' developed by paediatricians Klaus and Kennell. Finally, and of most interest to this study, are theories of maternal role attainment and maternal identity based on the work of nurse-midwife Reva Rubin, emphasising the cognitive and subjective experience of mothers.

In the following discussion I examine firstly, the psychoanalytic discourses of feminine identity that underpin the conceptual work on maternal subjectivity. This Freudian approach inherent in much early nursing work leads to an examination of the discourses surrounding the relationship between the mother and her infant, such as discourses of attachment and bonding. Secondly, the sociological discourses of the 50s and 60s are examined. These have influenced the understanding of motherhood as a role in which a woman must acquire confidence in the necessary skills and behaviours that demonstrate role attainment. Finally, this chapter examines the discourse of maternal role attainment in the work of Reva Rubin.

2.2 PSYCHOANALYTIC DISCOURSES, FEMININITY AND MATERNAL SUBJECTIVITY

There is an underlying assumption in the majority of nursing and midwifery literature that being a mother is a 'natural' or even 'essential' developmental stage of maturation and adult feminine identity (Bibring, Dwyer, Huntington & Valenstein, 1961; Rubin, 1984). Becoming a mother is represented as inherently good - it is desirable and necessary. Freudian understandings of personality development and gendered subjectivity have been influential in shaping nursing knowledge about the development of feminine and maternal identity as well as infant development and the relationship between a mother and her child.

Two closely related aspects of Freudian discourse are particularly relevant to this discussion. First is the presumed essential position of the mother as primary caregiver for an infant and young child. This account positions women as having central responsibility for the development of a stable personality in the developing child. Secondly, Freudian theories of psychosexual development attribute particular characteristics to women that are considered crucial to a maternal subjectivity. Freud focused much of his work on understanding the development of a stable personality in the child and subsequent adult.

At its simplest, psychoanalysis is concerned with understanding how unconscious drives and desires are structured in infancy and childhood in relation to interactions with the primary caregiver. Subsequently these drives and desires are believed to motivate behaviour and actions in adult life. In Freudian theory an individual's personality and gendered subjectivity are born out of the unconscious, an area of the mind that is not accessible to us and is the repository of all experiences that individuals find both pleasurable and painful or difficult to deal with at a rational conscious level. These repressed experiences, such as the experience of not having one's hunger as an infant immediately satisfied, may lead to anxieties and neuroses as an adult (Eyer, 1992; Tizard, 1991). The caring ability of the primary caregiver, which in the majority of situations is the mother, is typically questioned when pathology is presumed.

Freudian understandings of gendered subjectivity are based on the resolution of the Oedipus complex. This is described as a complex psychosexual process that is resolved differently for boys and girls and completed in the first five years of life. Freud, however, speaks more confidently of the development of male children and their separation from their mother than he does of females. The young boy, in recognising that his mother, girls and other women do not have a penis, begins to fear castration. To overcome this fear, Freud believes that the boy will renounce his desire for his mother, ceasing to compete with his father to possess his mother and subsequently start to identify with the father. As an adult, the male seeks his own female partner to replace the lost mother figure (Freud, 1962).

On the other hand, Freud believes a young girl will recognise that she indeed is already castrated and is like her mother. In her distress and feelings of inferiority the girl turns away from her mother as the initial love object and transfers her desire to the father (Freud, 1962). In the disappointment that her father cannot provide her with a penis, the girl becomes jealous (penis envy). Women, in their attempts to resolve the Oedipus complex, exhibit jealousy, reject masturbation, start to equate the penis with a child and desire to have a child to the father (Freud, 1962). The complexities of female psychosexual development, according to Freud, account for the passive, masochistic and narcissistic nature of feminine identity (Flaherty, 1973).

Dependency is also characteristic in adult women. The complexities of psychosexual development in women and the incomplete resolution of the Oedipus complex results in girls only partially separating from their mothers and developing a dependence upon the male strength, support and achievement in a way that inhibits their own creativeness and assertiveness (Lebe, 1982). This reaction, Lebe (1982) believes, is considered normal, healthy, feminine behaviour by society and is reproduced in the works of other psychoanalysts such as Helene Deutsch and Therese Benedek.

Critics of Freudian psychoanalysis describe it as a universal theory that privileges the psychosexual structures in the construction of subjectivity, particularly gendered subjectivity (Weedon, 1997). Certain groups of feminists from Millett (1970) onwards believe Freudian theory is hindered by a biological determinism that is static and fixed,

perpetuating a mind-body and individual-society dualism (Griffin, 1978). It is a theory of feminine identity based upon a negative view of women, representing women as lacking (Grosz, 1994) and possessing passive, masochistic and narcissistic characteristics that support women's position as mother within the nuclear household.

Others have found Freudian understandings of the unconscious to be useful. While rejecting Freud's psychosexual focus, some later psychoanalysts draw on Freud in the endeavour to theorise gendered subjectivity and to examine motivations and desires, such as the contradictory desire to be a mother (Klein, 1979; Chodorow, 1978; Holloway, 1989). The work of these object-relations theorists, however, has not been influential in nursing theories of maternal identity.

Freud's influence on shaping nursing and midwifery discourse is apparent mainly through the theories of infant attachment espoused by Bowlby and Ainsworth, as well as theories of maternal-infant attachment described by Klaus and Kennell and theories of feminine and maternal development in the work of Deutsch and Benedek. The work of each of these theorists is based in Freudian notions of personality development in the infant and the development of an adult feminine identity as instinctually maternal. Embedded within such discourse is the notion that a stable and consistent mother figure (preferably the mother) is essential for the development of a child.

Both Deutsch and Benedek are influential in nursing theories and both have directly applied Freudian psychoanalytic theory to their understanding of women's psychology, the development of feminine and maternal identity and 'motherliness'. Millet (1970: 206), in her critique of psychoanalysis, comments that Deutsch's two-volume work on female sexuality was regarded as a 'definitive statement of true femininity'. Following Freud, Deutsch (1944, Vol. 1) espouses that women are naturally passive, masochistic and narcissistic, however, she furthers Freud's work on penis envy to describe the early psychosexual development of a girl. According to Deutsch, the masochist character of a woman develops when she recognises the 'inadequacy' of her clitoris for sexual pleasure and has to transfer this pleasure to the passive vagina, requiring her to be overpowered by a male to gain sexual satisfaction (Deutsch, 1944, Vol. 1). For Deutsch, women only achieve psychological maturity by remaining passive and becoming

pregnant. In the work of both Deutsch and Benedek, women resolve psychosexual conflicts and mature by becoming mothers. Deutsch elaborates on the psychosexual development of women. 'She (the woman) passively awaits fecundation, her life is fully active and rooted in reality only when she becomes a mother. Until then all that is feminine in the woman, physiologically and psychologically, is passive and receptive' (1944, Vol. 1: 140). Thus feminine masochism becomes the most elemental force in a woman's life, drawing her to the tenderness of motherhood (motherliness) and to enjoy her maternity (Flaherty, 1973). This notion of femininity positions both girls and adult women as preparing for pregnancy and motherhood throughout childhood, adolescence and early adult life. Like Freud, Deutsch also tends to focus upon pathology.

Drawing on Deutsch's work, Benedek (1970) believes there is a primary biological need for motherhood. In contrast to Freud, Benedek (1970) sees motherhood as a primary need and not a secondary need based on finding a substitute for the missing penis, nor as being forced upon women by men to reproduce the species. Benedek (1970: 155) describes 'motherliness' as a normal characteristic of femininity, of women's psychosexual maturity and as part and parcel of motherhood. She also believes that 'motherliness' is an extremely complex concept and because of its enigmatic nature has eluded investigation. Benedek (1970: 153) romantically describes a mother, her physiological 'resources', her personality and her baby as a 'tapestry', where physiology and personality in each individual woman 'are tightly interwoven and cannot be isolated from the child who is part of the weave'. From this 'weave' of the biological and environmentally influenced personality, comes a woman's sense of 'motherliness' that is developed with each child (Benedek, 1970). Through a process of sublimination, 'motherliness' becomes an indivisible feature of a woman's psyche (Flaherty, 1973). As for Deutsch, Benedek emphasises the development of 'motherliness' in the girl and adolescent as she grows, learning the techniques and attitudes of giving, 'her ego ideal incorporates the aspiration to feed, to be a mother and a good mother' (Benedek, 1970: 154).

During pregnancy the fetus stimulates the receptive tendencies of the mother, however, labour and delivery interrupt 'the continuity of the mother-fetus symbiosis' (Benedek, 1970: 155). Benedek believes that following birth the infant represents the most

significant fulfillment of the mother's receptive needs. She states, 'With her baby the mother feels whole, complete but not without him' (Benedek, 1970: 162). Benedek highlights the place of lactation and the desire to breastfeed in what she sees as a continuing symbiosis between mother and infant following birth. She believes that the mother's desire to breastfeed her baby and be 'bodily' close to the infant, 'represents a continuation of the physiological symbiosis. While the infant incorporates the breast, the mother feels close to him' (Benedek, 1970: 155). As the reciprocal (transactional) emotional experiences of lactation mediate identification between mother and infant, they facilitate the integration of motherliness. The process of lactation and breastfeeding also facilitates such integration. Benedek goes on to describe the emptiness that many mothers feel when they are without the infant for a short period. For Benedek, the anxiety that many women feel upon separation from their infant symbolises the intensity of the meaning of separation trauma following birth. In an effort to undo the separation of birth, mothers are filled with an urge to incorporate their child, 'to eat him up', 'to hold onto him' (Benedek, 1970).

As the postpartum period progresses, an emotional symbiosis evolves parallel with the integration of motherliness and the mother goes through a period of individuation. Here the mother becomes confident in her ability to care for and love her child and can regain a sense of herself. This Benedek describes as a 'biologically prepared distancing from her child' (Benedek, 1970: 163).

Benedek (1959: 292) coined the term 'emotional symbiosis' to refer to a 'reciprocal interaction between mother and child which through the processes of 'introjection-identification' creates structural change in each of the participants'. Through each interaction and series of identification an image of the object is internalised as is the mirror image of the object's attitude to the self - 'I am good because she sees me as good. I am bad, because she is bad to me and she sees me as bad'. These details of identification draw directly on Freud's understandings of self-concept (Benedek, 1959: 292). Benedek states that there is a reciprocal ego development in the infant as through the introjection of good mother + good self the infant develops confidence. Likewise through introjection of good, thriving infant + good mother-self, the mother achieves a new integration in her personality (Benedek, 1970: 163).

Benedek (1970) sees that motherliness is burdened by conflicts that come from two sources; one from the psychosexual development of personality, the other related to the arduous tasks associated with mothering that frequently surpass the care of the infant. Benedek acknowledges in contemporary Western societies the active, extroverted, masculine ego ideal conflicts with passive tendencies inherent in reproductive function. She (1970: 160) comments that consequently many women cannot permit themselves the regressive function of lactation and bodily care of an infant. Thus, in contrast to the work of early psychoanalysis, Benedek does not simply see such conflicts as a result of unresolved psychosexual processes but rather acknowledges the social and cultural influence upon mothers.

2.3 INFANT ATTACHMENT AND MATERNAL DEPRIVATION - AN INFANT-CENTRED DISCOURSE

Attachment theory is the joint work of John Bowlby and Mary Ainsworth (Bretherton, 1992). Bowlby draws upon concepts from psychoanalysis, ethology and developmental and cognitive psychology to develop the principles of attachment theory. His work emphasises the child's tie to the mother and the disruptions caused by separation, deprivation and loss. Moving away from the Freudian notions that a child becomes attached to its mother because she satisfies its instinctual and oral drives, Bowlby believes that attachment itself is instinctual (Tizard, 1991). In addition, while Freud sees the satisfactory resolution of Oedipal crisis as the key to adult development, Bowlby emphasises the quality of the mother-infant relationship in the first three years of life for later development (Tizard, 1991).

Bowlby's early empirical work led him to conclude 'that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment' (Bowlby, 1951: 13). Bowlby drew upon concepts in ethology and developmental psychology to explain the reactions he observed in hospitalised children who had been separated from their mothers. He claims that infant behaviour promoting proximity to the mother is a biological adaptive behaviour related to survival of the species (Bowlby, 1969). Thus attachment is instinctual. Bowlby compares this instinctive response in humans to imprinting that occurs in birds. Bowlby describes a number of 'component instinctual

responses' such as sucking, clinging and following, and 'signalling behaviours' such as crying and smiling in one-year-old infants that make up attachment behaviour (Bowlby, 1969). Influenced by cognitive theory, Bowlby proposes that the primary relationship with the mothering person is internalised by the child as the 'internalised working model' of themselves and others. These models, developed at critical points in the infant's development, persist throughout life. A child that experiences a warm, loving relationship with its mother will develop a model of themselves as lovable and of others as trustworthy. A child who has an insecure early attachment is likely to devalue themselves and see others as untrustworthy (Bowlby, 1973). This parallels Benedek's notion of 'emotional symbiosis'.

Bowlby's colleague Mary Ainsworth, with her empirical observations and methodological approach, was able to test some of Bowlby's concepts. Ainsworth contributed to attachment theory through her articulation of the mother figure as a secure base from which the infant can explore the environment (Ainsworth, 1961; Ainsworth & Bell, 1969). Ainsworth developed the 'Strange Situation' to measure attachment behaviour. In this now famous laboratory experiment, Ainsworth described three categories of behaviour representing three discrete forms of attachment bonds as: 1. avoidant, insecurely attached 2. securely attached and 3. resistant, insecurely attached (Ainsworth & Bell, 1969; Ainsworth, et al., 1978). Ainsworth, et al. (1978) went on to state that securely attached infants had mothers who were sensitive to their needs and cues and more affectionate and interactive with their infants. The mothers of insecurely attached infants were less sensitive to their infant's cues and babies classed as avoidant had mothers that were more rejecting than others. Ainsworth also noted that sensitive mothers and their infants experienced smooth and co-operative feeding sessions as opposed to other mothers who had difficulty in adjusting their pacing and behaviours to the baby's cues (Bretherton, 1992). Mothers described as sensitive would tend to feed their infants on 'demand', whereas those described as less sensitive to their infants were observed to be more rigid in their feeding times, feeding even if the child was not hungry (Ainsworth & Bell, 1969). Donley (1993) comments that Ainsworth's research gives creditability to the popular accent that a responsive and available mother providing a secure base is more likely to produce a mature autonomous adult. A number of researchers have subsequently used the Strange Situation method to demonstrate a

relationship between mother-infant attachment and stability later in adult life (Sroufe, 1988; Belsky, Lang & Rovine, 1985; Bretherton, 1987; George & Solomon, 1989). Donley (1993) notes, however, that there has been continued focus on dyadic relationships, prioritising the mother-infant relationship and only sometimes examining the father-infant or father-mother relationship.

Attachment theory has not been without its critics. Even in the early stages of Bowlby's work, others, particularly psychoanalysts and developmental psychologists, were sceptical or resistant to his ethological developments (Eyer, 1992) and questioned the biased, small sample size (Rutter, 1979, 1981; Rajeck & Lamb, 1978). Ainsworth's work has also been criticised for employing too small and narrow a sample (Rajeck & Lamb, 1978; Kagan, Kearsley & Zelazo, 1978). Kagan, et al. (1978) believe that the Strange Situation experiment has more to say about a society's values, beliefs and interest in attachment than it has to say about individual relationships.

The work of Bowlby, Ainsworth and colleagues has had an enormous influence on health and welfare professionals, teachers, the public and mothers in particular. Attachment theory fuelled a change in institutional and hospital practices. Mothers of infants distressed by separation could no longer be accused by doctors of having spoilt their children. Children's emotional needs were now taken into consideration (Tizard, 1991; Eyer, 1992). However, the discourse and practices surrounding attachment theory also disadvantaged women, imposing severe limitations on women's activities (Tizard, 1991). Post war Britain, Europe and America actively discouraged women from entering the paid workforce and attachment theory provided a rationale for why mothers must remain with their children permanently until the age of three (preferably five) years. Tizard (1991) states that a whole generation of mothers followed these beliefs and if they did not, experienced inordinate guilt. Notions of infant attachment and the sensitive mother have been vehemently attacked by feminist authors as serving the inevitability and functionality of patriarchy (Millet, 1970; Chodorow, 1978; Eyer, 1992), providing a rationale for the '... idealisation and enforcement of women's maternal role' (Chodorow, 1978: 8) and minimising the importance of fathers and others on the development of the child. Eyer (1992), in her critique of maternal-infant

bonding, sees both attachment and bonding research as based upon particular views of women's role that act overtly to keep women in the home or private domain.

The psychoanalyst Winnicott furthered this account of the place of women. In attempts to 'rescue' the study of mothers from the purely biological and Freudian notions of psychosexual development, Winnicott (1958) described the 'ordinary devoted' mother and the 'good enough' mother. Winnicott (1958) described what he believed was a 'normal illness' in mothers, a state of heightened sensitivity towards their infant developing just prior to and continuing after the birth of a child. He nevertheless believed that only mothers could experience this important state of heightened sensitivity and hence advocated that a mother needed to be with her child. A mother could provide what he described as the 'good enough' environment for infant development (Winnicott, 1958: 302).

2.4 BONDING AND MATERNAL ATTACHMENT - CENTERING THE 'GOOD' MOTHER

Arguably one of the most influential discourses on mothers surrounds the development of the sense of love, attachment or bond that a mother has for her child. The discourse on bonding is of particular significance in understanding the experience of mothers. Influenced by Bowlby's work, Klaus and Kennell proposed, 'There is a sensitive period in the first minutes and hours of life, during which it is necessary that the mother and father have close contact with their neonate for later development to be optimal' (Klaus & Kennel, 1976: 14). They studied 28 mothers of full-term infants in an effort to identify if there is a period after birth uniquely important for mother-infant attachment (Klaus, Jerauld, Kreiger, McAlpine, et al. 1972, 1972). Mothers in the experimental group were given extended contact with their infants, one hour after birth and a further five hours each day for three days. The mothers acting as controls received the routine care with brief contact at birth and subsequently saw their babies for feeding fourth hourly. In following these mothers, Klaus, et al. (1972) concluded that the experimental group demonstrated more eye to eye contact, better mothering skills and the infants did better developmentally.

This scientific-medical discourse found much support from what we might call concurrent familialist, religious and feminist accounts. These widely varying accounts stressed support for family formation, heterosexual relationships, family as the basic societal unit and the central place of women in caring for children. Bonding theory also appealed to women's groups urging consumer rights. It appeared to give women more control over their birth experience and supported their desire to have their infants and other family members with them (Eyer, 1992). Paradoxically, notions of bonding also liberated women from the imperative of having to care exclusively for the young child, as a bond or enduring relationship could be secured in a short space of time. Crouch and Manderson (1995) note that bonding appeared just at the right time. Eyer (1992) states that for the medical profession bonding provided a legitimate and 'scientific' reason to alter hospital practices but still retain control. They were so successful that within medical texts, bonding was established as a natural process with human beings viewed within the context of evolutionary development (Klaus & Kennell, 1976: 16). Numerous attempts were made to demonstrate the crucial nature of the post-birth period (Curry, 1979; De Chateau, 1976, 1980; De Chateau & Wilberg, 1977a,b; Grossman, Thane & Grossman, 1981). A frequently cited study was conducted in Sweden by De Chatueau and Wilberg (1977). They studied 22 middle class mothers who experienced 15 to 20 minutes of skin-to-skin contact, beginning ten minutes after delivery. They found that the experimental group held their babies more when observed in a 25-minute observation 36 hours after the birth. This group also appeared more confident in handling their infants and breastfeeding proceeded more smoothly. In addition, these researchers found positive mothering behaviours at one and three years of age.

The highly influential scientific medical discourse of bonding has, despite criticism, successfully produced a public or popular notion of bonding that influences the majority of childbearing women. Popular literature espouses the advantages of early skin-to-skin contact with newborn infants. For example, Kitzinger (1978) holds firmly to the notion that the interactions between mother and baby during the first few hours after birth is instinctive. Personal accounts of the moments after birth frequently describe the 'immediate' or 'overwhelming' sense of love or 'bond' to the infant. These accounts are generally presented in magazines such as '*Parenting*' and '*Mother and Baby*', where we

rarely hear from women who have had premature babies or a 'bad' birth experience (Crouch & Manderson, 1995).

Crouch and Manderson (1993) comment that the popular belief that 'bonding' is a 'sudden, crucial and necessary part of the ‘good birth'' holds currency. In their study of new motherhood, most women presumed that bonding would be instantaneous at the moment of delivery. They expected to feel maternal and be able to incorporate the baby into their lives immediately (Crouch & Manderson, 1993: 120). The women were surprised and sometimes distressed when this did not eventuate as part of the perfect birth. Crouch and Manderson (1993: 185) believe that the meaning and importance of motherhood for contemporary women is symbolised by the myth of the 'good birth', the ideology of 'natural labour' and 'bonding'.

The scientific, medical discourse of bonding has maintained momentum and is still popular in professional, public and personal accounts. However, the discourse around 'bonding' has been resisted by many feminists and sociologists and is now disputed by sections of the medical and scientific community. Significant methodological criticisms have been made of their work, specifically questioning the notion of a critical period (Eyer, 1992; Goldberg, 1983; Lamb, 1982; Mitchell & Mills, 1983; Myers, 1984; Tulman, 1981). Studies that attempted to replicate these findings were unsuccessful (Myers, 1984). Critics concluded 'early skin-to-skin contact has no clear, universal and enduring effects on maternal behaviour' (Lamb, Campos, Hwang, Lederman, et al., 1983: 576).

In a broad sense, there has been great discomfort within feminist discussions at the linking of women's behaviour with that of animals such as cows, goats and sheep. Feminists doubt that the forming of an attachment or a relationship with one's infant is a biologically governed process, that all women 'naturally' take part in following the birth of their infant. More specifically, feminist critics have questioned the measurements used by bonding researchers. For example, Eyer (1992: 31) asks, ‘Are behaviours such as letting a baby cry it out, going out and leaving a baby in care and not thinking about the baby illustrations of poor mothering (while) en face gazing, holding (an) infant (so it is) touching mother's body and fondling the infant while feeding indications of better

mothering?' In conclusion, Eyer (1992) believes this work was founded on a belief about the proper role of women, women's place as childbearers and rearers and the necessity for women to be with their infant for the crucial early years.

Attachment and Bonding in Nursing Discourse

Within nursing discourse there has been a strong commitment to the rhetoric of attachment and bonding as espoused by Bowlby, Ainsworth, Klaus and Kennell. As discussed in the introduction to this chapter, descriptive and intervention studies have and continue to be, concerned to assess, monitor and promote particular attachment behaviours in mothers of newborn infants. Within nursing literature, however, there is a lack of clarity about what is meant by the terms bonding and attachment and they are often used interchangeably (Walker, 1992). The focus on bonding has continued despite substantial nursing research indicating that early parent-infant contact is not a predictor of attachment (Mercer & Ferkeitch, 1990; Mitchell & Mills, 1983). The response within practice, however, has been to expand the concept of bonding, stressing that nursing interventions can be useful at any time (Eyer, 1992). This focus continues despite warnings from researchers such as Mercer (1986a) and Stainton (1985, 1986) that maternal-infant attachment is a highly variable process occurring over time and experienced differently by individuals from different cultures as well as those within the same cultural and socioeconomic group. In a recent review, Symanski (1992: 725) held strongly to the notion of bonding, stating that no matter how good the prenatal care or how flawless the birth experience, the baby's fate rested largely with the mother after birth.

There have been a number of theoretical formulations by nurses that conceptualise bonding and attachment in more dynamic, fluid and continuous ways. Reva Rubin's work (discussed in detail in the next section of this chapter) constructs the loving relationship between a mother and her child as a process that commences in pregnancy, continuing and heightening after the birth. Rubin named this process 'binding-in' (Rubin, 1975, 1977). In the period following birth, Rubin noted patterns in new mothers' behaviour that comprised this process. These were 'identification' of the child, 'claiming' the child and polarization, where the now known child is seen as separate from the mother (Rubin, 1977). Similarly, Gottlieb (1978) questioned the notion that mothering

and attachment behaviours were equivalent. She proposed a conceptual framework for maternal attachment based on a core concept of a discovery process, where the unknown infant was transformed into one's familiar and personal child. Following birth, Gottlieb (1978) described a period of disbelief that motivated the discovery process. This process comprised three behaviours - identifying, relating and interpreting. Importantly Gottlieb (1978) noted variability in maternal desire for contact with the infant, as well as diversity in personal communication patterns.

Stainton (1986) is critical of the static understanding of bonding in research that treats it as an event rather than a dynamic process that varies between individuals. In her study of multigravid women, Stainton (1985) examined the development of cue sensitivity as a precursor to attachment, within the cultural context and shared body experience of pregnancy and the early postpartum. She concluded that the origins of attachment were in the embedded cultural meanings and embodied experience of pregnancy and the postpartum period. These studies provide a stark contrast to the static understanding of bonding in the work of Klaus and Kennel. Other nursing studies consistently report great variability about when mothers feel a close tie or attached to their infants (Curry, 1979; Robson & Moss, 1970; Mercer, 1986a; Tomlinson, 1990). Interestingly Gay (1981) presented a framework of bonding as a process that developed over time through a period of acquaintance, then attachment and later bonding. In this model, acquaintance is the foundation of the mother-infant relationship and bonding is defined as a 'gradual, continuing, reciprocal process that incorporates the process of acquaintance and attachment and links to individuals in a coordinated, constructive social relationship' (Gay, 1981: 442). What is confusing about Gay's model is the representation of mother and baby in the earlier postpartum relationship as two separate individuals gradually moving together through acquaintance and forming a union in bonding. In its visual representation (Gay, 1981) this model does not account for the already existing relationship between a mother and infant prior to the birth of the baby.

What is curious about the traditional accounts of attachment and bonding is the limited discussion of the relationship between a mother and fetus. The notion of symbiosis articulated in certain accounts, such as those of Deutsch and Benedek, is limited in the infant-centred work of Bowlby and Ainsworth and the over-concern of Klaus and

Kennell with a 'critical period'. Contradicting this work on attachment and bonding, Bibring, et al. (1961) and later Rubin (1975) identified the formation of a relationship between mother and fetus/child during pregnancy. This process was identified as a developmental task of pregnancy whereby the mother came to see the fetus as a separate person. According to Leifer (1977) and others (Ballou, 1978; Bibring, et al., 1961; Robson & Moss, 1970), the successful formation of a relationship with the developing infant during pregnancy was predictive of maternal behaviours and attitudes following birth. Despite these propositions, Cranley (1981) notes that the majority of attachment studies focused on the relationship with the infant following birth. Cranley (1981, 1992) critiqued the notion that attachment begins in the 'critical' period following birth, stressing that this is inconsistent with women's experience of pregnancy. Cranley's work explored the prenatal attachment behaviours of 30 pregnant women. Cranley (1981) measured five dimensions of attachment and in all areas women showed a significant attachment to their fetus. Mothers engaged most often in 'giving of self' and least often in interacting with the fetus. Following Cranley's (1981) initial work and the development of the Maternal-Fetal Attachment Scale (MFAS) there was a considerable amount of research that examined maternal-fetal attachment and its relation to postnatal attachment (e.g. Grace, 1989; Heidrich & Cranley, 1989; Mercer, Ferkeitch, May, DeJoseph, et al., 1988; Muller, 1996).

Despite the claims to variability in both prenatal and postnatal attachment, there has been a tendency to focus on the individual woman and to cast maternal-fetal attachment in a series of sequential stages and patterns of behaviour (Ballou, 1978; Bibring, et al., 1961; Rubin, 1975; Stainton, 1985). This negates the claims to variability in relationship formation.

2.5 ADDING THE SOCIAL: TRANSITION THEORIES

Transition theories are based upon the sociological work of the 1950s and 60s that developed frameworks of role theory (Burr, 1972; Parsons & Bales, 1955). Burr (1972: 407) states, 'Role transitions refer to the process of moving in and out of roles in a social system'. In this account, transition may involve the addition or termination of a role with or without change in other roles. Golan (1981) added that the transition from a known

world to unknown world involves moving from a relatively stable state to one of disruption and uncertainty to a new stable state. This is a rather static and linear view of life change, where attributes of a designated role exist 'somewhere' outside of a person, to be accepted or rejected by that person. The overall impression of harmony following a 'successful' transition to parenthood rests on Parson's description of the separate but equal roles played by men and women. In this functionalist or consensual approach to roles, women as mothers are believed to be suited to the emotional and expressive functions in the nuclear household, and men as fathers are considered to be more instrumental in their role. This accent on role occupies the nursing work that draws upon transition theory.

Early work conducted by sociologists examining the family conceptualised the arrival of the first child as a crisis event (Dyer, 1963; Hobbs, 1968; LeMasters, 1957). These authors all attempted to measure the degree of crisis experienced by a first-time parent. Numerous variables were believed to impact upon this crisis and check lists were designed to assess how long a couple had been married and state of the marriage, family organisation at the time of the birth, the couple's preparation for marriage and parenthood, planned pregnancy and so on. In these studies the presence of crisis was equivocal, prompting a number of researchers to begin thinking of this period as a transition (Hobbs & Cole, 1976; Rossi, 1968). Rossi (1968) suggested the focus be on the transition to and the impact of parenthood as opposed to crisis. Rossi's (1968) work was significant as she highlighted the tendency for many workers to dichotomise normality and pathology. Rossi (1968) stated that it was important to identify what was involved in the transition to parenthood, what needed to be learned and what readjustments of role commitments needed to take place in order to move smoothly through the transition. Trying to move away from notions of success or failure, Rossi (1968) viewed parenthood as a developmental process that most people move successfully through. Further concurrent work suggested the importance of examining the rewards or satisfactions of parenting (Jacoby, 1969; Russel, 1974).

In her work Rossi (1968) described four developmental stages in the transition to parenthood; anticipatory stage, equating with pregnancy, honeymoon, plateau and disengagement-termination stages. Burr (1972) further described several factors

influencing the ease or difficulty of role transitions, for example, anticipatory socialisation, role clarity, conflict and incompatibility. Each of these stages and factors has been considered to be relevant to the transition to parenthood and been examined in a number of nursing studies (Mercer, 1985a, 1986a,b; Majewski, 1986). In this account, however, the focus of the study of transition is upon the individual and their adaptation or maladaptation to motherhood. In contrast, Rossi (1968) provided important sociological reasons that strayed from the functionalist perspective, explaining why the transition to parenthood may be so difficult. According to Rossi (1968: 35), these were: 1. lack of the cultural option to reject parenthood or to terminate a pregnancy when it is not desired 2. the shift from marriage to the first pregnancy is the major transition point in adult women's lives 3. abruptness of the transition at childbirth and 4. the lack of guidelines to successful parenthood in our society. In highlighting the social and cultural pressures surrounding parenthood, Rossi (1968) took the analysis of transition further than previous work. Her work has been complemented by psychologists concerned with child development, and social psychologists began to seriously study the family (e.g. Belsky, 1984, 1985; Belsky, Lang, & Rovine, 1985; Miller & Sollie, 1980; Cowan, Cowan, Heming, Garrett, et al., 1985; Cowan & Cowan, 1988; Terry, McHugh & Noller, 1991).

Transition, as an account of change and development, has been considered to be central to the domain of nursing (Chick & Meleis, 1986). Many nurses with an interest in the maternal role have used transition as a central concept. Much of this work has been descriptive, focusing on ease and difficulty of transition, gender differences and marital satisfaction during the transition. Similar to sociological and psychological accounts, nurses have found that mothers report more normative changes in lifestyle than fathers following the birth of a first child (Doober, 1980; Gennaro, Grisemer & Musci, 1992; Roberts, 1983). In related work, Tomlinson (1987) and Mercer, Ferkeitch and DeJoseph (1993) reported a decline in marital satisfaction from pregnancy through to 12 weeks and eight months postpartum respectively. Mothers who report a more favourable attitude towards their marriage have greater ease of transition (Lenz, Soeken, Ranking & Fischman, 1985; Majewski, 1986; Pridham, 1987). One main source of marital dissatisfaction is the degree of paternal involvement in childcare activities (Hangsleden, 1983, Hummenick & Bugen, 1987; McCain, 1990). Hummenick and Bugen (1987)

compared the amount of expected involvement with actual involvement in childcare. Mothers found that their actual involvement far exceeded expectations, whereas fathers' expectations exceeded actual involvement.

Pridham and Chang (1992) comment that there are few conceptual models to guide nurses' understanding of transition. In 1983, Roberts proposed a model where infant obligatory behaviour (defined as behaviour requiring action on the part of parents) has a direct effect upon the ease of transition and perceptions of the infant held by the parent. Where the infant's behaviour is seen as more difficult or demanding then the transition is more difficult. Pridham, et al. (1991) conducted a study that they described as an early step in the development of a postpartum transition framework, extending the Chick and Meleis (1986) transition model. A number of variables and their relationship to ease of transition were examined, including maternal attributes such as parity, infant feeding plan, birthing conditions (supports and stressors during labour and delivery), birthing experience, usefulness of postpartum learning resources, adequacy of hospital stay. The transition markers employed were 'evaluation of parenting' and 'infant and self care capability'. Although there were relationships found among many of the variables being examined, such as support and postpartum resources contributing to infant and self care capability, the analysis was inconclusive (Pridham, et al., 1991). Following this work, Pridham and Chang (1992) explored components of a model that conceptualised the transition to motherhood during the first three months postpartum. The variables studied were: maternal personal condition, situational condition, maternal problem solving and self-appraisal. The relationship between these variables and two transition markers - maternal appraisal of problem solving competence and evaluation of parenting - were measured. The results indicated that infant care issues positively influenced the use of clinician help throughout the study period. In addition, the number of questions or issues a mother formulated (knowing issues) contributed positively to problem-solving competence and parenting evaluation (Pridham & Chang, 1992). The use of problem-solving help had no effect. While further study is needed, Pridham and Chang (1992: 213) conclude, 'The meaning a mother makes of her situation as well as the issues she formulates and her use of problem-solving help with parenting and infant care issues, may be critical to how well the transition is negotiated'.

Transition accounts of new parenthood emphasise the psychosocial and behavioural responses of individual women and men to the changes that parenthood brings. The central questions asked are: how does a particular woman or man, set within a sociocultural context, adapt to this change? And what are the factors that facilitate or hinder the progression to parenthood? The broad variables considered in such studies of parenthood are the individual and their personality, social factors that influence their response, and the maternal role as it is known and prescribed within that society or culture. Transition accounts perpetuate a dualist understanding of subjectivity, with individual and society seen as separate elements only ever in interaction. As Holloway (1989) insists, in this discourse the individual has no social core. In this account, the maternal role, broadly prescribed in a society is assumed to be 'good', constructed through accounts of the dominant social groups. There is little room for understanding social organisation and power relations in the maternal or paternal role. While transition accounts often describe the difficulty women experience as first-time mothers, they do not capture the magnitude of distress and disruption apparent in the more critical sociological accounts of new motherhood in the 1980s and 90s (Barclay, et al., 1997; Brown, et al., 1994; Crouch & Manderson, 1993; Everingham, 1994; Hays, 1996; Oakley, 1979, 1986; Phoenix, Woollett & Lloyd, 1991).

2.6 DECONSTRUCTING MATERNAL ROLE ATTAINMENT

The work of Reva Rubin, a North American nurse-midwife, has had an enormous influence upon the research and practice of maternity nurses as well as midwives. In her extensive work on maternal identity, Rubin (1984) drew heavily upon the work of Deutsch. Although developed in North America, the relevance of Rubin's work to us as midwives internationally is highlighted by British midwife, Rosamund Bryar (1995), who not only included Rubin's theory of maternal role attainment in her discussion on five midwifery theorists but gave her work first priority.

During the 1960s and 1970s Rubin developed a theoretical framework for understanding maternal role attainment and identity from a nursing and midwifery perspective. Through observation and extensive interviews with women over a period of 20 years, Rubin articulated two fundamental phenomena involved in becoming a

mother: 1. acquisition of the maternal role (role taking) and 2. identification of the partner that is infant (1967a,b).

Current critique of Rubin's work tends to be at a superficial level, focusing mainly on methodological issues. Positivist critiques identify Rubin's failure to demonstrate a systematic and rigorous approach to her research, claiming deficiencies in research design (Gay, Edgil & Douglas, 1988). This, together with Rubin's reliance upon psychoanalytic terminology, has made it difficult for midwife/nurse researchers to apply her theoretical work (Mercer, 1995; Walker, 1992). In addition, while Rubin has claimed her work to be phenomenological in approach, her insistence upon describing a woman's experience in 'validatable terms and in a way sufficient to test a hypothesis' (Rubin, 1984: 3), is paradoxical. It is important, however, that critics of Rubin's work consider the era in which she wrote and the lack of sophistication of nursing research at that time. What is disappointing about Rubin's work is that she rarely refers to the words of women. In fact an enormous amount of valuable qualitative data was broken down in quantifiable terms to 4,799 items (1967a) where 'low density behaviours and objects become meaningless' (1984: 149). While previous critiques are useful, the analysis presented here examines Rubin's work from a different perspective.

In approaching Rubin's writings on maternal identity as text, I deconstructed maternal role attainment in three ways: 1. discourse of the self as a rational and contained individual 2. discourse of feminine identity as essentially maternal and 3. discourse of mastery over task and role. In this section, I speak briefly about the first two accounts of self and feminine identity and the rest of this discussion will focus on the discourse of mastery over task and role.

Discourse of the Self as a Rational and Contained Individual

Rubin, unlike transition or attachment theorists, articulated a very clear definition of the 'self' and this understanding is central to her theoretical developments. She states, '(e)xperience is mediated in the self'(1984: 12). Rubin (1984) defines self as a system of selves in transaction and communication with each of the other selves. There are three spheres of the self - the ideal self, the known or actual self and the body self or body image. These spheres constitute conceptual images of the self. Much of this work

is based on Freud. Mercer (1995: 5-6) suggests that Rubin's notion of the ideal self is close to Freud's notion of ego ideal and is the internalised picture that a person holds of what they would like to be. Rubin's notion of self-image is more characteristic of Freud's notion of ego, the ability to organise behaviour. What is particularly interesting about Rubin's understanding of self, is her inclusion of the 'body-self' or body image as a central component of identity. In her work, the maternal body is not just a biological and physical entity, but is intricately related to conscious thought and unconscious fantasy.

The ideal self is the person's creation of desired attributes or qualities, identified as outside the self, that a person wishes to incorporate into the self, the cognitive structure as a guide for behaviours. Once a desired attribute is incorporated into the self or body image it no longer exists as part of the ideal self. Ideal images are continually restocked and renewed and new goals are set in the form of wishes and desires for the future (Rubin, 1984). It is through the ideal self that language, values and customs are transmitted. However, Rubin insists that this does not occur by force imposed upon the individual person but rather by volition. Rubin (1984: 11) states, 'The individual as I searches out selected elements that appear or are modelled in the accessible social ecosystem and that are relevant to the ideal self'. Mercer (1995) adds that societal customs, values, age, life stage and situation all influence the mother's selections for the ideal self.

The self-image, the known or actual self, arises from action in and interaction with the physical and social world and out of the spheres of the ideal and body selves (Rubin, 1984). The self-image incorporates the aspirations of the ideal self as a guide for behaviour. There is a measurement or evaluation of self against the current ideal image. When a person achieves elements of the ideal they experience a narcissistic pleasure. Attaining ideal elements is hard work, consisting of trials and errors and may often result in frustration, rejection or hostility. The self-image mirrors the self in action not only in observation but in evaluation as well (Rubin, 1984).

The third sphere of self - body image - is pivotal to the structure and function of the self image, delineating and orientating the self as an entity in a world (Rubin, 1984: 15;

Schilder, 1970). Body boundaries define and separate self from the environment. Rather than a biological entity, Rubin alludes to the self as an embodied subject. She describes body images as 'emanat(ing) from the inner spaces of the self to the service of self preservation, survival and potentiation in the world' (Rubin, 1984: 22). Rubin (1984: 22) adds, 'From this centered position, there is an orientation of self in action, mentally and physically, in the world'.

This contrasts with the common description of the person as a biological, psychosocial product and goes some way to redressing the mind and body dualism common in nursing research and theorising. Rubin attempts to integrate the self as a conscious, unconscious and social entity with ideals and desires. Yet as this analysis continues it becomes evident that Rubin privileged the cognitive capacities of the rational, conscious subject. While she acknowledges the central position of the body in the construction of identity, she is far more concerned with the processes of learning and of knowing. Rubin (1984: 3) states:

> All behavior, manifest or latent, originates in the mind, in the cognitive processing of subjective experience. The most striking characteristic of maternal behavior is the openness to new and additional learning, the silent organization in thought, and the high value placed on knowing.

This priority has perhaps been influenced by Rubin's use of role theory and her understanding of identity as a product of self and role. So while Rubin attempts to construct an understanding of identity as an embodied, social being, the social world is nothing more than the environment in which a person interacts as an agent, seeking desired attributes. Her work constantly emphasises the cognitive work undertaken by women during pregnancy (1967a,b, 1970, 1975) and the neomaternal period (1967a,b, 1984). This cognitive work is the creative process that interacts with the 'outside', the social environment.

Rubin employs a combination of psychoanalysis and symbolic interactionism to differentiate 'self' and 'role'. Drawing upon Sarbin's work on role theory of the 1960s, Rubin (1967a) regards 'human conduct as the product of self and role'. This distinction between self and role, individual and society is a dualism that parallels the mind/body

dualism frequently seen in medical discourse. In a poststructuralist understanding of subjectivity, the subject is seen as having a social core that exists as part of the subject and is not external to them. The reliance upon role theory has produced a particular discourse of learning and mastery over externally established roles that I have called 'mastery over task and role'. Here Rubin's work privileges the conscious, rational individual, detailing the cognitive operations involved in becoming a mother.

Rubin's work on the self as body-self or body image is perhaps most useful in gaining an understanding of the relationship between a mother and her child. Rubin's work on 'binding-in' to the child, the 'identification' and 'claiming' of the child', is described as a process concomitant with attaining a maternal identity. For Rubin, there is no maternal identity without a child. Maternal identity and binding-in are co-ordinates of the same process (Rubin, 1977, 1984).

Discourse of the Essential Feminine Identity

Drawing on a sociological and feminist framework, what becomes clear about Rubin's exposition is the inherent Freudian notion of female identity. While Rubin (1984) insists that maternal behaviours are not instinctive, she assumes a 'natural' imperative to be a mother. Becoming a mother is set in the context of the 'normal' development of a healthy adult female. Feminine identity is presented as stable, consistent and essentially maternal. Rubin states, 'the feminine woman wants a child someday' (1970: 502). Freudian accounts of maternity appear in many of Rubin's writings and construct an account of the essential nature of feminine identity. Rubin's Freudian approach perpetuates a negativity about the female body. Women's bodily functions are presented as an indisposition and menstruation, pregnancy and labour are perceived as 'dangerous' events. Menstruation is considered an 'unwanted messy discharge' and Rubin (1984:33) highlights the use of words such as the 'curse', describing them as good-natured expressions of the anger felt at being a woman.

The sense of ambivalence felt in early pregnancy is reiterated when Rubin discusses the approaching birth. Far from the contemporary accounts of a woman eagerly awaiting the onset of labour, prepared for the birth and positioning herself as active and powerful in the birth process, Rubin (1984) describes women as passive and reluctant to go into

labour. She talks of how a woman starts and stops in labour frequently. The uterus is described as irritable and tense like the woman. Haunted by images of 'an incompletely formed baby, the hazards awaiting such a baby and the dangers to the intactness and wholeness of her own body in childbirth', delays a woman going into labour (Rubin, 1984: 58). Ultimately Rubin states, 'It usually takes anger at the baby and at the entrapment of pregnancy to let go, to get out of the misery of pregnancy and to go into progressive labour, with all its antecedent threats to delivery' (Rubin, 1984:59).

Finally, released from her misery of pregnancy and the perils of labour and birth, the maternal subject emerges a mother. Rubin speaks of particular feminine traits that serve a woman well in mothering. Drawing on a Freudian understanding of masochism, she states:

> Feminine masochism is richly and assiduously developed antepartally and serves the mother well during childbirth and later. In maternal care, masochism seems to be strongly related to narcissism, but not necessarily in inverse relationship. An adequate supply of narcissism augurs well for beginning maternal identity. (Rubin, 1961: 604)

Following the birth, narcissism is seen as a necessary basis for maternal pride and concern for the child (Rubin, 1961: 684). In addition Rubin speaks of moral issues which are peculiarly feminine in nature, things not so much concerned with honesty but with 'the capacity to suffer, to endure for love of another' (Rubin, 1967a: 240).

Mastery Over Task and Role

Rubin's earliest observational work concentrated on specifying maternal behaviours and patterns of maternal touch in the first ten days postpartum (1961a,b, 1963). Rubin (1961b) conceptualised 'Puerperal Change', describing two phases of maternal behaviours: 'taking-in', characterised by passive and dependent maternal behaviour for one to three days after birth and 'taking-hold', characterised by independent and autonomous maternal behaviour. In 'taking-hold', the mother wants to regain control of her body's function and is concerned with learning the maternal tasks. The 'taking-hold' phase begins during day three and lasts approximately ten days (Rubin, 1961b). As she continued her research, Rubin (1963) detailed maternal touch as tentative, systematic

and progressive. She outlined a progressive exploration of the baby's body firstly using fingertips on extremities and later encircling the infant using hand and full arm contact. Rubin (1963) believes that this characteristic 'maternal touch' provides an important cue for nurses to assess the developing mother-infant relationship.

Rubin (1967a: 237-238) then began to inquire more globally asking, 'What are the processes involved in the acquisition of the maternal role?' and 'Who are the models or referents for maternal role expectations?' While this work drew upon Sarbin's notion of role as a cultural product, Rubin used language from psychoanalysis to label the processes she identified. In her analysis of observations and interviews, Rubin (1967a) identified five distinct processes and operations of acquiring the maternal role. Mimicry and role play, both later referred to as replication (1984: 39), were early tentative forms of 'taking-on' the role, involving a copying of the practices and customs of other women who have achieved maternal identity. Through role playing a woman goes beyond the symbolic manifestations into trying out the maternal role either in imagination or actually spending time around other women with young children (1967a).

The later and more discriminating processes of role acquisition Rubin describes as Fantasy and Introjection-Projection-Rejection (I-P-R) (Rubin, 1967a). Here a woman moves from taking-on the role to taking-in the role. She moves from 'how-does-one (stereotyped one) behave in this position to how-will-it-be-for-me in this position in this situation' (1967a: 242). Through fantasy there is a silent rehearsal of maternal role accomplished through wishes, fears, daydreams and dreams (Rubin, 1967a). During I-P-R the mother seeks out models and decides whether to accept or reject the behaviour. For Rubin, I-P-R reflects the apparently casual woman-talk, including clothing, talking, cooking, walking, child rearing, child bearing and personal relationships. Rubin states, 'It is the substance and essence in detail of what was involved in becoming or being a woman and particularly in becoming or being a mother' (1967a: 243). In the taking-on phase, anyone could interpret the behaviour of the baby for the subject and she would accept the interpretation even if it seemed incredible. Later when the subject moved into greater use of I-P-R, she was more selective, being reluctant, dubious or rejecting of another's interpretation (Rubin, 1967a: 243). The final process of maternal role attainment described by Rubin was 'grief work'. This referred to the progressive

relinquishment of former roles incompatible with the new role. Grief work did not occur sequentially as the last process but rather acted as a catalyst for other role-taking operations (1967b: 345).

Maternal identity is seen as the end point or goal of role taking and is described as '... a sense of being in (women's) roles, a sense of comfort about where they had been and where they were going, then role achievement could be said to exist' (1967a: 243). Here a woman will demonstrate more competence in the role as a mother, confidently stating 'I do' or 'I think' when discussing the care or needs of her child. Here she ceases to refer to a role model. Rubin (1984) noted that dedifferentiation from role models directly precedes this.

In interpreting Rubin's exposition of maternal role attainment there is a clear emphasis on the cognitive operations, thought processes and learning of appropriate maternal behaviours necessary in taking on the maternal role. In this, the woman is considered agential in the construction of self-image.

In the early 1970s, Rubin moved to examining the tasks that women accomplish during pregnancy. Specifically she noted that much of a woman's cognitive content of pregnancy 'work' involves progression through a series of four developmental tasks. 1. seeking safe passage for herself and her child through pregnancy, labour and delivery 2. ensuring the acceptance of the child she bears by significant persons in her family 3. binding in to the unknown child and 4. learning to give of herself (1975: 145). Completion of the first two tasks is believed to be essential for the third and fourth tasks to be completed. Again there is a favouring of conscious thought as a women goes through pregnancy.

Rubin's discussion of the maternal task 'binding-in' to the child in pregnancy (1975) and in the postpartum period (1977) elaborates her understanding of 'identification of the infant' as a concomitant process with maternal identity. There is no maternal identity without a child. Rubin's understanding of the relationship between a woman and her fetus/infant is of particular interest to my own study of maternal subjectivity. Rubin (1984) describes a 'cognitive mapping' of the 'I' as mother in relation to the 'you', the

child. There is a constant reformulation during pregnancy and the neomaternal period of the 'I' in relation to the 'you', a constant repositioning if you like of the relationship between mother and child. Rubin (1977) deliberately chose the term 'binding-in' to describe the formative stages of maternal-child relationship. She believed this term described the 'active, intermittent and accumulative process' of the relationship more adequately than 'attachment' or 'bonding'. According to Rubin (1977), it is the child that provides the initial stimulus for 'binding-in' through its movements. These are first experienced by the woman around 18 to 20 weeks and this internal, enteroceptive stimulus of fetal movement produces an awareness of another (Rubin, 1977: 67). This process continues until there is a 'separating out' or established separate identities of mother and child described by Rubin as 'polarization'. Deutsch (1944) had originally suggested that the term 'polarization', descriptive of a stage in cell reproduction before final separation of mother and daughter cells from each other, paralleled the experience of a woman and her infant following birth.

Polarization then, is 'the physical and conceptual separating-out process of the incorporated infant of pregnancy into a separate, external and constant entity postpartally' (Rubin, 1977: 70). While labour and birth are necessary for separation, they are not enough for polarization. Rubin (1977, 1984) highlights that individuation (or polarization) is a complex process. Polarization proceeds slowly over a three to four week period.

For Rubin, the incorporation and elaboration of the idea of a child and of self as a mother, is a 'progressive binding-in, a progressive investment of self...' in thought and actions. Using movements the fetus communicates, surprises and responds, becoming more than a theoretical idea. The fetus acquires personhood, an object that gives purpose and significance to the woman becoming a mother (Rubin, 1984). During pregnancy there is a sense of unity in wholeness and oneness. It is difficult to determine 'what is self and what is baby - what happens to self also happens to the baby' (Rubin, 1984: 9).

Rubin, however, is contradictory about the point at which polarization occurs. In some writings she suggests that the process of polarization begins near the end of pregnancy

(Rubin, 1975). Over this last trimester a woman develops a boundary between herself and the child, a clearer understanding of the 'I' and 'you', a 'separating out' from the psychological and physical unity of pregnancy. Thus, at birth or soon after there is a knowing of the child as a separate entity:

> Instead of the symbiotic oneness of pregnancy, there is an identification of the infant as an objective human entity, with its own form, appearance and behavior. Instead of the complex and exclusive possession of the infant in pregnancy, there is a claiming of her infant in a social context. Instead of the very significant incorporation of the infant into her self system during pregnancy, there is a polarization of selves in the postpartum period. (Rubin, 1977: 68)

Polarization as a delineation of what is self and what is baby, on the other hand, is also described as beginning some time after birth, through a process of individuation and boundary formation. Rubin (1977, 1984) suggests the sense of unity or identification of mother and child as one continues beyond pregnancy and even beyond the individuation process. The belief or feeling that what happens to child happens to self develops to become the special empathy of mother for her child that is characteristic of maternal identity (1984).

The bodily sensations that have allowed some knowing of the child during pregnancy change from the sensations of pressure and movement to visual, tactile, auditory and olfactory sensations. After birth there is an object, a child to see, hear, touch and smell (Rubin, 1977). It is after birth that a woman begins a process of identification of her child, locating the child in relation to herself and her behaviour. Rubin believes that sex, size and condition of the baby are paramount in this process occurring. The baby's wholeness and intactness must be determined prior to action or interaction with this child. If all is well the women feels as though she has been given a gift and proceeds with the process of 'binding-in' and 'polarization'. The first phase of 'polarization' Rubin calls 'identification of the infant', and occurs during the first four postpartal weeks. As the mother identifies her infant, she also identifies herself and her behaviour in relation to this child. Identification of the child evolves in interaction with the child.

The exclusivity of mother and child established in pregnancy is extended to include those close to her, those she claims as her own. In this process the mother identifies the

child's characteristics as belonging to herself and those of other family members. This process Rubin (1977) titles 'claiming', a process linking the newborn baby to her intimate social sphere. The exclusivity of pregnancy is lost and the woman must now share her baby with others (Rubin, 1977). Rubin (1977: 70) states, 'Identification and claiming are part of the polarization stage in neo-maternal identity and binding-in to the child'.

There has been some significant theoretical work that has attempted to further develop and test empirically the concepts of maternal identity and role attainment, particularly the work of Ramona Mercer (1981, 1985a,b, 1986a). Mercer continued the work of Rubin, but in contrast, she studied the first year following birth, maintaining that the majority of role-taking activities occur after the birth. Mercer's work relies upon symbolic interactionism and draws upon role and transition theories. Adapting the work of role theorists Thornton and Nardi (1975), Mercer describes maternal role attainment as occurring over four stages: anticipatory, formal, informal and personal. These stages parallel Rubin's cognitive processes and operations, but dispense with the psychoanalytic language. A woman progressively moves from learning what is expected of the role, visualising herself in the role, to following rules and directions of others and developing her own unique behaviours (Mercer, 1981: 74). Mercer states, 'The movement to the personal state, in which the mother experiences a sense of harmony, confidence and competence in how she performs the role is the endpoint of maternal role attainment' (1981: 74). This process begins during pregnancy and proceeds over a three to ten month period following the birth of the baby. She notes that while some women achieve maternal role identity within the first month following birth, others continue to work hard at achieving maternal identity in the period six to 12 months after birth (Mercer, 1985a, 1986a). Major components of the maternal role include becoming attached to the infant through identifying, claiming and interacting with the infant, acquiring skills in the care taking tasks involved in the role and expressing pleasure and gratification in the role (Mercer, 1985a).

In a longitudinal study of 242 women, Mercer (1986a) described a process model of adaptation to the maternal role. Adaptation occurred in three levels - biological, psychological and social - with all levels interacting and interdependent and occurring

across four time phases. The physical recovery phase occurred from birth to one month and here the biological level of adaptation dominated. The achievement phase from two to four or five months was dominated by psychological and social levels of adaptation. The disruption phase from five to eight months was characterised by many changes at the social level such as the return to work of the woman and biological changes in the infant. This phase often featured role and marital strain. Finally the reorganisation phase from about the eighth month to 12 months where there are further adjustments in biological, psychological and social phases of both mother and baby. In this final stage the mother's individuation from the infant becomes more evident (Mercer, 1986).

Maternal Subjectivity - Simple and Tidy versus Complex and Messy

After studying the theoretical work and subsequent research on maternal role attainment, I felt somewhat uncomfortable with the notions of role and identity that were represented. There appears to be a specificity about the maternal role, the processes and associated tasks defined in previous work. It was the language of these theories that drew my attention. For example, talk of 'the' maternal role, role behaviours, role attainment, achieving the role, process, operations, stages, tasks, competence in the role and pleasure and gratification in the role. The language and discourses surrounding maternal role attainment imply 'mastery' of mothering in Anglo-American culture, staged and managed in an orderly sequence of development. This, however, does not reflect the experience of women as they become mothers (Barclay, et al., 1997; Brown, et al., 1994; Crouch & Manderson, 1993; Oakley, 1979, 1986). As a theory, Maternal Role Attainment tends to be simple and 'tidy' rather than complex and 'messy', as the experience of new motherhood often can be.

The commitment of midwives and nurses to a maternal identity that is ordered and contained through a sequence of processes and tasks is well illustrated in recent work by British midwife, Rosamund Bryar. Bryar (1995) in her review of five midwifery theorists, developed conceptual models depicting Rubin's and Mercer's theories of maternal role attainment. Each of these models is linear in design, implying the need for a woman becoming a mother to pass through particular stages in sequential order. The first model is based on Rubin's representation of maternal role attainment as a sphere, with maternal identity at the centre surrounded by the operations of grief work, I-P-R

and fantasy. Mimicry and role-play appear at the outer rings of the sphere (Bryar, 1995). Bryar (1995) then suggests that the model could also be represented in a linear style, where a woman progresses from her pre-pregnant identity through mimicry, fantasy and so on, to polarization and maternal role identity. Not only does maternal role attainment occur in stages and phases but at different 'levels' of the self at different times. For example, Mercer's (1986a) adaptation model described the biological, psychological and social level of change.

The theories of maternal role attainment articulated in this discussion tend to be universalising. Again the language used in these frameworks is disconcerting. Rubin speaks of 'the' maternal woman, as though referring or generalising to all women. Often she just refers to women as the primigravida or the multigravida. Perhaps this use of language may be excused when we consider the era of Rubin's writing. However, in Lederman's recently revised work on psychosocial adaptation in pregnancy, there is a continual referral to the pregnant woman as the 'gravida' (Lederman, 1996). This language reduces a woman's status to the condition of her uterus. While cultural diversity or 'idiosyncrasy' is noted by both Rubin and Mercer (note Mercer's 1986a description of ethnicity, social class, marital status as confounding factors), there is no place for diversity amongst Anglo-American women.

The endpoint of maternal identity is somehow presented as an authentic and stable way of being as a mother rather than a construction that is historically and socially specific, and continually open to change. This notion of the maternal role reflects discourses of the 'good' mother, outlining how a woman should think, behave and feel in this role.

Rubin's work has engendered an enormous amount of subsequent research. The potential to 'categorise' and 'chronologise' a process of attaining a maternal identity has attracted nurse researchers. Researchers have been preoccupied with isolating, testing and validating a number of Rubin's specific concepts. For example, analysing maternal behaviours such as touch (Bampton, Jones & Mancini, 1981; Cannon, 1977; Tulman, 1985, 1986), patterns of identification and claiming of the baby (Chao, 1979; Gottleib, 1978; Mercer, 1986a) and 'puerperal change' (Ament, 1990; Martell & Mitchell, 1984).

Many of the research concerns highlighted in the beginning of this chapter are based both directly and indirectly on Rubin's cognitive processes.

What is interesting is that in Rubin's final exposition she actually moves away from the term maternal role attainment to talk only of maternal identity and the maternal experience. In this work there appears to be much greater understanding of the complexity of maternal subjectivity. Rubin (1984: 38) states, 'The outcome is more than a sentimental attachment and more than a role'. Mercer (1995: 11) cites personal communication with Rubin in 1995, where Rubin says she 'prefers to describe the maternal identity as an enlargement or a new part of self, an achieved identity that is greater than a social role'.

CONCLUSION

In examining the research interests presented in the Introduction, it is evident that nurses have remained concerned with role, role behaviours and the subtle nature of the relationship between perceived and demonstrated maternal role competence (Julian, 1983; Walker, Crain & Thompson, 1986a,b). Theory and research related to maternal role attainment has paid little or no attention to the context within which mothering occurs. Few studies have discussed the social impact of motherhood (McIntosh, 1993; Barclay, et al., 1997) yet an enormous number of studies have addressed postnatal depression, typically with a focus on the individual. Nowhere is there a discussion of the sociopolitical factors that shape the experience of women as mothers, or their happiness or unhappiness. Powerful social structures and relationships that construct and indeed constrain notions of being a mother are not discussed. Motherhood in midwifery and nursing texts is always assumed to be desired and 'good', an expression of feminine identity rather than demanding, stressful and alienating. Maternal role attainment as a theory poorly addresses societal change, cultural diversity and diversity within groups. This imbalance within midwifery and nursing writings must be redressed. Midwives and nurses need to draw upon the writings of sociologists and feminists such as Oakley (1980, 1986) from the United Kingdom, Rich (1976) and Rothman (1989) from USA and Wearing (1984), Richards (1985), Crouch and Manderson (1993) and Brown, et al. (1994) from Australia, to name but a few. The focus of maternal role attainment and

attachment and transition theories is upon the individual and her adaptation or 'maladaptation' to motherhood. In addition, much of the nursing research employing these frameworks has been conducted with middle class, white groups in America and reflects the values of marriage, parenting and the position of women during the period of study.

The theoretical frameworks presented here all provide accounts of maternal subjectivity, proposing varying notions of personhood or self. What is common to all these approaches is the continuation of a dualism between individual and society. Together these theories and related research have attempted to tell us 'the truth' about how a woman becomes a mother, how she may think, feel and act in her role and what external factors may facilitate or hinder the assumption of the maternal role. In these frameworks, motherhood is presented as a natural progression in a woman's life and this transition is almost always framed from the perspective of an individual whose personal characteristics or social circumstances may hinder the role transition. Embedded within the frameworks of attachment, transition and maternal role attainment are notions of what is a 'good' mother and how one acts or behaves as a 'good' mother. The influence of role theory on the work of Rubin, Mercer and transition theorists has prompted the development of definite processes or stages and associated behaviours in maternal role attainment. This representation depicts maternal role attainment as something located outside of any individual women, where as Holloway (1989:14) states, the individual '... is no more than a set of roles'. This identification of a 'normal' role transition leads to a focus on abnormal or 'pathological' mothering.

Dominant discourses surrounding motherhood within western society are accepted within nursing and midwifery research, for example the mother's central place in child rearing and the instinctive nature of the love that a mother has for her child are assumed. Unfortunately the research informing these frameworks is based predominantly on the study of white, middle class, Anglo-American, heterosexual and partnered women in their 20s and early 30s. Others who do not fall in with the characteristics of the 'normally' studied group are researched only to identify the ways in which they are 'other' or differ. There is an overall concern with the way in which a mother is supposed to be, rather than a questioning of the context within which she must mother. This

extensive literature rarely includes any analysis of power relations and social organisation. What is also notably absent from this theorising is the place of breastfeeding and its impact on maternal experience and the relationship with the baby.

Where to from here? Having spent much time critiquing the theory of maternal role attainment and the basis upon which it rests, I have found Reva Rubin to be one of the most insightful and challenging nursing/midwifery theorists. While others have continued to see motherhood or parenthood (as it is more commonly called) as merely a period of adjustment, Rubin captures the extent of change required of women becoming mothers. She states, 'From the onset to destination, childbearing requires an exchange of a known self in a known world to an unknown self in an unknown world' (1984: 52). While many nurses and midwives have focused on the pleasure and gratification that may be gained from mothering, Rubin (1984) spoke of the inordinate fatigue, hostility and depression that women experience as part of a 'normal' process of developing a new identity as a mother. What is most important for further theoretical development is recognition of Rubin's incorporation of the body as pivotal to maternal subjectivity. Her work on body boundaries and image during pregnancy, childbirth and the puerperium offer a starting point from which to examine mothering and breastfeeding as both as embodied experience and discursive construction.

CHAPTER THREE

BREASTFEEDING AS DISCURSIVE CONSTRUCTION: ANALYSING THE PROFESSIONAL AND POPULAR LITERATURE

In the Introduction to this thesis I described the way in which my original research question on motherhood and maternal subjectivity had changed to focus more specifically on the body and breastfeeding. This became important given the central position that the women in this study afforded breastfeeding and the lack of attention to breastfeeding in nursing theories of maternal identity. In this chapter I examine some of the wide range of literature on breastfeeding. As suggested in Chapter Two, instead of viewing published work as simply 'literature', I utilised this work as a source of data, which has been examined to identify the range of common discourses or accounts. While my emphasis was on examining the nursing and midwifery accounts of breastfeeding, I also have drawn upon writings in anthropology, sociology, feminism and public health. This analysis revealed a range of overlapping and contradictory discourses surrounding breastfeeding. These influence not only the practice of midwives, nurses and lactation consultants, but also women as they make their decision regarding infant feeding.

3.1 PUBLIC HEALTH DISCOURSE

Drawing upon the infant-centred rhetoric of 'breast is best', the advantage of breast milk for the newborn infant is rarely disputed in the professional and popular literature. For practitioners, researchers and mothers alike, including mothers who decide not to breastfeed, breast milk is considered best for the baby. In breastfeeding studies, only a few women (or men) consider formula to be equivalent or better than breast milk (Dix, 1991; Gabriel, Gabriel & Lawrence, 1986; Kessler, Carson Gielen, Diener-West & Paige, 1995). However, in developing and developed countries many thousands of women each year decide not to breastfeed or only breastfeed for a very short duration. Consequently, breastfeeding policy, research, education and practice, couched in public health discourse, are overwhelmingly focused upon education campaigns encouraging

more women to breastfeed. Carter (1995: 1-2) identified the three main concerns of policy makers and professionals: Why do so few women breastfeed? When they do breastfeed, why don't they do so for longer? How can this situation (low incidence and short duration) be altered?

Breast is Best for Baby, the Environment and the Global Economy

The documented advantages of breast milk for the human infant continue to grow rapidly (Riordan, 1997). The majority of professional and popular texts introduce breastfeeding with a broad statement of the nutritional advantages for the human infant. This statement often presents a 'taken for grantedness' about the health advantages of breastfeeding. There are, however, researchers who have made a concerted effort to methodically document the health, economic and ecological advantages of breast milk.

Walker (1993), for example, presents persuasive epidemiological accounts of the health advantages associated with breastfeeding and the health risks of artificial infant feeding even in developed nations. Walker (1993) states that formula fed babies develop acute diseases at higher rates. Ear infections are four times more common, there is a ten-fold risk for being hospitalised for bacterial infections such as meningitis, as well as respiratory infections which are directly attributable to bottle feeding. Diarrhoeal infections occur at three to four times the rate of breastfed babies. Walker (1993) adds, formula feeding is related to immune system disorders such as Crohn's disease and ulcerative colitis and a higher incidence of lymphoma. It is also estimated that one case of sudden infant death per 1000 live births occurs because an infant is not breastfed (Walker, 1993; Brodribb, 1997). Walker (1993: 98) also states that infant formula is associated with learning deficiencies and urges health professionals to take a firmer stance in their presentation of the differences between breast milk and artificial formula. She is critical of the concern that health professionals have about inciting guilt in non breastfeeding mothers, arguing that this really amounts to withholding important information from which a woman can make an informed decision.

Popular and professional literature also constructs an imperative to breastfeed through varying environmental and economic rationalist discourses. Breastfeeding is cast as economically (Meershoek, 1993; Riordan, 1997; Smith & Ingham, 1997) and

ecologically sound (Radford, 1992). Meershoek (1993) concludes that the material cost of formula feeding is three to four times higher than that associated with breastfeeding, and on a national level costs of poorer health are believed to be significant. Riordan (1997) cites estimates of health costs in the United States for infant diarrhea in non-breastfed infants as $291.3million, respiratory syncytial virus as $225 million, and ottitis media as $660million. Focusing on ecological issues, Radford (1992) claims breast milk is a valuable renewable resource. Increasing the number of bottle fed babies means deforestation, soil erosion, pollution, climatic changes and wasted resources. In this work, however, Radford (1992) disputes the risk to infant health from the presence of dioxins in breast milk. While most commentators concentrate on the economical advantages of breast milk for health budgets and personal household budgets, Smith and Ingham (1997) present detailed economic calculations to demonstrate the impact breast milk production can have on the national gross domestic product. Smith and Ingham (1997) suggest that making human milk available to virtually all Australian infants would increase domestic output by $3.5 billion per year (0.7% of GDP). What is particularly interesting about these persuasive accounts is the focus on the value of breast milk. Breast milk is represented as a product that somehow exists in isolation to the woman who produces the milk.

Discourses of Bonding and Attachment

For over 50 years professional discourse has linked attachment behaviours or the emotional tie between a mother and her baby to infant feeding practice. Breastfeeding is associated with enhanced maternal-attachment behaviour. In 1943, Levy stressed that rejecting mothers were more inclined to bottle feed their infants. Bowlby (1958) and Ainsworth and Bell (1969) reported that breastfeeding satisfaction fostered closer mother-infant ties. In 1977, Leifer reported that breastfeeding mothers found feeding to be emotionally gratifying and provided a sense of emotional union between mother and baby. Virden (1988) found women who were breastfeeding had lower scores of anxiety and higher mutuality than mothers who were bottle feeding. Jacobson, Jacobson and Frye (1991) found bottle feeding mothers were relatively lacking in feelings of empathy and nurturance. Others have added that bottle feeding mothers lack a clear sense of feminine identity (Barnes, Leggett & Durham, 1993). These accounts imply there is somehow a closer relationship between a woman and her baby if she breastfeeds. Such

assertions place breastfeeding firmly within the discourse of the 'good' mother. This is also implied in Bottorff's (1990) study where she stresses breastfeeding brings, for many women, feelings of companionship and closeness, which in turn help women find breastfeeding easier. Biological anthropologist, Dettwyler (1995: 171), adds that the release of maternal hormones during breastfeeding can affect maternal feelings and 'lead to more appropriate child promoting behaviours on the part of the mother'..

It is rare that nursing or midwifery studies compare the emotional attachment to infants of mothers who breastfeed with those who bottle feed. Martone and Nash (1988), sceptical of the rhetoric that breastfeeding enhances the emotional relationship between a mother and baby, studied the early attachment behaviours of breast and bottle feeding mothers. They found no significant difference between these two groups of mothers.

The Concern for Why Women Do Not Breastfeed

- breastfeeding rates

The research efforts of nurses reflect the public health imperative. Midwifery, nursing and medical research have predominantly focused on breastfeeding rates, factors contributing to 'unsuccessful' breastfeeding and education programs that increase the numbers of women who breastfeed. Australian and international studies attempt to establish regional breastfeeding initiation rates and duration (Fetherstone, 1995; Hitchcock & Coy, 1988; Lowe, 1993, 1994; Stamp & Crowther, 1995). The rates of initiation and continuation of breastfeeding to three and six months in Australia are some of the highest amongst western countries (Hauck & Dimmick, 1994). Between 85 and 90 percent of women choose to breastfeed (Cannold, 1995). Lowe (1993) reports, at six months 43 percent of Victorian women are still breastfeeding and in a study of 1009 Melbourne and Perth women, 55.3 percent were feeding at three months and 48.4 percent at six months (Scott, Binns & Aroni, 1997). Cannold (1995) comments that these rates are 'exceptional' when compared to other western countries, surpassed by only the Scandinavian countries where women receive substantial financial incentives in child rearing (Lowe, 1997). Crichton and Thornley (1996), however, insist that breastfeeding rates in Australia are nothing to be proud of. They note that despite the initiatives to promote breastfeeding, there has been little increase in the three and six month rates of breastfeeding and even the initiation of breastfeeding in hospital is

disappointing (Crichton & Thornley, 1996). Crichton and Thornley (1996) believe there are enormous discrepancies in reported breastfeeding rates. It is suggested this occurs because of the lack of consistency in the definition of breastfeeding (Auerbach, Renfrew & Minchin, 1991; Riordan, 1997). Ewing and Morse (1989) stress that different disciplines have different perspectives on what constitutes 'successful' breastfeeding. For example, medicine relates breastfeeding success to duration, nutrition equates success with growth and social sciences define success with maternal satisfaction (Ewing & Morse, 1989).

- identifying women who do not breastfeed

During the 1990s, much nursing and midwifery research has concentrated on identifying the characteristics of individual women that predict intention, initiation and duration of breastfeeding. For example, breastfeeding initiation and duration are associated with greater age, income level and education (Coreil & Murphy, 1988; Dix, 1991; Hellings, 1985; Hill, 1991; Hills-Bronczyk, Tromiczak, Avery, Potter, et al., 1994; Hitchcock & Coy, 1988; Janke, 1988; Jones, West & Newcombe, 1986; Lowe, 1994; Rentschler, 1991). In the United States and Australia, differences in breastfeeding rates in groups of women that do not belong to the dominant cultural group have been identified (Bailey & Sherriff, 1993; Baisch, Fox, Whitten & Pajewski, 1989; Baranowski, Bee, Rassin, Richardson, et al., 1983; Hill, 1991; Libbus & Kolostov, 1994). At the level of institutional policy, early mother-infant contact and suckling following the birth has been associated with increased duration of breastfeeding (Buxton, Carlson, Faden, Hendricks, et al., 1991; Coriel & Murphy, 1988; Fahy & Holschier, 1988; Hill, 1991; Lawson & Tullock, 1995; Stamp & Crowther, 1995). Similarly the extent of mother-infant contact in the first 72 hours (Lawson & Tullock, 1995; Anderson, 1989) and practices of rooming-in have been associated with significantly higher breastfeeding frequencies in the first week (Yamauchi & Yamauchi, 1992).

Nurses often ask women to explain their decision not to breastfeed or to cease breastfeeding within the first three months (Bailey & Sherriff, 1993; Fetherstone, 1995; Lawson & Tullock, 1995; Lowe, 1994; Stamp & Crowther, 1995). The most common reasons reported in these studies are poor milk supply, sore nipples, lactose intolerance, colic, and returning to work. Many health professionals conclude that ultimately women

cease breastfeeding due to ineffective or poor feeding practices, such as incorrect positioning and attachment. These scientific, physiological explanations influence the professional rhetoric of education. Breastfeeding education together with greater access to professional support is considered crucial (Bailey & Sherriff, 1993; Fetherstone, 1995; McNatt & Freston; 1992). For example, McNatt and Freston (1992) found those who rated their lactation experience as 'successful' had twice as much informational support.

The influence and importance of professional education and support, however, is equivocal. A number of studies support the findings of McNatt and Freston (1992), suggesting that breastfeeding support from professionals increases breastfeeding rates (Buckner & Matsubara, 1993; Giugliana, Caiffa, Vogelhut, Witter, et al., 1994; Izatt, 1997; Jones, 1987; Kaufman & Hall, 1989; Kessler, et al., 1995). However, the majority of mothers stress that it is partners, other family members and friends who influence infant feeding decisions and provide the support and encouragement (Buckner & Matsubara, 1993; Freed, Fraley & Schanler, 1992; Giugliana et al., 1994; McLorg & Bryant, 1989). Rutledge and Pridham (1987) also found that in the early postpartum period the amount of rest obtained influenced the perceived confidence of breastfeeding mothers. Interestingly, Giugliana, et al., (1994) found that while health professionals did not influence the decision to breastfeed, attendance at prenatal classes was associated with breastfeeding. This supports the findings of Maitch and Sims (1992). However, it is not known whether it was the classes per se that influenced the decision or whether those who attended classes were more likely to also decide to breastfeed. According to Starbird (1991) this may be the case.

- intervening to increase breastfeeding rates

Influenced by the medical, scientific and health promotional discourses, nurses, midwives and lactation consultants focus on interventions that will increase the duration of breastfeeding. Typically these studies involve additional professional (Bruce & Griffoen, 1995; Quarles, Williams, Hoyle, Brimeyer, et al., 1994; Sichy, Folker Maglaya, Mendelson, Race, et al., 1996) and peer support (Kistin, Abramson & Dublin, 1994; Locklin, 1995). Despite professional rhetoric of the need for emotional support while in hospital, mothers receive information and instrumental help but little emotional

support (Barclay, Everitt, Rogan, Schmied, et al., 1997; Chapman, Macey, Keegan, Borum, et al., 1985; Moss, Bolland, Foxman & Owen, 1987; Tarka & Paunonen, 1996). The attitudes that health professionals hold towards breastfeeding are also considered to be influential in the type of support a woman receives (Lazzaro, Anderson & Auld, 1995; Patton, Beaman, Csar & Lewinski, 1996).

Prior to the birth, nursing and midwifery practice emphasises the need for education in order to 'persuade' women of the advantages of breastfeeding. After birth the focus is on physiological problems with breastfeeding: the breasts, milk production, the ability of the mother to 'position' her baby properly and the ability of the baby to suck. Similar to nursing theories and empirical work on maternal identity discussed in Chapter Two, this research on breastfeeding retains a persistent focus on the individual woman and her rational cognitive processes. This persistent focus in nursing literature on either the mother or the infant is also identified by Kotowski (1995) who argues that midwifery and nursing theory, research and practice ignore the synergistic and symbiotic nature of breastfeeding interaction. This approach not only influences how health professionals view the breastfeeding situation but also how guidelines and policies are implemented (Carter, 1995; Kotowski, 1995).

- breast, nipples and babies: disembodiment in midwifery and nursing texts

Drawing upon this professional literature, midwives and nurses are very familiar with the advantages of breastfeeding. It appears, however, in order to promote, monitor and survey breastfeeding practices (Lund-Adams & Heywood, 1994; NSW Health Department, 1995), health professionals focus more on breasts and nipples, breast milk production and the infant's ability to attach to the breast than they do on the experience of the woman. This focus perpetuates an understanding of breasts as objects.

Interestingly, the professional breastfeeding literature directed towards the education of health workers emphasises the actual production of breast milk. Rather than breastfeeding being a significant relationship in a woman's life, it is the quality of her breast milk and the ability of her breasts to function adequately that concerns the health professionals. A recent publication, *'Breastfeeding: A Guide for Midwives'* by Henschel and Inch (1996), is presented as a guide for those involved in helping women to

breastfeed. A scan of the content pages, however, indicates this text concentrates firstly, on breast milk and babies, claiming 'human milk for human babies' and secondly, breast anatomy and physiology, production of breast milk, the breasts in pregnancy and the nature of suckling. It is only in Chapter Eight that the authors talk of the midwives role in supporting the mother in initiating breastfeeding. Here they examine routine hospital practices that have inhibited 'successful' breastfeeding. Finally, in Chapter Twelve the postpartum experience of mothers is briefly discussed. Women and their experience of breastfeeding are notably absent from this 'practical' guide. It is claimed the 'secret' to 'successful breastfeeding' is correct positioning (Henschel & Inch, 1996: 46). Similarly, the manual *'Successful Breastfeeding'* produced by the Royal College of Midwives in England commences with the process of lactation and how a baby breastfeeds, correct positioning of the infant for feeding, factors that are known to help breastfeeding and factors that can hinder 'success'. Breasts and nipples, their preparation for breastfeeding, their care and prevention of problems are not always discussed or indeed photographed in relation to women. In a well-known text for health professionals interested in breastfeeding (Riordan & Auerbach, 1993), the inside cover, both back and front, contains colour plates presenting breasts and nipples in varying stages of pathology. While the intention here is to protect the woman's anonymity, these pictures also cast these women in a disembodied way. Harrison, Morse and Prowse (1985), Ewing and Morse (1989) and Kotowski (1995) also highlight this sense of disconnection and disembodiment. Kotowski (1995) insists that breastfeeding texts and health professionals never approach mother and baby care as an integrated or connected system.

- public policy: promotion and support or regulation and surveillance?

A plethora of international and national government policies and hospital procedures surrounds breastfeeding practice. For over 15 years, international and national policies have been developed and implemented to increase the incidence of breastfeeding. In the early 80s most of the international community adopted the International Code of Marketing Breast Milk Substitutes. This code applies to how breast milk substitutes can be marketed, so as not to undermine the advantages of human milk. The World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) initiated a global aim to protect, promote and support breastfeeding exclusively from birth to four

to six months of age and thereafter partially for up to two years of age (WHO & UNICEF, 1990). The WHO has recommended that by the year 2000, all countries should aim to have 80% of newborn babies breastfeeding for the first four months. In Australia, *'The Goals and Targets for Australian's Health in the Year 2000 and Beyond'* sets Australian breastfeeding targets at 90% of babies breastfeeding up to two months of age, and 60-80% partially to fully breastfeeding up to six months of age (Commonwealth Department of Health, 1993).

As a development from the WHO Code, in 1991 WHO and UNICEF launched the Baby Friendly Hospital Initiative (BFHI). This initiative is an international program that encourages hospital and healthcare facilities to develop policies and practices to protect, promote and support breastfeeding. The BFHI has established global criteria couched in the *'Ten Steps to Successful Breastfeeding'* (see Appendix E). An external accreditation process has been established and hospitals must comply with the ten steps in order to achieve status as a Baby Friendly Hospital. The BFHI was launched in Australia in 1992.

The emphasis in the criteria or 'ten steps' is primarily upon hospital policy and staff education, knowledge, attitudes and practices, such as assisting women to breastfeed within half an hour of delivery. There are, however, a number of steps that although linked to greater 'success' with breastfeeding, enforce particular cultural approaches to mothering and breastfeeding. For example, the insistence upon 24-hour rooming-in, the recommendation that infants should not have any food or drink other than breast milk, the discouragement of the use of artificial teats and pacifiers. Some interpret these criteria as regimented practices that may be a source of distress for women (Cannold, 1995). Fox (1990) questions the appropriateness of these criteria as initially they were intended for developing countries. Fox (1990) stresses that these criteria, while perhaps essential in developing countries with poverty, poor sanitation and high rates of illiteracy, have incorrectly encouraged the belief in countries such as Australia that formula feeding is dangerous. A number of commentators (e.g. Kotowski, 1995) have also expressed concern over the use of the term 'Baby Friendly'. This title suggests that the focus of breastfeeding is on the infant. This is supported by Cannold's (1995: 5)

finding that some lactation consultants believe 'the pressure that women are under to breastfeed is a good thing as it means more babies get breast milk'.

Anecdotally, many midwives find the task of encouraging more women to breastfeed a frustrating experience. When health professionals 'fail' to resolve a problematic breastfeeding experience, some insist that it is the broader social and cultural context that influences a woman's breastfeeding decision and experience.

3.2 ADDING THE SOCIAL: DISCOURSES OF CULTURE

Dettwyler (1995: 168), a biological anthropologist, believes breastfeeding is presented as 'the simple and natural option, which all women would choose if they knew the health advantages and that they would succeed if only they had adequate support and encouragement'. Yet many cross-cultural studies have demonstrated that breastfeeding decisions and practices are embedded within the cultural context (Baumslag & Michels, 1995; Maher, 1992; Morse & Harrison, 1987). Morse and Harrison (1987: 205) suggest breastfeeding is 'a dynamic open relationship occurring within a social context'. The work of anthropologists takes the focus away from individual women and their intentions and practices regarding lactation, looking more widely at cultural factors that impinge on the breastfeeding experience. For example, Maher (1992) observes in some cultures the decision to breastfeed is influenced by adult male privilege, men decide who shall be breastfed, by whom and for how long. Carter's (1995) analysis of women breastfeeding in northern England between the 1920s to the late 1970s, found even though breastfeeding is overwhelmingly portrayed as a private, unpaid domestic responsibility, it remains a public issue, with women having to negotiate breastfeeding activity in relation to men and the health professionals. Morse and Harrison (1987) also suggest that in western cultures there are powerful social forces that prescribe how long women may breastfeed. Gabriel, Gabriel and Lawrence (1986) identified an increasing interest in breastfeeding amongst certain groups of women in western societies. They suggest this account is represented in cultural idioms such as 'return to nature' and 'control over one's body'. Interestingly, western breastfeeding practices are frequently compared to the feeding practices in developing countries, where the discourse of the

'primitive' woman freely feeding is cast as an example of how unproblematic breastfeeding can be (Maher, 1992).

Many commentators speaking of western societies, particularly the United States, believe we live in a society where bottle feeding is considered the norm. This has been linked to the aggressive marketing of breast milk substitutes by multinational companies (Baumslag & Michels, 1995; Palmer, 1988; Van Esterik, 1989). In such societies, women, men and children are bombarded with visual images where babies and bottles are linked together. For example, Altschuler (1995) found children's books reflect and reinforce our society's message that bottle feeding is the normal way to feed human babies. Commonly animal characters are presented bottle feeding the baby and even books with images of breastfeeding exist simultaneously with an image of bottle feeding, giving the impression that the two methods are of equal value (Altschuler, 1995).

One of the most commonly voiced cultural accounts relates the demise of breastfeeding to the meanings attached to the female breast in the culture within which the woman lives. Some insist that the preoccupation in western societies, particularly the United States, with the breasts as objects of sexual gratification is particularly influential in women's decision to breastfeed (Baumslag & Michels, 1995; Palmer, 1988; Rodriguez-Garca & Frazier, 1995; Van Esterik, 1989). In western societies the breasts are fetishised and produced as symbols of feminine sexuality (Young, 1990). Western culture is seen as idealising the breast, particularly the young or non-mature breast. Carter (1995: 149) suggests having 'the right size and shape of breasts is a metaphor for being the right sort of woman'. Indeed Young (1990) also suggests women in western society experience their breasts through the gaze of another, evaluating the look and shape of their breasts according to a 'norm' that women have not produced themselves. Importantly, however, cultural notions of the 'right' breast or the 'official' breast (Rodriguez-Garcia & Frazier, 1995; Yalom, 1997) are not static. This construction of the breast as a sexual object creates a contradiction between motherhood, breastfeeding and sexuality.

The media is considered important in shaping notions of the acceptable breast or the 'official' breast and breastfeeding practices (Rodriguez-Garcia & Frazier, 1995; Dettwyler, 1995). Henderson's (1998) recent analysis of the Australian print media suggests that while the 'breast is best' discourse is prominent in print media, this message is frequently contradicted by an overall adverse construction of breastfeeding. Images of breastfeeding suggest that it is difficult to do, requires patience, practice and time and is metaphorically a 'war to be won' or a problem to be solved (Henderson, 1998). Henderson (1998) adds that in many instances women are represented as the objects of discourse, cast as ignorant, ambivalent, needing support or failing to stay relaxed. In abandoning breastfeeding they are presented as, 'endangering their babies'. Underlying many accounts is the message that women require the assistance of health professionals to succeed at breastfeeding.

If a woman breastfeeds for a prolonged period, the lack of social acceptability, particularly breastfeeding in public, results in a social coercion to wean (Hills-Bronczyk, et al, 1994; Kendall-Tackett & Sugarman, 1995; Morse & Harrison, 1987). Morse and Harrison (1987) articulate breastfeeding support as passing through a number of stages from active support to being tolerated, to ignoring breastfeeding and finally to active encouragement to wean.

The demise or disinterest in breastfeeding amongst western women, particularly in countries such as the United States, is also linked to the medicalisation of breastfeeding (Van Esterik, 1989; Palmer, 1988). Martin (1987) wrote of the widespread denigration of women's bodies that in the 50s, 60s and 70s managed to convince women that a scientifically formulated product was superior to their own milk. More recently, Auerbach (1995) believes untrained and unsympathetic physicians are positioning themselves as experts in breastfeeding and problems of lactation. This is further undermining women's confidence in their ability to breastfeed. These accounts assert that women have come to view breastfeeding as problematic and a practice that requires continuous assistance and support of professionals (Apple, 1987; Barclay, 1997).

Studies examining the role of the father as well as significant others, such as grandmothers, cast these people as important influences on a woman's decision to breastfeed. A number of commentators are concerned about the degree of influence that

a woman's partner or mother can have on her decision to breastfeed. While partners are sometimes important sources of support for breastfeeding (Freed, Fraley & Schanler, 1992), other men prefer their baby to be bottle fed for reasons of convenience and a distaste for the undesirable changes that may occur in a woman's breasts as well as the interference with their sexual relationship (Freed, Fraley & Schanler, 1992; Kessler, et al., 1995). More recently, some men have started to see breastfeeding as interfering with the relationship a father may have with his child (Lupton & Barclay, 1997; Chandler & Field, 1997). The notion that men may feel excluded from their relationship with their female partner and from their baby because of breastfeeding is also perpetuated by many of the popular parenting and breastfeeding texts. These texts frequently advise women to be concerned for their husband's feelings. Women are instructed to recognise that he may feel left out or even jealous of the breastfeeding infant as prior to this, her breasts had belonged to him (Stanway & Stanway, 1978; Jordan, 1986; Jordan & Wall, 1990).

There is also a pervasive belief that contemporary grandmothers have an adverse impact on women's decision to breastfeed (Lowe, 1997; McConville, 1994). In pro breastfeeding texts, the woman's mother is rarely suggested as an appropriate support for breastfeeding. Rather, an experienced person, a friend, or a voluntary person from a breastfeeding organisation are suggested. Many popular and professional texts in the 1990s do not believe contemporary grandmothers have the knowledge to support breastfeeding women, as many did not breastfeed themselves.

In this diverse public health and cultural debate, women are left wondering who their breasts belong to. As Yalom (1997: 1-2) asks, 'Who owns the breast? The suckling child... the man or woman who idles it... the artist... the fashion arbiter... the fashion industry... the religious and moral judges... the law... the doctor... the plastic surgeon... the pornographer... or does it belong to the woman?'

3.3 SHIFTING PUBLIC DISCOURSE

The Traditional 'Good' Mother

In contrast to the nursing and midwifery texts for health professionals, popular texts on breastfeeding attempt to place the breasts, breast milk and babies in the context of the women's lives. The majority of popular breastfeeding texts commence with a broad statement about the benefits of breastfeeding for mothers. The rhetoric of 'breast is best' for the baby is almost taken for granted. Indeed the physiological and emotional advantages of breastfeeding for the mother are often prioritised over that of the baby.

Popular texts on breastfeeding are designed to 'persuade' women to breastfeed. In recent editions of *'The Womanly Art of Breastfeeding'*, produced by La Leche International in the 50s, breastfeeding is constructed as 'an integral part of good mothering' (La Leche International, 1971: 10) and the key to 'good' mothering (La Leche League International, 1991: 12). Women are advised that 'no one can teach you good mothering', all that can be done is to refer women back to 'wise nature's plan' (La Leche International, 1971: 11). Becoming a mother is viewed as a step to maturity, 'after you have brought your baby into the world, the first important step in your new role as a mother is to put the infant to your breast. Having come this far on the road to maturity, you find that the experience of giving yourself unstintingly to your child will bring you even further along' (La Leche League International, 1971: 12). Breastfeeding thus enhances the nature and personality of a woman, '(b)reastfeeding will benefit you by becoming a more real, more loving person' (La Leche League International, 1971: 12). Recent editions emphasise that a breastfeeding mother responds to her infant more intuitively and with less restraint (La Leche League International, 1991: 14). In this text a woman gains character and maturity in the giving of herself to her infant. In the earlier editions, there is little emphasis on the notion of the 'special' feelings, a 'closer bond' or sensual intimacy of breastfeeding that appears in other recent popular texts. La Leche League presents an infant-centred understanding of breastfeeding, with clear messages about women's role as mothers. Even in the more recent editions, this text prioritises the mother's place to be with her infant and actively discourages women from returning to work while their children are young. It maintains a clear separation between discourses of motherhood and discourses of sexuality.

Modern Accounts of the 'Good' Mother

A recent publication by the NMAA, *'Breastfeeding Naturally'* (Caferella, 1996), presents the decision to breastfeed as advantageous for both mother and baby. Interestingly, in this recent text breastfeeding is cast as not just feeding but nurturing a baby, the very essence of what a 'good' mother does. Breastfeeding is also presented as the best option for the independent, autonomous woman who wants to get on with things in her life. This account parallels the modern notion of the 'good' mother who can balance breastfeeding with her own personal needs for autonomy and independence. In viewing breastfeeding in this way women are encouraged as mothers to straddle the private and public domains. Breastfeeding does not mean the modern mother has to be confined to private domesticity. In the following account, however, women are told of the advantages of being at home with their baby. The midwife authors of '*Bestfeeding*', Renfrew, Fisher and Arms (1990), emphasize that breastfeeding provides the opportunity for mothers to have a quiet, relaxing time with their babies during the day. Here breastfeeding is portrayed as something that can facilitate the ideal of the relaxed, 'good' mother. They add, 'If breastfeeding works well, it is pleasurable for mother and baby and is good for the way a mother and her child feel about themselves and each other' (Renfrew, Fisher & Arms, 1990: 8). Thus women are told that breastfeeding advantages the relationship between a mother and baby in a way that bottle feeding does not. Morse, Jeble and Gamble (1990: 303) state, for example, the psychological benefits of breastfeeding for the mother will 'enhance survival of the infant by ensuring improved quality of maternal caretaking'.

Breastfeeding: a Satisfying and Sensual Experience

Together with changing notions of the 'right' breast, there are accounts that promote the sexual and sensual nature of breastfeeding. Resisting this so-called dominant account, the popular texts promoting breastfeeding attempt to allay the fears that breastfeeding on one hand diminishes a woman's sexual attractiveness and on the other hand provokes 'inappropriate' sexual feelings. Instead such texts claim that the sexual nature of breastfeeding has been de-emphasised (Oakley, 1980) and promote the benefits of sexual or intimate feelings with a baby during breastfeeding. Helsing and Savage-King (1982) describe sexual arousal during breastfeeding as perfectly normal and having a physiological basis. Many texts promoting breastfeeding cast the pleasurable and sexual

nature of breastfeeding as a source of female empowerment (Blum, 1995; Kitzinger, 1979; Palmer, 1988; Rich, 1976; Van Esterik, 1989; Young, 1990). Palmer (1988) and others have described breastfeeding as an exclusive form of female sexuality. Kitzinger (1979: 14) writes, 'Breastfeeding is psychosexual too, involving, as it does, a giving of the woman's body, release to let the milk flow, and relations between bodies, her own and the baby's'. It is claimed women will experience pleasurable sexual feelings during breastfeeding (Riordan & Rapp, 1980). Employing a biological discourse it is also suggested that the survival of the species is dependent upon this (La Leche League International, 1992; Newton & Newton, 1967; Riordan & Rapp, 1980).

In *'Breastfeeding Naturally'*, women are reassured that any sexual or orgasmic feelings they may experience while breastfeeding are natural, even positive, as they enhance 'good feelings' and this is positive for breastfeeding and the baby (NMAA, Cafarella, 1996: 137). Coupled with this positive account of the sexual nature of breastfeeding are suggestions for keeping the father of the baby involved in nurturing when a child is breastfed. Such advice in 'managing' the emotions of the new 'involved' father is now common in many parenting manuals (Marshall, 1991). Fisher, Renfrew and Arms (1990) encourage women who believe breastfeeding is distasteful to give breastfeeding a go. As midwives, Fisher and Renfrew stress that they have known many women who, after believing that breastfeeding is distasteful, have 'gained great comfort and pleasure in feeding that they never thought possible' (1990: 16).

Importantly Carter (1995) is critical of the assumption that women 'can have it all'. She describes how the context within which we are ‘allowed’ to ‘have it all’ is very limited. Carter (1995) argues the challenge to a dominant account of breasts and sexuality is only permissible within a discourse of heterosexuality. Within this account of breastfeeding as a sensual and sometimes sexual experience, women have a responsibility to keep their breasts 'respectable' and 'attractive'. Breastfeeding women have to manage the gaze of others (Carter, 1995).

There is another account, however, that is sceptical of the assumption that breastfeeding is a source of sexual pleasure. Dettwyler (1995) and Hytten (1991) assert that for many women breastfeeding is not pleasurable and is accompanied by discomfort and pain.

Dettwyler (1995) argues that while there are documented feelings of well being from the release of hormones associated with breastfeeding, these are general feelings of well being and relaxation as opposed to feelings of sexual stimulation and pleasure. Indeed, as described in Chapter Seven, for some women the let down reflex stimulated by the release of oxytocin is not warm and tingling but uncomfortable and unpleasant. It is interesting to note the increasing attention given to sexuality and breastfeeding in the popular breastfeeding texts. Carter (1995) believes there has been an increasing sexualisation of breastfeeding that could potentially be seen in Foucauldian terms as a reverse discourse.

The Language of Personal 'Success' and Achievement

The language within which many breastfeeding studies are couched is one of personal achievement. Pro breastfeeding rhetoric emphasises 'success'. The dominant biomedical account in both quantitative and qualitative studies links the decision to breastfeed and the initiation and duration of breastfeeding to 'success' or 'failure' with breastfeeding. The underlying question here is 'Why do so many women 'fail' to breastfeed?' Fahy and Holschier (1988) titled their study of breastfeeding practices *'Success or failure with breastfeeding'*. Leff, Gagne and Jeferis (1994) focus on maternal perceptions of 'successful' breastfeeding and Laufer (1990) describes a 'model of breastfeeding failure'. In some popular and professional accounts, 'success' is also linked to breastfeeding duration. In *'Breastfeeding Naturally'* (NMAA, Cobiella, 1996), it is implied that 'successful' breastfeeding may last from six months up until four years or longer. Here 'success' is defined by duration with anything less than six months perhaps not considered as 'successful'. It has also been suggested that a 'successful' breastfeeding experience can assist a woman in the resolution of an unsatisfying or disappointing pregnancy or birth experience. Couched in the language of 'failure', Laufer (1990: 43) states, 'By building up confidence and self esteem, a successful breastfeeding experience can help a woman to feel good about herself again'. The most common reason women give for prolonging breastfeeding relates not only to the health of the baby and a 'good' mother but to the personal enhancement or self-development of the mother. Women who have fed for more than nine months hold the perception that in breastfeeding they have established a 'special time' for mother and baby and the development of a closer mother-child bond (Hills-Bronczyk, et al., 1994; Kendall-Tackett & Sugarman, 1995;

Wrigley & Hutchinson, 1990). Mothers who breastfeed their children for longer believe prolonged breastfeeding is more likely to produce children who are emotionally secure, happy and more independent in the future (Beamer & Sugarman, 1987; Hills-Bronczyk, et al., 1994; Kendall-Tackett & Sugarman, 1995). These women feel they are successful as mothers. This personal priority for success reflects the western individual's intense commitment to and investment in producing the 'perfect' child (Beck & Beck-Gernsheim, 1995).

The preoccupation of our language of 'success' in professional and popular breastfeeding texts is rarely critiqued. In 1985, however, Harrison, Morse and Prouse reported that the definition of 'success' in breastfeeding varied widely across disciplines. Medical and nursing accounts, for example, framed success around infant health and duration of breastfeeding while the public or lay accounts focused on the mother-infant relationship. An editorial by Auerbach (1994: 69) challenged the need for health professionals to qualify breastfeeding. She states, '(W)hy must we qualify breastfeeding. A woman who is suckling her infant is breastfeeding - PERIOD'. Auerbach (1994: 70) goes on to say:

> Most mothers breastfeed. If it does not go well, some of these mothers may end up bottle feeding. But why must we qualify their experience? And when we do qualify breastfeeding, are we not also calling unnecessary attention to the fact that many mothers are not as successful as they would like to be.

Rational and Autonomous Decision Making: the Right to Choose

Within this account of 'success', women are praised for making a rational commitment to breastfeeding. For example, Cannold (1995) comments how the rhetoric of the NMAA implies every woman can and should be able to breastfeed. NMAA publications privilege accounts from women who made a commitment to breastfeeding and who, despite all obstacles, continued to feed. Cannold (1995) describes these women as the 'heroines' of the pro breastfeeding rhetoric, while those who decide not to or give up are rarely mentioned.

It is consistently stressed that women who make the decision to breastfeed during the prenatal period or even prior to conception, are more likely to breastfeed and do so for a longer duration (Bailey & Sherriff, 1993; Coriel & Murphy, 1988; Cox & Turnball,

1994; Lawson & Tullock, 1995). McNatt and Freston (1992) found those who were self-directed and determined to succeed at breastfeeding were more likely to achieve their goal. The commitment to breastfeed is couched within a rational, individualist perspective of the self. Some studies of the intention to breastfeed (for example, Kessler, et al., 1995) have utilised theoretical frameworks from social learning theory and the theory of 'reasoned action', where it is proposed that behaviour is mediated through rational intention. These texts advocate that women be self-reliant and determined to succeed at breastfeeding. Breastfeeding is a project. Indeed, as Bottorff (1990) suggests, the commitment to breastfeeding as a practice parallels the commitment that one may make to remain rigidly on a diet. Buxton, et al. (1991) and Lawson and Tullock (1995) stress that women who were strongly committed to a breastfeeding goal were more likely to breastfeed for longer.

It is argued that a woman who demonstrates a high level of confidence in her ability to breastfeed is more likely to achieve her goal regardless of the type of birth she has (Janke, 1988), or the difficulties with breastfeeding encountered in the postnatal period (Rentschler, 1991). In an Australia wide study, Lawson and Tullock (1995) examine prenatal attitudes and demographic variables that predict breastfeeding at three months. In this study women who have a negative attitude towards formula feeding and who, prior to conception, make a decision to breastfeed their babies for at least four to six months, are more likely to be breastfeeding at 12 weeks. Fetherstone (1995) describes in a sample of 'successful' mothers, the presence of personal beliefs that reflect a high level of motivation and personal determination to succeed with breastfeeding. Lawson and Tullock (1995: 848) conclude in their study of first time mothers that women often equate breastfeeding with their overall ability to mother their infant. They state, '(B)reastfeeding for many women encompasses more than fulfilling a physiological role, the accomplishment of nurturing an infant in the current cultural climate is a significant achievement'.

The authors of these popular texts all insist that women be given the opportunity to 'choose' freely whether to breastfeed or not. Within this rationalist framework, it is claimed that to be able to make a 'free choice', women must have all the information about breast and bottle feeding (Baumslag & Michels, 1995; Fisher, Renfrew & Arms,

1990; Van Esterik, 1989). Fisher, Renfrew and Arms (1990) believe that apart from the technical information about how breastfeeding works, women also need to have an understanding of how their culture may mitigate against breastfeeding. These writings articulate some type of absolute 'truth' about breastfeeding, where the 'information' about breastfeeding is free from social and cultural influence. This account does not see the pro breastfeeding rhetoric as a construction in itself, set within a particular historical and social period. This is illustrated by a recent debate in the United Kingdom, where one health trust has been challenged by various groups for its decision not to provide any information to women on breast milk substitutes prior to the birth of a baby. This decision was taken as part of the Baby Friendly Hospital Initiative (Radford, 1996), and designed to increase the numbers of breastfeeding women. Critics claim it deprives women of information necessary to make their own choice (Williams, 1996).
After examining a number of professional and popular texts on breastfeeding, it could easily be concluded that breastfeeding is almost a given rather than a choice.

3.4 WOMEN'S PERSONAL DISCOURSE AND EXPERIENCE

There are commentators who are dissatisfied with the direction that research on breastfeeding practices has taken. Authors such as Maher (1992) and Carter (1995) insist women's decisions regarding infant feeding are complex, related to her health, the health of her baby, the needs of other children and family members, living conditions and other demands on her time and energy (Carter, 1995; Gabriel, Gabriel & Lawrence, 1986; Maher, 1992). These issues of social class and race, as well as personal experience, are often lost in accounts of the health advantages of breast milk, the influence of multinational company marketing of breast milk substitutes and the portrayal of breasts in society.

It is rare that accounts focus on the experience of breastfeeding from the perspective of the woman. (Beasley, 1991; Dignam, 1995; Maclean, 1989, 1990). Critics believe most studies have failed to acknowledge the interdependence, interaction and complexity of the total breastfeeding experience (Dignam, 1995; Beasley, 1991). In 1987, Morse and Harrison drew attention to two decades of research on infant feeding that demonstrated

an unrelenting concern with the correlates of 'successful' breastfeeding. Ten years later this type of research remains common. The question 'Why do women breastfeed?' is rarely asked and there has been little interest in women's personal experience of breastfeeding (Carter, 1995; Maher, 1992).

In contrast to studies of intention, initiation and duration of breastfeeding and of interventions to increase breastfeeding rates, there are only a few studies by health professionals examining the experience of breastfeeding and the meanings women give to the breastfeeding relationship. Most commonly, qualitative studies are conducted in conjunction with quantitative studies of breastfeeding satisfaction. For example, in a grounded theory study, Leff, Gagne and Jefferies (1994) describe the notion of ‘working in harmony’ and its relation to ‘successful’ breastfeeding. In this study the categories of maternal enjoyment and desired maternal role attainment were considered most important by women who described breastfeeding as ‘successful’. Leff, Gagne and Jefferis (1994) suggest the category 'infant satisfaction' may be a necessary but not sufficient condition of 'successful' breastfeeding. In a phenomenological study, Bottorff (1990) identifies the need for many women to 'persist' with breastfeeding in order to achieve their personal goal. Wrigley and Hutchinson (1990), also in a grounded theory study, identify the importance breastfeeding women give to 'surrendering' to their infant and 're-orientating' their personal needs and goals. Wrigley and Hutchinson (1990) describe the 'secret bond' some women establish with their infant when choosing to breastfeed for longer than 12 months. These studies all highlight the significance that breastfeeding may have for women. Importantly, Leff, Gagne and Jeferis (1994: 99) describe breastfeeding as a 'complex, interactive process resulting in mutual satisfaction of maternal and infant needs'.

Alternatively, some studies emphasise the enormous dissatisfaction women may experience with breastfeeding. In the study by McNatt and Freston (1992), women who had not felt successful or satisfied in their feeding experience listed discomfort, inconvenience and lack of pleasure in breastfeeding as reasons they were not ‘successful’. These women expressed feelings of self-doubt and guilt when they decided to discontinue breastfeeding (McNatt & Freston, 1992: 75). Importantly, Maclean (1989) describes the dramatic changes breastfeeding brings to women's lives, their

dislike for their lactating breasts and the challenges breastfeeding presents for independent women in western societies.

The limited investigations by midwives, nurses and other health professionals into the breastfeeding experience have not necessarily been addressed by other disciplines. A number of commentators are puzzled by the lack of interest from sociologists and feminist academics in the topic of breastfeeding (Blum, 1995; Carter, 1995; Maher, 1992; Van Esterik, 1989). With few exceptions (Cannold, 1995; Carter, 1995; Maclean, 1990; Maher, 1992), the focus of writings on breastfeeding is on its promotion, continually asking why women do not breastfeed. Some feminists have articulated the possibility for breastfeeding to be seen as an expression of women's power and as providing us with new ways to view gender and being rather than the categories of women and man, mind and body (McConville, 1994; Palmer, 1988; Blum, 1995; Young, 1990). I pursue these ideas further in Chapter Four and again in Chapter Eight.

Critiques of the current imperative to breastfeed are rare. It is only in the work of Carter (1995), Maclean (1990) and Maushart (1997) that women challenge the pro breastfeeding account in any substantial way. Carter (1995) and Maushart (1997) are extremely critical of the demands upon women to breastfeed and Carter (1995) highlights the resistance that women have shown over many years to the imperative to breastfeed.

Using a poststructural approach, Carter (1995) analyses women's experiences of breastfeeding across a number of generations. She notes that for many women in the period from 1920s onwards 'breastfeeding was associated with exhaustion, poverty, discomfort, embarrassment and restriction as well as authoritarian hospital practices' (Carter, 1995: 90). Indeed, breastfeeding for the majority of women interviewed by Carter (1995) did not provide a romantic image of motherhood. Rather, it represented hard work. For some women, bottle feeding actually offered some respite from domestic work as it was something fathers or others might do (Carter, 1995).

For Carter, the current breast versus bottle debate has replaced the 18th century preoccupation with mother versus wet nurse. Both these debates illustrate a concern for

the appropriate behaviour of women. Carter's (1995) analysis is similar to Eyer's (1992) conclusion about the 'scientific' accounts that popularised mother-infant bonding. Carter (1995) believes the rhetoric associated with breastfeeding, as it is with bonding, is about the proper place of women. Breastfeeding, however, highlights the contradiction between motherhood and sexuality. Women as mothers are expected to breastfeed but they must do so in a way that does not compromise their sexuality. As Carter (1995: 121) notes, women are expected to be 'actively heterosexual' but they 'must avoid drawing attention to sexuality where this is connected with reproduction'.

Carter (1995) believes an examination of breastfeeding as a feminist issue is important, as although breastfeeding is only a small part of women's lives, it encapsulates or represents many of the central concerns of feminist theory and practice.

CONCLUSION

In this chapter I have examined the pro breastfeeding accounts that may motivate women to breastfeed. Here breastfeeding is a discursive construction, a script for a way of life as a 'good' mother. In both professional and public discourse there is an underlying belief that breastfeeding is an important part of the mothering role, breastfeeding is a feminine or womanly activity that in the 1990s can bring personal success and achievement.

In this chapter the concern within professional discourse to account for why women do <u>not</u> breastfeed is clear. Correspondingly, policy, research, education and practice stress the physiological and psychological benefits of breastfeeding. Despite the dissemination of the multiple advantages of breastfeeding, not all women breastfeed their infants and some breastfeed for very short periods. Why is this the case? Like motherhood, the study of breastfeeding is extremely complex and must be approached in diverse ways.

It was established in Chapter Two that the experience of breastfeeding was peripheral in the theoretical approaches of maternal subjectivity that inform our practice as nurses and midwives. Even in Rubin's extensive formulation of the 'body-self' as an interrelated

component of the self, breastfeeding appears as a cognitive aspect of maternal subjectivity. In this thesis, I explore the notion that breastfeeding is central to the development of an embodied maternal subjectivity.

CHAPTER FOUR

MATERNAL SUBJECTIVITY AND EMBODIMENT - SYNTHESISING THEORY

In Chapter Two I introduced the potential for nursing and midwifery to explore alternative understandings of maternal subjectivity and the maternal body. Rubin's understanding of self as a system of selves incorporating the body - not a biological entity separate from the mind but as a sensing and perceiving part of the self - was a significant and insightful development in theories of maternal identity. Rubin's interest in the body and maternity, however, has rarely featured in the further development of nursing theory and research. Most typically this research has focused only on the woman's perception of her body's changing appearance during pregnancy (Fawcett, et al., 1986; Tulman, et al., 1990). Relatively few nurse or midwife researchers have investigated the embodied nature of maternal experience. One notable exception is Stainton (1985) whose work highlights the embodied nature of maternal-infant attachment during pregnancy and the early postpartum. The theoretical developments proposed by Rubin, incorporating the body-self as central to maternal identity, provide a starting point for the examination of maternal subjectivity and the place of breastfeeding in the 1990s. This work provides an opening from which to link a range of perspectives articulating understandings of the body and subjectivity.

4.1 MERGING THEORETICAL PERSPECTIVES ON THE BODY

This chapter develops an understanding of embodied subjectivity. The premise that our experience of life is mediated through our bodies underlies the theoretical perspectives and analyses of subjectivity in this study. Turner emphasises the importance of bodies to our lives stating, 'human beings are embodied, just as they are enselved', and adds, '(b)odies, our embodiment, are a necessary requirement of our social identification' (1984: 8). Shilling (1993: 22) notes, 'We have bodies, we act with bodies', and thus we can alter our daily experience of living by altering the management of our bodies through time and space (Shilling, 1993). We simultaneously exist in and experience our bodies. It is through our bodies that we come to know ourselves and our world.

It is important to clarify the term 'body'. In a dualist approach, the body is viewed as separate from the mind, consciousness and imagination. Young (1990: 14) states that in such an approach the body is a person's physical aspect, the biological, the material complex, chemical and mechanical processes, the subject of medical and physiological science. This is the body that has interested nursing science, with maternity nursing and midwifery being no exception. The majority of nursing and midwifery research on women's experience of pregnancy, birth, the postpartum and breastfeeding, views the body as an object, a biological and fixed entity that requires observation, examination, monitoring and management. Indeed in the case of pregnancy this bio-medical discourse identifies two separate bodies, requiring that the developing fetus be observed, monitored and managed in a similar way to the mother. The fetus is approached by the midwife, nurse and doctor as separate from the mother.

In a dualistic approach the body is a fixed entity with clear boundaries. Young (1990: 14) adds, 'as such the body is meaningless and deterministic'. As noted in Chapter One, the humanities and social sciences, particularly psychology, have approached the body in a similar mechanistic fashion. These disciplines have examined emotions, attitudes and experiences as objects or extensions of the 'natural' body, a process described by Holloway (1989: 89) as 'naturalising the mind'. As evident in Chapters Two and Three, this approach has dominated research related to the transition to motherhood and the practice of breastfeeding. Turner (1984) and Shilling (1993) have also noted a similar disinterest in the body in much sociological work where the body has either been ignored or treated as a biological organism, at best emphasising the body's needs, desires and instincts, yet perpetuating the mind/body dichotomy.

Sociological theorists of the body such as Turner (1984), some anthropologists and more recent feminist work from authors such as Grosz (1994) and Young (1990), employ a different understanding of bodies. The work of anthropologist Mary Douglas (1966, 1970) promotes the body as a receptor of social meaning and a symbol of society. Douglas (1970) believes the body is a metaphor of society as a whole. In this work, the social body is seen as constraining how the physical body is perceived and experienced. Similarly, the work of Goffman (1968, 1969, 1974) on stigma, face work, embarrassment and social self, has played an important role in alerting sociologists to the body's role in the construction of a social actor. In Goffman's work, the body is the

site of enormous symbolic work and production as well as regulation and control through asceticism, training or denial (Turner, 1990). Feminist philosopher Young (1990: 14) emphasises, however, that while embodiment is 'laden with culture and significance, the meanings embodied in habit, feelings and perceptual orientation is usually non-discursive'.

Grosz (1994: 8) concludes that the natural and social sciences as well as traditional philosophical approaches '... share a common refusal to acknowledge the distinctive complexities of organic bodies, the fact that bodies construct and in turn are constructed by an interior, a psychical and a signifying view point, a consciousness or perspective'. In her understanding, bodies are active and viable in the construction of subjectivity. Grosz is not suggesting that we examine subjectivity as a unified cohesion of mind and body. Rather, she calls for subjectivity to be explored through the primacy of corporeality, placing the body at the centre, rather than the periphery of analyses (Grosz, 1994).

In this chapter I detail a number of theoretical perspectives and concepts that inform the analysis and provide a new approach to understanding motherhood and breastfeeding in the 1990s. Rather than drawing upon one grand hypothesis to theorise maternal subjectivity and the maternal body, I utilise or 'merge' concepts from a variety of disciplines such as phenomenology, neurophysiology and post-structural approaches from sociology, philosophy and feminism.

Rubin provides an important starting point from which to examine the maternal body. Her use of Schilder's work on body image and boundaries reflects what Grosz (1994) describes as studying the body from the 'inside out'. Schilder's work and Rubin's application of it, particularly in relation to pregnancy, is discussed in the first section of this chapter. While Schilder's work is rarely commented upon in sociological approaches to the body, it warrants discussion here as it has formed the basis for Rubin's interpretation of the body in childbearing. In addition, I draw upon some of the important phenomenological concepts developed by Merleau-Ponty and used by feminists such as Grosz (1994) and Young (1990). Merleau-Ponty's philosophical perspectives of the lived and active body provide an understanding of the 'embodied' nature of the self and attempt to link mind and body in a non-dualistic manner.

Second this chapter presents a range of theoretical concepts within contemporary post-structuralism that will assist in the analysis of an embodied maternal subjectivity. Here the body is not something biological or natural rather it is constructed or made (Lupton, 1994b). I outline important concepts such as power-knowledge and the body, technologies of discipline and practices of the self from the work of Foucault. Critique of Foucault's work leads me to more recent poststructural concepts from sociologists such as Turner, Shilling, Freund, Hochschild, and Lupton, exploring the concern that we have with the management of our own bodies and control of our emotions in contemporary society. Here I have also found Elias' work on the 'civilizing process' to be useful. Finally I draw upon certain feminist developments in understanding embodied subjectivity.

The particular approach to the body taken in this thesis attempts to redress the dualisms of individual-society and mind-body described in Chapter One. Shilling (1993) draws attention to both the individual-society split and the mind-body dualisms that exist in many understandings of the body and subjectivity. Firstly, he stresses that it is important to recognise that the body is not simply constrained by or invested with social relations but also actually forms a basis for and contributes towards these relations (Shilling, 1993: 13). Secondly, Shilling (1993: 13) wants to redress the mind-body dualism and calls for '... a view of the mind and body as inextricably linked as a result of the mind's location within the body'. Turner (1992: 17) argues that the body is 'simultaneously, conjointly and concurrently socially constructed and organically founded'. In supporting these contentions, Lupton (1995: 5) similarly favours 'a dialectical approach to the body, which recognises the location of bodies in nature but also the ways in which discourses act to shape bodies, and experiences of bodies, in certain ways over which individuals have only a degree of control'. She adds, 'There is therefore a symbiotic relationship between body and society which defies determinism of either a biological or social constructionist nature' (Lupton, 1995: 5). Shilling (1993: 22) illustrates the advantages of the merging of perspectives arguing that:

> the fundamental reason for the importance of the body is based on the assumption that... the capacities, senses and perceptions, experiences and management (of the body) are not only central to human agency and its constraints but also to the formation and maintenance of social systems.

This study takes a dialectical approach to theorising motherhood and the experience of breastfeeding, examining the relationship between discourse and lived experience.

4.2 BODY IMAGE AND BODY BOUNDARIES - THE WORK OF PAUL SCHILDER FROM A NURSING PERSPECTIVE

Rubin's theorising of the pregnancy and postpartum experience was informed by a definition of the 'self' that comprises three integrated 'selves'. This section describes in detail 'body image', the third sphere of the self. In this work Rubin draws upon Schilder's (1970) conception of body image which in turn has been influenced by Freud's work, particularly his work on narcissism and libidinal drives. For Schilder (1970), body image delineates and orientates the self as an entity in a world of people and events. Body image is conscious, unconscious, cognitive and emotional in nature and, according to Schilder (1970), constitutes the schema of the body. An individual's body schema develops through the contact and actions that a subject has with his/her environment or world and constantly changes, being constructed and reconstructed with movement, sensation and perception. Schilder (1970: 11) describes body image in the following way:

> The image of the human body means the picture of our own body which we form in our mind... the way in which the body appears to ourselves. There are sensations which are given to us. We see parts of the body-surface. We have tactile, thermal and pain impressions. There are sensations which come from muscles and their sheaths... and sensations coming from viscera. Beyond this there is the immediate experience that there is a unity of the body. This unity is perceived, yet it is more than a perception. We call it a schema of our body... a postural model of the body. The body schema is the tri-dimensional image everybody has about himself... we are not dealing with mere sensation or imagination. There is a self-appearance of the body... although it comes through the senses it is not a mere perception. There are mental pictures and representations involved in it.

Importantly in Schilder's work, while body image is seen as a characteristic of anatomy or an organic body with sensations, perceptions and movement, it is also psychically and libidinally invested. The body has meaning. Individuals have a commitment or investment in their own bodies, their body boundaries and inner contents, we have a love (or a hate) of our own bodies. Body image is linked to the social world by the

emotions (Richardson, 1990). Schilder's understandings are based on Freud's notion of narcissism, particularly primary narcissism in the developing infant.

Rubin (1984) takes Schilder's understanding of body image as pivotal to the structure and function of the self-image. Rubin (1984: 70) describes images of the body as the 'cognitive constructions or impressions that originate out of bodily sensations, out of sensory stimulation in all sensory modalities and out of the mirrored reflection of the self in the attitudes and responses of other persons'. Interestingly, Grosz (1994) also draws upon the work of Schilder in her recent theoretical development of a corporeal feminism. For Grosz (1994: 67) it is Schilder's notion of body image as comprising 'social and interpersonal attachments and investments as well as libidinal energy' that is particularly interesting for a feminist rethinking of the body. Grosz (1994) emphasises that Schilder's work suggests first, that the body schema becomes a model or anticipated plan for future action based upon current knowledge of the position of one's body in the world. Second, body image:

> comprises emotional and libidinal attitudes to the body, its parts and its capacity for certain kinds of performance and finally it is a social relation in which the subject's experience of its own body is connected to and mediated by others' relations to their own bodies and to the subject's body. (Grosz, 1994: 68)

Bodied experience is thus enmeshed with the emotional responses occurring in interactions with other persons. Schilder's insights on body image and Rubin's application of his work are relevant to an understanding of subjectivity as constructed within embodied experience and through interaction with others.

The Body Schema

Body sensations, postural tonus, mass and movement provide the information for body imagery (Schilder, 1970). In the state of good health we are unaware of such perceptions, sensations and movements. They are subliminal. Any change in the information we receive, for example hunger, fatigue, itching, fetal movement or the 'let down' reflex in the production of breast milk, bring an awareness of that sensation.

An awareness of self in space comes through the long axis of the body. Recognition of up/down, right/left and anterior/posterior involves firstly a location and orientation on

the body and this location is then projected outwards into physical space (Schilder, 1970). This two-step process of introjection and projection goes unnoticed - it is instantaneous (Schilder, 1970). For the developing child, this location and projection of the body in space is often incorrectly judged. Similarly an adult having to locate themselves in a new space situation requires an awareness of the location and orientation of the body. This may occur, for example, when learning to drive or when a pregnant woman near term, must move herself through a narrow space.

During pregnancy, particularly in the later stages, a woman becomes increasingly distressed by the changes to her postural model or body schema. The woman becomes aware of each movement or readjustment of position. Known images do not meet with current experience as she tries to move from sitting to standing, getting in or out of bed or walking up stairs. She must reassess the need for skeletal support and energy expenditure.

A healthy adult has a much greater ability to 'try on' through body imagery a particular action or event. Rubin (1984) notes that the same capacity to project one's body image in action, in physical space, operates in relation to the anticipation or prediction of events and situations. This makes it possible to 'try on' conditions of another person in imagery with projections of body tonus and effect, resulting in empathy for that person. Rubin (1984) and Mercer (1995) believe this is an important component of the maternal person, who can act in empathy with her child.

The Interior Body

Schilder was also concerned to describe the way an individual perceived the body's inner contents. Schilder (1970) believes the inner contents were understood as an undifferentiated mass, amorphous and indistinguishable. The torso contains vital organs that are indistinguishable in their size, shape, location and relation from one another. Awareness of the inner organs often only comes in dysfunction (Schilder, 1970). Rubin (1984: 21) comments that the 'substantive body-self is defined in functional terms. Adequacy, competence and excellence in body function are the essential measure of self-worth and self esteem'. Rubin (1984: 21) adds, 'In this there is no dichotomization of mind and body... wholeness is dependent on the synchronised function of many parts'. Loss of an inner body function is experienced as a disintegration of the body-self

in a similar way to loss of the more visible body parts. In the first trimester of pregnancy, Rubin (1984) stresses that a woman is only aware of 'the pregnancy' and the changes to the body-self. Amenorrhoea, extreme fatigue, nausea and more frequent urination are generally unpleasant or unwanted experiences. For most women, if there were not the desirable end of a child, few could tolerate such bodily changes and deprivations.

Body Boundaries

A particularly important part of Schilder's conception of body image relates to the notion of body boundaries. The body boundary is a vital phenomenological image of the body self (Rubin, 1984). There is a boundary defining self, containing and demarcating self as an entity separate from the surroundings (Schilder, 1970). Drawing on this work, Rubin (1984) suggests that the boundaries of the healthy adult are contained and intact. The dramatic changes to body boundaries during pregnancy highlights the vulnerability of the pregnant woman (Rubin, 1975). As she grows in size, her abdominal wall becomes thinner, creating a protective response. Rubin (1984) describes a sense of fragility of the body and self in the third trimester of pregnancy.

While the healthy adult strives to maintain body boundaries, Rubin (1984) acknowledges that in pain or illness body boundaries may become diffuse. The image that a person holds of their body becomes disrupted, uncontained and the individual will work towards achieving or maintaining their known body boundaries. The pain from a throbbing headache radiates through the head, down the jaw or the neck. The person suffering pain will attempt to localise it, applying pressure with their hand to support or reintegrate and contain the body boundary. This response to the pain of labour has been well described and women are encouraged to use supportive positions that contain the pain sensations. When the body boundary remains diffuse, there is a loss of self-control (Rubin, 1984). Rubin (1984: 20) assumes here a recognition 'that one is not one's self at the time'.

While the integeumentary system, skin, nails and hair are considered the 'container' or entry point to the body, Schilder (1970) believes that the most important parts of the body are the openings. These provide very specific sensations. However, Schilder (1970: 88) locates the 'most sensitive zones of the body' as near the openings, one to

two centimetres deeper into the body. We are all familiar with the desire to move away from objects that have the potential to intrude upon our body boundary. There is an automatic, reflexive response to threatened unwanted intrusion. A woman undergoing a vaginal examination will tense her buttock muscles and move away from the speculum or the examining hand (Rubin, 1984). Importantly Rubin (1984) points out that the newborn baby has no concept of body boundaries and does not respond to penetration of the skin, such as having a injection, until a few seconds after the skin has been broken.

We are also very familiar with the zones of sensitivity or comfort that surround the outer body, frequently referred to as body space. Intrusions into this are a violation of the body as much as actual penetration of the body itself (Grosz, 1994). The size of this outside zone varies individually, sexually and culturally. Even for the same body there are areas that have a larger or a smaller zone of sensitivity. Certain body areas, such as the openings of the body, are what Grosz (1994: 80) describes as more 'privatised' and consequently have a much larger or 'thicker' boundary or space.

The understanding that healthy adults establish rigid and contained boundaries is often assumed in the nursing literature on health and illness. However, Schilder (1970) and Grosz's (1994) interpretation of his work, relate the 'fluid' and dynamic nature of body boundaries in all subjects. Grosz (1994) describes Schilder's work on body boundaries as the 'social extensions of the body'. For Schilder (1970), body boundaries are not specified or characterised by anatomical borders. Rather they are extremely malleable and have the potential to be psychically or libidinally invested. Grosz states:

> The body image is as much a function of the subject's psychology and socio-historical context as of anatomy. The limits or borders of the body image are not fixed by nature or confined to the anatomical 'container', the skin. The body image is extremely fluid and dynamic, its borders, edges and contours are osmotic, they have the remarkable power of incorporating and expelling outside and inside in an ongoing interchange. (1984: 79)

This dynamic and shifting nature of body boundary is something that Rubin attempts to capture in her work on pregnancy and the postpartum. For example, Rubin (1984) describes the way in which a woman may incorporate the baby into her body image so that the fetus is perceived as part of her own body. For a number of weeks after the birth

a woman may continue to feel as though she is pregnant or indeed may miss the sensations of pregnancy. These understandings are particularly useful for this analysis and are discussed further in the final section of this chapter together with some current theorising of the maternal body in the work of Kristeva (1982, 1986), Grosz (1994) and Douglas (1966, 1970).

In articulating the fluid nature of body boundaries and the body image, Schilder (1970) believes that the body is capable of incorporating a variety of objects into the body image. Items of clothing, jewellery, tools used on a regular basis such as the carpenter's hammer, the typist's keyboard, the musician's instrument, as well as undertaking skills such as driving a car or using machinery, become incorporated into the body image - they are psychically invested. Most mothers will be familiar with their 'unconscious' tendency to rock a pram even though their baby may not be in the pram.

Of further interest to this study is the significance Schilder places on what Grosz (1994: 81) calls 'detachable' parts of the body. Fluids - sticky substances such as urine, faeces, saliva, menstrual blood - all contain something of the body in them. They are not separate and distinct as inorganic objects and thus, when lost to the body, still retain some meaning. Schilder states:

> ... objects which were once connected with the body, always something of the quality of the body image in them. I have specifically pointed out the fact that whatever originates in or emanates out of our body will still remain a part of the body image. The voice, the breath, the odour, faeces, menstrual blood, urine are still parts of the body even when separated in space from the body. (1970: 213)

Schilder's work on body image is clearly important in working to resolve the mind-body dualisms that pervade medicine and nursing. His work has been appraised by Grosz (1994) as unifying the postural, visual, tactile and kinesthetic sensations in such a way that the subject experiences these sensations in a coherent single space as their individual identity. There is a potent sense of the unity of individuals in such notions of body imagery. While body image and boundaries are malleable, there remains a sense of containment and maintaining unity of mind and body. For Schilder, however, this unity is only possible when the individual reaches full genital sexuality. This notion, however, is based on the assumption of male sexuality as the norm (Grosz, 1994).

Despite this claim to unity of the individual in Schilder's work and in Rubin's application of his work, one is left with little understanding of the individual having a social core. Through Rubin's notion of the ideal self, various aspects of culture and society are selected for incorporation into sense of self with the subsequent development of desirable images. However, there is no room for understanding of power and how power can shape the experience of the individual.

Rubin attempts to integrate the self as a conscious, unconscious and bodied self with ideals and desires. This goes some way to redressing the very common mind and body dualism that occurs in nursing research but it perpetuates the individual-society dualism. The individual self is paramount in constructing one's identity as a mother. However, her use of Schilder's theory of body image presents a neutral or indeed a masculine body (Grosz, 1994). There is considerable feminist philosophical work that represents female body boundaries as very different from male body boundaries (Chodorow, 1978; Gilligan, 1982; Grosz, 1994; Kristeva, 1982, 1986) and this is considered in the final section of this chapter.

4.3 THE SENSING AND PRECEIVING BODY: A PHENOMENOLOGICAL PERSPECTIVE

Prominent contemporary philosophers such as Sartre and Merleau-Ponty have attempted to transcend dualist thought, maintaining the argument that the body is never simply a physical object but always an embodiment of consciousness. Their writings acknowledge the place of the body in interactions with others as well as within the individual (Lawler, 1991). Although there has been constant debate within the work of many phenomenological thinkers as to whether individual theoretical formulations address the persistent dualism of mind and body, much of this writing has helped to provide a sense of the body's place in philosophical and sociological thought and an understanding of what it is to be embodied.

Sartre (1960), in his writings on the existential self, promotes the body as our contact with the world. He speaks of two aspects of the body. First, the body as 'being for itself', where a person's lived experience of the world is always understood from the point of view of their body. The body for itself cannot be an object, rather as Lawler

(1991: 57) relates in drawing upon Harre's work, 'It provides a personal sense of embodiment'. One's position in the world is indicated by objects around it - it is relational. Second, Sartre outlines the 'body for others', where a person perceives the body of another as an object. In understanding this, Sartre (1960) explains that I as subject then recognise my body as an object for others. The 'body for others' makes interpersonal interaction possible. Sartre tends to privilege the conscious self in articulating personhood, however, Lawler (1991: 57) states, '(for) Sartre, personhood and embodiment require each other'.

Merleau-Ponty also attempts to oppose dualism by locating consciousness in the body. Merleau-Ponty, in a similar way to Sartre, stresses that the body is not an object, rather it provides the condition and context through which one is able to have a relation to objects. It is a phenomena experienced by the person, and through the body's relation to space and time. It is also the vantage point which positions a person in the world and in relation to other objects and other bodies. Moving away from the primacy of consciousness, Merleau-Ponty understands our experience of the world to be mediated through our bodies. He states, 'The perceiving mind is an incarnate body...' (1963: 3), thus consciousness is embodied consciousness. For Merleau-Ponty (1962: 82), the body is 'the vehicle of being in the world...' and is 'sense-bestowing' and 'form-giving' (Grosz, 1994: 87). This understanding of the body is expressed in some of Merleau-Ponty's work by the well-used phrase 'the lived body'. Individuals hold a sense of ownership over their bodies and our bodies are unique to us. The way we walk, talk and use body actions are characteristics of our personal bodies that we do not share with others. Thus to be a body links us to a particular world in specific ways (Merleau-Ponty, 1962). Importantly, in contrast to the biological or materialist body, the 'lived body' in Merleau-Ponty's work has culture and meaning inscribed in its habits, movements, perceptions and presentation.

Drawing upon some of Schilder's work, Merleau-Ponty uses the term corporeal schema or body image to describe the body's ability to develop a practical relation to objects in the world and a psychic attachment to our body and body parts (Grosz, 1994). We do not perceive our body as an object as it is through our bodies that we are able to perceive and interact with other objects. Having such a perspective of our own bodies means that we are not able to perceive our bodies in their entirety, 'I do not observe it

itself' (Merleau-Ponty, 1962: 107). The body schema is also 'the field in which the subject's cohesion and identity as a subject take place' (Grosz, 1994: 95). Merleau-Ponty affirms Schilder's notion of the plasticity of body, the potential extensions of the body through driving a car, playing a piano and so on and also the crucial nature of the body image in establishing the lived space and time of the subject (Grosz, 1993: 91). For Merleau-Ponty (1962), it is through body sensations and body image that the body is aware of itself.

Merleau-Ponty draws our attention to individual bodies as known and experienced bodies. Even though the body and body image are characterised by great flexibility or plasticity, disruptions to the known 'habitual' body through disease, illness or developmental changes are disconcerting and distressing. Numerous nursing researchers have explored the difficulties or disruptions to the known body in disease and illness (see the volume edited by Lawler, 1997) and also in the changing body through puberty, pregnancy, childbirth, lactation and menopause. In experiencing these 'normal' life changes Boughton (1997: 166) states, '(T)he body can feel strange and unfamiliar, even distant'.

What Grosz (1994) sees as particularly useful in the work of Merleau-Ponty is his emphasis upon 'lived' experience and perception. Most importantly Grosz (1994) believes that Merleau-Ponty does not take experience as a given, authentic category or source of truth as occurs in some phenomenological writings, particularly from feminists. Rather, Merleau-Ponty insists that experience is not outside social, political, historical and social forces. In renouncing binary oppositions of mind and body, biology and psychology, Grosz (1994: 95) adds, 'Merleau-Ponty locates experience midway between mind and body... link(ing) experience to the privileged locus of consciousness... (and)... demonstrat(ing) that experience is always necessarily embodied, corporeally constituted, located in and as the subject's incarnation'. Thus for Merleau-Ponty, consciousness has its basis in perception. As Young (1990: 14) describes, 'The 'lived' body's feeling and moving amongst things, with an active purpose or orientation'.

Young (1990), in her relevant and extremely useful analyses of 'pregnancy and embodiment' and 'the breasted experience', employs an understanding of the body that

draws upon the phenomenology of Merleau-Ponty. Merleau-Ponty's writing on perception and the senses introduces an important 'non-discursive' dimension to understanding embodied experience. Young (1990: 14) believes that although Merleau-Ponty described the lived body as a cultural phenomena, 'the lived body, the tactile, weighted, mobile, painful and pleasurable experiences as embodied is not constructed purely through discourse but through the habits, feeling and perception, it is non-discursive'. While finding the work of Merleau-Ponty to be useful, Young (1990), however, also critiques this work for its insistence upon the unity of the individual. In her examination of pregnancy as an embodied experience, Young (1990) stresses that pregnancy profoundly challenges our notions of the unified, embodied self.

Turner (1984: 54) also argues that the understanding of embodiment outlined in the phenomenological work of Sartre and Merleau-Ponty provides only an individualistic account of embodiment from the point of view of the subject and is thus largely devoid of historical, political and sociological content. The persistent focus on 'my body' and the body of the other in phenomenology does not allow for an understanding of the body as socially and culturally formed and located (Turner, 1984).

4.4 POSTSTRUCTURALIST PERSPECTIVES

Michel Foucault and the Body

Foucault's understanding of subjectivity as socially constituted was introduced in Chapter One. Foucault rejects the privileged status of the mind in dualist understanding of personhood. Instead he approaches the body as the 'focus and concern of modern discourse' (Turner, 1984: 49). In reversing the centrality of the thinking subject, Foucault exposes the way in which the body and its changes are repositioned through changing discourse. Foucault's theorising is essentially a 'history of bodies' where he has been concerned with outlining the 'relations that exist between the body and the effects of power upon it' (1980: 58). Foucault uses the term 'biopower' to describe the way 'power relations work in and through the body' (Lupton, 1995: 6). Biopower acts on two dimensions. First, constituting the individual body, particularly through individual interactions with health workers (Lupton, 1995). Second, biopower acts as a disciplinary power that regulates the population, for example through the control of

fertility, management of health and illness and corporeal habits and customs, particularly the control of sexuality (Lupton, 1995; Shilling, 1993). It is this understanding of the body that Foucault believes should be the focus of history. Foucault's work insists upon historical specificity and places emphasis on the body as a surface and the scene of cultural inscription. Foucault (1984: 83) states, '(T)he body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of a substantial unity) and a volume in perpetual disintegration'.

Foucault's studies examine a particular historical period where emerging notions of modernity promoted a change in discourse, a change in thinking about the nature of the body and mind (Shilling, 1993). Prior to the Enlightenment there had been a much greater concern with 'fleshy bodies', with death and control of the individual through brute force. Within modern discourses, the attention moved to control of the mind or as Shilling (1993: 76) describes it, 'the mindful body' and the control of entire populations. Foucault believes that through various processes of objectification human beings were transformed into subjects (Rabinow, 1986). Modernity brought firstly a new status to individuals as the creators of 'scientific' knowledge, the holders of truth and secondly, new techniques of discipline, notably monitoring and surveillance techniques that categorised and separated individuals/bodies from each other and also from within themselves (Rabinow, 1986). Through 'dividing practices', governments became concerned to control and manage entire populations rather than individual bodies. Finally in the third stage of his work, Foucault emphasises the process by which human beings turn themselves into subjects (practices of the self) (Foucault, 1986, 1988). In this third mode, Foucault describes the processes of self-formation in which the person is active, rather than the constituted, passive position of the first two modes (Rabinow, 1986).

Foucault draws upon many examples to explore the way in which this change occurred. His early works, for example *'Madness and Civilization'* and *'Birth of the Clinic'*, centred upon systems of institutions, knowledge and practices surrounding those institutions, where he challenged the universal themes of what passes for the history of ideas. In *'Madness and Civilization'*, Foucault (1967) notes the significance of the isolation and observation of whole categories of people. Here the first glimmerings of

our modern medical, psychiatric and human sciences are to be seen, playing an even more crucial role later in the classification and control of human beings. In *'Birth of the Clinic'*, Foucault (1975) again dismantles this popular notion of truth and knowledge by defining the economic, political, legal and ideological conditions out of which the clinic and medical knowledge were born. This study is concerned with the changes in 'medical gaze', the way in which doctors could see and speak. Lupton (1994b) observes that the introduction of specific technologies such as physical examinations, postmortems and stethoscopes as well as medical specialisation and the creation of institutions like the hospital and doctor's surgery, all increased the power to observe, monitor and control the body.

Regulation, Surveillance and Monitoring

In developing his thesis of the body, Foucault shows us how our culture attempts to normalise individuals through increasingly rationalised means, 'turning them into meaningful subjects and docile objects' (Dreyfus & Rabinow, 1983: xxvii). In *'Discipline and Punish'*, Foucault (1977) advances that the body has been approached as an object to be analysed and separated into its constituent parts. Through what Foucault calls disciplinary technology, found in the daily practices of institutions, he describes how the body as a target of power has been manipulated, shaped, and trained, forging a 'docile body' (Foucault, 1977: 136). Whether in school, factory or hospital, many people become caught within the regulations, timetabling and examinations by which discipline is imposed (Foucault, 1977). The feeding, training, supervision and education of children in any given historical period and culture are examples of techniques of discipline and power over the body.

With his analysis of the prison system, Foucault (1977) illustrates the move from brutal control over the 'fleshy' body to control over the mindful body. In prison one of the main disciplinary techniques employed was surveillance. The development of panopticon, a circular building, allowed viewing of prisoners' cells from all areas in the prison. Prisoners could never be certain where or when they were being watched. Thus those who were jailed had to monitor and regulate their own behaviour according to the rules of the prison. This form of self-governing in prisons paralleled the form of control expected of individuals within society. Thus, for Foucault (1977), discipline takes effect at the point where power reaches into the very grain of individuals. Discipline 'touches

their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives' (Martin, 1988: 6). Surveillance and examination techniques work upon bodies, exerting a form of control through normalising bodily dispositions, habits and movement. Taking the hospital as another example, the main principles employed in the 'training of the body' become clear. Focusing on control of movement and of the timing and space of activities, patients are separated and distributed according to their diseased part (Foucault, 1977). The medical examination in the hospital provides the key to disciplinary technology - 'the art of surveillance, constant visibility' (Dreyfus & Rabinow, 1983: 159). Lawler (1991: 62) notes that in contemporary hospitals, the layout and organisation of wards such as Intensive Care Units allows for constant observation or 'surveillance' of patients.

What is also important here is Foucault's recognition of the way social spaces were controlled and the manner in which the surveillance of individuals and their practices tended to be undertaken by governments to ensure that individuals were separated out and made different (what Foucault called 'dividing practices'). This practice categorises people into sane and mad, the law-abiding and criminal, the healthy and the sick, the good mother and the bad mother (identifying, for example, those who do not breastfeed or immunize their children). Foucault (1979) uses the term 'governmentality' to describe these complex strategies and techniques through which varying authorities - military, political, theological, medicine and so on - act upon the lives and conduct of all individuals in a state to attain desirable levels of happiness, wealth and peace. Lupton (1995: 10) states, 'Governmentality depends upon systems of knowledge and truth, both to constitute and define the objects of its activities...' Experts and their related knowledge are central to governmentality (Lupton, 1995). Foucault (1979) emphasises, however, that the state or authorities must not be seen as a repressive power. Rather, power is diffuse and operates at all levels of society. These disciplinary techniques work to govern the masses, but they do so in a highly individualising way. Not only are people separated from others but also within themselves. Burkitt (1991) notes that individuals are encouraged to separate or compartmentalise aspects of their own selves or bodies. For Foucault, it is through these modes of objectification that individuals are produced and governed.

This preceding discussion illustrates the central place of the body in Foucault's work. As Lupton (1994: 23) comments, 'For Foucault and his followers, the body is the ultimate site of ideological and political control, surveillance and regulation'. In her examination of discourses and practices surrounding public health, Lupton (1994b, 1995) refers to the way in which health professionals and welfare authorities monitor and regulate the practices of mothering. Historical analyses have also examined the introduction in the early 20th century of regular monitoring of the growth of babies and the routine visits by maternal and child health nurses or welfare agencies to monitor progress and the social environment (Donzelot, 1979; Reiger, 1985). The scrutiny of mothers continues today and this has been examined using a Foucauldian approach (Bloor & McIntosh, 1990; Phoenix & Woollett, 1991; Urwin, 1985). Urwin (1985) found that although many women in her study were cynical of health professionals, they nevertheless embraced the importance of routine screenings and tests for their child both during pregnancy and after birth. These tests, described by Urwin (1985: 170) as 'normalising apparatuses', help define what constitutes 'normal development' and mothers are central in producing this norm. Carter (1995) also describes a similar pattern of surveillance and monitoring of breastfeeding over a 50-year period from late 1920s to 1980. It has recently been suggested by Barclay (1997) that the monitoring and surveillance of breastfeeding is currently reaching a peak in Australia, with increasing numbers of a relatively new brand of health professionals, the lactation consultant.

Power and Resistance

Power is a central concept in Foucault's work. Yet power is not a repressive force. Foucault (1980: 100) states, 'We must not imagine a world of discourse divided between accepted discourse and excluded discourse or between the dominant discourse and the dominated one'. He sees a multiplicity of force relations. These 'force relations' are relations of power which take specific forms in particular societies, influenced by class, race, gender, religion and age. Power is 'a material force that does and makes things' (Grosz, 1988: 64). Power invests the body and creates the capacities and dispositions of individuals. Foucault (1980b: 98) notes, 'It is one of the effects of power that certain bodies, certain gestures, certain discourses, certain desires come to be identified and constituted as individuals'. For Foucault (1980a: 93), power is everywhere not because it embraces everything but because it comes from everywhere. And importantly power comes from below. Power is a positive phenomenon not a

negative one. Knowledge is a major instrument and technique of power. Foucault relates a power-knowledge-pleasure spiral, as power produces a subject's desires and pleasures to create knowledge and truths, which in turn produce ever increasing, more efficient forms of surveillance and control of bodies (Grosz, 1994).

Foucault believes that if power was only repressive it would not survive, nobody would accept it. Thus, while a discourse may offer a preferred form of subjectivity, it also offers the possibility of reversal. A reversal of discourse enables the subject of a discourse to speak out in their own right, to position themselves in ulterior ways. 'Where there is power there is always resistance, one is always inside power, there is no escaping it.' (Foucault, 1980: 94) In *'The History of Sexuality'*, Foucault develops his understanding of resistance (1980a). With the emphasis placed on sexual practices by 19th century psychiatry, jurisprudence and literature, Foucault describes how a whole series of discourses around sexuality opened up and homosexuality began to speak on its own behalf (Foucault, 1980a: 101). Thus the production of homosexuality is seen as a subject position open to everyone rather than merely a mode of behaviour.

In summary, for Foucault, bodies are highly malleable phenomena immersed in relations of power. Grosz (1994: 146) describes the body in Foucault's work as a 'black box' that is 'acted upon, peered into, information is extracted from it, and disciplinary regimes are impose upon it, yet its materiality also entails a resilience and thus also (potential) modes of resistance to power's capillary elements'. The body is perhaps well described as the medium on which power operates, bodies are the 'object, target and instrument of power' (Grosz, 1994: 146).

There have been many critiques of Foucault's notion of power and the body. Foucault's work has been criticised for its overemphasis upon the constituting effects of discourse. Discourse is continually presented as the dominant, organising principle of the social domain. As Turner (1984) notes, Foucault created the view of humans as language receivers but not as language producers. Foucault demonstrates how individuals become the subjects of discourse but cannot demonstrate how groups of individuals create certain discourses or bodies of knowledge. Despite Foucault's emphasis upon the productive nature of power, the majority of his analyses depict power as forceful, centralised and monolithic (McNay, 1992). The totalising effect of power upon the

body results in a reduction of social agents to passive, 'docile' bodies and does not provide any openings for how individuals may act in an autonomous way (McNay, 1992). Power is only understood in a repressive or disabling way.

Shilling (1993) highlights that in Foucault's work, the body is somehow 'always there', already positioned in discourse. This view, according to Shilling (1993), leaves no room for diversity or difference in human embodiment. He adds that in Foucault's work the body as a physical and biological entity disappears. In Foucault's work one can never quite see the body, '(t)he body is present as a topic of discussion but is absent as a focus of investigation' (Shilling, 1993: 80). It becomes extremely difficult to understand the body as a material component of social action (Shilling, 1993). Turner (1984: 245) believes that Foucault ignores the 'phenomenology of embodiment'. Personal, sensuous experiences of the ownership and occupation of a body are marginalised (Turner, 1984). Lupton (1995: 152) asks, 'What is the role of the non-discursive in the constitution of subjectivity?' It is argued the neglect of the embodied experience in Foucault's work maintains the dualistic thought around nature and the social that Foucault sought to overcome. Finally, there have been many criticisms of Foucault's failure to examine discourses which pay attention to the position of women, perpetuating the silence and exclusion of women (Braidotti, 1991).

Practices of the Self

In response to the criticisms of Foucault's over-deterministic portrayal of power and the body, various authors (e.g. McNay, 1992; Rose, 1996) have turned to Foucault's later works, *'The Use of Pleasure'* (1986) and *'Care of the Self'* (1988), to formulate notions of the self that give credit to human agency. This final work of Foucault's identifies 'technologies of the self', that is, practices and techniques by which individuals fashion their own identities. Foucault identifies the moral codes through which individuals structure their own conduct, forming 'practices of the self', where 'the individual becomes the ethical subject of action' (Burkitt, 1991: 106). In following overt or covert moral prescriptions and expectations, the body, its processes and functions are conceived in very specific, highly regimented and regulated ways. Foucault (1986, 1988) analyses these practices of the self from the Graeco-Roman ethical tradition of 'taking care of the self' - practices which involved careful attention to the conduct of one's self in relationships with others, in marriage and in the political economy.

Through the proper conduct of oneself in pleasurable activities would come the proper management of the household, and therefore of the state (Foucault, 1986).

Practices of the self involve techniques through which individuals determine the ethical substance of the self, how one constructs oneself. In ancient traditions, such mastery of self produced a man of temperance and virtue (Foucault, 1986). In Foucault's writings the formation of the self as an ethical subject is:

> a process in which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve his moral goal. And this requires him to act upon himself, to monitor, test, improve and transform himself. There is no specific moral action that does not refer to a unified moral conduct, no moral conduct that does not call for the forming of oneself as an ethical subject, and so forming of the ethical subject without 'modes of subjectivation' and an 'ascetics' or practices of the self that support them (Foucault, 1986: 28).

The change of direction in Foucault's later work was prompted by his increasing interest in 'the interactions between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself... in the technology of the self' (Foucault, 1988: 19). One learns to be passive and to master control of the self and its desires. Thus 'technologies of the self' permit individuals to work on their own 'bodies, souls, thoughts, conduct and ways of being' with the purpose of achieving 'a certain state of happiness, purity, wisdom, perfection or immortality' (Foucault, 1988: 18). This analysis of ancient traditions, Foucault (1988) believes parallels the modern obsession with examining the inner self.

Foucault, however, is also concerned to avoid a return to the humanist subject. Foucault stresses that these practices and techniques remain discursively constructed. Thus while an individual has a certain degree of ability to construct their own subjectivity, this 'choice' always operates within the discursive field, the social context available to that individual (Foucault, 1988). Referring back to his analysis of power relations, Foucault articulates that the free subject, an agent in constructing the self, remains immersed in power relations even at the point of ordering their own lives. In doing so, however, they also attempt to influence others (McNay, 1992). Foucault employs the illustration of psychoanalysis as a modern day 'practice of the self', whereby the individual's

endeavour to greater self knowledge through disclosure of one's inner self and unconscious desires results in a greater regulation and normalisation of sexuality through a production of self-policing subjects (McNay, 1992). Foucault proposes a mutual dependence of structure and agency, stating:

> I am interested in the way in which the subject constitutes himself in an active fashion by the practices of the self. These practices are nevertheless not something that the individual invents by himself. They are patterns that he finds in his culture and which are proposed, suggested and imposed on him by his culture, his society and his social group. (1988: 11)

Practices of the self embody mechanisms by which individuals constrain themselves as opposed to being 'forcibly constrained by external agents' (Lupton, 1995: 12). Individuals belonging to a particular group thus hold shared understandings of what a 'good' person is. There are no explicitly defined rules or codes (Lupton, 1995). Contrary to previous practices of domination and control, practices of the modern day self are aimed at producing a sense of happiness, fulfillment and achievement in individuals (Lupton, 1995; Rose, 1996). For Foucault, power does not negate the vitality and capacity of individuals but rather creates, shapes and utilises human beings as subjects. 'Power, that is to say works through and not against subjectivity.' (Rose, 1996: 151)

Linked to these notions of practices of the self is the concept of governmentality (McNay, 1992). The intricate practices of self-government combine with the more apparent technologies of discipline (policing, surveillance) undertaken by authorities (Lupton, 1995: 9). Here it is the professional, the expert, who mediates between systems of authority and practices of individuals (Lupton, 1995). As discussed earlier, in a similar way to disciplinary power governmentality also targets the individual in highly individualising ways. Through the power of expert knowledge or 'truth' authorities shape the beliefs and practices of individuals. Thus governmentality appears to operate as a form of social control. Paradoxically McNay (1992: 68) states, 'Foucault also argues that it is through techniques of self-government that individuals can resist this 'government of individualisation''. Self-government thus implies both the way in which individuals police themselves and the way individuals ensure their freedom. Turner (1990) adds that the workings of the modern state do not rely solely upon the techniques of domination. Rather the present day citizen has learnt an extensive range of

techniques for self-mastery and restraint. Analyses of oppression and powerlessness become redundant in this framework. This position may be illustrated by Cosslett's (1994) examination of the dominant discourses surrounding modern childbirth: the medical model and natural childbirth model (the midwifery model). Using literary accounts Cosslett (1994) demonstrates the differing forms of subjectivity created in these two opposing accounts of birth. In the medical model of birth women are constructed as vulnerable, passive victims under the control of powerful medical patriarchy, while in the natural birth model, women are often described as powerful, active and in control. Cosslett (1994) draws upon the teaching of Sheila Kitzinger to show the way in which women can learn to have control over birth, to master this experience. And indeed many women do. Others, after 'failing' in the natural birth model, turn to embrace the medical model, heralding that technology brings them choice and control in their decisions regarding birth.

The nature of governmentality is important for feminists seeking to move away from models that explain women's position purely in terms of dominance, dependence and powerlessness. Here McNay (1992) cites the very useful example of women who work exclusively in the domestic sphere. Contrary to analyses that describe this position as isolating and dependent, many women view the caring and nurturing role as preferable to the masculine rational approach to work. Women often view their domestic situation as a place where they have autonomy, control and a flexible life style (Boulton, 1983; Doucett, 1995; Oakley, 1992).

The work of Foucault and later, Bryan Turner (1984), draws attention to the central place that the body plays in the construction of a person's sense of self or identity. Many writers comment that in recent times there has been an increasing concern with the body, its shape, its appearance, its ability, its potential and its control (Lupton, 1994b, 1995; Shilling, 1993). There is a contemporary personal concern with presentation of one's body and what this body reflects about one's self. Lupton (1994b: 31) states, 'Self control and self discipline over the body, both within and without the workplace, have become the new work ethic'. Maintaining a body that looks fit, healthy, beautiful, young and sexy reflects a well-controlled and disciplined body and demonstrates a person's capacity for control of their desires and will (Lupton, 1995).

Simultaneously with the concern for our bodies, there is a prevalent desire to know and understand one's self through participation in psychotherapy, meditation, writing of diaries, self help groups, etc. Rose (1996) highlights the present day preoccupation with our individuality, autonomy, identity, freedom to choose and personal fulfillment or achievement. He believes, '(I)t is in terms of our autonomous selves, that we understand our passions and desires, shape our lifestyles, choose our partners, marriage, even parenthood' (Rose, 1996: 1). Rose (1996: 151) adds that this way of thinking about ourselves and judging ourselves is linked to certain practices or ways of 'acting'. Guidance for the presentation of self comes no longer from religion or traditional morality but from an increasing variety of 'experts of subjectivity'. Rose (1996: 157) uses the term 'identity projects' to describe the way in which a contemporary spirit of 'enterprise culture' incites human beings to live in particular ways. Individuals live '... as if making a project of themselves, they are to work on their emotional self, their domestic and conjugal arrangements, their relations with employment and their techniques of sexual pleasure to develop a style of living that will maximize the worth of their existence to themselves' (Rose, 1996: 158). In Foucauldian terms autonomous subjectivity is embodied in techniques for understanding and improving the self in relation to what is considered true, permitted and desirable (Rose, 1996). Lupton (1995) points out, however, that this endeavour to know one's true or authentic self perpetuates the mind-body dualism that post-structuralist approaches try to dismantle. This view heightens the belief in the transcendence of mind over body. In this understanding the body is a possession in need of training and discipline.

Shilling (1993) and others draw our attention to the modern concept of the 'body as project'. Increasingly women and men in western societies are viewing the body as an entity in 'the process of becoming' (Shilling, 1993: 5). Grosz (1994: 12) states, 'The human body is conceived of being in a state of becoming rather than a fixed entity'. The body as a project represents the body as something that is unfinished (Elias, 1978; Freund, 1988), as something that needs to be worked at on a continual daily basis to achieve one's potential and one's self identity. Individuals are conscious of and actively engaged in the management and maintenance of their bodies. As Shilling (1993: 5) states, 'Self-care regimes require individuals to take on board the notion that the body is a project whose interiors and exteriors can be monitored, nurtured and maintained as fully functioning'. Shilling and others illustrate this increasing concern with the body

through notions of health, the burgeoning of plastic surgery to fashion the perfect body and the intense perseverance of body builders to achieve a particular body type. Feminist analysis such as that of Bordo (1986) highlights the contemporary desire of women to achieve a slender body. It is this concern for a particular type of female body that many argue promotes a negative self and body image amongst western women when they are pregnant (Mercer, 1995; Richardson, 1990). Pregnant women can select from any number of 'self help' manuals for techniques (exercises) to train their growing body to stay fit and attractive during pregnancy, reduce the scarring from stretch marks and prepare the body to birth 'naturally'. This concern for the perfect body and perfect breasts is also thought to influence women's decision to breastfeed (Dettwyler, 1995; Rodriguez-Garcia & Frazier, 1995).

The Emotional Body

One particularly interesting and relevant example of 'practices of the self', or our concern to manage and maintain our bodies, is the project of managing our emotions. Wouters (1989) argues that in both the public and private realm we are expected to manage and control our emotions. Few sociologists have studied the 'emotional self' and it is even harder to find an examination of emotions that considers the biophysical component of emotions and its effect on the body (Shilling, 1993). The emotions link society and the personal arena, an individual's experience, and they straddle mental and physical aspects of being. Freund (1990) suggests that the study of emotions is a useful endeavour as it can help to expose or deconstruct dualist divides of mind and body, society and individual.

Freund in his work on the sociology of health, disease and illness develops a holistic view of health, which he terms 'bodily well-being'. He is concerned with the relationship between mind and body, attempting to link a social constructionist account, a phenomenological account of subjective experience and an account of physiological processes (Freund, 1990). The body must be able to regulate and maintain physiological processes as well as having sufficient control over the close integration between mind and body - a person must be 'in touch' and posses an awareness of the mind-body relationship (Freund, 1982). For Freund, bodily wellbeing is intricately related to our social existence via 'emotional modes of being'. He argues that 'emotions are integral to our being' (1990: 453) and they arise out of our interactions with others. Feelings of

disempowerment and empowerment can impinge upon the interior of our bodies (Freund, 1990) affecting, for example, our neuro-hormonal system. According to Freund, emotional modes connect to our embodied selves to social relations in ways which shape our 'bodily well-being' (Shilling, 1993: 116). We are familiar with the numerous medical and psychological studies that demonstrate the effect of stress or anxiety on biophysical measures such as blood pressure. The studies of Lederman, et al. (1979, 1985) also provide illustrations of the emotional interplay between maternal anxiety and the progress of labour.

Hochschild's (1983) notion of 'emotion work' is also important. Emotion work refers to management of our emotions to create or present particular facial expressions and bodily demeanours. Hochschild (1983) studied the emotion work of flight attendants to examine the way in which employees must present themselves. She identified three components of emotion work; face-to-face or voice-to-voice contact with the public, the requirement that employees produce a particular emotional state in another person and the methods of training and supervision which allow an employer a degree of control over the emotional state of its employees (Hochschild, 1983). While women as mothers are not employees in this sense, they are still required to do an enormous amount of emotion work within the family and to present a socially approved emotional state (Doyal, 1990; Hochschild, 1989). Other studies have demonstrated the high levels of emotion work expected in particular occupations and the gendered nature of this work. Typically it is areas where women are employed in greater numbers that require this level of 'emotion work'. For example, the work that nurses have to undertake in controlling their emotions in response to particular aspects of bodily care (Lawler, 1991) and secretarial work has been presented as akin to many of the duties of a wife and mother (Pringle, 1989).

Hochschild (1983) and others have described the detrimental impact that such 'emotion work' may have on the body of the employee and they suggest that there are notable examples of resistance to the demands of such work. Because emotion work is embodied in nature, it cannot be completely dictated or dominated by those more powerful. For example, Hochschild (1983) cites the change in practices in the service and presentation of emotions between economy and first class passengers. This intense work on the body and the control of emotions impacted on the flight attendants.

Hochschild (1983) found evidence of sexual problems appearing in this group of workers and she understood this to be constructed within a realm of protest or resistance at the demands on their body.

The Civilised Body

A number of researchers have found Norbert Elias' work, *'The Civilizing Process'*, to be particularly useful when articulating theories of the social self (e.g. Burkitt, 1991) or theorising and studying the body (e.g. Shilling, 1993). In drawing upon the work of Elias, Shilling coined the term the 'civilized body', describing this as being:

> ... highly individualised... demarcated from its social and natural environments... it has the ability to rationalise and to exert a high degree of control over its emotions, to monitor its own actions and those of others and to internalize a finely demarcated set of rules about what constitutes appropriate behaviour in various situations. (1993: 150-151)

Shilling (1993) gives much credit to Elias' work in attempting to address humans as embodied. Shilling (1993: 150), however, notes that Elias' work does not focus upon the body but rather upon changes in bodily behaviours and what these represent in the broader historical transformation in behavioural codes and forms of emotional control. Elias' examination of the changing understandings of manners, behaviour and effect and its application by Shilling is relevant to my study of motherhood.

Elias traced the emergence of the 'civilized' body to court society in the Middle Ages. Examining written records in the period from the 13th to the 19th centuries, Elias wrote a history of manners. In the Middle Ages behaviour was unpredictable, personality structures were volatile and violence was a part of everyday life (Shilling, 1993). Behaviours such as burping or urinating in pubic were acceptable and pleasure was often taken in torture or mutilation. This 'uncivilized' or grotesque body contrasts with the 'civilized' body appearing during the Renaissance. At this time there was a rise in court society, court etiquette and individual search for distinction. In attempts to distinguish themselves from the distasteful or disreputable members of court, society gradually changed what was considered acceptable behaviour (Elias, 1978). There was a much greater concern to control emotions and manage bodily functions. The presentation of the body became important for success (Shilling, 1993). Elias (1994)

describes the civilizing process as a change of human conduct and sentiment occurring in a specific direction. Society became concerned with manners of greeting, politeness, favouring certain sleeping arrangements. The emphasis in many of these writings was on the instruction of young children in appropriate behaviours. There was a much stronger emphasis upon the control of emotions and a recasting of violent acts as less acceptable.

For Elias (1994), this study of court society demonstrates the role played by changes in feelings of shame and delicacy in the civilizing process. There was a developing opposition to what had previously been considered 'natural'. The biological function of bodies became increasingly invisible (Shilling, 1993). Lupton (1995: 8) notes, 'Body management norms became internalised, they were not imposed from outside'. This increasing 'civilizing process' has resulted in individuals' greater concern to observe or monitor the behaviour, actions and expressions of oneself and others, 'taking a more conscious account of how one's behaviour will be interpreted by others' (Shilling, 1993: 159). People became concerned with saving face. The increasing concern for presentation of the self also means a greater identification with, and observation of, an increasing number of others around us. This interest in our own and others behaviour has prompted a concern to 'plan ahead', to consider the consequences of our actions (Shilling, 1993: 160). Finally, the changes with court society produced an increasing 'bodily and psychological distance between adults and children' (Shilling, 1993: 160). Shilling (1993) notes that in contemporary western society there is a continuing concern to 'civilize' the body of the young child - children are expected at a comparatively young age to gain control of their emotions and manage their bodily functions.

What is important in Elias' work is that in theorising changes to manners and behaviour in court society, Elias has strongly emphasised the social nature of the individual. For Elias (1978), human beings can never be viewed as separate from the 'figuration' of social relations that they form between themselves. This figuration can be simultaneously held together and changed by the power balance between groups and individuals within it. In a similar way to Foucault, Elias (1978) articulates a field of possible action structured by power relations. For Elias, however, individuals are understood to be free to act in certain ways and as part of their interdependence they are restricted at other times. Living within these figurations, individuals are always linked

in interaction to others. Our actions, behaviours and personalities depend upon the processes within these configurations. In such configurations, individuals form alliances as well as develop conflict with others. For Elias (1978: 130) these figurations are characterised by a 'lattice-work of tensions... a figuration may be an interdependence of allies or opponents'. In this work, Elias linked the civilizing process to the changing balances of power in society and the transformation of personality structures (Elias, 1978).

Importantly, Shilling (1993) also believes that Elias' work moves away from notions of the 'naturalistic' or pre-existing biological body. Instead Shilling (1993: 170) states, 'Elias is concerned with humans whose embodiment is the product of the biological and social processes involved in evolutionary development'. Shilling (1993) adds that Elias' approach to the body is also different from that of social constructionists. While Elias agrees that bodies are constructed, this is facilitated by the biological characteristics of humans that are essential to history (Shilling, 1993). Shilling (1993: 150) emphasises that for Elias, 'the body is an unfinished, biological and social entity, which requires a lengthy process of education before it is accepted fully into society'.

Elias' work develops a theoretical perspective of the body that demonstrates the way in which bodies have become socialised, rationalised and increasingly individualised. Individual bodies form the boundary between self and others (Shilling, 1993). This focus on the individualisation of bodies has encouraged in people a greater reflexivity about their bodies, with a concern to maintain that boundary between self and others (Shilling, 1993). Shilling (1993) observes that we are left more alone with our bodies, increasing our efforts at monitoring and managing our bodies. Elias' notion of the civilizing process and Shilling's adaptation of the term the 'civilized body' are particularly useful in understanding the relationship contemporary Australian mothers are encouraged to pursue with their babies. From the moment the baby is born there is a prevailing concern with developing independence in the child, a 'civilizing' of the child's behaviour, and the encouragement of mothers to be separate or individual from their babies.

4.5 A FEMINIST APPROACH: CORPOREAL FLOWS AND BODILY CONNECTIONS

In this final section I introduce some theoretical concepts, particularly from the work of Grosz (1994), Kristeva (1982, 1986) and Douglas (1966, 1970), related to women's corporeal existence and the study of maternal subjectivity. These recent feminist understandings of the body are particularly important in attempting to conceptualise the personally challenging shared body experiences of pregnancy, birth and breastfeeding. The foregoing discussion has established the centrality of the body across diverse perspectives. The work of Schilder, Rubin and Merleau-Ponty emphasises the psychical or interior aspects of subjectivity. Here the body, its functions, sensations and perceptions are emotionally and libidinally invested, providing an individual with a sense of boundary and being in the world. These perspectives move towards redressing the mind-body dualism present in humanist notions of subjectivity. Alternatively, poststructural work, particularly that of Foucault, represents the body as a surface socially and culturally inscribed through powerful discourses.

In some feminist work, however, these perspectives are criticised for privileging the notion of body unity. Grosz argues that the work of Schilder and phenomenological frameworks, represent a desire to contain, to bind or to restore the 'habitual' body or the known body-self. This, Grosz (1994) and Young (1990) argue, is informed by a masculine or at best neutral approach to the body. The body in the work of Schilder, as well as Merleau-Ponty and even Foucault, presents the 'masculine' body taking itself as 'the unquestioned norm' (Grosz, 1994: 188), the baseline from which the experience of women may deviate. The healthy body is considered to be the body in a steady state, not one that is in flux or constantly changing as do the bodies of women, male and female elderly or the disabled (Young, 1990). What is evident across these frameworks is the lack of discussion of women's corporeal existence and its difference to that of men.

The female body poses many challenges to this 'masculine' norm, as it differs from the notion of the contained, bounded, separated and 'civilized' body. The work of Douglas, (1966), Kristeva (1982) and Grosz (1994) alert us to the 'horror' or discomfort felt at the female body, constructed as a leaking, permeable and absorbing body. Kristeva (1982:

4) asks, 'How can I be without borders?' For centuries, female bodily secretions or flows such as menstrual blood, and women's more 'emotional' nature, have been represented as uncontrollable and uncontained. Even Rubin, in her theorising of feminine identity as examined in Chapter Two, describes menstruation as an 'unwanted messy discharge' that provokes feelings of anger in a woman (Rubin, 1984: 33). Pregnancy is described as an indisposition where a woman manifests somatic symptoms of nausea and vomiting as a response to her ambivalence of pregnancy and of being a woman (Rubin, 1984). An increasing number of feminist studies have demonstrated the various ways in which contemporary masculine discourse, particularly medical discourses, have constructed women as unclean, uncontrolled and dangerous (Martin, 1989; Poovey, 1990; Treichler, 1990). Others have illustrated the various ways that women are incited to manage, 'civilize' and 'sanitize' their bodies (Bordo, 1990; Pateman, 1988). Pateman (1988) suggests, for example, women are not only responsible for their own bodily flows but also for men's sexual flows through use of contraceptives. Given that men also 'leak' or emit body fluids, Grosz (1994: 203) asks:

> Can it be that the in the West, in our time, the female body has been constructed not only as a lack or absence, but with more complexity, as a leaking, uncontrolled seeping liquid, as formless flow, as viscosity, entrapping, secreting, as lacking not so much or simply the phallus but self-containment - not a cracked or porous vessel, like a leaking ship but a formlessness that engulfs all form, a disorder that threatens all order?

Only recently, in the wake of AIDS, has there been a concern for men's sexual flows..In the self-regulation of one's body, there has been an increasing concern to control the leakage or seepage of body fluids or the contamination of body fluids by viruses. Kroker and Kroker (1988) describe this as 'body McCarthyism' (Lupton, 1994b).

Grosz (1994: 203) is not suggesting that this is an ontological status of women, rather women's corporeality is constructed as 'seepage'. Women have been represented by metaphors of the uncontrolled, irrational, dangerous and polluting. Women's bodies are capable of absorption. It is a body that leaks, that bleeds and is at the mercy of hormonal flows and reproductive capacities. This flow of blood occurs any time and place, not just in sleep or dreams as do the nocturnal emissions for the pubescent boy, and as such represents the uncontrolled status associated with dirt (Grosz, 1994). To date it is rare that male bodily fluids are constructed in this way. Kristeva (1982: 70)

highlights the contradictions when she asks why it is that one sees everywhere 'the importance, both social and symbolic of women and particularly the mother' yet at the same time there exists a 'ritualization of defilement accompanied with a concern to separate the sexes and give men privilege over women'.

Grosz (1994: 194) describes the fear of being absorbed into something that has no boundaries of its own, 'the viscous or fluid do not conform to rules of the clean and proper - the contained, solid or self-identified'. In the work of Douglas (1966) these indeterminate, unbounded states and uncontrolled flows are identified as dangers, as pollutants, dirt or contaminants. That which is marginal or different is always located as a source of danger and vulnerability.

For Douglas and Kristeva, dirt or filth is not a quality in itself rather it is something that is not in place or in order. It is the lack of containment that is horrifying. Kristeva writes of the disgust expressed at the recognition of the lack of boundedness of the body. It is the disruptions or distortions of known boundaries or borders that are represented as dirt. In Kristeva's theorising, this dirt or disruption to order is the 'abject' (Kristeva, 1982). Kristeva states (1982: 4), 'It is not a lack of cleanliness or health that causes abjection but what disturbs identity, system, order. What does not respect order, positions and rules'. The 'abject' transgresses borders, it is 'in between' and ambiguous. Dirt relates to a boundary and more particularly Kristeva (1982: 69) states, dirt 'represents the object jettisoned out of that boundary, its other side, a margin'.

The 'abject' represents the collapse between the inside and the outside, the loss of distinct boundaries (Kristeva, 1982). The permeability of the body and the seepage of body fluids confront the subject's aspiration for autonomy and self-identity (Grosz, 1994; Lupton & Barclay, 1997). Female subjectivity, female sexuality and maternity are represented as a threat to this order. The 'abject' designates that which has been expelled from the body, discharged as excrement, literally rendered the 'Other'. Yet the abject remains somewhat ambiguous, while rejected it is something which one does not part from completely. Here Kristeva's notion of an attachment to parts of the inner body resembles Schilder's understanding of detachable body parts. Butler (1990: 134), in drawing upon Kristeva, describes how this process of expulsion, 'of rendering what was originally part of identity as 'Other', establishes the linguistic notions of inner and

outer'. The 'abject' becomes 'not me', as it establishes boundaries of the body or contours of the subject. Butler (1990: 134) concludes that inner and outer constitute a binary distinction that stabilises and consolidates the coherent subject. When that subject is challenged, as it is in maternity, the meaning and necessity of the terms are subject to displacement (Butler, 1990). The maternal body challenges known boundaries and borders.

Kristeva associates the maternal with the 'abject' and hence it is a site for both fascination and horror (Doane, 1990). Kristeva (1986: 178) remarks, 'A mother is a continuous separation, a division of the very flesh'. In this ambiguity, the maternal body is subject to many cultural taboos and is marginalised (Doane, 1990). Doane (1990: 170) draws upon Kristeva (1980) to elaborate on the maternal experience in pregnancy:

> The maternal space is 'a place both double and foreign'. In its internalisation of heterogeneity, an otherness within the self, motherhood deconstructs certain conceptual boundaries. Kristeva delineates the maternal through the assertion, 'In a body there is grafted, unmasterable an other'. The confusion of identities threatens to collapse a signifying system based on the paternal law of differentiation. It would seem that the concept of motherhood automatically throws into question ideas concerning the self, boundaries between self and other, and hence identity.

Here it is clear that in pregnancy, subjectivity and the notion of the autonomous and contained self is challenged. As Young (1990: 163) describes, 'Pregnancy challenges the integration of bodily experience by rendering fluid the boundary between what is within myself and what is outside, separate. I experience my insides as the space of another, yet my own body'. Young (1990: 163) describes this as a 'strange externality of the inside'.

Importantly, Rubin also articulates the lack of boundary between mother and fetus during pregnancy. Drawing upon Schilder, Rubin (1984) describes the way in which a woman may incorporate the baby into her body image so that fetus is perceived as part of her own body. Viewed as an inner organ the fetus has no separable physical boundaries, differentiated only by its movement and mass (Rubin, 1984). The fetus is not thought of as having its own body boundaries with skin, nails and hair. The image of the fetus as contained in the uterus inside its own sac is lost in the changing size and

shape of the woman and the indiscernible mix of sensations (Rubin, 1984). In her theorising, Rubin emphasises the 'oneness' or unity of mother and fetus:

> The physical unity of one being within the other achieved during pregnancy through adaptation and accommodation of the mother to the constant enlarging presence of her infant is an embedded, nested and contained stage of mothering and nurturing. The concomitant incorporation of the infant into the self system (the ideal, self and body image) of the mother during pregnancy, consolidates the unity psychosocially as well as psychobiologically so that there is no difference between what is within and the self. (1977: 70)

Rubin's work, however, presents this sense of unity as an universal experience and as such she does not capture the diverse, shifting and ambiguous relationship between mother and fetus that occurs in the work of Kristeva and other feminist theorists.

Notions of the self or subjectivity are further challenged during birthing. For Kristeva, birth further disrupts our contemporary understandings of the autonomous self. The strange position of one individual dividing into two is foreign and difficult to understand - it is out of order:

> Then there is this other abyss that opens up between the body and what has been its inside, there is the abyss between the mother and the child. What connection is there between myself and even more unassumingly between my body and this internal graft and fold, which once the umbilical cord has been severed is an inaccessible other. My body... and him. No connection. Trying to think through that abyss: staggering vertigo. No identity holds up. (Kristeva, 1986: 178-179)

The bodily processes of childbirth as well as pregnancy challenge individuality. Kristeva heralds the confusion and ambiguity experienced by women in the birthing of 'another'. Cosslett (1994: 133) adds, 'It is hard to locate a consistent sense of self, mental or physical, during this process and the self often disappears altogether'. Although Rubin (1984) focuses little on the experience of birth in her theorising, she also depicts birth as a disruption or distortion of the known body. Rubin (1984) describes labour as a time when body boundaries are uncontained, diffused by the intense pain that moves through the body. Cosslett (1994) reminds us that this loss of sense of self is often accentuated by medical practices that treat women as machines, a series of bodily parts.

In pregnancy and birth the maternal body is clear in its connection through its very flesh, to that of another. Following birth the maternal body remains 'abject', something out of order, not in place, in its persistent connection to another. Here Kristeva appears to take a more psychoanalytic approach, talking more of the child's relation to the maternal body. The maternal body is powerful and controlling, becoming simultaneously a site of 'strong revulsion and strong desire' (Lupton & Barclay, 1997: 31). The maternal body is nurturing, nourishing, giving life but it is also 'threatening because of its very omnipotence and ownership of one's body' (Lupton & Barclay, 1997: 31). Kristeva (1982: 72) describes how the abject maternal body or maternal authority shapes, through frustration and prohibition, the (infant) body into 'a *territory* having areas, orifices, points and lines, surfaces and hollows... a primal mapping of the body. Maternal authority is the trustee of that mapping of the self's clean and proper body' (emphasis in original). The mother's care of the infant body constructs the borders and separations and as such poses dangers to the notion of subjectivity itself (Jacobus, 1990). The child is only able to separate from the mother by making her the 'abject', something that is reviled, terrifying and disgusting (Kaplan, 1992). Kristeva emphasises that the mother is the one against whom the child must develop subjectivity.

These thoughts on the maternal body are influenced by psychoanalytic thought that privileges the place of the mother and her relationship to the developing infant, striving for individuation. Flax (1993) notes that certain approaches to psychoanalysis have emphasised the primacy of the mother's body in the infant's fantasy life and development. The mother's body provides the first home and in many instances the first source of food. As Flax (1993: 148) describes, in infancy our mother's 'smell, feel, voice and touch pervade the senses and provide a bounded sense of space within which security and continuity become possible'.

Emphasising the fluid, uncontained characteristics of femininity, Kristeva and other feminist theorists advocate new approaches to gendered subjectivity and a reconstruction of the symbolic order (Grosz, 1994). The shifting and fluid nature of the female body suggests in any symbolic order a multiplicity of ways of being. Theorists such as Kristeva, Irigaray and Cixous privilege the place of the pre-Oedipal relationship with the mother. Employing Lacan's term '*jouissance*' to describe a 'bodily feminine

ecstasy, beyond the phallus' (Kaplan, 1992: 35), these feminist theorists highlight the central place of the non-discursive, pleasurable bodily experiences.

Kristeva has suggested, for example, that in childbirth and mothering a woman may rediscover her early attachment to her own mother, experience '*jouissance*' and value the maternal in a way that is at odds with social devaluation. By attending to their experience women as mothers might distance themselves from existing images that do not give voice to that experience, create new images of motherhood and in the process transform the symbolic order of culture. In this way motherhood can be considered creation rather than reproduction (Kristeva, 1980).

The suggestion to change the symbolic order by privileging feminine corporeal flows, to value the connectedness and relatedness characterised by the maternal, occurs in other feminist work. Cixous (1981) suggests women have an ability to attain a more fluid sense of self, particularly because of their capacity to empathise with or incorporate the other. She states, 'All women do all virtually or in fact have an experience of the inside, an experience of the capacity for other, an experience of non-negative change brought about by the other, of positive reciprocity (Cixous, 1981: 18).

Irigaray (1985) also proposes a metaphysics generated from feminine desire, where being might be thought of as fluid rather than solid. As a fluid being, one does not have defined boundaries. For Irigaray (1985), fluids merge and move, they change in contrast to objects in the Cartesian world, which are static and inert. Fluids have no definite borders, there is no distinction of inside and outside. Drawing on Irigaray, Young (1990) and Grosz (1994) argue that a metaphysics of fluids is contradictory to Cartesian dualist thought. Young (1990) suggests that a move in thinking of subjectivity or identity as being within a metaphysics of objects to viewing identity as a metaphysics of fluids is a powerful way to remove boundaries and binaries between the inside and outside of bodies, between nature and culture, subject and object. To illustrate, Young (1990) considers the importance of touch rather than sight. Through touch the boundary between subject and object becomes unclear. Unlike the 'gaze', touch cannot be from a distance. The 'toucher' cannot touch without also 'being touched' and thus the position of subject and object constantly changes (1990: 193).

Young (1990) contends this move in privileging a metaphysics of fluids may be more liberating for women. Young (1990) applied this notion to the way we consider women's breasts. She suggests that breasts, from a woman's view point, could be considered 'blurry, mushy, indefinite, multiple and without clear identity' (Young, 1990: 192). Women's 'breasted experience' has the potential to challenge the objectification of the breast through the male gaze as well as challenge the strict boundary between mother and child, particularly when the child is breastfeeding. It is this notion of breastfeeding as a dynamic and unbounded experience that I wish to explore further in women's experiences of mothering and breastfeeding.

CONCLUSION

In this chapter I have argued that the study of an embodied subjectivity could benefit from being examined within a range of theoretical perspectives. I advocated a 'merging' of frameworks to acknowledge, as Grosz (1994: 189) suggests, 'both the psychical or interior dimensions of subjectivity and the surface corporeal exposure of the subject to social inscription and training'.

The diverse theoretical perspectives presented here articulate numerous concepts important for the study of embodied subjectivity in motherhood and breastfeeding. The work of Schilder, Rubin, Merleau-Ponty and feminist applications of Merleau-Ponty's work such as that by Young (1990), highlight the importance of studying the self as embodied, where function, sensations, perceptions and movement are libidinally invested and not simply biological. In these works the notion of body boundary and the body's relationship to other bodies and objects are important in studying the relationship between mother and fetus/baby. Although Schilder and Merleau-Ponty both present body boundaries as dynamic and able to move or change, their approaches emphasise the desire of individuals to maintain known boundaries. The understanding that body boundaries are fluid in nature, constantly shifting and able to incorporate other bodies or objects is explored more convincingly in the work of feminists such as Kristeva, Grosz, Irigaray and Young.

The work of Schilder and Merleau-Ponty focuses on the body, as Grosz (1994) suggests, 'from the inside'. However, the embodied subject in this work somehow lacks a social core. Thus, I argue that the writing of various poststructural thinkers is important in understanding embodied subjectivity as socially constructed. The work of Foucault emphasises the place of power-knowledge in creating certain types of bodies. Through techniques of expert knowledge, surveillance and regulation, the body has come to govern itself. Most recent poststructuralist work has established the intense concern that contemporary western individuals have for their bodies. The body is best described as a project becoming increasingly managed and 'civilized'.

This chapter has highlighted the embodied nature of the self as pivotal to the constitution of subjectivity. I suggest that the personal, public and professional discourses governing contemporary practices of motherhood and breastfeeding need to be studied in relation to the sensed and perceived experience of motherhood and breastfeeding.

CHAPTER FIVE

PERSONAL CONSTRUCTIONS: OF MOTHERHOOD AND BREASTFEEDING

In this chapter I begin my discussion of the analysis, exploring the way in which these 25 Australian women constructed their experience of motherhood and breastfeeding. Informed by the theoretical perspectives discussed in the previous chapter, this analysis examines both the discursive meanings and embodied experiences of motherhood and breastfeeding. An enormous amount of transcribed data has been generated and subsequently analysed. In Chapters Six, Seven and Eight I use the data to illustrate the analysis and developing theoretical insights. The discussion in these chapters, however, cannot provide a complete story of the individual women who participated, and for this reason I begin the discussion with a series of three case studies presented in this chapter. The three women portrayed in these case studies have been chosen because their stories represent the diverse aspects of the personal experience of breastfeeding and motherhood. Each of these case studies represents my interpretation of the experience of an individual woman, as this evolved through interviews and transcripts of those interviews. In each case study I introduce the woman and her partner, talk briefly about the pregnancy and birth experience and discuss in detail their experience of mothering and breastfeeding.

5.1 TRISH AND BABY MITCHELL

Trish is 26 years old and married to Adrian, a 28-year-old research analyst. Trish is a neonatal nurse and has been working in a private hospital nursery. The couple recently purchased a three-bedroom home unit. Trish is an outgoing person who described herself as organised and competent. In our first interview prior to Mitchell's birth, Trish talked of always being in control of a situation and available to help and support others rather than being one to need help herself. She and her partner are 'Christians' and their church is very important in their lives. Trish said she had always wanted to be a mother for as long as she can remember and her friends used to give her presents with baby motifs as a joke. The couple had planned to have children some time, but had not

planned this pregnancy. Trish described how, without realising it, '*unconsciously*' she had not taken the pill for a week. After telling Adrian, they decided to play a bit of 'Russian roulette'. When she found that she was pregnant, Trish was '*over the moon*'.
The pregnancy Trish experienced was complicated by high blood pressure. This did not, however, disturb the connected and harmonious relationship she created with her baby during pregnancy. Trish talked of the baby in utero as '*my baby*', he was her '*beautiful constant companion*' and she really enjoyed having him there. She stressed '*he is a part of me*'.. Trish described a connection with her baby through which she knew intuitively about the baby and how it was developing. Interestingly, she often used the pronoun 'he' even though she did not know the baby was a boy.

Trish felt quite prepared for motherhood and believed she was under no illusion as to the reality of hard work and the daunting 24-hour a day demands, the lack of sleep and the responsibility. With her professional background, she also knew of and accepted that there were many approaches to caring for a baby and did not doubt that she would be able to competently care for her baby. Her only concern was that breastfeeding at irregular hours might be very disruptive and inhibit her ability to undertake household work. She was determined not to succumb to the pressures of undertaking all the housework. She wanted to be flexible.

Trish was definite about the characteristics of a 'good' mother. She believed a 'good' mother was someone who loves her children unconditionally, '*accepts the child's downfalls*', encourages their development, plays and talks with them, spends time with them. A 'good' mother also was someone who was '*balanced in herself*' and '*willing to handle the situation*'. Trish positioned breastfeeding as an important component of being a 'good' mother and placed significant value on breastfeeding for the benefit of society. '*It's the closeness to you with your baby, as well as all the medical... sort of stuff... It's important for producing productive members of today's society... Yeah, I think breastfeeding's really important for... the relationship between mum and the baby.*'

Trish was very keen for her partner to be fully involved in caring for the baby. She believed, however, that in the first few months after the birth Adrian's role would be peripheral, a role that supported her in her position as mother, the primary carer.

Trish did not have her baby prematurely as she had expected. Her labour was induced when she was 39 weeks pregnant. Trish had a fairly quick labour and despite her stance that a 'natural' birth was '*not the be all and end all*', she announced proudly that she only used gas for pain relief and her baby was delivered vaginally. Trish described labour and birth as the 'best bit'.. Compared to the worrisome drawn out pregnancy, labour and birth was '*great*'. Now she finally had 'her' baby.

Soon after giving birth to Mitchell, Trish had to go to the operating theatre to have a large vaginal tear that was bleeding repaired. At this point Trish insisted that she give baby Mitchell a breastfeed:

> *I was just so determined to feed Mitchell. I already had this fixation on the things that people teach, you know they say that if you breastfeed a baby it should be fed within the first hour of delivery... well so fixated on that, but as they're dragging me out to go to theatre, I'm going 'But I just want to give him a few sucks' (laughs), and so here I am sort of fairly well out of it and the hormones I'm sure and wanting to feed him, so he had a bit of a lick and that was about it.*

Determined to establish breastfeeding and maintain a connection with her baby, Trish again insisted that she feed the baby immediately after surgery. At this point she started to bleed heavily from her uterus and had to stop the breastfeed as she was in so much pain. Trish added, '*I felt really guilty afterwards because here's my little baby and I'm pushing him away*'. Trish was extremely unwell in the evening following Mitchell's birth and remained in the delivery suite overnight for intensive observation. Due to her tenuous health status, her baby was put in Special Care Nursery for the night and her partner, Adrian, remained with her.

Trish felt cheated or '*gipped off*' as she put it when her baby had to go to the nursery soon after birth. She described how the baby had been in her tummy for nine months and now he was '*taken away from me*'. Trish felt that the midwives had not really

understood how she felt and she had to insist that the baby be put to her breast before going to the nursery.

Trish struggled to maintain continuity and connection with her baby by requesting particular approaches to his care when in the nursery. For example, she requested he be fed artificial formula by tube rather than by bottle. Her motivation for this rested on her strong desire to breastfeed, and using a professional account she believed that giving the baby a bottle may interfere with his sucking pattern. However, in a frustrated tone, Trish added, '*... although later on I gave in and let him have a bottle because I was so intimidated by some of the nursing staff*'. During that night in labour ward, Trish, although quite ill, was very concerned to remain connected to her baby and made two calls to Special Care to see how he was going. She stated, '*I just want to see how my baby is going*'. According to Trish, this action was interpreted as her being ready to care for the baby. Despite the necessity of the baby being in the nursery overnight, Trish remained distressed about the baby receiving artificial formula for some time:

> *It didn't worry me so much at the time, but now I sort of think 'Oh, he had formula you know, he is classified as artificially fed'. I also think 'Oh well, he had his S26 (formula) and I'm allergic to sort of everything in the world' and I thought 'Oh I hope that hasn't affected him and stuff like that'.*

The following morning Trish was moved to the postnatal ward, still unwell with a urinary catheter and intravenous infusions, but she was keen to care for her baby. With much help and support from her partner, mother and midwives, Trish stated that '*we managed*' (she and baby Mitchell) to initiate breastfeeding and she gave credit to her baby. '*It was fortunate because he really did know what to do.*' She went on to state, '*Breastfeeding's unreal (laughs)... nobody told me how wonderful breastfeeding was. 'Cause the hormones would just go flying and 'Weeee' (laughs) so it was great...That was the only thing that did go well, didn't it Mitchell?*'

Three days after the birth Trish started to feel much better, but it was just at this point that Mitchell developed jaundice which required treatment under the lights in Special Care Nursery. Trish told me again that she felt really '*gipped off*' when this happened. She was just starting to get to know her baby and was able to care for him and then '*they*

took him away from me... it was horrible'. Trish was very familiar with all the care required by a baby receiving phototherapy and so she insisted that she be able to totally care for her baby herself. The staff was happy for Trish to do this. While spending time in the nursery, Trish made many observations of the care provided there and talked critically of many practices she observed. By the time Trish and baby Mitchell were ready for discharge, she had already learnt a few things about her baby, for example, she felt he was a very easy baby to settle requiring only three pats on the bottom to do this.

Trish went home from hospital when her baby was seven days old. Trish felt very confident about taking her baby home, even though her partner was going to be away for the first two nights. This contrasted with the concerns, even fear, expressed by many of the women when they left hospital. For Trish one of the very special parts of being home by herself with her baby was being able to snuggle up in bed with him. She stated, *'I have had him sleep with me sometimes... it was easier... it was especially when Adrian was away, I thought 'Oh well if I can't have one man I'll have the other''.*

I spoke with Trish when they had been home for four days. During my interviews with Trish, baby Mitchell was often with us. At 11 days old he lay asleep on a sheepskin on the lounge room floor and at other interviews he was often awake and breastfeeding.

Already at 11 days, breastfeeding was an integral and harmonious part of life for Trish with her baby. She stated that she had not had any problems at all with feeding. Trish talked excitedly about breastfeeding, reiterating that nobody had told her how wonderful it was. She was quite amazed at how well breastfeeding made her feel and she elaborated on this surprising embodied experience:

> *Oh the hormones (laughs)... at the first, oh, probably five days the hormones six days maybe, the hormones just flew around, like I'd sit there and I'd just feel great, or I'd nod off. That was the other thing there, you'd talk to me and just, after the conversation I'd have to say well after I'd finish breastfeeding I'd have to say 'can we repeat that conversation I can't remember any of it'. It's just great, nobody tells me, I was the one that found it easier to get back to sleep at night... and after I fed him put him down I'm gone... nobody really told me.*

Few women in this study cast the embodied experience of breastfeeding in the first few days after birth as pleasurable and rewarding. Trish, however, believed that breastfeeding had a calming and relaxing effect upon her. Trish contrasted her experience with women she encountered through her work as a neonatal nurse. Her everyday professional experience had told her that breastfeeding was difficult and painful. She said, '*I think because I work with people and I hear about their sore nipples and how painful it is... that is what I expected*'. Her personal experience of breastfeeding, however, contrasted markedly with her professional experience.

This early breastfeeding experience reinforced for Trish the professional nursing and medical accounts that stress the 'correct' approach to breastfeeding will reduce difficulties and can facilitate a very satisfying experience of breastfeeding. Trish spoke somewhat negatively about many new mothers she encountered in her work, presenting them as 'irrational'. '*Breastfeeding is better than I ever thought... well 'cause I think I had so many bad experiences from other women, 'cause that's my work, they're sitting there going 'Err Err Err it hurts'...Well I was waiting for difficulties to happen (laughs).*'

Trish attributed her success to her knowledge of how to position a baby for breastfeeding and also to the nature she perceived her baby to have. She felt he was very placid and Trish illustrated this by describing her baby's patience in waiting for her milk to come in:

> *The only time it really hurt I had tender nipples on day three and that was for a couple of feeds and that was it... and I'm sure that was just because it's never been used before, you know... I was conscious of positioning him properly... yeah, chest-to-chest, all that sort of stuff... the only time that he was really fussy, I'm sure it was because my milk hadn't come in and he was really anxious to have it, but he's such a placid baby that, oh he was so patient in there... he waited for it.*

In this interview, at 11 days following birth, it was clear that Trish felt comfortable in the professional knowledge she held and drew heavily upon this. She had an explanation for why she felt so good and an explanation of why she did not experience sore nipples and why the baby was fussy. Professional accounts seemed to tell her that breastfeeding

was relatively easy if certain things were considered or acted upon, while her professional experience told her that many women experienced pain and difficulty. Trish had been prepared for the difficulties that she said never happened. Even when her baby was waking for a two or three hour period in the middle of the night, she was not particularly troubled. Her acceptance of the patterns of newborn babies allowed her to be fairly comfortable with her baby's wakefulness during the night.

For Trish, the satisfaction of being a mother and breastfeeding was continuing when her baby was six weeks old. Trish highlighted at our third interview that the best bit about motherhood was *'he's mine'*. This sense of ownership had grown over the six weeks since his birth and she continued to be annoyed and disappointed that her baby was '*taken away*', spending his first night in Special Care Nursery. Trish stated, *'I felt really gipped off when I was sick the first night when he was taken away from me, I thought he's mine why are you taking him away from me'*.

For Trish this early separation brought into question her ability as a mother and the impact upon her close relationship with her baby. At six weeks following the birth, she was very reluctant to leave her baby at all, even with her partner or her mother. Trish found her baby to be totally portable. He was no problem to her and she preferred to take him with her everywhere she went, '*I've got the backpack and his mat and rug and off I go*'. In contrast to some of the other women, Trish did not feel restricted in any sense by taking her baby with her all of the time. She believed that it was more trouble for her to leave him, as she would have to express breast milk.

During these first six weeks Trish really enjoyed having her baby in bed with her. She talked about him having a good nighttime routine, but if he was at all unsettled, what she described as 'pooh days', or she was tired, she would not hesitate to get into the single bed with him. Trish talked of *'wanting to go to bed with him'*. *'I was definitely not going to have him in my bed (both laugh). It's me that wants to go in the bed with him. It's so nice... it's so nice to have you (talking to baby) with me.'*

When I spoke with Trish for the fourth time her baby was five-and-a-half months old. Trish was really enjoying motherhood and talked of having a very good but flexible

routine, just fitting in with what he wanted. Trish stated, *'He seems to tell me what his needs are'*. She later added, *'He just does his own thing and that's probably why he is so contented'*. Trish was besotted by him, which she described as 'puppy love'.

> *I just fit in with Mitchell. He's got me wrapped around his little finger. I'll do anything for him. It's amazing, luckily 'cause sometimes I plan to do this and this and this, it doesn't work like that 'cause, oh look at those beautiful eyes, I'll do anything for you. It's really like that puppy love, remember when you were about you know 10 or 12 or something like that.*

Trish really enjoyed breastfeeding and she told me excitedly about the time Mitchell noticed she was connected to the breast.

> *It was really funny when Mitchell worked out that I was a part of the breast, like (laughs) that he connected it all. 'You're connected, oh oh you're connected' (both laugh), like, I remember him looking at me like, sort of looking from one to the other and just sort of with this funny expression.*

Trish could now tell from the look on his face when he was ready for a feed.

> *When he's hungry now... like he looks straight at me, like, and I can tell before any, before he cries or anything that he's hungry 'cause the way he looks at me, like, like this really intense stare, really particular look that he gets. No one else would be able to pick it up.*

Trish talked of breastfeeding in an emotional way. *'I love it. I never want to give it up.'* She particularly loved the early morning feed when baby Mitchell would get into bed with her and feed, have a cuddle and then fall asleep again.

Trish would sometimes go out for a swim at 6.30 in the morning but she would always put the baby back in the cot, leaving her partner to sleep. She would be back before Adrian had to go to work. Interestingly the baby was not left to lie with his father. Here Trish appeared to treat her relationship with the baby in an exclusive way, preventing her partner from experiencing some of the rewards she was gaining from the baby.

Trish found it hard to understand why someone would choose not to feed and she emphasised, *'It's so nice once you get (breastfeeding) established and once they can roll*

over and, you know, help them themselves'. At this stage she was planning to feed for 12 months or until the baby weaned himself. Trish, however, was ambivalent about whether to feed for much longer than this. Drawing upon professional knowledge, she liked the idea of feeding up until two years of age, for the added protection from gastrointestinal and ear infections. On the other hand, Trish was also influenced by public discourses of breastfeeding that dictated the 'appropriate length of time to breastfeed'. She was concerned that it was not appropriate to feed a child as long as two years, particularly if the child used language to demand a breastfeed.

Trish also described the way in which she talked with her baby. She included him totally in her daily routine, always telling him what she was doing and she described excitedly the way that they played with each other. From Trish's talk it was apparent that their days were spent in a connected and harmonious way. Where many women find the constant needs of a baby demanding, Trish insisted that Mitchell was included in everything they did. '*He's included with everything, yeah, I suppose Mitchell and I are a package.*'

Trish was very confident in the knowledge that she had about caring for an infant and in recognising the baby's needs. Their breastfeeding pattern was established early and Trish had remained totally confident in the practice of breastfeeding. Advice and suggestions from relatives, friends and health workers were tolerated patiently but generally ignored. For example, she described the information that friends had been given at a day stay program for mothers and babies. '*I was told I was doing it all wrong by one friend who had been there and came back saying that a baby must sleep, eat, play, sleep, eat, play. Well if Mitchell in the middle of the day wants to feed and sleep, I'm not going to insist he play.*' Trish was adamant that she was able to do her 'own thing' but she immediately corrected this using a child-centre's statement, '*he's told me what to do*'.

Trish described in detail the connected and sensual embodied relationship that she has with her baby and when prompted to talk about changes in her relationship with her partner, Trish was quite open about changes to their sexual relationship in the early months after the birth:

> *It certainly changed, umm it's pretty consistent that we don't have sex. I mean Adrian's been pretty understanding. I mean, sex at four months, I suddenly just started to get 'oh yuk', how can anybody do it, like my mum said 'sex was just fantastic after I had my baby' she loved it, you know, and I just said like 'Mum that's just horrible', 'No way', but now, like, I'm starting to get a little bit more interested in that part of our relationship.*

Trish commented that she and her partner both had to make an effort to communicate well with each other. She had noticed at times that they had not been clear in expressing their individual needs and confusion had resulted.

Trish said that motherhood was very much as she imagined it to be. She thought that she would have a lot of sleepless nights but that hadn't been the case and she had not had a crying baby to contend with. She really felt like a mother and when people asked her what she did she used to say she was a registered nurse but now she says *'I am a mother and I love it'.*

5.2 JANE AND BABY LOUISE

Jane was 31 years old when she gave birth to her daughter, Louise. Jane and her partner, Jeff, live in a southern Sydney middle class suburb and are purchasing their two-bedroom house. They have been in their relationship for six years and married two years prior to Louise's birth. Jane had been working as an administrative officer in a busy office and Jeff was a nurse. Both Jane and Jeff wanted to have children soon after they had married.

In the first interview Jane constructed her desire to be a mother in two opposing ways. First she talked of motherhood as an important dimension of her personal identity. It was something she wanted 'to experience' and she stated that she would have considered motherhood even if she did not have a partner. On the other hand, however, Jane talked of becoming a mother as an expected or 'natural' progression in a woman's identity, always imagining that she would be a mother. Jane stressed that both she and Jeff came from large families where having children 'seemed natural'. Jane's pregnancy had been carefully planned around Jeff gaining secure employment and establishing

their mortgage. Finding out she was pregnant was very exciting and Jane presented the positive pregnancy test to her partner as a present for their anniversary.

Jane had though about the characteristics of a 'good' mother, stressing it was important to remain calm and relaxed and be able to cope: and not panic. On the other hand, Jane also believed there was something 'natural' about mothering:

> *I suppose doing what comes naturally, sometimes you think oh... she won't make a good mother and then they really surprise you and they're a real natural mother... as if that's what they were put on earth to do. So... hopefully just doing what comes naturally, like you know, picking up with what's wrong with the baby.*

When describing the characteristics of a 'good' mother, Jane included breastfeeding. Jane was very committed to breastfeeding. In our first interview she talked of wanting to breastfeed to '*really create a bond*'. It was something she had '*just expected*' she would do. She had not even discussed it with her partner. While believing that 'breastfeeding was natural', Jane was aware of the difficulties that family and friends experienced and she decided that breastfeeding was something that one had to '*try and try... to persevere and accomplish*'. Jane seemed also to value breastfeeding as a source of personal satisfaction and achievement of an identity as a mother. Jane stated, '*I think it's a major motherhood thing*'.

Jane gave birth in a Birth Centre and she described her birth very positively. It was more painful and much harder work than she had ever imagined but quicker than she thought and she was '*a little surprised everything went as well as it did*'.

The first interview following the birth of the baby took place in the hospital when Louise was four days old. The remaining three interviews all took place at their home. Jane always appeared concerned that the baby might disrupt our interview and she tried to schedule times when Louise would be asleep. During the first interview Jane kept glancing at the baby to see if she was waking. It was rare that I saw Louise awake when we went to interview Jane and her partner.

Jane described baby Louise as 'beautiful' and she was amazed at how the baby knew her voice. At this point Jane saw herself as being more of a 'natural' in caring for her baby than she thought she would be. '*Just in handling her, and the soothing part of it... you just talk to her and she seems to know straight away... or if midwife's got her and she's screaming and they give her back to me... she stops. It's comforting to know that she knows (me).'*

During the early days in hospital Jane had trouble breastfeeding, particularly in getting the baby to 'attach' to her breast. The baby had required tube feeding on two occasions. Jane received a lot of help and advice from staff and at times she believed that perhaps there had been '*too much advice, too much being told what to do*'. At times of uncertainty Jane sometimes felt that she would have managed better if she was '*allowed*' to get on with feeding the baby herself. She highlighted this particularly in her decision to try a nipple shield. The practice of using nipple shields is controversial, and midwives gave Jane conflicting advice and help. In her confusion, Jane asked her partner for his thoughts and he suggested she '*do what you feel is best, there are too many people telling you different things*'. This confirmed Jane's belief that she as the mother should decide what is best and she then talked with great satisfaction about the times that she successfully put the baby to the breast herself. Jane believed she had 'worked out their **secret** way to do it':

> *I feel sometimes midwives might stress her out a little bit with trying...I mean you've got to try and try and try and try but I just think maybe if it's just me and her we might get it together. Like last night I did it all by myself without a problem. Yeah I thought I'd found the secret way to do it (chuckling)...So that was satisfying.*

Jane was striving to establish her position as the mother of this child, the person who knows what is best for the baby. Jane was desperate to be able to breastfeed her baby without assistance.

Taking the baby home was a daunting prospect for Jane and her partner. Jane recounted how scared they were bringing the baby home, and given the difficulties with breastfeeding both Jane and her partner were worried that they would not be able to feed

the baby, particularly in the middle of the night. They were quite distressed leaving hospital, both crying as they got her in the car. They prepared for the possibility of not being able to feed the baby by calling at the chemist to buy some formula on the way home.

The first weeks at home with their baby were very difficult. In telephone conversations Jane told me about the problems she was having with feeding and how painful it was. Scheduling a time for the interview had to be carefully planned around when the baby might feed. It was too distressing for Jane to have anyone there during the feed or for about half an hour after the feed. I was very conscious of Jane's difficult situation and offered her the opportunity not to continue in the study or to delay the interviews but she was happy to continue.

At our third meeting baby Louise was four weeks old and Jane had already cast Louise as a little person, developing a personality and making many different noises. She told me how 'beautiful' and 'contented' the baby was and how she settled well. She was a 'good' baby. This account of the perfect baby, settled and contented, however, did not sit comfortably with much of Jane's later talk of her difficulties in feeding and developing problems in settling the baby. Jane implied that the enormous difficulties she was having with breastfeeding were her problem and strangely appeared unrelated to the baby.

Ever since bringing the baby home from hospital Jane had experienced difficulties breastfeeding her baby. For a few days Jane used the nipple shield but then baby Louise started to refuse to take the breast both with and without the nipple shield. Jane described the way that the baby became very distressed, 'fighting' Jane when put to the breast:

> *Like I'm sure she was dreading it... she'd think oh here we go again...A big fight. And you'd just put her in that position and she'd just (fight)...I'm sure it was trauma from hospital where the nurse tried to put her on. I reckon she had a thing about it because she'd be as calm as anything. You'd hold her up here, just put her in that position and she would just scream her head off. It was horrible.*

During this two-week period Jane received a lot of help from the community lactation consultant, who Jane described as '*great, absolutely terrific.*' The lactation consultant had suggested that Jane stop breastfeeding the baby for a short while and to feed Louise expressed breast milk in a bottle. Jane was very reluctant to do this at first stating, '*I felt I was really missing out on something, just missing out on something, that closeness or... bonding'*.. However, Jane became very concerned about the trauma that the baby was experiencing when put to the breast and this notion of breastfeeding as traumatic was reinforced by one of Jane's friends:

> *Well one afternoon... I'm crying and she's crying and... and my girlfriend knocked at the door and I said 'I c-a-n-t get up, you'll have to come around the back and she's walked in and I'm crying my eyes out and she goes 'what's wrong with you?' She's going 'oh, look she's traumatised', she could see it too.*

Following this, Jane and her partner decided to feed Louise with a bottle for 24 hours. Here Jane used the phrase, 'we decided' which was one of the few times she actively included her partner in decision making. Jane continued to express breast milk, feeding the baby with a bottle for ten days. She very quickly corrected me when I asked her if she had been using a combination of formula and expressed breast milk stating, '*Louise has only had two formula feeds at most*'. When Jane fed Louise expressed breast milk from a bottle, she talked of cuddling her baby close to her breast with her shirt undone. Jane believed that this might encourage Louise to find comfort in being at the breast.

Prior to this third interview Jane had expressed breast milk for a period of ten days and fed the baby by bottle but in the last ten days or so the baby had been taking the breast again. She described excitedly how one day she had given the baby half the bottle and she just thought '*oh what the heck, I'll give it another go*'. Jane put the baby to her breast and she could not believe it when the baby started sucking. '*I just looked at her and I went... my god father, what's going on here and I just went go go go.*' Jane was really thrilled that this had happened and she stated, '*She was fine and ever since then she's been on*'. However, she added, '*Unfortunately I've had cracked nipples... and all that type of thing*'. Jane was not quite sure why she put the baby to the breast again stating, '*And then for some reason I just tried it out of the blue. I'm glad I did. I wasn't going to*

but something just made me.... I think because I was so calm about it after being hyped up'. Here Jane persisted with her view that a 'good' mother was calm and relaxed.

For ten days prior to this interview, Louise had been feeding at Jane's breast. Over this time Jane had suffered badly cracked nipples and had just developed mastitis. The cracked nipples were so painful that Jane cried every time the baby fed and she continued to have pain for about half an hour after the feed. Jane was prepared to put up with these problems for another week to see if her breasts and nipples healed and if the baby continued to go happily to the breast. She told me that if at the end of that time things were not sorted out then she would give up breastfeeding. '*It's not going to upset me anymore.*'

Here Jane found support for the problems that she was having by referring to stories of numerous friends who also had trouble breastfeeding. Jane now doubted the 'breastfeeding is natural' discourse stating, '*I don't think anyone really realises... I mean they say it happens naturally but it doesn't. The fact that we rang ten chemists... No breast pumps available, I said I'm not the only one that's having trouble*'.

During this interview Jane reiterated that '*everybody keeps telling me what a good baby she is and how lucky I am*'. Yet Jane did not really feel that lucky. She had experienced difficulties with breastfeeding that few women would tolerate. When she talked about how she felt about breastfeeding and why she was so committed to it, Jane did not employ the rhetoric of 'breast is best'. She talked about missing out on some aspect of motherhood, such as the 'closeness' and a particular relationship with her daughter that she found hard to articulate. Believing that breastfeeding brings a mother 'closer' to her child, Jane accounted for her persistence with breastfeeding:

> *So I suppose it was just that I felt like I was missing out on something, that closeness or something and maybe you know, it might affect her later which is probably a load of garbage. I was thinking you know... she's going to hate me because I'm trying to get her this breast and she doesn't want to go and I felt that she was probably rejecting me and that type of thing.*

Here Jane was influenced by a traditional psychoanalytic discourse suggesting that this traumatic experience of breastfeeding may lead to a later rejection of her as a mother.

Jane desired an intimate and connected relationship with her daughter through breastfeeding. Instead her distressing experience of breastfeeding appeared to separate her or disconnect her from her baby.

In the final part of this third interview, Jane talked about her experience of motherhood in these first four weeks. For Jane motherhood had not been 'as magical' as Jane thought it would be. *'It's just sheer hard work and constant slog.'* The emotions and atmosphere, the warm, wonderful feelings of satisfaction and joy that she had imagined or expected were not there:

> *Like I knew it would be tiring...I thought it would be more... O-h-h-h isn't this wonderful type thing, where it's not. It's hard work. I mean it's nice but basically they sleep, you change their nappy and feed them, they cry and you just find yourself having only two hours and it's all over again type thing, especially with feeding time. They used to say they feed four-hourly, like you get a four-hour break. But that's garbage... I think I thought it would be more wonderful.*

In the above Jane has taken a risk in expressing her feelings about motherhood, knowing that they contradict the public accounts of motherhood. She was very quick to assure me that she loved the baby stating, *'Don't get me wrong. I don't not love her or anything like that. You think it's real magical'*. Jane then added that she was now receiving some satisfaction or reward, *'And I can see just in the last week she's becoming more of a little person'*.

I next spoke with Jane when her baby was eight weeks old. Jane continued to cast baby Louise in a positive way, emphasising the baby's separate identity, her individuality, *'becoming her own little person'*. Jane always talked excitedly about what the baby was doing. In her talk Jane attached thoughts and words to the baby's behaviours. Jane talked in detail again of how the baby knew her voice. At this point Jane also talked in a more confident manner about knowing what the baby wanted.

The problems she had been experiencing with breastfeeding had not resolved and she had a second bout of mastitis. At this point, one week after the last interview, Jane stopped breastfeeding. In the fourth interview Jane talked in detail about the difficulties they were now having settling the baby during the day and she described in minute

detail the baby's sleeping pattern. Jane believed that the settling problems coincided with the ceasing of breastfeeding and the introduction of formula. Jane's commitment to breastfeeding remained evident. When she developed mastitis for the second time, the lactation consultant suggested that she stop feeding for ten days and then try again. At this point Jane decided that 'enough was enough' and if she was giving up for ten days, she would 'give up for good'. Jane was disappointed about this, feeling that it was a real shame. However, in taking note of numerous other accounts she stated:

> *That's it. That's as far as I can go, there's nothing else I can do. But even like two or three days after I was still umming and aahing because I then got engorged breasts because I had that much milk it took a good three weeks, I still got it. But it just settled down... but yeah, I don't think she's missing out on anything, you know, like she's not going to remember I'm sure whether she was breastfed or not. Yeah that was a really trying time.*

Jane used examples from friends' experience to justify her decision to bottle feed. However, even a week after her decision not to feed she still entertained the idea of putting the baby back to the breast. *'I don't know... I was just thinking whether, you know, maybe I can, and it may not happen again.'* As soon as she had uttered this statement, however, Jane was reminded of the pain and distress of breastfeeding. She quickly added, '*It was nice to have my body back*', to be able to put a towel around her body or for her partner to cuddle her without feeling pain from her breasts and nipples.

However, this emerging sense of release and power through ceasing breastfeeding was contradicted by her very strong emotional response when sitting with a group of breastfeeding women at a day stay mothercraft program. In the following, Jane talked of bottle feeding as though it paralleled being a 'bad' mother. She felt as though she had to always explain why she was not breastfeeding:

> *You still feel like you're missing out, like when I went to a day stay program... we were sitting around, like in the lecture room and they (were) bringing babies in as they woke for feeding, all of them were breastfeeding and 'cause when mine came I thought 'Oh I'm going to get a bottle', when I still felt really 'Oh what do they think of you'...I don't know why and I just felt so horrible again... that they were sitting there just breastfeeding the baby and the one sitting next to me was like two weeks and she was doing great and I was going 'So lucky it isn't even hurting you'. 'No no it's not hurting'.*

During this interview, Jane's focus shifted from breastfeeding to settling her baby. Jane talked at great length about her concern for the amount of sleep the baby was having and the frustrations of the daytime 'catnap' behaviour of Louise. The following text demonstrates Jane concern to establish a routine and regimented sleeping pattern for the baby, this separate person. (Note the following piece of text has been condensed from over four transcribed pages of talk.)

> *Really I knew she was having enough sleep because I've been writing it down so I knew she was having between six and seven hours a day which is enough. I knew she was having enough at night, like after eight or nine hours I'd wake her as I was really worried that if she was hungry or if she was hot or cold that she wouldn't wake herself, so I was getting worried about it... but now she's going back to this 45 minutes to an hour cycle (during the day) and you know, all professionals that I've spoken to said, she should be having 18 hours sleep, blah blah blah, I was going 'There's no way this kid's having 18 hours sleep'. I said 'She's not unhappy by it, it's me that's more upset or worried that she's not getting enough sleep and I don't want her to get in the pattern where Ok sleep 45 minute nap and I'm up all day'. You know if she just wants some more in the afternoon. One day I can't remember the day she was up maybe between one of the feeds or after an hour's sleep and she'd be just a nightmare come 6 o'clock in the evening. And then I started to sit back and look over 24 hours she was getting 14, 15 hours sleep, and then I thought 'Oh well, 15 hours sleep over 24 hours I feel that's all she needs' and then at one of the centres (residential care centre for mothers' and babies) they said when she woke she was trying to focus on something so they put a sheet over her head...I nearly had a fit and then I noticed that they had an air conditioner on and it made a whirring noise and I thought the heat and the noise that is why she is sleeping...*

Following this lengthy talk about the sleeping pattern and the numerous encounters with professionals, Jane came to the conclusion that Louise was just 'a bad baby'. However, in her search for a 'proper' explanation, she went on to talk about the baby's tendency to gulp at her bottle and drink it in a space of five minutes if allowed, producing yet another account of the problems they were experiencing. She described Louise's settling problem as either wind or even the 'medical' condition of reflux and decided to visit a paediatrician.

At the same time, however, Jane reflected upon the professional help she had sought, concluding that she had perhaps received '*too much advice*', from too many sources. Finally her partner told her she didn't really need any more advice and Jane agreed,

'Well he's probably right'.. Jane started to recognise she was 'working it out' (Barclay, et al., 1997).

For the last seven weeks after the birth of her daughter, Jane had been striving to gain a connection and harmony with her baby. More recently she was trying to establish a routine and gain a sense of control over her life as a mother. This endeavour required her to be constantly vigilant of the baby's feeding and sleeping pattern and to work out the conflicting opinions of numerous health professionals. In addition, Jane continued to hold to the rhetoric of a 'good' mother as relaxed and calm. This notion, however, competed with her chaotic experience to date. Ultimately Jane told me that she had been feeling really 'down' in her life as a mother and that she thought she may have been a *'bit postnatal'*. This term is created by Jane to refer to 'postnatal depression'. However, Jane has a rational biological explanation for why she may have felt this way:

> *One day I just felt like I was in there every ten minutes all day FIGHTING to get her to sleep and I was scared, but I think I might be getting a bit hormonal since I weaned her, I'm sure my periods are due to come as well and I think I might be premenstrual as well and I think 'Well, my body's going through one minute all the pregnancy and the birth and then the breastfeeding and then weaning her... and then sure it's trying to get back to normal now and get my periods normal.*

Despite this personal distress, Jane maintained that she was starting to enjoy the baby and particularly talked about fostering her development as a growing individual. Even at this early age Jane started to see the baby becoming independent, being happy to wait in her cot while Jane prepared her early morning feed. Through this experience of the early days of motherhood, Jane stressed the importance of remaining relaxed and calm. *'If a person is relaxed and calm the baby will automatically sense it.'*

Throughout the interview Jane talked little of her partner's role in these early weeks with their baby and it became evident that Jane was striving to gain confidence in herself as a mother and she was reluctant to allow her partner to take an involved position. For example, when she had trouble settling the baby, she was unlikely to ask her partner to have a go because she believed that *'this is confusing for the baby'*. Jane believed that the baby would settle better if she was used to one person doing it. Jane

also felt intensely irritated when her partner returning from work, would pick the baby up when she woke if she had only 45 minutes sleep:

> *I'm trying to battle against, I've been home all day working at her to go to sleep now, if she wakes in 45 minutes we've got to get her back to sleep because she hasn't had any proper sleep... But it is hard to say 'don't get her up because that's just breaking what I'm doing'. I can see his point of view too, I mean it must be hard for him to try and say 'OK the mother's trying to get them into a routine'. I feel horrible saying to Jeff, 'don't pick her up'. I must seem like a real bitch.*

Our fifth interview with Jane and Jeff occurred when baby Louise was five months old. Again Jane described her baby as 'wonderful' stating, *'We're so lucky that she is so settled and contented and rarely cries'*. Jane provided an overview of the baby's routine:

> *She's a very, very good sleeper, sleeps for 11, 12 hours of a night. Wakes up talking to herself. You can leave her talking to herself before you get up. She gets up, has a bottle, has a play, goes back to bed... might wake up within the hour but talks to herself and goes back to sleep. Um does that three times of a day. Has a muck up time in the afternoon like four till seven which I believe is normal. And um... she's very, very happy, contented.*

Jane appeared to have been very successful in establishing a sleeping routine for her baby. Her persistence over the past three months had resulted in a baby that slept frequently and for long periods. Yet she continued to talk in detail of the challenges in establishing the baby's feeding, settling and sleeping routine. Now that the baby was sleeping 'so well', Jane had difficulty ensuring that she was having enough formula to drink. It appeared that Jane still needed to gain control over the daily routines and patterns of her baby. This became very evident in her continuous talk of millilitres of formula and her problems in deciding the best approach to the evening settling routine. Jane talked at length about the practices that she put into place to reduce the disruption to the evenings. She talked about the timing of the bath and bottle and the advantages or disadvantages of getting her to have a little catnap in the evening (again this piece of text is condensed from approximately four pages of transcript).

Oh everyday I go oh what's the plan, I still haven't worked out what to do with her. But what I did the other day worked out really well so I might try that (chuckling). 'Cause I... she just can't stay awake for like she'll wake in the... you know, maybe quarter to five, five o'clock... and she's due to feed until seven and she won't... even if I try and feed her half hour to an hour before... she'll only have a little bit, because she's not hungry.. So I've tried feeding her a little bit early to get her into bed early so she's not too tired but that doesn't work. So she's got to stay up like for two and a half hours. Now I know come two hours, she's exhausted... so what I did the other day was let her get up for an hour... an hour and 15 minutes until she started to get tired... which I've done in the past... but I've had trouble getting her back to sleep so I gave her a little bit of juice and water... and she fell fast asleep and I just put her to bed and she woke up an hour and a half later and I nearly fell off the chair. I went ohhhh... gave her a bottle and she went back in and I thought there's no way she's going to sleep... didn't wake till 6 o'clock in the morning. I gave her a bath... that's right... 'cause I know when she has... what I've done in the past is bath, bottle, bed of a night time. And I was really worried that if I gave her the bath... she'd think I'm not going to sleep until I get my bottle. I mean I don't know how clever they are but... I just think...I was really scared... I'm sitting here going... if I give you a bath you're going to think you want your bottle and yet your not hungry... I know that but you might have a little bit. So I sat there and thought 'ohhhh I know what I'll do'.

Jane was able to provide minute details of her attempts to gain order and control. Yet she also contradicted this concern when drawing upon accounts of the flexible 'good' mother and notions of maintaining some form of individuality. Jane simultaneously insisted that a mother should not be overly concerned with the baby's sleeping routine and that some compromises have to be made. *'You've got to have a life too so, well in the beginning I used to think... oh she's asleep, I'm not going anywhere until she wakes but now I think you get a lot more relaxed about it all.'* Jane talked about her partner's belief that the baby had to fit in with their routine and life rather than the other way around. It appeared that his views were starting to influence Jane.

Jane went on to describe a good father as someone who helps the mother and who gets involved. While she considered that her partner was very involved, Jane tended to take on all the care for the baby especially when she desperately needed to gain confidence and establish a routine. Consequently Louise was most used to her mother. Jane described how the baby had trouble taking the bottle from anyone except her and she suggested to her partner one day that he put her dressing gown on, so the baby would have the familiar smell. Yet she went on to say that there should not be any real

difference between a mother and father, *'they are both parents'*. This prompted Jane to talk about some of the conflicts that she and Jeff were having and she recognised that perhaps he felt excluded:

> *We argue a bit over what to do with her sometimes. Oh especially in the afternoon... when she wakes and we look at her and I'll go 'she hasn't had enough sleep... she needs at least an hour or an hour and a half and she's only had half an hour'. (And he'll say) 'Just get her up and put her out here on the floor and see what she does' (and I'll say) 'no, she's got to go back to sleep' (and he'll say) 'just get her up she's happy to lay out here, just leave her'. And I say 'yeah but she'd be happy to lay there for three hours'. (and he'll say) 'Well let her lay there for three hours.' And I said 'if you do that you feed her because I know she's too tired then'. So little conflicts like that. Um... because I think I know her a little bit better... 'cause I'm at home more... I know what her limits are. But then sometimes I think well okay... we'll do it, and you'll see. And 90 percent of the time... I'm right.*

At five months Jane presented herself as more confident and believed she was more relaxed about things. Jane talked of knowing the baby much better than anybody else could know her. She knew exactly what Louise wanted at different times of the day and was able to leave her with her partner or relatives, giving them a precise description of the baby's routine. Jane also talked of catching onto the baby's 'little tricks' and in desiring control she added, *'she didn't pull that one over me'*. Again one gets the feeling, however, that Jane knows the baby's routine very much by the clock rather than by 'reading the baby'. Jane told me that really Louise does not show signs of being tired or hungry, *'basically you have to guess with her'*. The baby appeared to be so routinised or alternatively, Jane was in such a routine meeting the baby's needs almost before they have arisen.

At this stage Jane stated that she was ready to start paid work. While Jane would have preferred to work from home doing clerical work, she was considering working one day per week in her old job. Jane believed that going to the office one day a week would be really good for her. Now that the baby was sleeping so much in the day, Jane found she was a 'little bored' and wanted adult company and stimulation. At this point Jane maintained her preference for family members such as her partner, mother or mother-in-law to care for the baby if she was working. Jane believed that there was social pressure for women to be at home and that people always tend to question why you would want

to work. Paid work for Jane was not solely for money but also as an outlet for adult stimulation.

5.3 SIMONE AND BABY CATHERINE

Simone is 30 years old, of Northern European background and has been living in Australia for 13 years. She has been with her partner Greg for ten years. Most recently Simone was employed as a researcher in science at a university and describes herself as a scientist. Her partner Greg works as an accountant employed by the government and also teaches two or three nights a week. The couple owns a small two-bedroom house. They have also just purchased a large house in a middle class southern suburb and this house is currently rented. They both talk of having large financial commitments. Simone's mother is living with them. Simone describes herself as a highly organised, ambitious woman. She becomes anxious and stressed when aspects of her life are not tightly controlled.

Simone was quite definite that she did not have a strong 'maternal instinct'. Simone had not planned on becoming pregnant and believed that it was unlikely to occur because of previous gynaecological problems. She felt comfortable with the notion of not becoming a mother, believing life without children could also '*be wonderful*'. The pregnancy was a big shock to her. As an autonomous, self-reliant individual, Simone described a loss of control. To have an unplanned pregnancy was very disconcerting. Her immediate thought was, 'W*ell should I tell anybody... should I go through with this then I thought no that's a silly thought. Of course you know, you're 30'.*

Simone proceeded to take a scientific and technological approach to the pregnancy. Drawing upon her knowledge as a scientist, she gathered information on fetal development. She took vitamin and mineral supplements and availed herself of diagnostic technology such as ultrasound and amniocentesis. The first interview with Simone conducted in late pregnancy contained little talk of the baby and its characteristics, behaviour patterns or interactions in utero. For Simone, the embodied

experience of pregnancy was unpleasant and her limited knowledge of the baby came to her as an observer through diagnostic technology.

Simone went on to tell me that she hated being pregnant. She experienced a great deal of nausea and vomiting in early pregnancy and while she believed that this was 'psychosomatic', there was nothing she could do about it. In late pregnancy Simone was still experiencing constant burping and the 'throwing up', which she attributed to both indigestion and also the severe back pain she has been experiencing from the position of the baby. Simone was annoyed that she had not read or been told about the '*negative aspects*' of pregnancy. During the first five months of pregnancy, Simone had become increasingly frustrated at the imposition that the pregnancy made on her ordered and productive life.

Simone was somewhat concerned that her negative perception of the pregnancy experience may somehow impact upon her baby. In an attempt to resolve this conflict between the experience of pregnancy and the developing baby, she objectified the pregnancy, removing the experience from the existence of the baby. She stated, '*I tried to blame it on the pregnancy not on the child, separate the two hopefully because I also reckon your negative emotions can be packed on the fetus too. So I thought I better not*'. At a personal level, however, the account of the perfect pregnancy and the attempt to separate the pregnancy from the child further irritated Simone. '*I thought it just isn't fair, it's hard enough as it is and you still have to be positive about it too, you must be kidding. I could virtually take out I'd say five months of my life was just like a waste, a waste land, wasted. Fortunately I'm forgetting it all now anyway.*'

Simone viewed motherhood as a huge responsibility and believed that mothers had the biggest influence in the life of a child, teaching the child 'values'. Simone had already had many discussions about raising children with her mother and while she was glad that her mother was living with them, she openly told her mother that she wanted to avoid the 'mistakes' that her parents made with her. Simone hoped to provide a stimulating and positive environment within which her daughter could develop. Simone talked of a 'good' mother as '*not being too regimented*', '*being open and flexible*'. Simone insisted that one cannot 'dictate' what is going to happen or what her daughter

would be like. Included in Simone's discussion of a 'good' mother was the importance of breastfeeding. As a research scientist with interests in microbiology, immunology and genetics, Simone was totally committed to a 'breast is best' discourse'. She believed breastfeeding was natural, stating '*we are animals after all*'. Breastfeeding held great nutritional value, benefited the baby immunologically and was convenient. Simone was also motivated to avoid the personal pain of the withdrawal of breast milk in the early days. Simone, however, remained unconvinced that breastfeeding led to 'nurturing feelings' or a closeness between mother and baby, '... *it will probably be really awful but I'll still persevere because I just believe so strongly that it is better for the baby*'.

Just past her due date, Simone developed an acute uterine infection. After seeing her doctor, she was rushed to hospital and gave birth by emergency caesarean section under general anaesthetic two hours later. She found this an alienating and disconnecting experience, stating:

> *All of a sudden I wasn't pregnant any more and you're presented with a baby... without the birth experience... why aren't I feeling any kicks in my abdomen any more? And there's the baby and it's very hard to relate to it after the birthing experience. It was very umm am I really a mother? I really don't want to be a mother.*

She was left wondering what her daughter's first minutes and hours of life were like and proceeded to reconstruct the events surrounding her daughter's birth. Immediately upon waking in recovery she wanted to establish some connection with her baby, seeking information from the staff. '*I kept asking in recovery how is my baby? And where is my baby? And they said we don't know anything about your baby and so that was a real horrible introduction... they wouldn't let me out and they didn't know anything about my baby.*'

After leaving recovery, Simone was taken to Special Care Nursery where she had her first introduction to her baby. Her immediate response was '*What a harsh start to life*'. Simone's baby spent four days in Special Care Nursery. For the first two days Simone found this very distressing. Her talk highlighted the openness and exposure of life in a nursery. However by the second day in the nursery Simone became more comfortable

with the technology and was very happy to have the staff care for her baby. She did not feel she needed to be with her baby all the time. Her main motivation for wanting to do things herself was financial, staying in hospital was costing them money as they were not insured and Simone reasoned that soon enough she would have to go home and manage herself.

Simone and her baby went home on day five. Simone found the first few months at home with her baby extremely difficult. She was totally exhausted from the lack of sleep in hospital and once home her baby woke two and three hourly 24 hours a day. Simone believed that she had no opportunity to regain any strength or composure following the birth.

Baby Catherine was four weeks old when I was first met with Simone after the birth. Prior to this I had many telephone conversations with her, but it was difficult to find an appropriate time to interview her. Despite her distressed state she was happy to continue in the study.

At four weeks, when I asked Simone to describe her baby, she told me that she was '*a witch*'.. In an open and powerful manner Simone elaborated, linking her strongly negative experience of her baby to their breastfeeding relationship:

> *She's a witch... basically, definitely. She scratches me and she fights me and umm although I love her very much but umm ohh it's sometimes terrible, it's really bad. We haven't settled, we don't have a routine yet, she keeps me up all the time and the scratching is really bad, you know around the nipple and the breast. I mean it's terrible.*

While Simone insisted that she loved her daughter, breastfeeding was a battle where Simone must 'fight' with the child to get her to the breast. Simone experienced the baby's scratching at her breast as a 'violent' action that produced bodily mutilation. The scratches were evident on her breast and damaged nipples. In addition the baby was unsettled and demanding, not allowing Simone to gain any rest or peace. The baby's advanced stage of head control and ability to push herself along with her knees, did not impress Simone. Here she described the physical restraint that she found necessary to

entice the baby towards the breast, '*... she's strong, I really have to use all my strength to support her towards my breast and so she doesn't muck around. I hold her hands away. Finally after ten minutes then she calms down, she doesn't fight anymore obviously 'cause she enjoys her food'*.

Simone found the changes to her breasts and her body disconcerting. She spoke with disgust at the size of her lactating breasts:

> *... and then they got bigger and bigger and bigger (chuckles) so painful. I'm only a size B but now I'm a double D, it's not what I wanted or expected. I don't appreciate it at all. Well B wasn't big, it's not big but it was big enough for me. I was quite happy. And I couldn't sleep on my stomach during pregnancy and now I still can't sleep on my stomach for another six months or whatever.*

She was unprepared for these changes and did not enjoy it. Simone talked of having too much breast milk, finding the continuous leaking from her breasts distasteful and extremely inconvenient, particularly in choosing appropriate clothing:

> *This leaking all over the place is really awful, I have to change my whole wardrobe. Nobody mentioned to me that after the pregnancy wardrobe you have to have a breastfeeding wardrobe. You need access to the breast and not reveal too much and where breast milk won't show up you know, loud patterns and darker, darkish colours (chuckling)... with the right buttons and or with the ohh right bra and ahh. It sucks.*

Simone was particularly aware of breast milk leaking after feeding the baby at night in her bed. Prior to birth, she had constructed an image of nighttime feeding as calm, relaxed and pleasant and instead it was dirty, messy and uncomfortable. '*I assumed the baby will detach itself from the breast, there'd be no spillage, your baby would be clean and, you know, we'd all feed and all go back to sleep nice and calm. I didn't expect this huge mess, the bed to be wet with my breast milk.*' Breastfeeding was also demanding and painful:

> *You have to be there all the time on tap. I have a breast pump now but I haven't been able to operate it yet because there just hasn't been enough time. I dread when my breasts start to really get painful 'cause I know it's going to be feeding time soon, I hate that. Not that I hate feeding but ohh in the beginning the first few umm seconds or the first couple of minutes are painful.*

In describing so powerfully a disruptive embodied experience, I was interested to explore Simone's continued motivation for breastfeeding. Here she provided a medical account, '*...I knew I had to breastfeed because it was so vitally important that she get the antibodies. They... the paediatrician explained it to me too, as if I wasn't going to breastfeed anyway, an extra added incentive, you must breastfeed this child*'. Simone was one of the few woman who continued to emphasise a 'breast is best' discourse above or instead of a discourse of breastfeeding that emphasised the construction of a relationship or bond between the mother and baby.

Simone went on to describe her baby, particularly the baby's sleeping patterns. She described Catherine as a very wakeful baby and difficult to settle. Some days were just a '*disaster*', the baby would be awake for most of the day. Simone believed that Catherine liked to be with people and only settled when she was carried around and sometimes she would be crying even when being carried. Simone told me she '*never really gets quality time with the baby, to just play with her*'. Simone worried that she may be 'spoiling' her, picking her up all the time, but at the same time she said, '*It is really heart wrenching to hear a baby cry*' and added, '*Then they say you can't spoil a new child too much*'. Simone was struck by the amount there was to learn about a baby and stated, '*It is such an alien thing to have this child here because I've never had any experience with newborns before*'.

In addition to the uncontrolled leaking breasts, Simone found her bed became wet from the body fluids that leak out unexpectedly from the baby. This she also found distasteful:

> *... and from her vomiting and sometimes urine can go through two lots of nappies 'cause I put a cloth nappy over the top of a disposable nappy at night in anticipation of leakages. and I certainly didn't expect to have to change the baby so often and I have to worry about nappy rash and ohh man. It's just too many things, if you've never had anybody with a baby near you that you can watch and even if you do have a best friend whose just raising her child.*

Simone acknowledged that she was totally unprepared for this experience and was adamant that nobody told her any of this, not even the antenatal classes she attended.

Her immediate desire was to put her baby back into her uterus for another three months and then start all over again with some rest and experience behind her. '*I'll have 3 months to you know... prepare myself mentally and physically and surrounding wise for a baby 'cause we weren't really prepared, I thought we were but we weren't. Not at all... oh not at all.*' These difficult four weeks with her new baby gave Simone cause to reflect on what her life would have been like without children:

> *Of course I don't regret what I've done but the other path in life without children can be just as good I think... some people really, really desire children you know and their life would be unfulfilled without children or empty without (a) child, but I'm not one of those people. I sort of resigned myself to not having children so... maybe some women have really maternal feelings and instincts and really want to have children but I really don't want to be a mother. It's nice, she's wonderful in many, many ways, I love her more than life itself but... I'd like my old life back, yeah I would like my old life back.*

It is important to note that Simone appeared to have had little constructive social support. Her partner was able to have three weeks off work with the birth of the baby, however, the couple had just recently purchased a house in another suburb and it required quite a lot of work to make it livable and possible to rent. The couple were financially over-committed and aside from spending time with his new daughter, Greg, her partner and Simone's mother were committed to undertaking minor renovations on this new house during his three week holiday. Simone consequently spent this time as the sole carer for her baby. Simone did not want to ask too much of her mother and was very conscious of not interrupting her mother's nighttime sleeping due to her age. As an independent person, Simone was determined to struggle along without requesting help. During the early weeks and months Simone became quite resentful of her partner's freedom to go to work and his evening part-time teaching job and his little consideration for her housebound position. She received little help from him and was frustrated when she had to show him three or four times how to fold a nappy.

Simone was aware that she was taking a risk in representing her daughter and her life as a mother in such a negative light. It made her angry that few other women were prepared to be so honest. Simone knew her account contradicted both public and

professional discourses of motherhood and breastfeeding and she constantly assured me that she loved her daughter stating, '*I love her more than life itself*'.

After this interview we discussed the possibility of Simone and baby Catherine attending a residential program at one of the mother and baby centres in Sydney. She had already discussed this with the early childhood nurse and felt it was a good idea.
I next met with Simone when her baby was 14 weeks old. Since our last interview Simone had spent ten days at a residential program for mothers and babies. According to Simone the program was very helpful and provided '*a very good training routine*'. Despite her earlier dislike of breastfeeding and the impact on her body, Simone was continuing to breastfeed.

At the start of this interview Simone talked in a more positive way about her baby. She described the baby as 'bewitching' rather than as a 'witch'. She believed Catherine was quite a placid baby, inheriting her father's temperament. Simone stated that she was more relaxed about her daughter's pattern and despite her disruptive routine, she said that her baby was 'wonderful'. Simone was particularly absorbed by baby Catherine's development and the milestones that she appeared to be achieving earlier than average. She worked actively to encourage her development:

> *She really enjoys the books. I can't believe, it's just like at the magical age of three months, the concentration you know, her staring at the page when I don't think it would have happened before...I noticed that the stickers too, I put them up much earlier and she never gazed at them long enough to notice that they were there. Now she just stares, it's fascinating... if you're not there then you miss it, like Greg does miss a lot of... and it's really wonderful to watch them learn.*

During her stay at the residential program, baby Catherine was seen by a paediatrician and Simone was told that her baby had lactose intolerance and was recommended to use medicated drops before feeding. This seemed to make a difference. Simone discussed in detail the numerous practices of infant care she was taught at the mothercraft residential program. She started by telling me she found out all the things that she was doing 'wrong'. Simone learnt 'better' ways to relax her baby to go to sleep, to wrap her baby for sleep, to pat her baby to sleep and the use of music for sleep. Most importantly,

Simone stressed, '**the cot is for sleeping, the breast is for feeding.** I had to teach her to separate the breast from the bed'.

Simone had regained some control over what was happening and the demands upon her body. For Simone, regaining a sense of her rational autonomous self seemed paramount. *'I think children can manipulate their parents, it's not a nice word to use but they can, even at a very young age, they want to get the most out of you, but it isn't the best situation, so you have to control the situation.'*

During her stay at the residential program, Simone had the opportunity to discuss how she was feeling in those early weeks when she was absolutely exhausted, with little support. She firstly attempted to account for these feelings using a professional discourse of postnatal depression. In the following text, however, Simone employed more of a sociological account, describing new motherhood as exhausting, isolating and distressing, but not a form of depression:

> *And then I must have had some sort of postnatal depression for about three weeks before I went to (the residential unit). Because I wasn't really positive in my outlook, I never cried and I was never sad and I still have a good sense of humour but not as good as before. I was really, really resentful that Greg had the old life and I didn't have mine, his life didn't change at all. And you go through a period of mourning too for your old life, if you were so well entrenched, and you have very self-centred view to life. And that's why I didn't think I was depressed because I was never sad and I never cried. I wasn't weepy, I wasn't anything like that, but they call it something different now because it's not like depression, it's a different type of thing. I can't think of what they call it... postnatal shock would be better, a better term. I had visions of you know going for walks and the baby in the pram, but it just didn't eventuate or if it did, it took six hours to get there you know. And there's not, you just don't have any idea, the digestive system in a baby is new and every single like half hour she would be doing a pooh so... oh man. Yes and the projectile vomiting and you just have no idea, the theory is so different from practice, you can read all you like but there's no way some one can explain it to you.*

At 14 weeks Simone was still breastfeeding her baby. She remained completely motivated by a 'breast is best' discourse. For Simone, however, the personal experience of breastfeeding was unpleasant and totally demanding of her time and energy. It was not a practice that fostered a connection between herself and her baby:

> *... breastfeeding is so unpleasant. The nipples hurt so much and the breast milk just goes everywhere, spurting all over the place and all your clothes and furniture gets wet, so there's nothing you can do about it and when the baby sucks all the time and it's painful, that's not pleasant. I don't think that's a good way of fostering a connection with the baby and they are so dependent all the time you have to be there for breastfeeding, when you're bottle feeding you can go away and do something else for a few hours, it's every four hours, very rigid and breastfeeding isn't a rigid schedule, you feel worse than a cow.*

Added to this disturbing experience of breastfeeding, Simone was extremely disappointed by the lack of response from her baby in the first few weeks. Simone had expected that even a newborn baby would provide some feedback, give some sort of response and in the following text she eludes to an important connection between a mother and her baby:

> *And I really thought that babies had some sort of response from birth some umm... ESP connection with the baby or something (chuckles) like you felt like when you were pregnant... but you don't get any feedback, you really feel like a martyr... no response from the baby, no interaction at all. No reward for all the hard work that you've been doing it takes a while too. For the first six weeks there was no eye contact, she just didn't look at people's faces. No real response to your voice... I wish somebody had told me this.*

Simone was open and honest as she constructed this personal account of breastfeeding and the relationship with her baby. Again it was evident that she saw this as taking a risk and she moved to talk about her feelings for her baby. She emphasised the account of unconditional love, stressing that she loved her baby but chose to use the word 'bond' to describe a developing relationship with her baby that was not automatic:

> *You don't automatically feel love for the baby, unconditional love but it's not the love, not a bond, not really. It takes a little while and I heard people say they don't fall in love with the baby until after a year and I'm not surprised. I shouldn't be criticised for that. You can't have a bonding (that) is spontaneous, you might expect it but it doesn't happen. It's a different person and you can't predict how they're going to act and you've had a, you've kept them in a restricted environment in your uterus which is easy to do but outside in the real world, it's all new and it's not a restricted environment any more, you can't predict what's going to happen, you can't control what's happening and umm and it takes a lot to get to know the baby.*

In this account Simone clearly casts her baby as a separate individual operating in her own new environment in totally unpredictable and uncontrolled ways. The child thus competes with Simone's rational autonomous position. In the following text Simone is able to identify the conflict and tensions between life with a new baby who wants continuous access to the breast, and her rational autonomous world as an adult woman:

> *If your world is very regimented and organised like mine was, especially working at the university and in the laboratory, you know, sterile technique, procedure and because babies are just haywire you know...I've learnt a lot about myself, actually you sort of find you actually paint quite a different person to what you thought you might have been before you have children...*

Simone believes that things have improved considerably and she no longer pines for her old life but takes pleasure in the child's development. She stated, '*I'm quite happy to look after her because watching her learn is really fascinating and it's really nice to be able to help her, show her something once or twice and then she copies you, it's really cute*'.

For Simone, being a good mother involves providing a stimulating environment. She goes on to say that while it was not essential that they need a lot of toys to develop, '*you can enhance or speed up by helping the child along*'. Simone then added that a child needs comfort and a lot of it. This, in Simone's mind, required a lot of 'selflessness', learning to segregate her wants and needs.

> *So it's always a balance, a balancing act you know. You've got to give yourself time and then you'll feel better about yourself and then you'll be able to give more to the baby to the child. I hate it when people make you feel guilty for umm leaving the child for a few hours in someone else's care, it's just silly.*

Here Simone appears to be comfortable in insisting that a mother must have time for herself and leaving the baby in someone's care, particularly her partner or her mother, is essential. Simone had always considered that her mother would be better able to care for the baby than she could but since her daughter's birth she talks differently. '*There's no one that can replace the mother. And not even the grandmother (chuckling).*' Finally Simone reiterated that it was not necessary to have a child to have a fulfilling life. While

she believed that children can enhance your life, she also thought that many have children for the wrong reasons.

> *Yes, but I still believe that it isn't necessary to have children to complete your life. I still think that if you're very happy without children, I've been criticised for saying this... it's definitely true and I would have been happy continuing my life the way it was and holidays and a wonderful lifestyle and doing everything that I wanted to do and self-centred you know, you put yourself first and that's the way it should be, you should always put yourself first. There are some people who worship their partner, their partner comes first but hopefully they are few and far between us... but if you have a really dependent child then you have to put the child first and it's quite natural to do that. Children enhance your life. I'm very happy with a child now but it's not necessary to have a child to be happy. I think people have children for the wrong reasons. It's definitely enhanced my life having a different person here. I love having this person here. Because she's totally different and I think you really grow to love them and you love your children more than anything else or anyone else because of the time factor, you know them so completely from birth onwards and I think that that is because you know them so well from birth onwards that you love them more than anyone else .*

CONCLUSION

The stories presented here represent detailed aspects of the experiences of three women in the early months of motherhood. The creation of these stories from the interview data provides a sense of continuity for the reader about the lives of each of these women. Experiences from the remaining 22 participants are drawn upon in the following chapters. Similarly, these women also present rich and diverse accounts, but unfortunately their experiences remain somewhat fragmented. It is important to reiterate that the stories created here are my interpretation of the transcribed interview data.

The purpose of presenting these case studies was to introduce the diversity and complexity of the experience of pregnancy, birth and motherhood in Australia in the 1990s. Each of these women presented themselves as organised, competent individuals leading active, productive lives. Becoming a mother was an important life plan for Trish and Jane. Jane in particular had carefully planned her pregnancy, embarking upon motherhood as another life project. For Simone, the news of an unplanned pregnancy was particularly disruptive. During pregnancy and early motherhood, Simone held

firmly to a sense of individuality and rational autonomy. She felt she had lost control over the direction that her life was taking at this point in time.

When asked to speak of their lives as new mothers, Jane, Trish, Simone and many others in this study turned to describe their experience of breastfeeding. Breastfeeding was discursively constructed by women as they described their baby, talked of the relationship with the baby, discussed infant care tasks, talked of the good mother and the father's position in relation to the baby and finally, when speaking of returning to paid work. For Jane, Trish, Simone and others in this study, the early weeks and months of mothering were synonymous with breastfeeding.

Jane found little reward or 'magic' in breastfeeding or motherhood. However, she was so determined to make breastfeeding work that she rarely constructed breastfeeding itself as demanding. Jane seemed to be prepared to persevere with breastfeeding through extraordinary difficulty and pain. Simone talked relentlessly of the 'uncivilized' nature of her baby and the disruptions that breastfeeding imposed on her life. Simone spoke many times of wanting her old life back, desiring some predictability and control. She was appalled by the messiness of breastfeeding and the changes to her breasts. In the accounts provided by Jane and Simone there is a strong sense that the embodied experience of breastfeeding produced a disconnected, even antagonistic relationship between mother and baby.

Trish provided a strong contrast with many of the women in this study. There was no time in my discussions with Trish that she talked of pregnancy, breastfeeding or caring for her baby as demanding or consuming of her energies. Trish positioned herself as a rational autonomous individual. This, however, did not create tension in the development of a connected and flowing relationship with her baby. The experience of breastfeeding that Trish described introduces the notion that some women experience breastfeeding as a sensual and connected embodiment. Trish thoroughly enjoyed breastfeeding and felt very comfortable as a breastfeeding mother. Trish willingly relinquished her rational autonomous position. She positioned herself and her baby as one, 'a package'.

These stories all portray emotions - they speak of the excitement, joy and contentment and of the exhaustion, disappointment, distress, conflict and confusion that motherhood and in particular breastfeeding brought. These stories highlight the numerous and often contradictory discourses, such as the 'good' mother, the 'good' baby, the rhetoric of shared parenting and 'breast is best', that shaped the meanings and practices of motherhood for these Australian women. What was surprising in these three case studies was the place afforded to breastfeeding. For Trish, Jane and Simone breastfeeding was constructed as central to mothering and for Simone it was imperative for the child's health. Concomitant with the central place of breastfeeding discourses in the experience of these three women, were accounts about changing relationships, changing subjectivities and the embodied experience of breastfeeding. Motherhood and breastfeeding brought a new and developing relationship between a mother and her baby and emphasised the changing relationship between the woman and her partner.

These three case studies set the direction for the further analysis and discussion of the data. Chapters Six and Seven examine the meanings, practices and embodied experience of breastfeeding for these 25 Australian women.

CHAPTER SIX

BREASTFEEDING AND THE MATERNAL BODY: THE CONNECTED EXPERIENCE

The women in this study talked in great detail about their babies, their birth experience and their lives as mothers. Most surprising is the central place afforded breastfeeding in women's construction of a maternal subjectivity. As suggested in the previous chapter, breastfeeding is central in shaping the experience of motherhood in the early weeks and months following birth. In Chapters Six and Seven, I examine the experience and meanings of breastfeeding as both a discursive construction and as an embodied experience.

In Chapter Six, I examine the discourses of breastfeeding present in the accounts of these 25 women. Prior to the birth of their baby, the majority of these women drew upon a public health account, describing breastfeeding as 'best for the baby' as well as economical and environmentally sound. However, it was the personal accounts of relationship and success as a mother that were most important for these women. Breastfeeding was synonymous with mothering. Breastfeeding was to be a source of personal growth and together with parenting, would enhance their experience in life. Breastfeeding was not a choice. It was something that had to 'persevered' with.

Breastfeeding, however, was not only constructed through the varying accounts of 'breast is best', bonding and relationship and personal success, it was also an embodied experience. Breastfeeding was an activity that was sensed and perceived yet difficult to articulate - it was non-discursive. In the second part of this chapter and in Chapter Seven, I examine the embodied experience of breastfeeding. For some women, described in this chapter, breastfeeding was a connected, harmonious and intimate experience, while for others, as discussed in Chapter Seven, breastfeeding was intrusive on their sense of self, it was a disruptive, distorting and disconnected experience.

There is not the space within this thesis to present an analysis of the pregnancy and birth experience of these women. By way of introduction, I provide only a brief overview of

the women's thoughts on motherhood and their notions of the 'good' mother, described in the first interview prior to the birth of the baby. Importantly, however, the analysis of breastfeeding presented in this and the following chapters, exemplifies many of the tensions and contradictions of motherhood in the 1990s.

6.1 CONSTRUCTING MOTHERHOOD AND THE 'GOOD' MOTHER: AN OVERVIEW

The majority of women in this study expressed a strong desire to be a mother. Most had always imagined they would become mothers. For many the pregnancy had been planned, and as rational and autonomous individuals the women described exercising 'choice' and 'control' in their decision to have a child. The timing of the pregnancy was important. Having considered the career path or employment prospects of both partners, home ownership, the length of their relationship and the woman's age, the majority decided they were 'ready to start a family'.

While most stated they were looking forward to motherhood, they were adamant they held few illusions of motherhood as easy, glamorous or totally fulfilling. Motherhood was something they were prepared to 'work' at, it was a challenge. Being a mother was also seen as a creative and rewarding endeavour, and as others (e.g. Beck & Beck-Gernsheim, 1995; Hays, 1996; Walzer, 1996) have described, it would contribute to personal growth. Few of the women talked of motherhood as an obligatory part of female development. Indeed, many of the women were approaching motherhood as someone may approach a career change, a change in their life's direction.

Prior to the birth of their babies, these women also constructed notions of the 'good' mother. Their ideas and beliefs incorporated both 'modern' and 'traditional' accounts of the 'good' mother (Brown, et al., 1994; Harper & Richards, 1979; McMahon, 1995; Marshall, 1991; Richards, 1985). First and foremost the 'modern good' mother was cast as someone who could remain relaxed and calm and be able to 'go with the flow', to be flexible. Simultaneously, a 'good' mother would remain rational and in 'control' of the situation. The 'modern good' mother should also maintain a sense of self and autonomy from the baby. Finally, she must allow her partner to be equally involved in caring for

the baby. These women were committed to the shared parenting discourse, believing there is little difference between a mother and a father, both are parents.

Analyses of accounts of the traditional 'good' mother (e.g. Brown, et al., 1994; Harper & Richards, 1979; Marshall, 1991; Richards, 1985) emphasises a mother's ability to provide unconditional love. As described by many nursing and psychological accounts of the 60s and 70s, a mother must give of herself (Rubin, 1975; Lederman, 1984). The term 'being there' appeared regularly in this traditional account provided by the women. This term illustrated a mother's constant availability to her child, placing the physical, social and emotional needs of the child above her own. These women often referred to their own mothers as 'being there'. For some women, a 'good' mother also carried a moral responsibility for setting the child in the 'right' direction in life, moulding or shaping the child, so that they become productive members of society.

The issue of returning to paid work was contentious amongst this group of women. While six women were determined they would not be returning to work, others stressed that for financial reasons or personal preference, they planned to work. The majority of women, however, wanted to work part time, no more than two or three days a week. Only one woman returned to full-time work within the first six months. This contrasts with the findings from some North American studies (McMahon, 1995; Hays, 1996), where there is a general acceptance amongst women that to be a mother and also be in paid employment is preferable to being a full-time mother.

At various times following the birth, I asked the women to compare their thoughts on motherhood with the images or pictures they had held prior to the birth. Here the women provided varied and sometimes contradictory responses. For some women motherhood was 'wonderful', their babies 'perfect', and life as a mother was 'what they had hoped for' and 'worth all the effort'. Tina described how she had prepared for the worst with *'images of drained women hanging on the line'*, but added, *'I didn't realise the happiness, the joy that you feel in just having him'*. It was also common for the women to present the acceptable public discourse of motherhood as enjoyable and later articulate a personal discourse that spoke of disappointment and distress. For example, Simone found motherhood horrendous and was well aware that this contradicted

popular accounts. Over time many women showed this ambivalence. Motherhood was far more demanding than they had ever thought, and in the early weeks they received little reward from their infants. These findings were to be anticipated and are congruent with many studies of new motherhood in Australia and overseas (Barclay, et al., 1997; Brown, et al., 1994; Crouch & Manderson, 1993; Hays, 1996; McMahon, 1995; Maushart, 1997; Oakley, 1985; Richards, 1985; Wearing, 1984). Interestingly, the women who described motherhood as wonderful tended to be those who found breastfeeding very enjoyable and experienced few problems with lactation and feeding.

6.2 BREASTFEEDING AS SYNOMYMOUS WITH MOTHERING

The case studies presented in Chapter Five introduced the notion that breastfeeding is central in the construction of maternal subjectivity in the 1990s. In the stories of Trish, Jane and Simone, a range of competing discourses shaped the meanings and practices of breastfeeding. These discourses were prominent in interviews prior to the birth. For example, in our discussion prior to the birth, Jane firstly presented breastfeeding as something she had taken for granted. She just expected to breastfeed. With prompting, she drew upon an account of 'bonding', placing breastfeeding as crucial for the developing relationship between herself and her baby 'to create a bond'. The formation of the relationship through breastfeeding was so important that Jane would persevere to '*get it right*'. She then introduced the public account that stresses breastfeeding is difficult and not possible for all women. Stories from friends cast breastfeeding as difficult to '*get under control*'. This troubled Jane as it conflicted with her expectations of breastfeeding as something she would '*naturally*' do. But she was determined to succeed. '*I'm going to try it (to) get through that.*' Finally, Jane introduced an account of breastfeeding as an important aspect of motherhood, an important '*accomplishment*' of identity as a mother. She stated, '*I think it's a major motherhood thing... that you have to... try and persevere and accomplish*'. Jane demonstrated a strong desire for personal mastery over breastfeeding, coveting the satisfaction she believed this might bring. Jane was also partly persuaded by the notion that breastfeeding was part of being a 'good' mother. However, like most of the other women, Jane was not prepared to criticise women who chose not to breastfeed.

In this section I elaborate on the pro breastfeeding discourses that shape women's choice about infant feeding and what this means for maternal subjectivity.

Breastfeeding: 'Natural' and Taken for Granted

Prior to the birth of their babies, all the women in this study planned to breastfeed. I asked the women what had influenced their decision to breastfeed and initially they responded using words such as 'natural', 'expected' and 'assumed'. Only five women in the study spoke of consciously deciding *'to give breastfeeding a go'*. Overall there was a 'taken for grantedness' about the decision to breastfeed, and this initial response to my question did not necessarily reflect a rational or conscious construction. Jane, for example, spoke about breastfeeding as something she had 'expected' to do, it was something so 'natural' or everyday that she *'didn't even think about it'*. She had not even considered it necessary to discuss it with her partner. Jane spent time with a number of women who had breastfed their babies and she felt totally comfortable with the idea. Breastfeeding was *'something that you just did'*. Joanna agreed with this. *'I always imagined that I would breastfeed I think because it's natural... and everybody, my mother, everyone I know has breastfed their babies.'*

In a similar way, Denise, Amanda, Maggie and others had not ever considered that there was a choice or an option, *'there was no decision to be made'*, unless there were problems with breastfeeding that could not be overcome. Kate stated, *'It was simply, that's what you do'*. Christine compared her decision regarding breastfeeding with her thoughts on where the baby should sleep. *'I'm constantly in a dilemma about sleeping, where to sleep the baby, like breastfeeding wasn't an issue, like I just thought I'd just do it...I wasn't really in two minds about that.'*

This account of breastfeeding as 'natural' or 'taken for granted' constructs breastfeeding as an everyday occurrence and as accepted cultural practice. While Maggie, Linda and Joanna stressed that feeding is what breasts were designed for, this was not their motive for feeding. This acceptance or 'taken for grantedness' about breastfeeding parallels the rhetoric of the pro breastfeeding discourses. For example, in a recent editorial in the *'Journal of Human Lactation'*, Auerbach (1996) calls for breastfeeding to be cast as the 'default' form of infant feeding.

Breastfeeding: Establishing a Relationship Between Mother and Child

When asked to explain their decision to breastfeed and the importance that they attached to breastfeeding, the majority of women talked primarily of their desire to establish a 'close relationship', 'bond' or 'closeness' with their baby. Donna presented her intentions to breastfeed as indicative of a desire for a particularly close relationship with her baby. *'I hope it will be a close, bonding relationship...I'm planning on breastfeeding, so I'm wanting that closeness.'*

Despite their commitment to the 'shared parenting' rhetoric, some women also alluded to the notion that breastfeeding may establish an exclusive relationship between the mother and baby. For Donna, choosing to breastfeed reflected her desire to achieve a particularly 'close' relationship with her child which she described as *'my time (with the baby)'*. Kate and Linda spoke of the importance of breastfeeding in re-establishing the close bodily link between a mother and her baby that exists during pregnancy. Kate described this relationship as *'Just you and the baby again... when you're pregnant it was just you and the baby and then like breastfeeding, it's just... it's something only I can do unless I express... yeah. It's that close contact again'*. Linda constructed breastfeeding in a way that privileged the mother-infant relationship. She talked of breastfeeding as a form of symbiosis between a mother and baby. *'I mean you can bottle feed anything... a cow or a little lamb or something, but when it's your own child and it's feeding off YOU... I don't know how anyone could bottle feed a baby...I hope to do it for as long as I can.'* For Linda, breastfeeding was so important that she found it hard to imagine why anyone would not want to do it.

In some of these accounts, breastfeeding is established as a practice of mothering that extends the traditional medical account of bonding and maternal-infant attachment. In the original work on bonding, Klaus and Kennell (1976, 1982) stress the importance of mother and baby being together for at least the first hour after birth, preferably having skin-to-skin contact. Donna described her plans for the birth and her desire to breastfeed immediately after the birth, *'even if it doesn't breastfeed... at least it's... you know, skin-to-skin (contact)'*. Here Donna links breastfeeding with the pervasive public discourse of bonding. While there was not a widespread belief in this study that bonding would be

instantaneous, the majority of the women ascribed to the belief that breastfeeding would make a difference in their relationship with their baby.

The powerful and popular professional rhetoric espousing a stronger relationship or 'bond' between a breastfed baby and its mother has influenced these women in their decision to breastfeed. As described in Chapter Three, a similar account is articulated in other studies (Bottorff, 1990; Hills-Bronczyk, et al., 1994; Kendall-Tackett & Sugarman, 1995; Wrigley & Hutchinson, 1990), where women believe they have a closer relationship with their breastfed babies than woman who bottle feed. In articulating this 'bonding' account, however, the women in my study were quick to defend those who chose to bottle feed. Katrina, for example, considered the situation where breastfeeding was in fact so difficult that it was detrimental to the relationship between mother and baby. She stressed, *'It's just not worth keeping it going if it's affecting their relationship with the baby and that's not worth it anymore'*. None of the women, however, were prepared to question their partner's bond or relationship with the baby given that he was not breastfeeding. Instead they all stressed that their partner would share equally in the care of the baby.

'Breast is Best' - The Perfect Gift for Your Baby

Prior to the birth of their babies, all but three women were convinced by the current 'breast is best' rhetoric. All were fluent in the advantages of breastfeeding the baby. The messages of thriving, breastfed babies, easily digesting the tailor-made milk that comes at the right temperature and provides immunity from illness and infection were well known. Katrina outlined the benefits of nutritional 'content' of breast milk, *'the vitamins, the antibodies, and the fats'*. She also spoke of the *'answers they are finding'*, drawing upon recent scientific discourse proclaiming the advantages of breastfeeding for the child's intellectual development. Katrina concluded, '*You can't beat that, you can't argue against it, there's no way*'.

Carmen was very clear about her motivations to breastfeed. Firstly, Carmen had been born prematurely and spent one month in an incubator, preventing her mother from breastfeeding. Before she was a year old, Carmen had developed asthma. She linked this directly to not being breastfed and she was determined to feed her own baby for as long

as possible. Secondly, her partner was extremely 'health conscious'. He had spent considerable time researching potential allergens in food products and had modified their diet accordingly. He believed it was imperative that Carmen breastfeed their baby and his beliefs were extremely influential in their early months of parenthood. As discussed in Chapter Five, Simone was also determined to breastfeed purely for the nutritional and developmental advantages for the baby. Unlike the majority of other women, Simone's account was dominated by the medical and scientific discourses and she disregarded the popular, emotional account of the importance of breastfeeding for the relationship between a mother and her baby.

A few women mentioned texts that they had read in preparation for breastfeeding, however, as Maggie stated, *'This was preaching to the converted'*. To confirm her opinion, Maggie had read the book *'Breastfeeding Naturally'*, produced by the Nursing Mother's Association of Australia, and she emphasised that exclusive breastfeeding was the best all round. From her reading Maggie believed that most difficulties could be overcome and she tended to dismiss the stories of difficulty she had heard from relatives. Lyndall added, *'It was a combination of things like all the books that I'd read have always promoted (breastfeeding)... they're always pushing it and when I came to the (antenatal) classes they were you know very much for it'*.

Given the prevalence of child-centred, healthy baby messages in medical and nursing accounts, it is interesting that many of the women chose to prioritise the psychological account that stressed the emotional benefits for the breastfeeding mother. The women's desire to establish a 'close' relationship with their baby was dominant. For example, prior to the birth of her baby, Jane did not refer to the professional breastfeeding discourses of 'breast is best'. Even when it became inevitable that she would have to give up breastfeeding, Jane expressed her disappointment through an account of 'bonding' rather than the infant-centred medical discourse. Similarly, Trish as a neonatal nurse was well versed on the infant-centred medical and nursing discourses associated with breastfeeding but only fleetingly drew upon these professional discourses. Instead she related the importance of breastfeeding to the role of a 'good' mother and the developing relationship between mother and baby.

The 'breast is best' account sits comfortably with the 'taken for grantedness' of breastfeeding. As discussed previously there was a strong sense that most of these women had just expected or assumed that they would breastfeed. It was not even worthy of discussion or debate with their partners. In the same way it is probable that the infant-centred medical discourses stressing the health advantages of breastfeeding are so well known that they also do not need mentioning. The decision to breastfeed becomes 'natural' and of course rational.

A 'Good' Mother Breastfeeds

Prior to the birth it was not uncommon for the women to introduce their accounts of breastfeeding when responding to the prompt, 'What is a good mother?' Breastfeeding seemed 'the proper thing to do', exemplifying the 'good' mother. Trish cast breastfeeding as important for the development of the infant and as described in Chapter Five, Trish made a quantum leap when she linked breastfeeding to the production of *'productive members of today's society'*.

Denise also constructed breastfeeding as a characteristic of a 'good' mother. Denise was very careful to position herself as flexible in her approach, stressing that every baby and every mother were different. Different practices would suit different families. Yet when asked to talk about a 'good' mother, Denise introduced the importance of breastfeeding. Breastfeeding, particularly demand feeding, was a practice that assisted in providing a secure, sound and positive environment for the baby. On the other hand, Denise insisted that she was not going to criticise someone who chose not to breastfeed. This contradiction was common. For example, Trish, after linking breastfeeding to the tasks performed by 'good' mothers, stated, *'I don't perceive it as if you're a good mother you breastfeed and you're a bad mother if you don't, it's that person's choice'*. These women were very concerned to position themselves as supportive of the diverse beliefs and practices of other women. This contrasts with a previous Australian study, where women were more prepared to criticise those who chose not to breastfeed (Cooke, 1996).

Persevering: Breastfeeding Shaping Maternal Subjectivity

What has influenced the strong desire to breastfeed exhibited by Jane, Trish, even Simone and many of the other women in this study? In this analysis two main sources appear to be currently fuelling the desire described here to breastfeed. The first imperative is discursively constructed through the child-centred professional discourse of 'breast is best', the popular 'bonding' or relationship discourses and the account of the 'good' mother. In deciding to breastfeed, these women established at a rational or conscious level a desire to satisfy the requirements of these discourses. Breastfeeding, like motherhood, was to be approached as a project. It was goal oriented. The second imperative to breastfeed was much more difficult to articulate and focused on the 'special feelings' and experiences that these women had heard could be gained from breastfeeding. This desire to breastfeed was in some senses non-discursive (Young, 1990).

In approaching breastfeeding as a project or a goal, many of these women believed that breastfeeding would be a source of satisfaction, contributing to personal growth and identity (cf. Bottorff, 1990; Lawson & Tullock, 1995; Maclean, 1990). This account parallels notions of the rational, autonomous individual, highlighting a contemporary concern with control over our lives in order to achieve our potential as individuals (Rose, 1996). In line with contemporary management discourses and our orientation to goals, breastfeeding was something that had to be mastered, 'got under control' and 'accomplished'. Once accomplished, the sense of being a mother, a maternal subjectivity would be complete/achieved. Jane exemplified this position when she stated, *'Breastfeeding is a major motherhood thing'*. Linda also put this position well:

> *(Breastfeeding is) just important to me, I don't know why it's so important, 'cause Mark (partner) said 'Are you sure you want to do that, like you'll have to get up all the time. I can't just take a bottle out' and, and I went 'That's something that I, I don't know, I've always said if I had a child that I'd breastfeed it as long as I could.'*

Amanda stressed breastfeeding was *'personally really important to me'*. She planned to breastfeed for as long as possible. Joanna was quite *'excited'* by the prospect of breastfeeding and Denise stressed that she would be *'disappointed'* if she could not feed.

For Donna and Christine, breastfeeding was *'part and parcel'* of motherhood. Donna stated, *'I need to feed my baby, it's something that is important to me'.*

Lyndall also said that she would be disappointed if she could not breastfeed, however, she produced a different account of her desire to breastfeed. Lyndall was determined to breastfeed to prove her critics wrong: family and friends had all emphasised that breastfeeding was so difficult it was hardly worth it, *'all they say are the negative things'*. Lyndall was convinced that breastfeeding could be a positive experience.

Despite the 'taken for grantedness' of breastfeeding described earlier, it was also described as a difficult and demanding. These women emphasised the need to 'persevere' with breastfeeding. It was approached almost as an athletic endeavour, where women had to train their bodies to undertake a particular activity. The early weeks of breastfeeding had to be endured in order to reap the personal benefits. When problems were encountered they believed they should seek advice, to get breastfeeding *'under control'*. Ultimately many women hoped they could achieve a satisfying breastfeeding experience that was *'well worth it', 'everything that the books make it out to be'.* The women in this study were prepared to 'persevere'. They were not going to give up easily. Christine stated, *'It was worth the initial sacrifice',* and Maggie had determined she would *'battle through the first six weeks'.* Bottorff (1990) in her study of a group of Canadian women also found an imperative to breastfeed that motivated women to 'persist' through any difficulties they encountered to achieve their goal.

What if breastfeeding were to be 'unsuccessful'? What if they could not breastfeed? All the women described the 'horror' stories, the talk of the difficulties of breastfeeding that they had heard. These personal stories presented breastfeeding as problematic, it was painful, there was not enough milk or their milk may not be 'good' enough. While the women wanted to remain optimistic they were guarded. They did not want to appear to be *'setting themselves up for failure'*. If breastfeeding was not successful, Trish decided, *'Well that was no big deal...I'll certainly try. I mean if it doesn't work, it doesn't work, I'm not going to let the baby starve'.* Christine felt that it was best to just face the problems if they arose. *'I don't like to be this optimist but hopefully I won't have any problems.'* But she added, *'I'm not going to be committing suicide if I can't do it'.*

Katrina was hoping to breastfeed but described how she planned the *'big picture'. 'I hope to feed for as long as I can, but if you can get those first three days in that's great, and then if you can get a couple of months down the track, well that's wonderful.'*

In a similar way to their discussion about their plans for their birth, these women did not want to have 'unrealistic' expectations. Denise stated:

> *Well I'll try (to breastfeed)...that's all you can live at. I mean I'm not sort of putting conditions on myself to say that I have to do this and that...I know that it doesn't work for everybody and I'm prepared, just like, I want to have my baby in the Birth Centre but that doesn't necessarily mean I'll really have it there.*

Katrina in fact drew a parallel between what she saw as the pressure to have a 'natural' birth and the pressure to breastfeed:

> *I think breastfeeding and birth are probably the two things that you are under a lot of pressure, to have a natural birth and then full on breastfeeding. I've had a friend who had to have a Caesarean and she wasn't able to breastfeed for as long as she wanted to... she had to work through all of that and (yet) she's perfectly healthy and she's got a gorgeous little boy. She's thankful that there are alternatives for her um, but you know there's pressure definitely, pressure... to be as natural as possible.*

'Something Special About Breastfeeding'

The second imperative to breastfeed appears to be more difficult to articulate. For many of the women in this study, there was 'something special' about breastfeeding. This 'something special', however, was difficult to describe. Some women had read in parenting manuals about the 'special feelings' associated with breastfeeding. Most related this to the child-centred discourse and the importance of these feelings for 'bonding'. A few traced their ideas about breastfeeding being 'special' to discussions in antenatal classes, what they were 'told'. Most women, however, had spoken with and observed family and friends breastfeeding and it was these images that they tried to describe. There was something *'very nice'*, or *'lovely'* about breastfeeding. Aesthetically and visually breastfeeding appealed to them, appealing perhaps to their sense of connectedness and close intimate and sensual contact with another human being. Marianne stated that she really would 'love' to breastfeed. Katrina and Marianne

believed women *'look really nice'* when they're breastfeeding. Marianne added, *'It's lovely, it looks so easy when they do it I can't imagine that they've gone through a lot of trauma'.* Donna thought, *'It's beautiful to see a woman feeding her baby'.* At the same time, however, the notion of a baby feeding at their breast was weird, strange and, perhaps like birth, almost impossible to conceptualise at a conscious level. It was something that they wanted to do.

In their attempts to articulate these images of mother and baby peacefully breastfeeding, sharing intimate times together, a couple of the women chose to contrast this image of breastfeeding with their image of feeding an infant formula in a bottle. Here bottles were represented in a negative way. Marianne showed almost a revulsion to the sight of a baby being bottle fed. *'Yeah I've always thought 'oh yuk, bottle feeding.''* Trish, who prior to the birth was aware that her baby may need to be cared for in a Special Care Nursery, was adamant that her baby would not be formula fed at all. *'I don't want it to be labelled as ARTIFICIALLY fed.'* Sally just felt somehow *'it was not right to feed a baby by bottle'*

.Breastfeeding - a Non Committed Approach

For some women the breastfeeding relationship between a mother and baby is not the ultimate relationship and would have no bearing on their identity as a mother. Cooke (1996) found some women were 'pragmatic' in their decision to breastfeed. There were five women in this study for whom breastfeeding was simply a means of feeding a baby, a pragmatic or rational decision constructed in terms of convenience for the mother and health for the baby. Tess positioned herself in this way. For most of her pregnancy she had stated that she was not going to breastfeed, she did not like the idea. Two weeks before the birth of her baby, Tess, while not totally committed to breastfeeding, felt she would give it a go. Breastfeeding did not hold the key to a close 'bond' between her and her baby. With a similar thought, Jacki told the story of one of her friends who had breastfed for two years. Jacki found this practice *'excessive'* and described her friend as an *'insecure'* sort of person. Jacki was adamant that breastfeeding was not an important part of her identity as a mother. Unlike the majority of women in this study, Tess, Anna and Kylie believed that the advantages of bottle feeding almost equalled the advantages of breastfeeding.

In Chapter Three, breastfeeding was described as both a public health issue and a cultural practice. The majority of writings on breastfeeding argue for the promotion and support of breastfeeding, constructing a dominant account around the demise of breastfeeding in western societies and the insidious impact this has had on infant feeding in developing countries. Critics argue cultural beliefs such as place of breasts in (hetero)sexual activity (Rodriguez-Garcia & Frazier, 1995; Van Esterik, 1989) and the aggressive marketing of breast milk substitutes (Baumslag & Michel, 1995; Palmer, 1988) restrict the practice of breastfeeding as a nurturing female activity. Paradoxically, most of the women in this study described the pro breastfeeding accounts as the most influential in their lives as new mothers.

During the interviews following the birth, the women talked in detail about breastfeeding. All the women in this study breastfed their babies. The length of time varied from five days to well over 12 months. Following the birth, they reiterated their commitment to breastfeeding and the discourses of bonding, relationship and the child-centred account of 'breast is best'. Most importantly, however, breastfeeding was not simply a discursive construction where women's beliefs and practices were shaped by dominant discourse. Breastfeeding was a non-discursive, embodied experience.

Many of the women in this study worked very hard to articulate the non-discursive, embodied experience of breastfeeding. Phrases such as 'nobody told me breastfeeding would be like this', 'it's hard to explain it' and 'I can't describe it' were common. None of these women had been able to imagine or prepare for the embodied nature of breastfeeding. Sally captured the nature of this experience particularly well and in the following quote attempts to describe the 'strange' and different sensations associated with breastfeeding.

> *Because you don't have that much sort of physical (p) not contact... um (p) physical um... association with things that you do in life so much...Yeah but that (breastfeeding) is one thing that is so... that's all there is to it, it's so physical that... well I don't think that I have ever done anything that, not even exercising to a great deal that makes you feel as so much a part of what you are doing... it's very strange.*

Here Sally tried to capture the way in which she was totally a part of her physical being during breastfeeding. There is no separation of mind and body. It was an embodied experience.

6.3 BREASTFEEDING AS A CONNECTED, HARMONIOUS AND INTIMATE EMBODIMENT

In the interview prior to the birth, some of the women talked of experiencing a close relationship with the baby in utero. They described a connected, harmonious and intimate experience of pregnancy. The embodied sense that they and their baby were one, as though belonging to the same body, was exhilarating. These women did not expect to experience such a sensual and harmonious embodiment once their baby was born. Marianne's comment is illustrative, *'Now it is part of me, but at birth I see it as a separate person'*. They anticipated their physical separation at birth would be permanent and the baby individual and autonomous. During labour and birth the embodied continuity of pregnancy is often disrupted and body boundaries are distorted (Rubin, 1984) as the cervix dilates, perineal muscles stretch and the body is 'torn' by pain. The impact of separation at birth is often dramatic. In this study, however, the continuity, the sense of oneness, was restored for a few women almost immediately following the birth and for others, some time after the birth, with the commencement and establishment of breastfeeding.

For many women in this study, breastfeeding, and by extension motherhood, was a wonderful experience. In Chapter Five, Trish provided an account of breastfeeding that demonstrated the continuing close connection with her baby developed during pregnancy. Despite the distressing early separation from her baby, she spoke of breastfeeding and motherhood as wonderful within the first week of her baby's life. Trish provided one of the most striking examples of women who experienced breastfeeding as connected, harmonious and sensual. Trish worked hard to articulate it as an embodied experience. She spoke of an increased awareness of her own body as a *'shared body'*, connected to her baby. Breastfeeding offered intimacy, a sense of being needed and a reward of ownership. Trish described a sense of harmony or flow between herself and the baby. They were *'a package'*.

Shared Bodies

Trish was one of the few women who articulated in personal discourse an awareness of her body through breastfeeding. The first week after her baby's birth, Trish described how her body felt relaxed during breastfeeding and she sensed a '*calmness*' in herself. Breastfeeding placed her in another world where the events happening around her did not matter. This felt wonderful and Trish stated, '*Breastfeeding's unreal...I feel great*'. In a similar way Joanna also sensed and tried to articulate an embodied self experienced through breastfeeding:

> *I don't know how to explain it...I used to get very vague. I couldn't do things... 'cause I'm always someone who can do ten things at once and get them all done. Whereas I couldn't do one thing properly...I used to say is this normal? Am I supposed to feel like this? And people used to say yeah... you always feel like this. And I used to think if I'm going to feel like this for the rest of my life... I'm not going to have any more kids (chuckling). And now it's like second nature. I really like the feeling. It's a nice feeling.*

Here Joanna identifies her difficulty in trying to put this experience into words. She had a strong sense that breastfeeding her baby was making her more relaxed and directing much of her conscious thoughts into caring for the baby. To account for this 'wonderful', 'unreal' and 'nice' embodied feeling, Trish draws on a biological discourse of the body, speaking of the hormonal action that produced this effect. This sits comfortably with her rational approach and her professional account of breastfeeding. Joanna, who did not have a medical or health-related occupational background, also employed a similar account to explain the way she felt:

> *I didn't know that when you breastfed you produce a hormone that makes you go back to sleep straight away - Prolactin. Well I have noticed...Mum said having a baby would calm me down. 'Cause I've always been very... not stressed out but... always on the go. And since I've had him I can sit down and relax a lot... which is good.*

This sense of a 'calm' and 'relaxed' self prompted Trish and Joanna to praise the biological discourses of breastfeeding, privileging the effect of hormones. Other women found this embodied experience frustrating and disconcerting. Kylie talked of being '*irrational*' in the first few weeks at home with her baby and Jane represented her body as battered, constantly changing as the level of hormones fluctuated due to pregnancy,

birth, breastfeeding, weaning and finally menstruation. Indeed Trish, once able to articulate this experience, recognised it as different from many of the women she had cared for. With this personal experience of harmony and satisfaction, Trish seemed convinced that most first time mothers were somewhat '*irrational*'.

In our first discussion after the birth, Joanna attempted to articulate the connected embodied experience she was sensing - the notion of unity, of experiencing a 'shared body':

> *Yeah, well I felt more when I first had him that he was... like... I can't quite explain like... to think that he... I said to my father-in-law yesterday to think that Tristan (has) lived off me...I think it's unreal...I fed him inside and now I've breastfed him and I feel really good...It's hard to explain it isn't it? But it's all so natural.*

This sensed embodied experience is typically difficult for women to articulate and here Joanna posits that a 'shared body' is somehow 'natural'. At six months, Joanna reiterated her notion of a 'shared body' maintained through breastfeeding. Now breastfeeding was important in establishing possession or ownership of a child. *'It will be sad the day I have to give up feeding him...I don't know... when it works. It doesn't always work so well... there's this real link between the baby and you... and it... really establishes you as the baby's mother.'*

For others the link between their own body and that of their baby was evident through the baby's recognition of the mother's smell, in particular the scent of the breast milk she produced. Linda described Todd's ability to sense that his mother was nearby because he could smell the breast milk even when asleep.

Trish and Joanna also highlighted the baby's ability to recognise the breast, not merely as a separate object but as something that was either an extension of their mother or alternatively an extension of themselves. In Chapter Five Trish described with excitement the amazed look on her baby's face when at about five months he realised *'I was connected to the breast'*. Joanna further described the link between herself and her child after six months with the baby identifying her breasts as belonging to his body

rather than hers. 'W*ell the other day... actually I was sitting up with no top on. I was holding Tristan and he just latched on and Malcolm said, 'Are you due to feed him?' and I went 'Oh well it is now'. Because he just saw it and helped himself as though it was his breast... he gets so excited when he is being fed.'*

The notion of the breast as something shared between mother and baby is also illustrated in Amanda and Denise's descriptions of their efforts to clear a blocked duct in their breast. This was constructed as a joint venture between mother and baby. Amanda described drawing upon the literature she had read when she discovered a 'lump' in her left breast:

> *The other night my left breast felt really uncomfortable and I thought, 'Gosh it feels SORE' and I let it out, you know, under the bra and I had this really hard lump and it was really tender. I just sat there just sort of rubbing it. Jim said, 'Shouldn't you massage it or something?' I said, 'He'll wake up soon so I'll get him to feed from that side first' and I remembered reading or hearing somewhere about it and they said something (about when) they've got a lump, 'You have the baby's face the chin is facing the lump (as he feeds)'... and he woke up about 20 minutes later and I tried the old football pass which I'd never had done before but I gave it a go and umm, yeah it (the lump) went away, so we're very clever...*

Amanda felt very pleased with the way she had combined a professional discourse and the strong sense that she and the baby together solved this problem. In a similar account, Denise talked of her increasing confidence when she managed to clear a blocked milk duct in her breast by massaging it. She then related her decision to get the baby to solve this problem. *'I've just changed my position (how I hold him) in order for him to get at the ducts and... so I just sort of swapped him over.'*

In this personal discourse of the embodiment of breastfeeding was a sense of pleasure at 'sharing' their body with another. Even when the women spoke of foods eaten or medications taken, there was this sense of satisfaction in recognising that this may or indeed did impact upon the baby. Their own bodies and what they ate or drank became important, almost precious, and heightened their and others awareness of their central relationship to the baby. This pleasure in sharing or 'giving of' their body, described by Rubin (1975) as a maternal task in pregnancy, was not universal. As discussed later in

this chapter, many other women in this study found the demand to share their body intrusive.

Dependent and Needed Bodies

Comfortable in the notion that they were 'sharing' their body with another, some women also found personal reward in the dependence that their baby had upon them. Some used humour to illustrate their position as the 'milk cow' or the 'feeding machine'. However, in moving from humour, some women found satisfaction in the feeling that they were so central to their baby's survival. It was a 'nice' feeling and Lyndall added, *'That it is my milk satisfying him'.*

In our first interview Linda spoke of her commitment to breastfeeding and the importance of feeding *'your own child, when it is your child and it's feeding off you'.* Linda's commitment to an account of interdependence or symbiosis between a mother and her baby was compromised when her baby spent six days in Special Care Nursery. Within two weeks of being home from hospital, however, Linda described breastfeeding as wonderful. Linda gained much satisfaction from the feeling that her breastfeeding baby was dependent upon her, a mutually satisfying dependence or connection, something that was far more important than her afterthought of '*convenience*':

> *...No, that's a special kind of moment, when you breastfeed, when you look up and then you look down and they're down there looking at you and you think, 'Oh, this is when they need you the most'... that you know that they REALLY need you. Oh no, it's a wonderful thing to breastfeed and it's so convenient.*

Here Linda articulates an embodied connection to her baby through firstly, a 'shared gaze' and secondly, a rewarding sense of the dependence that her breastfeeding baby has upon her. Lyndall also recognised the enabling power of this total feeling of being needed. *'I suppose it's a bit of an ego trip or something you know. I like feeling that... I'm responsible for him.'* As an afterthought Lyndall added a rational account, *'I enjoy feeding him, I'm really pleased with breastfeeding... it's going so well and I feel really needed... crucial, I just feel so confident because that's worked'.*

During the interviews the women were asked to describe their relationship with their baby which proved difficult particularly when their infant was still very young. Most described having a close relationship with their baby and all aspired to a close relationship where life experiences could be openly shared. At this time, however, most of the women saw themselves as crucial to their baby's survival. Donna, for example, constructed a very close relationship with her baby based around the dependence on breastfeeding. She stated, '*Firstly nobody else can feed him*'. Donna is interesting here in the way she includes her partner. If she were away she was certain her baby would survive but he would be very upset and take much longer to settle than if she or her partner were there.

> *If I was away from him for a time... I think he probably would not miss (me) I mean I don't know that they've got feelings like that but firstly nobody else can breastfeed him so I'd think he'd get hungry (chuckling). I don't know how well he'd take to a formula... let's put it that way...I don't know how quick he'd be able to settle for anybody else... he'd probably miss Paul too... so it's that sort of closeness thing...Ultimately he'd survive regardless.*

Many of the women demonstrated the interconnectedness and dependence that breastfeeding brought between themselves and their baby. This dependence meant that it was very difficult for them to be away from their baby for any length of time. Amanda described leaving the baby with her partner while she went to get her hair cut. Afterwards she rang to check on the baby, hoping that she would be able to do a bit of shopping. The baby had woken just before she rang and was screaming to be fed. In a bit of a panic but determined not to get a speeding ticket, Amanda rushed home. This is an interesting link between the mother and the baby and for Amanda this was the first time she really recognised her baby's dependence and immediately vowed to start expressing breast milk. *'I just can't escape, not that I want to escape but if I ever need to be away from him I'll have to leave some milk.'*

Contrary to other reports (Maclean, 1989, 1990; Carter, 1995), some of the women in this study enjoyed the dependence of their breastfed baby. Wrigley and Hutchinson (1990) have also described the satisfaction women gain from being able to meet the needs of a dependent baby. In their study, Wrigley and Hutchinson (1990) found women who breastfed for a prolonged period (over one year) had rearranged their lifestyle to

focus on the child and his or her needs. They were prepared to engage in what Hays (1996) describes as 'intensive' mothering. The women in this study who described such dependence in the early weeks and months after the birth felt positive about themselves. They felt good that it was their own body sustaining their infant. Susan described with pleasure her baby's refusal to take the bottle when it was offered to him, even though she had purchased one of the bottles with an *'advanced teat that is very close to the nipple'*. She stated, *'He likes the real thing'*. Within these discussions, a certain disdain for feeding with formula crept in. Sally believed that she would feel *'odd'* or *'alien'* if she did not breastfeed and added, *'I just think... why, why are you doing that? Um when... you're the best-equipped person to feed the child... instead of using a bottle as food. And these bottle fed babies do seem to be pretty chunky babies... it's almost an obesity'.*

Even Tess, who constructed her relationship with her baby in a different way to those women experiencing breastfeeding as connected, harmonious and pleasurable, still described herself as the baby's 'lifeline'. However, for Tess there was a strong sense of morality implied in this relationship. It was her place to bring up her child in the 'best' and 'healthiest' way possible.

Harmonious and Flowing Bodies

Previous qualitative studies of breastfeeding have highlighted a sense of harmony, synchronicity or reciprocity between a mother and her breastfed infant (see Bottorff, 1990; Hewat & Ellis, 1984; Leff, Gagne & Jeferis, 1994; Wrigley & Hutchinson, 1990). Commonly this harmony is described as a central finding or core category of the experience of 'successful' breastfeeding. For some women in this study there was similarly a sense of harmony and synchronicity in their relationship with their baby. At an early stage Trish was able to talk about the way she communicated with her baby and could read his needs. She knew when he was tired, hungry or just needed a cuddle. Indeed four weeks following his birth, Trish was so confident in caring for her baby that she was able to spend considerable time helping her neighbour who was floundering in caring for her seven-week-old baby. Trish described vividly in Chapter Five how she had learnt to recognise the intense stare that her baby gave her when he wanted a feed and added proudly, *'Nobody else would be able to pick it'*.

As these women came to know their babies, they became increasingly more satisfied in their experience as mothers. Linda continually used illustrations from her breastfeeding experience to describe her developing relationship with her baby:

> *When he's breastfeeding he looks straight at me all the time, sometimes I'd be looking around like this and I look down, he's just staring at me and I think 'I should be talking to you or something'. I know that he knows it's me and then, like he hears my voice, his little eye will turn around and things like that and he has a different little way with Mark than he has with me, like Mark talks to him and then he goes 'Ah' sighs and things like that. I talk to him and I don't make much noise and he really stares at me. When he's cranky he gives me a cross sound, but no, I suppose we have our own little way we get to know each other...*

Even though in her early accounts Linda always represented breastfeeding and motherhood as harmonious and satisfying, she talked about it all 'clicking' or coming together when he was about four months old. 'Y*eah probably when he was about four months I started to click into the way of thinking of the little one.'* Linda enjoyed cuddling and playing with the baby and described the way that she communicated with Todd and how they have come to know each other so well, depicting a sense of harmony and connection between mother and baby:

> *I sing to him and he laughs. He knows my voice, he knows, I think, when I'm in one of my moods... and he knows when to be happy with me like, I can make him really, really happy sometimes sad I suppose (unhappy) when I don't pick him up when he wants me to. But I think we communicate well enough, we know each other, I know what he wants and he knows how to get it off me... so I suppose we can read each other like a book as they say.*

The harmony and synchrony Linda enjoyed with her baby by four months of age contrasted with the frustration she later felt when she returned to paid work, '... *that was when he was a perfect child and I was the perfect mother. Oh I'm not a very good mother now'*. Returning to work when her baby was five months old, Linda continued to breastfeed when at home but felt everything was a rush now and that she had lost the harmony in her relationship with Todd.

The final time that I spoke with Joanna when Tristan was six months old, she was so captivated by her son that she could not wait for him to wake up after each sleep. Indeed

she missed him when he was asleep for a few hours in the other room. Family and friends had commented that the novelty would wear off but Joanna did not believe this would ever happen. She spoke of only one occasion where she had the urge to have some time away from the baby. She added that even her partner, Malcolm, stated one Saturday, *'I'm really looking forward to him waking up'*.

Sensual, Intimate and Pleasurable Bodies

In the interviews prior to the birth many women spoke of breastfeeding as crucial for the 'bond' between them and their baby. When asked to elaborate, they talked of it bringing a mother and baby closer together. Many of the women had imagined themselves breastfeeding and hinted at the pleasure or enjoyment they had heard could be gained from it. These notions were based primarily on what they had heard from friends and read about or heard in classes.

The women were well versed on the behaviours or actions that are believed to heighten this sense of closeness or 'bond' between mother and baby. For example, Linda talked of it being essential that a mother look at, talk to and stroke her baby while breastfeeding. This same message played on Sally's mind when she would read a book while breastfeeding her baby. She felt that somehow she was ignoring her baby in doing this and so decided to read aloud so the baby could listen to her voice.

After birth and even six months later, this 'closeness' or 'bond' was not easily articulated. When describing their feelings about breastfeeding some of the women who experienced breastfeeding as connected and harmonious stated, *'It's hard to explain, I don't know how to describe it, it's just something so special, so pure', 'Nobody had told me about these feelings'*. Susan insisted that this intimate relationship was not something that she had just heard about, rather it was something she had experienced through continuous, intimate contact with her baby. It was *'a personal touch'*. It appeared that breastfeeding meant more to these women than just closeness. There was something indescribably 'special' about their relationship. Trish loved breastfeeding, and as her relationship grew with her baby she talked of herself and the baby as a *'package'*. They were always together and shared many 'special times' alone. She cherished special times with him, particularly getting into the single bed with him when

he wouldn't settle in the middle of the night. She was clearly torn by her own desire to have the baby in bed with her stating, *'It's me that wants to go to bed with him'* and the account of a 'good' baby that insists a baby must be in its own bed. She justified her decision by stressing that it did not happen all the time and the baby was really very settled and therefore lying with him was only necessary sometimes.

In the early weeks of motherhood, Linda, like Trish, experienced breastfeeding as intimate and satisfying and she repeatedly stated *'breastfeeding is wonderful'*. Linda's baby was born five weeks early by caesarean section and he spent his first six days of life in the Special Care Nursery. The opportunity to breastfeed her baby for the first time occurred when he was five days old, which Linda found *'thrilling'*. She immediately sensed a heightened closeness to her baby stating, *'Nothing could replace that feeling, that closeness. So special... it was wonderful.'*

A number of women spoke of the intimacy and pleasure they felt when they looked intently at their baby during feeding. Linda introduced this notion of a 'shared gaze' when she talked of her baby's dependence upon her and his tendency to look at her while feeding. This 'shared gaze' was also well described by Amanda. When baby Josh was three weeks old, Amanda spoke about her main motivation for breastfeeding:

> *It's just lovely, the face, and you get that beautiful, peaceful face just looking up at you and you watch all the expressions as they're feeding and then just finished, it's just, there's just some really beautiful moments just looking at them. I mean, I could sit there and look at him for hours anyway, but just when they're drifting off to sleep and they've had a feed or there's, so calm, it's the closeness, that intimacy...*

The three-week-old baby was totally absorbing, taking all her time, energy and emotion. *'It's definitely an all consuming thing in terms of time and emotions... it's just wanting to sit there and stare at him all day whether he's awake or asleep.'* Articulating such intimacy and pleasure prompted Amanda's next thought of the sensual nature of the baby's body and the desire to share skin-to-skin contact:

> *I was thinking the other day, about the skin-to-skin thing. I thought 'It's like taking everything off but his nappy because he's very dangerous without his*

> *nappy on' and actually having that whole skin-to-skin rather than, 'cause he's always, sometime I'll just leave a singlet on but just to, just to feel that...I'd love to have a bath with him because he loves kicking and splashing. It would be lovely to sit there with him.*

This desire for closeness also prompted Joanna to bath with her baby. She elaborated on the sensual nature of her breastfeeding experience, *'I fed him in the bath. But it was such a nice feeling to think that I had... I was lying in the bath and I thought well... Oh this is lovely. Their bodies are just so perfect'.*

Other women described with pleasure the way their baby appeared very excited as they were put near the breast. Susan talked of loving the way that her baby snuggled into her body to breastfeed. *'I love it, he still snuggles up to me, now he really cuddles me to him, it's even better now, he's all excited when I put him there for feeding, his legs like... kicking with excitement.'* Fiona also savoured some of the pleasurable moments of breastfeeding. *'I love the closeness, the warmth and I love looking at his little face if he comes down to the breast and he's got it in his view and even his mouth gets ready. He latches on, gets his mouth in the position and he starts to breathe and get excited.'* Fiona tended to feed her baby while she was lying down in order to slow the flow of her breast milk and described how this position brought their bodies even closer together as he lay on top of her.

The sensual intimacy of this relationship was very powerful and the women were sometimes cautious in their descriptions. Yet this intimate experience of breastfeeding was so pleasurable and sensuous that these women often participated in practices that would maintain this embodied connection. Most commonly this consisted of establishing special times with the baby where they could cuddle up intimately. In Chapter Five, Trish talked about '*wanting to go to bed*' with baby Mitchell. While her baby had a 'good' routine according to Trish and did not need someone to lie with him, she found herself wanting to do this, '*it's so nice*'. Linda talked at great length about the '*special times*' that she enjoyed with Todd.

> *I like giving him his bath... that's the favourite part of the day, and the morning feeds he lays up in bed with me and I feed him in bed and then he'll um will take all his clothes, well I take the bottom half of him I've to change his nappy after*

I've fed him, and he'll have a kick and I'll play and we talk, (laughs) and I try to read him nursery rhymes and things like that...That's my favourite time... when it's just me and him now... and then during the day, like I spend time with him but it's not the same as in the morning, 'cause I lay in bed and he gets into bed with me...

This is a particularly vivid description of a mother's notion of 'special time'. Linda gives great detail of her early morning time with baby Todd. Often he has no clothes on other than a nappy and they cuddle and play together in an intimate way. Linda resents the intrusion of her partner's phone call from work to check that she hasn't fallen asleep or rolled on top of the baby. This is a special time of day for Linda and she indulges them both as later in the day she has housework and washing to get done.

Sally had found breastfeeding difficult in the early weeks and while not a particularly enjoyable experience personally, she maintained that it was better for the baby. However, three months following the birth Sally found breastfeeding to be a very important part of their relationship. She was already worrying about introducing the baby to solid food, *'I don't want to I know it's silly... it sort of makes my role a bit obsolete'*. Sally knew she would be distressed if he suddenly decided to wean himself. In a similar way to Linda, Sally also enjoyed the morning feeds when she would get up and sit with her baby in the sunroom to feed:

I like... even though I'm tired at 5 or 6 (in the morning), I like that feed because... it's quiet, no one else is up... it's just me. You can't do it with anybody else, and... it's nice, he's just really cute then. Even though I'm here most of the time by myself, it's the morning feeds, I don't know. Maybe it's the light in the morning, I don't know, it's soft or something like that.

In our discussion of 'special time' with the baby, Linda reiterated her conviction that breastfeeding brought a mother and baby closer together:

My idea is that a breastfed baby is closer to the mother, I don't know if that's right or not, but other people that I know that breastfed... their babies seem closer to them than those who have had bottle... um, I just think there will always be something really close between us.

This parallels much of Linda's talk of an exclusive relationship between herself and her baby discussed in Chapter Seven. However, in recognising that she was creating an intimate relationship between herself and her son, Linda was quick to cast her son as a 'real boy' stating immediately:

> *I don't know, but I think he's going to be a man's man... like, I don't think he's going to be a sooky little boy, well it's not saying that if he is that doesn't matter, I've got this idea that he's going to be like, a bit of a boy, you know, like a real little boy and won't want mummy around people but he will when he's on his own... that is what I've got in my mind what he'll be like... so, that's certainly... that's what I'm getting off him.*

Connection or Possession?

Trish talked often of the possessive nature of her relationship with baby Mitchell. Even during pregnancy the baby was constructed as '*mine*' and when her baby was six weeks old Trish announced proudly, '*The best bit about motherhood is that he's mine*'. Sally also related her tendency to think of the baby as '*mine*', '*wow that's my baby*'. Her partner was at work all day and she was the only one caring for the baby and thus it was easy for her to conceive of the baby as '*only mine*'.

Joanna provided a very clear illustration of the desire to maintain the connection with her baby, a unity with something that was '*nearly part of me*' and how this linked to the possessive feeling of '*my baby*'. Joanna did not like having to 'share' her baby so soon after coming home from hospital. She felt as though she had not really seen her baby all day and continually '*wanted him back*':

> *... even though I enjoy being at home, I've got to share him. When I got home on Sunday night I felt that I hadn't had him for the day. Because I fed him and then someone would say 'oh I'll burp him for you' and I'd say 'okay' and 'cause I had fed him and so my cousin said 'oh I've had my dinner, so you sit down and have yours'... then when I got home I felt like I hadn't had him for the day. And that was the first time that I felt that I want him back he's mine and I've never ever felt like that about anything and then on Monday I had a couple of friends come in and my friend's husband nursed him for about half an hour and I was folding up the washing as I was talking to them and I thought... he's my baby... give him back. And it's a funny feeling. <u>It's possessiveness</u>... isn't it? I guess <u>he's nearly part of me still</u>...On Sunday night when I got home, I wanted to feed him when I got home when he was due because I wanted him back. So what's it going to be like when he gets married? (laughing)Or leaves home?*

Here Joanna seems very aware of the 'claims' that others are making of the baby. Rubin (1977) articulated the stage of 'claiming' as important in the process of externalization and polarization. Yet many women in this study were not keen to 'share' their baby in the early weeks following the birth. Similarly in her literary analysis, Cosslett (1994) describes the response of Stephanie, the character in Byatt's (1986) novel *'Still Life'*. After naming her baby, Stephanie could feel the community around closing in, family visitors taking possession of her baby when he was only a few hours old (Cosslett, 1994; 147). This sense of connection and possession is addressed in the next chapter, where it becomes clear that some women worked very hard to maintain a connected and intimate embodied relationship with their baby to the exclusion of others.

Alternatively, Susan described her enjoyment of the baby reaching out for her when she put him to the breast. She interpreted this action as the baby making a claim to her, a sign of recognition. For Susan it was hard to state what this meant but she compared this with bonding. *'Before I used to huggle and cuddle him to me and now I can feel him doing it **TOO**. He's very affectionate. And he goes like that to grab out to me, I really feel like he is saying that you are my mum.'*

CONCLUSION

The notion of separation of mother and baby at birth or within the first postpartum month, described by Deutsch (1944), Bibring, et al. (1961) and Rubin (1984), is challenged by this data. For some women there is a continuity of mother and baby, a blurring of boundaries of self and other previously present during the pregnancy experience. The crucial point of connection, the practice that facilitated this connected relationship was breastfeeding. Breastfeeding provided a sense of 'oneness' or 'completeness' with their baby.

During these interviews some women worked hard to articulate breastfeeding as an embodied experience that was connected, harmonious and intimate. For these women breastfeeding was a wonderful experience, and at a discursive level, it was everything they had anticipated. Some of these personal accounts parallel the popular pro breastfeeding discourses, which present romantic images of 'mothers breastfeeding

blissful and contented babies' (Cannold, 1995: 6). In these popular accounts women are encouraged to create breastfeeding as a sensual, womanly experience. However, in these popular accounts, it is implied that all women are able to achieve this level of pleasure and satisfaction if they persist with breastfeeding. The analysis of data in Chapter Seven suggests that this is not the experience of all women.

CHAPTER SEVEN

BREASTFEEDING AND THE MATERNAL BODY: THE DISCONNECTED EXPERIENCE

Not all the women in this study shared the connected, harmonious and sensual embodiment of breastfeeding. Indeed, women such as Trish, Amanda, Linda, and Joanna who enjoyed this experience were in the minority. In this chapter, women represent an embodied experience of breastfeeding that opposes accounts of connection, harmony and pleasure. Here I introduce the ambiguities and tensions existing between breastfeeding rhetoric and experience. Many of these women struggled with the contradictions between the embodied experience of breastfeeding, the pro breastfeeding discourses and the prominent notions of rational autonomy that prevail in our lives today. First, this analysis positions breastfeeding as demanding and disruptive of body boundaries and bodily routines. Many women talked of the intense and demanding nature of the breastfeeding relationship. This relationship always demanded their presence and drained them of any sense of personal identity. Here the infant is cast as 'uncivilized' in its continual and unrelenting demands. Second, the analysis examines women's talk of their breasts and breastfeeding. For a number of women there is a sense that breastfeeding has 'distorted' their known breasts and body. They talk of searing pain, leaking milk and undesirable changes to the size and appearance of their breasts. Finally, some women talk of their experience of breastfeeding and mothering as disconnected and disembodied. The baby is cast as a separate other that is unpredictable, 'uncivilized' and often antagonistic towards the mother. These disruptions, distortions and disconnections not only cast doubts upon the satisfying and connected embodied experience but also challenge particular pro breastfeeding discourses.

The accounts of the majority of women, including those who experienced a connected and harmonious relationship with their breastfeeding baby, have contributed something to this section. Many women experienced breastfeeding in a paradoxical or ambivalent way.

7.1 DISRUPTED AND 'UNCIVILIZED' BODIES

> *Oh... the never ending supply and demand... at the moment he cries I'm there, if he wants a feed I'm there and sometimes it gets demanding and very draining but I'm on call and I think that I'm more on call because there is not much Steve can do.* (Lyndall)

The majority of women in this study talked of the constant demands of motherhood, particularly breastfeeding. The demands of breastfeeding and caring for their baby produced a sense of disruption to self, to known bodily routines and patterns. Breastfeeding required their presence and restricted many activities they had previously enjoyed. While the baby's dependence was personally satisfying for some women, constructing an exclusive relationship with their baby, it was also stifling and intrusive. The baby's needs or demands were often cast as 'uncivilized'. This introduced tensions and contradictions to the experience of motherhood. Breastfeeding challenged their sense of rational autonomy and individuality.

In discussions one to four weeks after the birth, the intensity of the breastfeeding relationship was often portrayed using metaphor and humour. The woman as a breastfeeding mother was objectified - she was a *'feeding machine', 'a walking and talking cow'* or *'the milk bar'*. One of the couples had a message on their answer machine casting the baby as a famous actor who would return the telephone call once he had finished at the 'milk bar'. His parents were merely his publicity agents. Often women breastfed their infants feeling that there was little reward or recognition for their efforts. Even when the baby began to respond, Tina for example continued to position herself as the 'milk supply'. *'He actually seems to be looking at me now so... maybe I'm not just the feeding machine any more. He looks like he's listening to me when I'm talking. Yeah. He's probably just saying 'oh shut up Mum and get the boobs out'.'*

After representing themselves in this objectified albeit humorous way, many women spoke straightforwardly about the loss of self and their known subjectivity. Maggie explained, *'I feel like... I'm sort of just hanging around waiting for him to wake up and be fed, to a certain extent my life's gone on hold at the moment'*. Maggie's baby was six weeks old when she described these feelings of disruption to self. This was a common sentiment amongst many of the women and Maggie stressed that she had not realised

the extent to which it would happen. Donna described herself as '*not my own person, I am his person*'. Marianne saw herself as being 'separate' from her partner and the outside world. For Simone, having a baby was '*such an alien thing*' and she '*wanted to have her old life back*'.

Half a year after the birth some women could still only construct their lives in relation to their infants' needs and demands. For example, Kylie stated at our fifth interview:

> *I think it's just that you don't have time to yourself, you really, you're on call 24 hours, it's just getting used to the idea of, you know, I'll never be just me again. It's 24 hours owned, somebody's mother and I have to be there for them, that's all it is, so... that was one of the hardest things I think to get used to.*

At this point Kylie's baby was five months old and she still found it difficult to think of herself as a mother, '*It is still trying to sink in*'. Kylie presented herself as a very independent person who enjoyed her own company and did not have a great need to have others around her constantly. She felt completely enslaved by her baby, '*you cannot get away*', and accomplishing tasks or doing something for herself seemed impossible. She lamented, '*Can't do it with the little thing from hell at the moment*'.

Kate described the changes to her life and highlighted her constant thinking and worrying about the baby, attempting to predict what would happen next. In our discussion she realised her entire day revolved around the baby and her need to breastfeed. Alternatively she described how her partner, Simon, '*takes each hour basically as it comes*'. Walzer (1996) has identified this constant thinking about the baby or 'worry work' as gender differentiated work. Kate knew her partner did not think or worry about the baby in the same way.

In Chapter Five both Jane and Simone found life with their baby demanding and totally exhausting. For many of these women, the breastfeeding relationship created the most tension for their sense of self as a rational autonomous individual. Simone talked of '*having to be on tap all the time*' but she was prepared to put up with this because she was adamant that it was crucial for her baby's health. Alternatively, Tess and Jacki were

not prepared to put up with the constant demands of breastfeeding, *'she was always at me'* and weaned early (at eight weeks and six weeks respectively).

Sally told me when her baby was seven weeks old that motherhood and breastfeeding were nothing like she had imagined and she compared being a full-time mother with the world that she knew much better, that of paid work:

> *I did not think it would be as time consuming, as draining, as hard, um I think going out to work is much easier than being at home... just because you do the same things over and over again. If you go out to work you are performing some task, getting some feedback from how well you have performed and rewarded monetarily but staying home and looking after a baby you don't get any of those things. You see your child grow but there isn't interchange... so you miss out on that.*

Sally drew attention to the demands of mothering and breastfeeding and the little recognition or value afforded to this role. Productivity and success are rewarded financially in our lives as rational and autonomous beings. As employees we are given monetary reward and recognition for our hard work and when this is not forth coming women are left wondering about the value of the work they are undertaking as mothers of young babies. In a Canadian study, Maclean (1990) similarly drew attention to the impact of the culturally bound norms of time management, productivity and the lower value placed on mothering in the public domain.

For some women the contradictions of being a breastfeeding mother were emphasised by their partner's comparative freedom to do as they wanted, *'his life had not changed'*. Here women realised their sense of self had changed forever. In the early weeks of motherhood, Amanda had revelled in the emotional closeness and total dependence her baby had on her. She had not moved from their house for any particular outings at all, enjoying the peace at home. When her baby was five weeks old, Amanda ventured out to go shopping with the baby. It was only at about eight or nine weeks after the birth that she started to talk about being tied down by the baby and his needs:

> *... it's how, the realisation of this is forever. Jim the other night just announced, 'I'm going to a lecture'... and I thought 'Oh you can just go to a lecture just like*

that, I can't'... you know, and it wasn't a resentment thing to Josh, I suppose... I still, I did resent Jim that he could but it was just sort of me realising it.

This prompted Amanda to talk of the need to be away from the baby for a short period of time. While very much desired and constructed by some of the women, including Amanda, this sense of total connectedness and dependence contradicted their position as rational autonomous individuals. This caused tension for some of the women and motivated their thoughts about expressing breast milk. For example Amanda stated, *'I can't just disappear until I've worked out this... how I'm going to go about expressing some milk, so I can, not that I want to escape all the time but just if I do want to go out and leave him at home for something'.* Paradoxically expressing breast milk was something that few of these women ever *'got around to'*.

Tess provided a clear illustration of the ambivalence and competing demands that many women feel. Women want to have some time away from their baby and yet like to have the baby nearby. Tess clearly resented her partner's freedom to undertake leisure activities, however, at the same time she was not prepared to leave the baby with anyone. Breastfeeding guaranteed her close proximity to the baby. The decision to bottle feed her baby at eight weeks of age brought a sense of personal freedom and control. Now, however, she had no excuse for not leaving the baby with others, which was daunting. Making arrangements for the baby to be cared for was difficult for most women in the study. It was common that the only person they felt comfortable leaving the baby with was their partner.

In the previous section, Susan described a connected and intimate embodiment of breastfeeding. When her baby was three weeks old she talked of a sense of connection with her baby and the feelings of pleasure gained from his dependence upon her. Simultaneously, however, she resented the interruptions to her previous lifestyle. After two weeks at home with her baby she was already feeling tired and exhausted from his feeding pattern. The baby was feeding two to three hourly and Susan believed that babies should not wake so frequently. This pattern conflicted with the lifestyle position she valued. She talked of an active lifestyle and was keen to return to her previous level of activity almost immediately.

I was forever getting tired and exhausted and even when the baby sleeps I never have any time to do anything or go out even just for a walk and I was fairly isolated too. I thought I'm not going to have to feed like this all the time, I thought there's got to be another way. I felt like some inactive person and it was really getting me down because I wanted to do things like just even go for a walk or just going out to you know visit a friend or something and I felt like I didn't have any energy to do anything really, even just spending time just to have a shower and getting organised in myself, it was just like a really big effort.

Even though Susan had anticipated difficulties in the first couple of weeks, particularly getting up early in the morning, she had somehow expected or desired to continue her life in much the same way as before the birth. Concerned that her baby was not sleeping for long periods between feeds and thus restricting her activity, Susan consulted a number of her friends who assured her that the first six weeks were the hardest. They advised her that the baby was feeding '*too frequently, there must be something wrong*'. Correcting the baby's feeding pattern became a priority for Susan when she first saw the early childhood nurse, a week and a half after she was home with her baby. She seemed very comfortable to change her breastfeeding practice in order to reduce the frequency of feeding:

I really had trouble when I come home about just using one side (only offering one breast at each feed). The baby was just getting what he wanted and so he only lasted two hours, three hours at the most and so the Clinic told me to use both sides at each feed and now he lasts five hours and it's really been um made a difference.

In contrast to Amanda who had decided to take her new life very quietly in the first five or six weeks after the birth, Susan and others were much more determined that this new baby would not restrict their lifestyle. Some women made an enormous effort to be out of the house within the first week after the birth. Tina found her baby very easy to take out and about and was often out visiting and shopping. However, when I met with her six weeks later her first comment was, '*Things are not going as good as earlier on*'. A change in her baby's pattern was causing her much distress. For a period of three or four days her baby just wanted to feed continuously, disrupting her new routine. Tina started to doubt that she had the 'good' baby she had constructed in the first week or two:

> *The last couple of days he's sort of been awake a lot more and he's wanted to feed like all the time without stopping... he'll be there for ages and ages, like over an hour, and then you'll go to take him off... as soon as you go to take him off he'll start sucking again... and he won't let go. And so last night I think from six thirty 'til eleven thirty, you know, he was basically feeding the whole time...Because we had plans to go here and go there and go to the airport to pick up tickets and things like that yeah and we just didn't get chance to do anything with him. I felt like really quite restricted with him, whereas, you know, I've been able to get out and do things previously.*

Her 'good', contented baby is now described as a 'hog', 'crafty', and 'whingy'. His changed feeding pattern restricted Tina's activities. She described one attempt to get out of the house to visit a friend in hospital. As she was about to leave, Lachlan decided he wanted a feed again and then he did *'a huge poo that went everywhere. It was like you know he was determined to sabotage my visit to the hospital...He just sort of picked that time so I ended up not going'.* Recognising her expression of anger at her baby's behaviour, Tina then reflected upon her position, clearly identifying how her rational autonomous position conflicted with the demands of breastfeeding and caring for an infant:

> *I think I was quite stressed because I was really keen. I wanted to go and see my friend and I'd got her a present with a basket of things and a card and I was really looking forward to seeing her baby and mm it's just you know you have everything planned and then all of a... it's just like I say, it's like he sabotaged my whole afternoon, so I was quite stressed with it. Grrrr why do you have to do it now? And then you think oh how can I get angry with this little thing looking at you, mouth agape, I'm hungry again.*

For a couple of the women in this study, the tensions and contradictions in their experience of motherhood and breastfeeding came some months after the birth when they returned to paid work. Only five women returned to work prior to their baby turning six months old. Recent studies (Hays, 1996; McMahon, 1995) of motherhood have emphasised the ambivalence and contradictions between the private world of mothering and the public arena of paid work. Indeed Sally has already described earlier in this discussion the powerful difference and the devaluing of mothering and breastfeeding.

Tina returned to work four days a week when her baby was four months old. She had fully breastfed until then and intended to continue by expressing her milk. This proved extremely arduous and time consuming for her. She had great difficulty expressing enough milk for the baby and within the first week at work had to prepare some formula milk for the daytime feeds. By the following week she had stopped expressing as she found it much easier to provide formula for the baby. She reconciled this by continuing to breastfeed Lachlan at night. However, after one month her milk supply was low and the baby decided he was not interested in drinking from the breast any more. Tina was very disappointed about this as she had a strong commitment to breastfeeding and had enjoyed it. When she described her working day and the preparation necessary to send the baby to child care, it seemed eminently rational that she should cease breastfeeding. The baby was being cared for by her partner's cousin who lived close to where Carl, her partner worked. This was a 45 to 60 minutes drive away from their home so Carl needed to leave for work at six each morning to allow enough time to drop the baby off. This meant that Tina would feed the baby at four and then try to doze for a while. Carl got up at five and at five thirty Tina got up and dressed the baby. This early morning schedule meant Tina would have to prepare all his clothes and bottles the night before. While Carl assisted her with some of these preparations, she was the main organiser of the baby's needs. Despite the huge amount of work this entailed, Tina felt that being at work made her more confident as a mother and as a person:

> *I just feel when you're at home all the time you tend to lose the sense of yourself and like your qualities as a human being, like your self esteem...When you come to work... that's you and you're capable of doing your job and you get appreciated for that but when you're at home you're a mother but you don't necessarily get any recognition for that.*

Linda also provided a particularly important example of the contradictions and tensions between paid work, motherhood and breastfeeding. For Linda, the return to part-time paid work resulted in a disruption to the connected and pleasurable embodied relationship she had with her baby through breastfeeding. The fourth interview with Linda was conducted when her baby was almost six months old and she had returned to work two weeks previously. She talked at length about breastfeeding, the disruption to feeding due to work and her ambivalence at completely weaning her baby. As described

in the previous section of this chapter, Linda had afforded breastfeeding a central position in her life as a mother. She rarely referred to the discourses of 'breast is best' for the baby, speaking rather of the sheer pleasure and enjoyment she got from the connectedness with her baby. Consequently the disruption and disconnection she experienced upon commencing work could perhaps have been anticipated.

This was a new job for Linda working part time (five half days a week) as a clerk. At the time of this interview she was still settling into the routine of work and of organising baby Todd each day for care by her aunt living nearby. Linda consciously compartmentalised life as a mother into two time periods - motherhood before and after commencing paid work. While quite exhausted by the pace of caring for her baby and going to work, the extra income prior to Christmas was very attractive to her. The job seemed like a perfect opportunity to combine working with mothering. Interestingly, from her partner's perspective she did not need to return to work, they could have managed.

With this sense of disruption, Linda contemplated completely weaning Todd. However, she was still drawn by the connectedness and harmony with her baby, which she believed breastfeeding fostered. Linda constructed a negative image of herself as a working mother. She described the baby as unsettled and experiencing colic, which she attributed to the very sudden introduction of one formula feed a day. *'He went from being all breast to being on a bottle... even though it was only one bottle a day because I was only gone for four hours... it was still immediate and he never had time to get used to it.'*

Since starting work the baby's night time routine had also changed and he was waking two or three times a night. Linda found she was very tired and in an attempt to get enough sleep put Todd in bed with her. This practice was something that she *'hoped to sort out over Christmas'*. She also believed she had been remiss in her mothering role by not preparing fresh fruit and vegetables for Todd now that she was working. This was a difficult time for Linda and she stated, *'I'm not a very good mother at the moment...I am not a good mum am I?'* This feeling was intense and prompted her to ask *'Why have things gone wrong... why isn't as good as it used to be?'*

In summary, little of this analysis of the experience of motherhood and the demands of breastfeeding is surprising. There have been many detailed studies of the experience of motherhood by sociologists, feminists (see Brown, et al., 1994; Crouch & Manderson, 1993; Everingham, 1994; Hays, 1996; McMahon, 1995; Oakley, 1979, 1985; Ribbens, 1994; Richards, 1985; Rothman, 1989; Wearing, 1984), and recent popular writers (Benn, 1998; Maushart, 1997) voicing the constant demands, tensions and few rewards associated with mothering. These disruptions may be exacerbated when the woman is breastfeeding. As already discussed, little of this has influenced nursing and midwifery research and practice (Barclay, et al., 1997). Rarely have the contradictions, tensions and ambiguities of motherhood or breastfeeding been highlighted in the professional literature.

7.2 DISTORTED BODIES AND 'UNCIVILIZED' CONNECTIONS

For some of the women in this study the embodied experience of breastfeeding was not pleasant or sensual, rather it was marked by searing pain and discomfort. Despite receiving information and support from health professionals, women such as Jane, Denise and Simone talked of their breastfeeding experience in the early weeks and months as 'damaging' and 'violent'. Their embodied experience was 'distorting'. In employing the term 'distorted bodies' I am referring to the pain, discomfort and disconcerting changes that breastfeeding may bring to a woman's known 'breasted' experience (Young, 1990). The experience of having breasts - what one's breasts feel like, look like and how they are personally sensed - changes with the experience of breastfeeding. Maggie described how she was anxious to feed her baby after birth because she was 'curious' to know how it felt. For a first time mother, breastfeeding, similar to pregnancy, brings new sources of embodied sensations and new ways of experiencing one's body. For women such as Trish, Amanda and Linda, it was pleasurable and often sensual. These women described it as wonderful. They highlighted the closeness of their developing relationship with their breastfeeding infant and 'played down' the breast or nipple soreness common in the early days.

In contrast some women who experienced difficulties and pain when their baby 'attached' to the breast spoke differently. Here breastfeeding was 'distorting' their

known 'breasted' self and was often described as a battleground, 'a fight'. The baby's behaviour or actions were cast as 'uncivilized', with the baby 'latching on', 'scratching, biting and chewing on the nipple'. The women also spoke about their breasts in an objectified way describing how the breast 'deflated', the milk 'curdled' and 'the stuff' just poured out of their breasts.

It was not comfortable or easy for all of the women to talk of the intimate changes to their breasts and nipples or to describe breastfeeding in a negative way. When first asked how they found breastfeeding, many women would draw upon baby-centred accounts, describing the thriving appearance of their baby, the increase in weight and contented appearance of their infant. It was only with further prompting that they elaborated on their feelings about breastfeeding.

Searing Pain and Mutilation

Breastfeeding in the early weeks after the birth can be uncomfortable and painful. Breast and nipple soreness from engorgement, grazed or cracked nipples, a blocked duct or mastitis has continually posed a challenge for health professionals supporting the breastfeeding woman. Over the past 10 to 15 years increasing research evidence has provided enormous insights into the understanding of the physiology of milk production and appropriate feeding positioning of infants, improving the knowledge and practice of clinical experts. We now have what is believed to be much of the 'right' information to minimise breast and nipple damage and pain and thereby facilitate successful breastfeeding (Maher, 1992).

Contrary to many professional accounts, some of the women in this study experienced discomfort and pain from breastfeeding that they described as agonising, horrendous and violent. In interviews conducted at between one to two weeks and even at six weeks after the birth, many women started their breastfeeding description with 'I'm surprised how painful it is'. In Chapter Five both Jane and Simone provided powerful illustrations of the pain associated with breastfeeding. Simone dreaded feeling her breasts become tense and full with milk as this signalled that the baby would soon feed again and the first few minutes of feeding were so painful. Jane talked of her distress, crying in pain with every feed and similarly Donna described the times she would cry as her baby

started to feed. Donna, experiencing this pain for four weeks, had not expected that the *'soreness'* would last as long as it did. Denise described breastfeeding as *'agonising when he first hops on... sort of excruciating really'*. Joanna showed me the *'huge gash'* she had on her right nipple stating, *'Every time I put him on I cringe'*. Sally was surprised that breastfeeding would hurt and particularly disliked the sensation associated with her let down reflex:

> *I never realised it would hurt so much. It's not an act that has no sensation to it at all. I had no concept that it would actually pinch and the let down would even be painful... that tingling, it's not even a nice tingling, it's like an electrical sort of tingling, it's like ohhh yuk...Yeah I can understand why some women just don't want to experience it. It still hurts as he gets on when I'm not using the shield and I have to grit my teeth.*

However, some women presented this pain as being quite understandable. Their breasts had never been used in this way before. Kerry talked about her breasts *'getting used to it'*, and Maggie believed her nipples were only sore *'from overuse'*. Denise was more amazed by the powerful sucking action of the baby stating, *'Considering you know you barely touch them, you don't do anything to them beforehand, there's one minute they're just totally soft and pliable and the next minute they just have all this force on them, it's no wonder they get sore'*.

The 'soreness', the 'agonising' and 'excruciating' pain was most often attributed to the attachment behaviour or sucking action of the baby, what I have called the 'uncivilized nature' of a baby's feeding behaviour. Donna elaborated, *'I like breastfeeding but... from time to time he'll grab a good hold of the nipple and sort of just grabs (it) between his jaw and squishes his jaw around or something'*. In moments of severe discomfort, Donna felt justified in considering an alternative to breastfeeding. *'In the middle of the night, that's when it hurt the most... you've just woken up and you're half asleep and suddenly you get this sharp pain...I almost was tempted to go and make up a bottle of formula and then I thought no... no (I'm) not going to do that.'* This action of a baby clenching his/her jaw around the mother's nipple is understandably painful. Sally described how baby Henry would sometimes *'hang on, like there is no tomorrow, as though he was going to rip it off'*. She added, *'It takes a bit of restraint on my part just to take his arms away rather than throw him away from me...God it's a terrible feeling'*.

Soon after birth Kate described having a grazed nipple that while sore, did not distress her excessively. However, when her baby was four weeks old she talked of the graze being much more severe. One day her baby vomited after a feed and Kate saw fresh blood. Kate told me she was '*hysterical*'. She was relieved a moment later to notice that her nipple was bleeding badly and hoped that this was the source of the blood in the baby's vomit. Kate explained the bleeding, '*she had a bite of me...It was just so sore'.* This experience cast doubts on Kate's motivation to continue feeding but she resolved '*to give it until the next day*'. Kate assured me that it was getting much better and she now '*only*' experienced pins and needles in her nipple, '*... like (a) paining in me. You know... it's only probably once a day'.*

Simone vividly described how her daughter used to scratch at her breast and 'fight' her when feeding. She experienced the baby's scratching at her breast as a '*violent*' action resulting in bodily mutilation, the scratches evident on her breast and damaged nipples. Tina also talked of feeling angry with her baby when he would fuss at the breast and scratch her. He was feeding well from the right but on the left he would scratch her and start crying and '*fussing*'. Tina called these times '*feeding frenzies'*. In their descriptions of the baby that 'latched' on, scratched the breast, bit or clenched with their jaw, or grabbed the nipple, the women often implied such behaviours were 'uncivilized'. The baby needed to be 'tamed' or trained and, as discussed in the next section, was often positioned as an 'antagonist' working against the mother. Sally felt confused by her baby's actions which seemed '*extremely counterproductive... because it's not sucking, it's just a clench and when they sort of push your breast away with their hand, I thought 'why are you doing it, when this is what you are here for''*. She described how Henry's arms would go all over the place at the same time making it even more of an ordeal. She had thought that '*a baby would lie there and just sort of suckle contentedly and it's not like that at all. It's almost a battle'.*

In a differing account Denise constructed breastfeeding and the resulting 'damage' to her breast as a joint venture. She stated, '*He damaged the nipple*' then immediately changed it to '***We*** (my emphasis) *damaged the nipple early in the piece'*. Breastfeeding was something that included equally the mother and baby. She did not blame her baby for damaging her nipple, but placed herself also at fault.

Maclean's (1989) study is one of the few professional accounts to describe the bodily changes experienced by breastfeeding women. The women in this Canadian study found the changes in the appearance and size of their lactating breasts to be distressing. They talked of the pain and discomfort associated with the let down reflex, breast engorgement and nipple damage. Women also lamented the frequent change of clothes necessary because of leaking breasts. Maclean (1989) describes a sense of dislike for the maternal body.

Portrayal of Lactating Breasts and Breast Milk

It is interesting to look at the way the women talked about their breasts when lactating. Few women expressed delight in the changes to their breasts due to lactation. More commonly the women, and importantly also various health professionals, would objectify their lactating breasts and milk in some way, as though separating their breasts from their body. For example, Fiona described the way she had been '*taught to squeeze them to get the smallest bits into his mouth*' (my emphasis) and Joanna talked of how it was much easier for her baby to '*latch on*' once her breasts had '*deflated*'. Sally found her engorged breasts '*atrocious*' but added, '*Now that they have really gone down I feel a bit more comfortable with them (her breasts)*'.

Susan talked of her experience with mastitis. She had difficulty understanding why she would have developed mastitis, as she was always conscious to position the baby 'properly' at the breast. Here Susan's general practitioner provided an explanation that cast doubt on the quality of her breast milk.

> *I had a really good doctor. She explained to me that because I was hot, my milk would be hot, so he wouldn't want as much because my milk was not off but, sort of curdled, so he wouldn't want as much.. I thought oh no, I'm doing this to him.*

Simone was quite disgusted at the size of her lactating breasts which was something she had not expected. Tina was concerned that she was going to end up with '*lopsided*' breasts and if her baby's '*feeding frenzy*' didn't subside, she imagined herself looking like '*one of these haggard wives with droopy breasts whose babies cry all the time and drain them*'. Denise fleetingly entertained that '*it was nice to have a cleavage*', but added that she preferred her breasts being their normal size.

Denise was left with a permanently scarred breast following the draining of a breast abscess. Like Jane, Denise had many breast problems during the first four months following her son's birth. She developed mastitis and was treated with inappropriate antibiotics and the infection worsened, developing a breast abscess. She received treatment at a specialised centre, requiring three courses of antibiotics and surgical draining of the abscess. For a few weeks the community nurse came to dress the wound which was deep and required packing. Denise located the initial source of her breast problems to misinformation she was given in hospital following the birth about the way in which her baby should attach to the breast. She remained angry with the general practitioner who had prescribed the wrong antibiotics. When her son was six months old, Denise described her breasts as a 'mess' and talked about the scar that remained after having the breast abscess drained:

> *...Well it's the only time I'll ever go and have a cleavage and I can't show it off to anyone. Oh it's not bad... I'm quite a small breasted girl anyway...I've never been one to sort of have low cut dresses...I think 'ugh' when I feed Callum. I'm consciously trying to cover it up just because it looks so nasty... whereas I'm not so conscious (of) the other breast... (but) when I look down to it, oh that looks pretty awful.*

The notion that breasts produce milk and that it flows freely from their breasts was both 'taken for granted' as the 'naturalness' of breastfeeding and simultaneously 'amazing', something to marvel at. A number of women were quite surprised that milk was available for their baby so soon after delivery. Simone thought this was *'weird... there was nothing to give, there's nothing here but I still put her to my breast and she sucked, so there must have been something there'*. Kate was similarly surprised at the availability of breast milk but she objectified it, calling colostrum '*stuff*'. This seemed to parallel the manner in which her breasts were 'handled' by the midwife, as she 'squeezed' Kate's breast to demonstrate the presence of breast milk. Kate stated, *'I was amazed as soon as I came back (from recovery), they got her out and said do you want to see if she'll have a feed. I said is there going to be anything there and she (the midwife) <u>just squeezed and stuff</u> came out'* (my emphasis).

This wonderment at the ability to produce milk so soon after birth later became disconcerting or even disgusting as it flowed freely from their breasts in response to

their baby. It was totally out of their control. When her baby was four weeks old, Fiona said the only thing she did not like about breastfeeding was the leaking, 'sticky' breast milk that goes everywhere unable to be contained by the cotton breast pads. She lamented she was still unable to wear most of her pre-pregnancy clothes because of her leaking breasts.

Both Tess and Simone were dismayed at the experience of milk leaking from their breasts. Tess appeared removed from her breasts, talking about her breasts, breast milk and baby in an objectified or disembodied way: *'The stuff just pours out of you'*. In the first week after the birth, she believed she had so much breast milk that her partner and her decided *'we'd try and bottle the stuff that was coming out, 'cause it's like saturated all the time, we had the breast pump on one, we were pumping...I was just squeezing it and had that pump thing on it and I had her on the other one'*. In Chapter Five Simone described how distressing she found leaking breast milk which was particularly bad at night. The soaking wet clothes and bed shattered her image of peaceful, calm and relaxed night time feeds where the satiated baby would *'detach'* itself and fall asleep. She was also annoyed by the amount of care that she had to take with appropriate dressing for breastfeeding. This was the final straw for Simone - *'It sucks'* (no pun intended).

In the following, Joanna describes the need to control the fluid leaking from her 'maternal' body. Her thoughts highlight the notion of the maternal body as a fluid and leaky body. Joanna was quite frustrated by the amount of fluid leaking from her body in the early weeks following the birth and she emphasised, *'You've got to pad up... you've got to pad your boobs... you've got to pad your fanny...That's what frustrates me when I have a shower in the morning, I have to pad up... pads here... pads there'*. She also described breast milk as having a very distinctive smell that she found hard to tolerate when it leaked on her own clothes:

> *I leaked on my dressing gown the other night and I said 'Malcolm, can you smell this?' and he says 'No', and I still could smell it. So I had to wash it. But it's just... just a very different smell... but on him (the baby) it's a nice smell... 'cause it's a newborn's smell.*

Women's personal experience of the 'let down' reflex and leaking milk is rarely described. Morse and Bottorff (1989) found that milk leakage was a very common occurrence and despite the rhetoric in professional texts, 66 percent of women in their study continued to experience leaking milk at six months postpartum. Women in their study described the leaking of breast milk as a negative experience, feeling embarrassed and dirty, 'it was annoying... horrible and irritating' (Morse & Bottorff, 1989: 18). The women described leaking as an involuntary thing, 'it never lets up' (Morse & Bottorff, 1989: 16). At best leaking was something that had to be tolerated as part of breastfeeding and women made enormous efforts to predict, control and manage leaking. They were constantly 'on guard' (Morse & Bottorff, 1989: 18), undertaking 'emotion work' as they resisted thinking or worrying about their babies. While away from their baby women kept busy trying to consciously stop the flow of milk by repeating one word commands or short phrases to themselves. Britton (1997) and Balsamo, et al. (1992) have also described women's tendency to locate their breasts and breast milk as something separate from themselves. Britton, talking particularly about the 'let down' reflex, found women gave the unpredictable leaking of breast milk an identity of its own. The 'let down' was believed to have a 'mind of its own' (1997: 181) and it was the woman's responsibility to control these bodily flows (Morse & Bottorff, 1989; Britton, 1997).

For some women the end of pain and discomfort came only when they ceased breastfeeding. In Chapter Five Jane provided an example of a woman determined to breastfeed her baby. Jane persevered with breastfeeding for six weeks through enormous difficulties, experiencing badly cracked nipples and two bouts of mastitis. The cracked nipples were so painful that she cried every time she fed the baby and the pain continued for about half an hour after the feed. Professional discourse would suggest that this baby was not positioned correctly at the breast and that 'attachment' to the breast was poor. While this may have been so, Jane was certainly not short of support from lactation consultants and other professional resources to assist with this problem. Despite this, Jane felt as though it was no longer her own known body. She talked in detail about her embodied experience of breastfeeding. Through her talk of pain, even mutilation, experienced through mastitis and cracked nipples, Jane represented breastfeeding in a disembodied and distorted way. This is clear in her reflections after ceasing breastfeeding:

> *... it was nice to have my body back too... just to go into the shower and come out and be able to put a towel around myself without going 'ouch, ouch, ouch'... it was really painful... yeah like I couldn't put a top on, so I was glad I could feel normal again...I couldn't even walk you know down the street, so, yeah it was better for me I think to feel better in myself as well... you know, and be able to let Jeff cuddle me, you know, things like that, without going 'Oh stay back there'.*

When Jane decided to stop breastfeeding she was able to regain her known 'breasted' body and articulated an embodied sense of comfort and increasing control.

It is rare to find detailed personal accounts of women's experience of the pain or discomfort associated with breastfeeding (for exceptions see Maclean, 1990; Cannold, 1995; Carter, 1995; Britton, 1997). Professional discourse often attributes such discomfort simply to the incorrect positioning of the infant at the breast, while accounts in the popular literature attribute women's discomfort to the sexualisation of the breast in our society. These popular accounts gloss over the descriptions of women's experience to focus on how the difficulties were resolved and a happy breastfeeding experience established (Cannold, 1995). In this study some women 'persevered' through the 'distorting' experience of breastfeeding and established a satisfying breastfeeding relationship and, as in the cases of Joanna and Sally, a harmonious embodied experience. Despite the distressing experiences of breastfeeding described here, Denise and Donna found breastfeeding enjoyable yet were primarily motivated by the pro breastfeeding discourses rather than the connected and pleasurable experience of breastfeeding. The blurred boundaries of discursive construction and embodied experience are discussed in detail in Chapter Nine. The final section of this chapter examines the women who represented breastfeeding as a disconnected experience.

7.3 DISCONNECTED BODIES

The notion of 'disconnection' between a mother and her infant is used here to describe a sense of individuation, a separate embodied existence of mother and baby. In varying ways the accounts drawn upon in this chapter speak of the experience as a breastfeeding mother as 'disrupting' to the sense of embodied self and 'distorting' of the known breasted experience. For a number of women in this study, the 'disruption and distortion' also exist with a sense of 'disconnectedness' or a desire for separation from the baby.

Here the mother and baby appear as separate, autonomous individuals each with their own competing needs and desires. When the relationship between the mother and baby is cast in this way, numerous conflicts and contradictions arise between the needs or desires of the mother and the baby. In some instances, the woman feels wounded or rejected by her infant's behaviour and actions and at other times feels extraordinarily 'put upon' or intruded on by the demands of her newborn (as described in first section of this chapter). In some cases the mother and baby are cast as different actors who do not perhaps share the same experience and appear to have different and conflicting needs.

In introducing the notion that some women feel disconnected from their baby, it must be stressed again that all the women in this study stated continually that they loved their children. Even Simone, who volunteered that if she had her time over again would not choose to have a child, emphasised that she loved her daughter *'more than life itself'*. There was a sense of unconditional love evident in all the women's descriptions of their relationship with their baby. This public discourse, which assumes that 'mother love' is always present, instinctual or natural, is powerful and pervasive. For most of the women in this study, unconditional love was a characteristic of being a 'good' mother. Therefore when they spoke in a negative or disparaging way about their baby, they would consciously stress their love for their child, quickly rephrasing their words if they appeared too negative. They wanted to 'save face'. Kylie, when asked how things were going responded with, *'Oh, God it's hell. The first three weeks are hell, I mean that's the only word I can think'*, but immediately followed this with, *'No it's good, I'm enjoying it more because I'm getting more feedback from him. He's starting to smile and laugh and it's not so thankless'*.

With the knowledge that all of these women loved their children and held their baby's welfare as a main priority in their life, it is important to examine the different relationships constructed between these women and their babies, particularly through diverse experiences of breastfeeding. In Chapter Five, Jane and Simone's stories illustrate a disconnectedness between mother and baby that both women struggled to alter in many ways. Yet their stories are very different. Jane continually cast baby Louise as a 'good' baby, believing that as a mother she was not able to do the 'right' thing by

her daughter and had 'failed' as a breastfeeding mother. Simone on the other hand cast baby Catherine as an antagonist, an unsettled and 'uncivilized' baby who gave her mother little peace or rest. These two accounts of 'disconnection': the 'good' baby/'bad' mother and the 'uncivilized' baby/'good enough' mother, were evident in varying degrees in the accounts of Anna, Marianne, Kylie, Tess and Barbara.

The 'Good' Baby/'Bad' Mother

Jane's story, presented in detail in Chapter Five, provides a striking illustration of the way in which a woman shaped her personal desire to breastfeed through the public and professional discourses of breastfeeding. Jane strove to achieve a close breastfeeding relationship and a connection with her daughter through breastfeeding. Instead of connection Jane was only able to articulate their relationship as separate and disconnected.

In Jane's early discussions, she always described baby Louise as a 'good' baby. She believed that Louise was settled, contented and a good sleeper. Yet her experience of motherhood and breastfeeding was traumatic and distressing in the early months. Interestingly Jane did not relate the problems with breastfeeding to the baby herself and described the baby as particularly settled when she was having expressed breast milk in a bottle. When put to the breast, however, Louise would become very upset and Jane believed that Louise found the breast *'a frightening place to be'*, explaining that the baby had been *'traumatised'* by her earliest experience of breastfeeding in hospital. Jane described the way in which Louise used to fight her when put to the breast. Drawing upon a popular psychoanalytic account, she talked of her concern for her relationship with her daughter, that perhaps Louise would 'hate' her mother for forcing her to go to the breast. She felt she was somehow rejecting her daughter by not being able to breastfeed her and alternatively felt that perhaps Louise was rejecting her by not taking the breast.

In a similar way to Jane, Marianne experienced many difficulties breastfeeding but again she rarely blamed these problems on her baby's temperament or behaviour. Marianne described her baby as very unsettled and fussy at some feeds. The most distressing aspect for Marianne was the way baby Charlotte would suddenly scream, go quite red in

the face and pull away from the breast. It was a loud piercing scream and very upsetting for Marianne. It was also very embarrassing and she felt she could not go out and feed in public. Even a recent visit to her aunt's had been very uncomfortable. When her baby was six weeks old Marianne described breastfeeding as *'a struggle', 'breastfeeding's not been pleasurable at all... it's been a negative experience in the last week'*. Even though she was still breastfeeding, Marianne felt she had failed because she really wanted to breastfeed. In contrast to others, Jane and Marianne did not cast the baby as an antagonist, invading or taking from the mother, rather they positioned themselves as somehow lacking as a mother, the cause of their baby's distress and pain. For Marianne this notion was reinforced by her partner and others who suggested she bottle feed her baby and gave conflicting messages. Marianne stated, *'I'm sure Damian thinks I'm poisoning her... that's what he said 'It's not doing her any good look at her, you'll have to bottle feed her''*. At other times Marianne, believing the 'failure' discourse, would tell her partner *'it's my milk'* and he would reply *'oh no it's her immature stomach'*.

Anna also provided a similar account of rejection and failure when she experienced breastfeeding difficulties. Anna, whose limited time at breastfeeding was frustrating and depressing, held concerns for the strength of her feelings for her baby. For the first three days following the birth of her baby, she had great difficulty in getting baby Luke to go to the breast. As Anna put it *'He did not give a 'you know what''*. Under the guidance of the midwives or the 'ladies' as Anna called them, she expressed colostrum and the baby was fed first by cup and then by syringe. She described with emphasis that each time he was fed he vomited the colostrum. She found this extremely stressful and drawing upon the account of the good mother as relaxed, believed that her tension was impacting upon the baby stating, *'I'm stressing out and I think it was stressing him out... because he must have been hungry'*. Ultimately baby Luke had to be tube fed as his blood sugar level was dropping. After this the baby slept well and then managed to have a breastfeed. Anna lamented, *'It worked but that didn't last long'*. She did not feel satisfied or successful when Luke finally had a breastfeed. Rather, she saw herself as quite passive, almost subsidiary to the breastfeed. Anna explained, *'It worked but it was only the fact that someone had hold... (of) his hands and they were attaching him onto me... like he just wouldn't do it with me'*.

Over the few days in hospital, Anna found each feed more and more distressing and became concerned that her baby would sense that she did not want to feed him because '*every time he would wake (for a feed)... I was crying*'. She convinced the staff to let her go home when Luke was four days old, believing she would be much more relaxed at home. As it was Boxing Day, they went straight to her partner's parents' place for lunch. Anna said that she was dreading the time when Luke would wake and need a feed. She described crying again as she talked with her partner's sister and sister-in-law. They reassured her that they had both experienced difficulty with breastfeeding but things worked out in the end. However, Anna had started to question whether she had the '*wrong*' feelings as a mother, *'I had feelings that I can't love you that much if I don't want to feed you'*. Her breastfeeding experience did not improve. The following day she was at her mother's place and found herself tense and crying not just before each feed but constantly. Her mother told her that she *'could not go on like this'* and Anna agreed. The next morning she visited her general practitioner for advice about bottle feeding and sat in the surgery, *'balling my eyes out, saying 'I hate it (breastfeeding)''*. She received the support that she wanted from the doctor, who recommended a formula for the baby and in Anna's view did not give a 'biased' opinion.

The following account from Donna provides an illustration of disruption in maternal subjectivity that occurred when the baby was three months old. Donna believed strongly that breastfeeding enhances the relationship between a mother and baby and the closeness in this relationship was special. Prior to her baby's birth, she had talked excitedly of breastfeeding and had particularly looked forward to being able to hug and cuddle her baby. This image of herself and her child had been realised soon after the birth of her baby. Despite experiencing significant pain with breastfeeding and requiring treatment for an intrauterine infection, all was going well for Donna when Alex was six weeks old. She *'loved'* being a mother and *'motherhood was everything she had imagined it to be'*. However, when her baby was five months old, Donna talked with distress of the *'big change'* that had occurred over the past eight weeks. The *'contented'*, *'perfect'* baby that Alex had been, suddenly changed. He became wakeful, difficult to settle, cried a lot and did not like to be held close.

> *... life's gotten somewhat more chaotic. It had been so predictable for a while and then it just all went berserk... he's certainly keeping us on our toes. He's gone through a lot of changes and demanded food in the end. Whereas before he'd been quite predictable suddenly he was no longer predictable or content and I had no idea what he was doing, when he was doing it, he just started crying all the time for no reason and it didn't matter what I did. He wouldn't stop. I thought, you know, my milk's not good enough and his sleep went all haywire and he didn't want any day sleeps and I started going crazy I'm sure.*

Donna's distress and uncertainty seemed to be fuelled by Alex's rapid rate of development. At four months he was already rolling over, soon followed by sitting and at five months he was on his hands and knees crawling. This active baby did not want to be held and cuddled, pushing away from Donna, preferring to look outwards at what was going on around him. Simultaneously, Alex had cut down the length of time that he would breastfeed. This gave Donna great concern for her milk supply, which seemed to be decreasing. Although Alex had started on solids, Donna was not ready to totally wean him from the breast. She related the discussion with her partner, Paul, '*I don't feel up to him just cutting me off at the moment...I was hoping for 12 months... at least with one feed still*'. These events occurred over a period of three or four weeks, challenging Donna's identity as a mother. This was not how a three or four-month-old baby should be. In an effort to maintain her milk supply, Donna 'allowed' Alex to feed during the night. '*I know that is not recommended but it is the only time that he will lie still and have a good feed and also go back to sleep without crying for an hour*'.

Donna found her inability to settle her baby distressing. After all, that is what a '*mother should be able to do*'. Her baby's desire to be free and moving rather than cuddled destroyed Donna's image of motherhood. One morning, very distressed, she contacted the Early Childhood Nurse. Donna stated, '*I though I was really going crazy... and the nurse said, 'Has anybody ever mentioned... Postnatal Depression?' and I thought oh my God they're putting a label on me... I've really lost it*'. The Early Childhood Nurse suggested that Donna talk with a counsellor. After much reservation, she found her discussions with the psychologist very helpful. She was reassured that she did not have Postnatal Depression but was certainly distressed. Donna seemed comforted by an analogy the counsellor suggested that motherhood was a job with huge responsibility, little recognition, 24 hours a day with no pay. Donna added, '*Who wouldn't feel down*'.

At the time of our final discussion, things had improved for Donna. Her partner had been very supportive, although he was working longer hours. The baby was now on solids and much more settled, although very active. Donna had altered her expectations of motherhood, acknowledging that there were good and bad days. However, she now spoke of a desire to return to part-time work and the importance of becoming her 'own person' again. *'At least at work you're your own person so to speak, whereas in your home, as much as I love being home with him, I'm his person, I'm not my own person... I'm mother... mother wholly and purely.'* As often occurred with the women when they contradicted dominant public discourses of motherhood, Donna felt the need to reassure me that she did love her child. *'Not that I regret it. I love him to death but um at least at work you have an identity other than mother.'*

The 'Uncivilized' Baby/'Good Enough' Mother

In the previous section, Jane, Marianne, Anna and Donna described their babies as 'good', 'beautiful' and 'wonderful'. However, most of these women had difficulties with breastfeeding and their relationship with their babies was far from harmonious, flowing or connected. They chose not to construct their infants as the 'villains'. Jane's horrendous problems with breastfeeding were strangely unrelated to the baby. In a disconnected way, it was as though they and their baby existed in complete separation.

In contrast Simone, Kylie, Barbara and at times Tess and Fiona, were more prepared to describe their babies as 'uncivilized' or antagonistic. Metaphors of demons, hell and leeches described vividly the disconnected experience. Simone spoke of four-week-old Catherine as a '*witch*' and similarly, Kylie described five-week-old Jeremy as *'the child from hell'*. Fiona, at times described Marcus as '*a rotten, sucking little* leech' and Barbara felt that while her five-week-old daughter was '*thriving*', the baby was *'sucking the life out of me'*. Here Barabara constructs Ruth's breastfeeding efforts as parasitic and not of benefit to the 'host' mother.

Simone's earliest memories of life with her daughter resonate with a sense of separate existence. Her experience of caesarean section under general anaesthetic was very distressing. She felt completely deprived of any knowledge of her daughter's birth and described powerfully her sense of disconnection. 'Y*ou're presented with a baby without*

the birth experience...I don't feel any kicks in my abdomen and there's the baby.' She was unable to describe the link between pregnancy and her daughter's presence in the nursery. In contrast, however, to other women who had their babies in the nursery, she did not construct the baby as physically absent from her and did not speak of 'something missing' or a sense of feeling incomplete as a mother. Simone was more than happy for her baby to be cared for in the nursery and her main motivation to take over the care of her baby was financial.

Simone's descriptions of her baby scratching and fighting at her breasts were vivid. Throughout our discussions, Simone cast her baby as a separate other, an antagonist working against or fighting her. Breastfeeding was constructed as a battleground where Simone must *'fight'* with the child to get her to the breast. In a similar way Barbara constructed a relationship with her baby that cast the baby as very demanding, draining - *'she is sucking the life out of me'* - the baby is a parasite, taking all she can get. The baby was constructed as a separate, antagonistic individual, appearing to be self-interested. The baby was stacking on the weight and Barbara was exhausted. *'She's doing very well... always happy...I'm not always happy.'* In contrast to others, Barbara was not caught up in a sense of pride about the baby's weight gain.

Barbara described her baby as demanding. Although the baby slept fairly well at night, she did not sleep much during the day, demanding constant attention and wanting to be carried around. Barbara saw her daughter as *'a very strong willed young lady'* and described her as very alert, not wanting many cuddles, preferring to look around. It may be that Barbara was not receiving the sensual and rewarding experience from her baby, but she did not present herself as a woman who desired a child for cuddles and hugs. Others such as Donna and Fiona were disappointed that their child appeared to dislike close body contact. Barbara moved quickly from this comment about cuddles and talked of the developmental stimulation that she thought her baby needed at five weeks. She believed that Ruth was more *'mature than a one-month-old baby'*, doing *'things ahead of her age'*, such as smiling, gurgling, holding her head up and appearing to look at the environment around her.

Barbara found many aspects of motherhood frustrating but accepted this as *'part of the course'*. She added that most of the time there was no real problem, just some days she felt as though *'the walls were closing in'*. By five months Barbara described breastfeeding as a *'bit of a hassle'*. The baby wanted to feed all the time and refused to take water from a bottle. She had decided that it was time to give herself *'some freedom'* and had started playing netball, intending to give the baby one formula bottle a day, *'just to have a break'*.

Similarly Kylie found life with her new baby to be *'hell'* and over the six months following the birth she frequently described baby Jeremy as the *'child from hell'*. The first three weeks had been *'horrifying'* and she added *'we were so naive'*. Kylie and her partner spent most of the first five weeks with their baby pacing up and down the hallway trying to work out how to get their baby to stop crying and go to sleep. During these early weeks Kylie sought a lot of help from the early childhood nurse, whom she referred to as 'God'. Kylie and her partner found it frustrating that it would take so long to settle the baby. She was clearly irritated by her child's alert behaviour which she described as *'too curious'*. During this period Kylie also became increasingly annoyed by the baby's night waking. Her expectations of a baby's sleeping pattern were contradictory to Jeremy's behaviour.

In our discussions Kylie presented her baby in a very negative way, talking of his *'bad temper and impatience'*. She described vividly the way he would *'throw his head back and scream for his feed'*. Kylie was determined to *'sort that one out'*. However, she recognised that she was presenting an account that challenged the dominant view of mothers and would continually qualify her statements with *'oh no... it's not that bad'*, *'it's getting better'* or *'I'm just enjoying it, having a little body around here'*. In Kylie's account there appeared to be a sense of alienation, of not knowing the baby and of two individuals acting as separate beings out of step with each other. Kylie found motherhood to be a process of *'trial and error, with none of this instinct business'*. Contrasting with Simone and Barbara, Kylie rarely mentioned her breastfeeding experience. She described breastfeeding in a pragmatic way. In the early weeks after the birth, it was playtime rather than breastfeeding that she enjoyed with the baby. She

talked in detail of their early nights at home and how they would bring the baby in with them and *'break all the rules'*, the baby cuddling up with them both.

In the first three interviews with Kylie after the birth, talk about breastfeeding was blatantly missing. It was not included in any discussion of relationship or communication with the baby. When asked how breastfeeding was going at five weeks, Kylie stated, *'fine, no problems'*. As so much of her discussions had been about sleeping, I asked Kylie about the relationship between breastfeeding and the baby's sleeping pattern. She acknowledged that breastfeeding did not really *'thrill'* her. She resented the *'bind'* of having to get up at night, having her sleep disrupted by a screaming cry which she interpreted as *'I'm hungry, feed me right now'*.

Kylie decided to wean the baby at three months. Unlike the majority of women, she had not had any problems but stated, *'I didn't really enjoy (breastfeeding) that much...I can't explain it, I just didn't enjoy (it) and (I had) no problems at all...I just really didn't enjoy, that's all there was to it, so it was a big relief actually to get him on the bottle'*. She talked about the pressures to breastfeed, *'If you do not breastfeed you're a lousy mother'* and felt that the health professionals *' would prefer it if I continued'*. Finally she decided *'who cares what they want, it's me that matters'*. For Kylie, the *'disruption'* of the continual night feeding left her no choice but to *'throw him on the bottle'*. Interestingly she went away from Sydney to her mother's place to wean the baby. Following this decision, she felt much stronger to go by her own feelings and *'instinct'*. She now felt confident to advise friends in relation to breastfeeding. She related telling her girlfriend, *'You just do what you want to do, don't listen to anybody'*.

For Simone, Barbara and Kylie, breastfeeding was central in shaping their relationship with their baby. Even though all three infants were 'thriving' on breast milk there was no sense of pleasure or achievement for these women and no sense of a connected and harmonious relationship. Rather these women saw the baby and its needs as separate and distinct from their own bodies. They constructed breastfeeding as disruptive of their sense of self, preferring that their infant gained increasing independence from them as mothers. In the following chapter, I examine a number of practices these women

employed to regain control in their lives and to restore their sense of autonomous and independent self.

CONCLUSION

In this and the previous chapter, I have explored women's experience of breastfeeding as both a discursive construction and an embodied experience. Prior to the birth of their babies, the majority of women participating in this study had embraced the pro breastfeeding rhetoric, constructing breastfeeding as central to their identity as a mother. They expected to breastfeed and were prepared to 'persevere' with any difficulties.

Following the birth, however, some women in this study did not experience breastfeeding as a connected or harmonious experience, nor was it pleasurable or sensual. Rather, breastfeeding was disruptive of their bodily routines and distorting of their known body and breasts. Instead of maintaining a unity of mother and baby, the breastfeeding experience highlighted a desire for separation and independence of mother and baby. Within this difficult and distressing breastfeeding experience, the discourses persuading women to breastfeed are continuously challenged. Breastfeeding posed a threat to women's sense of autonomy and independence. In the following chapter I examine some of the practices of regulation and control that women established in order to regain their sense of personal identity.

CHAPTER EIGHT

BREASTFEEDING AND THE MATERNAL BODY: PRACTICES OF EXCLUSION, PERSERVERANCE AND REGULATION

In this chapter I examine the 'work' or practices that women undertook at both a conscious and unconscious level to achieve an identity as a breastfeeding mother. The women who were experiencing a connected, intimate and harmonious experience of breastfeeding found this relationship so satisfying that they wanted to maintain the connection or continuity with their baby for as long as possible. To ensure continuity they participated in practices of exclusion, constructing 'special times' and intimacy with their infant. Others desperately wanted to experience a connection with their infant through breastfeeding. They had been persuaded by the pro breastfeeding discourses that there was 'something special' about breastfeeding and strove to achieve this 'embodied' experience. These women 'persevered' with breastfeeding and drew upon extraordinary levels of personal resources and strength to construct breastfeeding as an intimate and pleasurable experience. Through the practice of 'perseverance' these women hoped to achieve a connected and intimate experience with their infant, a crucial component of maternal subjectivity. Finally in this chapter I examine women's desire to present themselves as the relaxed, calm and flexible 'good' mother. Here I use the example of settling and sleeping to illustrate the amount of 'mother worry' (Walzer, 1996) and 'emotional work' (Hochschild, 1983) that women undertake to regain order in their lives.

8.1 MAINTAINING THE CONNECTED AND INTIMATE EXPERIENCE OF BREASTFEEDING: PRACTICES OF EXCLUSION

Rubin (1977) identifies the process of 'claiming' as an important component of 'binding-in' to the infant in the postpartum period. In 'claiming', a woman moves to include others close to her in a relationship with the child. Research or my empirical data, however, does not always support evidence of this process of 'claiming'. For example, Stainton (1985) describes the preference of second, third and fourth time mothers to keep their baby close to them, tending to provide all care. She notes a tendency for women to lie

their babies across their abdomen in the first month following birth (Stainton, 1985). In this section I examine the practices that some of the women in this study used to maintain their connected and intimate relationship with their baby.

Chapter Six established the connected embodied experience of mothering as intimately intertwined with the breastfeeding relationship. Indeed for some women in this study, breastfeeding was synonymous with being a mother. There is, however, a contradiction in these women's accounts of breastfeeding and their commitment to a shared parenting discourse. In talking about breastfeeding and their relationship with the baby some women highlighted the very special closeness between themselves and their baby and the intimacy and pleasure they were experiencing. Significantly it was breastfeeding that established the relationship with the baby as different from the relationship that anybody else, particularly the father, had with the baby. Breastfeeding was established as exclusively the mother's domain, privileging her relationship with the baby. The women who were experiencing breastfeeding as connected, sensual and pleasurable savoured this relationship. These women 'worked' to establish a connection with their baby, constructing this as a highly emotional experience and ensuring a high level of availability. Wrigley and Hutchinson (1990) describe this as 'presencing'. They were always available to their infant, often making it very difficult for their partner to get close to the baby. They created 'special' or intimate times with their baby. For example, they frequently slept with their baby at differing times of the day or night and strongly resisted many of the child-rearing accounts promoting regulation in a baby's routine.

The Connected Embodied Experience of Breastfeeding Contradicts the Rhetoric of Shared Parenting

This practice markedly contradicts many of the accounts of a shared parenting discourse women claimed in the first interview, where they had stressed that there was little difference between a mother and father. Most of the women in this study expected their partners to be fully involved with their new baby. They imagined that their partner would be able to care equally well for the baby and would of course continue to contribute or indeed increase their contribution to household tasks. Tina, for example, described a good father as:

The same sort of thing (as a good mother) exactly. I don't think that there should be much role distinction, other than that the man can't breastfeed, he can do everything else and provide as much love and support for the child as the woman can. I think that's happening more in today's society than it used to when the husband wouldn't change the nappy and wouldn't be there at the birth or didn't really take an active part and it was all women's work...

Similarly, for Linda, a good father was very much the same as a good mother. In our first discussion she talked about the decision they had made that everything except the feeding would be 50/50, they would share all the work including the baby care.

...Feminist, no what do they call it, male chauvinist... I don't know what you call that one. I think as a man and a woman it has to be DEFINITELY shared...I don't care what anyone else says that's the way I think...Mark and I decided that when we had children we'd do everything equally together apart from the feeding.

In her discussion about the early weeks of motherhood and breastfeeding, Amanda resisted talking about being a 'mother' and frequently corrected herself when she used the term, substituting it with 'parent'. This attempt to maintain an account of equality between herself and her partner is contradicted by the way in which she positions herself as 'different' in the following text:

I still think of it more as my role before when, I remember talking to you before and I said something about what are the parenting things of a mother or father and before it was, the distinguishing factor was that I was pregnant that made my role different to Jim's, now that I feed and Jim can't but everything else is still pretty much a parenting thing.

Amanda has stressed the importance of women and men contributing equally to the work of child rearing. However, Amanda also isolated breastfeeding as the one exception. Maggie also talked of the difference that breastfeeding imposed, believing that the relationship between father and child may be different if the mother was bottle feeding. Maggie stated, *'When you breastfeed you spend more time in a way that nurtures and nourishes the baby'* adding, *'Changing all the nappies in the world I don't (think) is going to... really increase the bonding sort of feeling'.* Here difference was introduced. It was not possible for a man to breastfeed. Exclusive breastfeeding thus

introduces contradictions into the numerous discourses surrounding our lives as rational autonomous women.

Linda provided one of the most detailed accounts of the tensions between breastfeeding and a shared parenting discourse. Early in our discussions she elaborated on the sleeping and feeding practices she used during the night. Her partner had encouraged her from the beginning to put the baby next to their bed to sleep. He had suggested that she could just feed the baby in bed and would not have to get out in the cold. This was perhaps a way in which he also could retain some proximity or closeness to the baby. After a couple of nights, however, Linda found that her back became sore when feeding in bed and she decided to feed the baby in the other room. She described putting on the heater and music '*just like in Special Care*' and feeding him in the rocking chair. While Linda stated that she was considering the sleeping needs of her partner, she also was meeting her personal needs, desiring a private closeness with her baby. This time at night constituted a 'special time' for Linda, providing a certain environment for the baby. Interestingly, Linda would take the baby back to their bedroom after the feed, put him in the crib and in the morning when her partner got up for work, would feed the baby 'in bed' and then lie with him there.

Linda continued to describe her breastfeeding relationship with baby Todd as 'wonderful' and felt certain that he knew her, telling how she believed he could distinguish between his mother and his father. She talked about his way of communicating with her and related this to breastfeeding. She described the special look that Todd reserved for her when feeding. Here Linda constructed her relationship with the baby as the central relationship and talked with pleasure of the very strange look Todd had on his face the first time he was fed a bottle by his father:

> *Last night was the first night he had a bottle with Mark and Mark's going, 'Oh he's really looking at me strange, he's trying to figure out why I'm feeding', you know... so 'cause I'm the only one that's ever fed him 'cause he's been all on here, on my breast. Mark said, 'He's really looking strange'... when I'm feeding him he looks like he's really calm...*

When Todd was eight weeks old, Linda talked about the difficulty Mark had in settling him when she went to the shops for half an hour. Although he had been fed he woke up and screamed continually, leaving Mark feeling useless:

> *Mark reckons that, like when he cries and that, if I pick him up he'll start to slow down a bit, whereas if he picked him up it doesn't change. I think that's because a mother tends to spend more time with him... and Mark says that... well he can't just give him a feed and he said that Todd will think his Dad starved him when he was a baby.*

Here Linda clearly had an advantage in being able to settle the baby with a breastfeed. In their discussions some of the women became reflexive about these practices. In recognising the privileged position that breastfeeding provided in relation to the baby, Amanda commented, '*Mind you, I think I selfishly really enjoy all the time that I have him to myself*'. This tendency to covet the exclusive relationship with the baby was recognised by other women. Linda stated, '*I want to breastfeed him on my own, it's like being selfish I'd say*'. She spoke of the difficulties men face in trying to establish a close relationship with their baby and like Amanda, commented on her desires:

> *I think the husband misses out a bit... it is hard when you're breastfeeding because I really think he's missing out on something and sometimes he'll say 'Oh, he doesn't want me he wants YOU, look he's trying to go for the BREAST you know'. But I think he feels a bit left out too... you feel like it's me and him and I think 'Oh I don't want to give him to you'. I mean, if I bottle fed I think Mark would have more involvement... but then I want to breastfeed him on my own.*

Trish also acknowledged her privileged position in relation to the baby and spoke of being grateful that Adrian (her partner) was prepared to forfeit much of his time with the baby to 'allow' her to be the one to stay at home and care for him. '*I tell people Adrian goes out to work so that I can be at home.*' Trish seemed to be conscious that perhaps her partner was missing out on time with the baby stating, '*We've offered to go back to work*'. Interestingly she didn't say 'I'. It seems that the baby is constructed as part of her (a package). To this suggestion Adrian replied, '*I've got my job and you've got yours*'. He appeared to be quite categorical about role delineation and felt more comfortable in his role as breadwinner.

Trish talked about encouraging Adrian to look after Mitchell on Saturday mornings while she went to aquarobics. She said Adrian still became quite frustrated when things didn't go his way with the baby and gave the example of going out one Saturday morning for her swim and how Mitchell cried the whole time she was gone but was happy and smiling the minute she appeared. Adrian felt like a 'failure' and Trish believed this was *'only natural because I'm with him all the time'.* Attempting to explain her baby's reaction, Trish reasoned this situation of feeling incompetent only arose when she went out because Mitchell fretted for her. Since Mitchell's birth, she had encouraged her partner to be totally involved in his care, *'changing him, bathing him and everything'.* However, Trish contradicted this account of involvement when she described how on a regular basis the baby was asleep by six and consequently his father often did not see him at night.

The women spoke of compensating their partners for the lack of opportunity to be involved in the baby's care. These women were all aware of the popular parenting texts advocating the importance of a father's involvement. Susan, for example, conscious of her partner's position and the exclusive nature of breastfeeding, was planning to express breast milk as soon as she gained confidence. This would allow her partner to *'have that special time with the feeding too...He feels a bit left out because he can't feed him'.* Linda also talked of sharing with her partner the 'special times' with the baby:

> *Today we got home at 2 o'clock and had a sleep, and he slept in between us and that was really cute 'cause that's like, of a morning when Mark goes to work I put him into bed with me after that and that's nice. So then today was really nice, we both laid down and he laid in the middle and that was really quite nice...*

Joanna encouraged her partner to lie down with the baby when he came home from work and provided a rare illustration of how a woman may encourage her partner to have the same intimate bodily contact that she enjoyed with the baby. During a weekend away Joanna suggested that her partner shower with the baby. This was the first time the baby had had a shower and Joanna described, *'He's got such a hairy chest so he soaped up his chest and washed him with it... the baby* ***loved*** *it. And it was really nice... for him to do that for him. So when he's home I'll get him to do it'.*

According to some of the women the fathers in this study did not position themselves centrally in their infant's life. Trish, Joanna and Fiona, although conscious of their partner's exclusion from contact with their baby, believed that in many ways their partners were happy with this situation. Fiona described her partner's involvement at night when their baby was only a week old:

> *Yeah, well I think Graham's got mixed feelings about it. I think he, on the one hand, wishes that he could be a part of it and breastfeed or feed (him) or be more helpful or do more and then on the other hand I think he's quite thankful that he doesn't because he sleeps through the night.*

As the baby grew, Fiona continued to stress the importance of a father's involvement yet constructed an image of Graham as a vicarious father. Once the baby was weaned at five months he settled and slept all night, so often Graham did not see him from Monday to Friday unless he got up with the baby in the morning. Fiona argued that he was not really missing out as she was able to provide a blow-by-blow description of the baby's day and anything new he had done. She admitted, '*Personally I would be devastated if Graham suggested that he stay home and I go back to work...I wouldn't be able to do that*'. She added, '*In a way I don't know whether men would be able to cope. I think some women are just born with maternal feelings*'.

Men Challenging the Boundaries Between Mother and Baby

Interestingly the findings from the men's data analysis in the associated study (Lupton & Barclay, 1997) contradict this notion that men prefer a lower level of involvement in caring for the baby. There were some occasions described by these women where their partners were overtly wanting more involvement with their infant. Men such as Carl, Dominic and Jeff (Tina, Maggie and Jane's partners) tried to challenge the boundaries between mother and baby. Maggie described how her partner, Dominic, had been the one to buy a manual breast milk expression kit so that he could bottle feed the baby. Similarly, Carl had planned without discussion with Tina that she start expressing milk so he could feed the baby. In fact, Carl's desire to be involved with the baby caused conflict at times for Tina. In Tina's interviews there was talk of competition between herself and Carl to have close proximity to the baby. In the first week home following the birth, Carl constantly wanted time with the baby and Tina remarked that she was

glad she was breastfeeding, *'At least I have to have him then'*. Carl appeared to be very aware of his secondary position and seemed insistent about gaining a place with the baby. *'He'd been dying to sleep with him because I said 'Oh he slept with me last night in the hospital' and he was really jealous. He said 'he's sleeping with me tonight' and he sort of had him in his arms all night, didn't let go of him.'* Tina commented that although Carl and the baby slept well, she was constantly waking to check on them. Here Carl appears to be attempting to create a similar closeness to the baby:

> *He loves having him in there. He wants to bring him to bed every night. I said 'no you can't have him in bed all the time'. He's even like trying to ship me out to the other bed so he can have Lachlan in with him. He said to me last night Lachlan can sleep with me tonight and you can sleep in the spare bed. It was good when he went back to work. I got to see the baby more (laugh).*

Rationalising the Desire for Exclusivity

In a reflexive way, some women demonstrated discomfort in recognising and expressing their personal desire for an exclusive relationship with their baby. The contradictions between the personally satisfying experience of breastfeeding and the powerful shared parenting discourse motivated the women to justify their desires with such statements as 'He's not here most of the time therefore I need to be able to do it'. Amanda, for example, found that in the early weeks her baby would have a prolonged crying period in the evening. Typically her partner would not yet be home from work and she found her own way to manage this situation. Eventually the baby would calm down and Amanda felt annoyed if her partner came home during this time and tried to *'help'* or *'hyped up'* the baby. While Amanda espoused the parenting rhetoric, she was the one caring for the baby all of the time and did not want her partner interrupting this pattern. In the following quote, Amanda again restricts or controls her partner's access to the baby:

> *....The other night he was having, he was upset about something and Jim said, 'Look I'll take him for a walk' and I just said 'No'. He can't get used to going for a walk outside when he's upset at this time of night. I said 'Because I can't do that every night. I'm here seven nights a week, you're here three nights a week when he has his tantrums'... and there has to be something that I can do every night, something I can live with...*

Women also need to develop confidence in their ability to demonstrate that they can competently care for their baby. Jane's story presented in Chapter Five illustrates the strong need that some women have to be autonomous and in control of caring for their baby. Jane believed that a 'good' mother was one who '*coped*' and '*knew what the baby needed*'. While still in hospital, Jane struggled to gain autonomy from the midwives, desperately wanting to feed Louise without their assistance or '*interference*'. Jane's early weeks caring for her baby were very difficult and she constantly faced new dilemmas with breastfeeding. She would often exclude her partner from being involved with the baby believing, '*The baby would get confused if more than one person tried to settle her*'. When Jane actively included Jeff in the baby's care, she would sometimes trivialise his input.

> *Her father spoils her rotten. Yes, first big outing to the early childhood centre, he dressed her all up, little hat on and a big cardigan and a little bib and she just looks so funny, I killed myself laughing. He quite likes fussing over her...I think it's a novelty for him because I'm constantly changing her and doing that type of stuff when he's not here. When he does get the chance he likes to make sure that she looks nice.*

Jane's description here diminishes the value of his participation. While Jane previously supported the rhetoric of an involved partner, she positions Jeff in a subsidiary role in this example of him dressing the baby. This activity is no big deal for her because she does it all the time. It was imperative for Jane to build her confidence in caring for the baby before she could ask someone else to do it or recognise their contribution.

Women Including Their Partner

Barbara, Denise, Donna and Anna each found considerable comfort in including their partners in the everyday care of their babies and these men also contributed significantly to household tasks. As with the majority of women in the study they strongly espoused a shared parenting discourse prior to the birth of their babies. Interestingly these women differed in their own position as mothers. Barbara and Anna were very happy to give an equal role to their partners. Barbara, while still breastfeeding at six months, found caring for her baby extremely demanding and frequently enlisted her partner to settle the baby at night or take over when she had '*had enough*'. Barbara frequently praised her partner's ability to settle their baby when she had been unable to. Anna, at 23 years old,

was one of the few women who did not hold any notions of traditional gender roles. Anna returned to full-time work as a teacher when her baby was almost four months old. Breastfeeding had been difficult and two days after coming home from hospital she happily stopped. She relied heavily upon her partner for his contribution to all aspects of infant care and household work.

Donna and Denise on the other hand positioned themselves as the primary carers for their infants. They were both very committed to breastfeeding, feeding for ten months and 16 months respectively. Six months after the birth, however, both reflected that breastfeeding could have been more personally satisfying. Like Barbara and Anna, these two women openly discussed issues with their partners and in the early weeks following the birth developed confidence in both their own and their partner's ability to care for their infant. It is important to note that neither Donna nor Denise was able to represent breastfeeding as a connected and sensual embodied experience. Donna, although very loving towards her baby and seeking close contact in the form of cuddles, simply constructed breastfeeding as a 'special time' that she shared with her baby without constructing an embodied connectedness. Denise, as described in the following section, was anticipating personal pleasure through the breastfeeding relationship. She was disappointed when these feelings were not realised.

Five weeks after the birth Donna talked at length about her partner's involvement with the baby and how things were shared between them. Here she provides an illustration of their joint 'trouble shooting' at three in the morning:

> *Paul's just really enjoying, you know, all those **little things.** He still feels very much involved... and in fact I think it was about three o'clock in the morning we have conversations. And he was saying 'Look it's quite good', he said, 'the way it's working out', he said 'I'll get up and I change his nappy and you give him his feed' he said 'I go back to sleep, you fall asleep and we're all right sort of thing'. I got up to go to the toilet at one stage last night and Alex was whinging so Paul took the lock out of the cradle and he started rocking it with his foot, it's like 'All right I'll do what I can right here right now'. I think he could have rolled over and just fallen asleep and ignored it but umm, no he still did his **little bit.***

Here Donna positions both herself and Paul as contributing to the baby's care. However, she also demonstrates resistance to giving equal weight to Paul's contribution,

employing the word 'little' to describe the things that he did, somehow implying that she does the **'big bit'**, presumably the feeding of the baby. This subtle privileging of her own position was also evident when Donna described Paul's skills in settling the baby. She was grateful that he was able to do this but did not promote the notion that he was 'equally' as good at settling. After all, she could always offer the breast. Despite this slight contradiction, Donna maintained an interest in a shared parenting account. '*It makes me feel a little bit more relaxed knowing that I'm not the only one that can settle him and that's certainly not what I wanted. I've seen often that the only one that can settle them is the mother.*'

These are subtle reminders of her position but they do not disrupt her partner's important position. She talked about her baby's early smiles in the middle of the night feeds.

> *His first smiles were great... the funny thing is it's usually always at early morning feed somewhere between say midnight and three o'clock... some times there when he's having a feed and um... he'll stop and he'll pull himself off and he'll have a look around and then he'll look at Paul or myself and have a little smile.*

Similarly Denise talked about how she included her partner in the decision making and care of their infant:

> *So for instance if Colin's going to change his nappy then I'll often get together the stuff that he needs...and he seems to be doing the same kind of thing too. 'Do you want a drink or whatever', so we're sort of just working together... as much as we can, I mean obviously Colin can't feed him. I've we we're both really aware that we want him to be as involved as possible, I don't want to take over all the all the mothering involved because then there's nothing at this point, there's not much left for Dad.*

A good example of Denise's confidence in her partner occurred while we were conducting an interview in their lounge room. Colin was in the kitchen with the baby, who was crying. Normally she would hover around to see what the problem was but she continued talking with me, resisting going into the kitchen. Many others would have raced in there and she stated, *'Well but, you know I'm not the only one who can do it'.. I'm so aware how easy it is for women to take on all the roles, just because you're there*

most of the time, I've got to be aware if we're going to share all those things then I've got to give him time to catch up'.

This part of the analysis has focused particularly on the practice of exclusivity. To maintain an embodied connection and intimacy with their infant, some of the women in this study engaged in practices that excluded others from frequent intimate contact with the baby. Such practices contradicted the commitment that many had made towards shared parenting. The practice of 'exclusive' mothering also tends to contradict their commitment to the relaxed and flexible 'good' mother discourse. There were times that this practice of 'exclusive' mothering was an important part of women gaining confidence in their ability to care for the baby. Here they gained a sense that they were 'in control'.

8.2 SEEKING IDENTITY, CONNECTION AND INTIMACY: PRACTICES OF ''PERSEVERANCE

What both surprised and confronted me most as a midwife and mother who has breastfed, was the enormous amount of physical and emotional work that many women in this study put into breastfeeding. Several women struggled to maintain their commitment to breastfeeding, 'working' at, 'persevering with' and demonstrating enormous resilience in the attempt to achieve their goal as breastfeeding mothers.

In Chapter Six the majority of women in this study constructed breastfeeding as a central and crucial component of being a mother. For some it actually implied a woman was a 'good' mother. These women had heard the breastfeeding difficulties of friends and family and while hoping that 'their experience would be different', many knew that it was necessary to really work at breastfeeding, 'to persevere' to achieve an identity as a breastfeeding mother.

Following the birth, the majority of these women remained committed to breastfeeding as a symbol of mothering and part of their new identity. For example, Sally stated, *'I think it's an important part of my relationship with him... if for whatever reason, he*

weaned himself suddenly or if something happened that I couldn't breastfeed him, I think I'd feel pretty odd giving him a bottle... it's part of motherhood that to me is important'. Not only did these women want to breastfeed - they wanted to do so 'properly'. Sally, for example, had used a nipple shield, yet somehow she felt this was *'not quite doing the job properly'*, *'I think using a shield is a bit of a cop out*'. Sally cast the nipple shield as *'separate from the breast'* but added, *'at least it's not as separate to breastfeeding as using a bottle'*. She felt uncomfortable or inadequate in resorting to the nipple shield. *'I would have to explain like why I am using the breast shield, that used to really piss me off... other people's expectations of you, like really imposing as if you're not fulfilling (the role).*'

The finding that breastfeeding in the 1990s is constructed by women as synonymous with 'good' mothering is not new. Other recent works (cf. Bottorff, 1990; Lawson & Tullock, 1995; Maclean, 1989; Wrigley & Hutchinson, 1990) have produced similar findings. What is interesting about these comparable findings is the lack of questioning by the authors as to the **appropriateness** of linking breastfeeding directly to a maternal subjectivity. As Barclay (1997) suggests, there are many other avenues for a mother to develop an intimate and loving relationship with her baby.

The women in this study 'persevered' with breastfeeding. The phrase 'it's worthwhile persevering' occurred commonly in their discussions. Many of the women used this phrase more often in the two interviews that followed the birth of the baby. Donna described a determination to achieve a 'special time' with her baby through breastfeeding. This motivated her to '*persist*' with the pain and discomfort of the early weeks of breastfeeding. She emphasised that it was *'well worth persevering'*. Sally described the need to '*persevere*' with breastfeeding in the early weeks when her baby seemed totally disinterested in breastfeeding. Even Tess, who was not committed to breastfeeding, talked of *'persevering'* with breastfeeding one week after the birth as *'it seemed to be going quite well'*.

In Chapter Five Jane demonstrated a powerful commitment to breastfeeding. Overwhelmingly influenced by the pro breastfeeding accounts, Jane wanted to breastfeed her baby to achieve an identity as a mother. Breastfeeding was *'a major*

motherhood thing', something she took for granted. Breastfeeding was going to establish a particularly close relationship between herself and her baby. For Jane, the embodied experience of breastfeeding contradicted this discursive construction. It was disruptive and distorting. In an effort to establish a connection with her baby, Jane desperately encouraged her baby to go to the breast and *'not find it such a frightening place'*. She bottle fed with her shirt undone so she could have skin-to-skin contact, particularly breast contact with her baby. Jane remained very committed to breastfeeding believing *'it is worthwhile persevering'*. After feeding expressed milk for ten days, Jane could not say why she tried to put her baby to the breast again, *'something just made me'*. Eventually she stopped breastfeeding and had to reconcile her strong commitment to breastfeeding with her identity as a non-breastfeeding mother. For a long time Jane felt as thought she had *'missed out'* on something (just what she was unable to articulate) by not feeding her baby.

There are other women whose stories specifically illustrate the continuous work, the prolonged effort that they put into establishing breastfeeding and achieving a satisfying, pleasurable breastfeeding relationship. Illustrations from Fiona and Denise demonstrate the practice of 'perseverance', emphasising that breastfeeding is a project (cf. Bottorff, 1990; Maclean, 1990; Wrigley & Hutchinson, 1990), a practice of the self.

Seeking Connection and Harmony

Fiona was totally committed to breastfeeding her baby. In our discussions prior to the birth Fiona constructed breastfeeding as 'natural', 'best for the baby' and necessary for the 'bond' between herself and the baby. Similar to her plans for birth she did not want to interrupt what was a 'natural event'. It was only during the antenatal classes that Fiona first heard of the difficulties associated with breastfeeding and this prompted her to commit herself to breastfeeding. *'I know it's going to take a lot more perseverance than I thought it would be. But at this stage I'm prepared to put that in.'*

Following the birth of her baby Fiona went home on the early discharge program and everything went very well for the first two or three weeks. Fiona believed that her relaxed approach to her baby facilitated her success with breastfeeding in these early weeks. At this early stage Fiona described breastfeeding as a pleasurable and satisfying

embodied experience, enjoying the closeness of her baby's body. Breastfeeding was all she had to do to meet his needs. By the time her baby was four weeks old, however, this experience had changed. The baby was sleeping for no more than two or three hours in a row day and night and he could be awake for five or six hours during the day. Fiona described him as an 'active' and alert baby who liked to be carried high on her shoulder so that he could see. She predicted that he was going to be '*impulsive, a child that will not be happy to sit around placidly*'. Fiona started to realise that her plans to undertake another degree while home caring for children was, at present, totally unrealistic.

This disruptive and disconnected relationship continued for five months, during which Fiona sought little professional help. She had found the early childhood nurse generally unhelpful and her telephone calls to the 24-hour counselling services only confirmed the settling practices she was using. When Marcus was three months old, Fiona needed a break so desperately that she considered giving up breastfeeding. Both her mother and mother-in-law suggested that it may be her milk supply that was the problem, but Fiona was convinced that she had enough milk and breastfeeding was one thing that she really was enjoying:

> *The closeness of it and stuff, and we often communicate with each other while he feeds cause his eyes are always wide open looking into mine and he smiles at me a lot while he feeds... and also there's the convenience of it. And so I mean I decided to possibly try the formula feeding and see would it make him sleep for longer but in the end I thought 'I don't want to'. So I will persevere and see how I go... hopefully, you always hope that tomorrow he'll sleep don't you...*

For the next two months Fiona was totally exhausted by her baby, who's sleeping pattern was not at all 'civilized'. Her entire focus was on getting Marcus to sleep. Throughout this time Fiona believed that she was maintaining a relaxed and calm demeanour. She described quietly stroking her baby asking him '*What's wrong, don't you feel loved or something, what's the matter, what am I doing wrong*?' She concluded, '*He's just being a baby isn't he?*' Fiona also talked of moments when she felt really frustrated with her baby. She described maintaining control, keeping a gentle tone of voice while under her breathe she would be saying '*you rotten little sucking leech*'.

During these difficult months, Fiona demonstrated remarkable resilience and personal strength to attain her goal as a breastfeeding mother. Her commitment to breastfeeding prompted her to separate the baby's sleeping pattern from the experience of breastfeeding. She continued to feed Marcus for a further two months. She resisted the suggested explanation of gastric reflux and was particularly averse to using medications. During our discussions Fiona captured the strong and ambivalent emotional experience of being a mother:

> *The absolute complete love you feel for the tiny little thing, that's what I thought it would be, but then at the same time... I think it is a bit of a love/hate relationship like I absolutely love this little baby and I would just die if anything happened to him and, you know umm... can't really put into words, but at the same time, sometimes I just think, just wish he'd just go away and to just give me some peace...*

Here Fiona reassured me that she did not regret having her baby at all and added '*we are planning our second baby*'. Nevertheless she stressed being mother was much harder than what she had expected. '*I never ever realised it, how constant and how dependent on you they are.*' She was scathing of the emphasis antenatal classes have upon the birth and the limited discussions provided about caring for a baby.

Fiona ceased breastfeeding Marcus when he was five months old. The disruptive sleeping pattern had continued up until this time. The baby was constantly crying and she did not know whether he was in pain, had reflux or whether he was just 'snack feeding'. While uncertain about this, suggestions that she should institute 'controlled crying' were not appealing, as she did not like to let him cry for longer than two minutes. Fiona had asked the early childhood nurse whether breastfeeding was the problem and was told continuously, 'No it can't be the breastfeeding, breastfeeding is the best thing for the baby'. Everybody told her, 'Look he's only three months, give it another month, look he's only four months give it another month'. Fiona didn't know whether bottle feeding would make things better but all she wanted was '*to have a break*'. By the time Fiona decided to wean, breastfeeding was not enjoyable. '*When Marcus was being breastfed he was like a parasite, constantly attached... if I got him to go over an hour it was a major accomplishment. I was breastfeeding him day and night for the last month.*'

Fiona was very committed to breastfeeding and she *'persevered and persevered'*. However, in contrast to Jane, after five months of breastfeeding Fiona was comfortable with her decision to wean Marcus. She had thought a lot about how she would feel not *'giving him his nourishment'*. Fiona travelled to her mother's place one hour north of Sydney to wean Marcus. She knew she would need someone else to give him the bottle as *'he would smell the milk'*. Fiona told me that she really thought about his last feed, *'I wanted to try and savour that feed and I sort of tried to savour it a lot while it was happening, but I think I was just so relieved that it was all over'*. She added, *'The little bugger didn't seem to care'*. Fiona was thoroughly exhausted and had no regrets. *'I don't wish that I'm still breastfeeding at all... the closeness was nice but we still have a great time bottle feeding him, it's nice to see Graham doing that... I'd had enough.'* Ultimately Fiona had to rework her commitment to breastfeeding. She was left with no doubt that she had *'done everything possible'* and had effectively breastfed her baby for five months. In contrast to Jane, Fiona did not remain committed to breastfeeding, *'the next baby has got six weeks, if it's not a happy baby after its six weeks that's it straight to the bottle'*.

Seeking Sensuality and Pleasure

Denise's story illustrates particularly well the notion that there is something intrinsically 'special' and pleasurable about breastfeeding. Like the majority of women in this study Denise had always planned to breastfeed and believed that she would have been very disappointed if this had not been possible. She saw breastfeeding as *'natural'*, *'environmentally sound'* and felt that it promoted a closeness between mother and baby. She had also heard that breastfeeding could be very pleasurable for the mother. Denise experienced badly cracked nipples and later, blocked ducts, severe mastitis and a breast abscess that required lengthy treatment. Despite the 'damaged nipple' and severe infections, Denise continued breastfeeding and felt this was successful. She insisted that the blocked ducts, mastitis and breast abscess did not cause her much pain and she never considered ceasing breastfeeding. The aspect of breastfeeding that appeared to distress or disappoint Denise the most was the lack of personal pleasure she gained from breastfeeding. At six weeks I asked Denise if she was enjoying breastfeeding. She responded hesitantly with *'Yeah, no it's nice, it's nice yeah'*. There was a sense that

Denise felt she should agree with me, breastfeeding was 'nice' but she was certainly not enthusiastic about it.

Denise had difficulty articulating her feelings about breastfeeding. She was not finding it as pleasurable and rewarding as she had thought it would be. *'I'm certainly not on the high pleasure or satisfying part of it, I feel that it's something I have to, well not persevere, (but it's) not as pleasurable as I thought it would be actually... so I'm a little bit disappointed there'*. I suggested to Denise that perhaps this was due to suffering mastitis, however, she stated *'It didn't affect it at all'* and she elaborated:

> *....No no...I don't know, he's only six weeks old too, so they sort of say, it doesn't really pay, you don't really get your act together with it till the six weeks...I suppose I was hoping to be... on the high end of you know the pleasure sort of thing...*

For Denise breastfeeding at six weeks had not really provided the rewards she expected, there were no benefits yet. She had been expecting personal rewards from breastfeeding, particularly an embodied sense of intimacy and pleasure. Consoling
herself with the thought that perhaps the 'pleasure' was still to come, Denise described to me what she meant by 'pleasure' in relation to breastfeeding:

> *I really don't know I suppose...I still find my breast and nipples are very tender and... I wasn't expecting it to be that way. But you know that's OK, that's certainly nothing that I can't deal with now, yeah we'll get through it. But it's... I mean it's just, you know I thought it would be, (p) more rewarding, like good feelings...I suppose I'm disappointed that I've not picked up the total, the pleasurable thing that I thought it would be...I mean I don't feel like I'm persevering, like I don't think I'm just suffering it... I thought it would different... but I mean I certainly wouldn't change it really, and I mean there's no way that I, that I'm going to give up breastfeeding.*

At six months Denise remained committed to breastfeeding, albeit for pragmatic reasons, *'I suppose in some ways it wasn't really painful... it's so easy, doesn't cost anything, I don't have to do anything, I don't have to cart bottles around, I don't have to sterilise things'*. I suggested to Denise that she had persevered through quite an ordeal for little gain, but she maintained that *'the whole time I never had any trouble with actual feeding you know but my breasts were a mess but I could still feed. I could have*

feed off one breast but I was not going to give him formula'. While Denise was gaining no personal pleasure from breastfeeding her baby, she remained determined that her child would have breast milk.

In this study Fiona, Denise, Jane and others such as Marianne and Katrina 'persevered' with breastfeeding. In this analysis, 'persevering' represents the extraordinary physical and emotional work that women undertake to achieve an identity as a breastfeeding mother. Perseverance is a practice of the self. The work of Bottorff (1990) is particularly relevant to this analysis. In her phenomenological study of the breastfeeding experience, Bottorff (1990) develops the concept of 'persistence' in breastfeeding. She was particularly interested to know why women in western societies continue to breastfeed when other alternatives are available. This work found there were many women who were prepared to 'persist' with breastfeeding and Bottorff (1990: 201) poses the question 'What is it about breastfeeding that calls for persistence?' Similar to the analysis in this Australian study, Bottorff (1990) establishes breastfeeding as a project and a volutional act. Women who breastfeed are choosing to act or position themselves in the world in a particular way. Bottorff (1990) notes that for some women 'persistence' was so much a part of their breastfeeding experience they came to view it as a way of life. Bottorff (1990: 203) identified a powerful need to succeed and 'to be tenacious of purpose and to remain determined' that in turn gives a woman the sense of being capable of breastfeeding. According to Bottorff, positive affirmation significantly impacts upon women's ability to breastfeed successfully. The use of self-talk appropriately compared to the decision to remain on a diet or stick to a particular exercise regime. This further highlights the nature of breastfeeding as a practice of the self. Once a mother has made the commitment she is 'stuck' to breastfeeding, her personal strength and commitment being put to the test (Bottorff, 1990: 206). In this construction of breastfeeding, Bottorff (1990: 203) argues that 'one's self as a person, one's self as a woman is at risk'. To question one's commitment to breastfeeding is also to question a woman's commitment to this new responsibility. Breastfeeding is believed to 'epitomise motherhood' and 'becomes a way of validating our womanliness and motherhood' (Bottorff, 1990: 204).

Bottorff's analysis exposes clearly the tenacity with which some women will approach breastfeeding. These Canadian findings concur with the experience of these Australian

women. What is of particular importance is the different motivation for persistence in Bottorff's analysis and this Australian study. The Canadian women appear to be resisting dominant accounts of a societal discomfort with breastfeeding and the promotion of formula feeding as a satisfactory alternative to breastfeeding. Ten years later in the Australian context, 'perseverance' is motivated by a desire to satisfy the dominant account that 'breast is best' for mother and baby. What needs to be also questioned is the degree of support that Bottorff gives to the centrality of breastfeeding in the construction of a maternal subjectivity. Accounts such as those by Bottorff (1990) and Wrigley and Hutchinson (1990) do not consider the place of powerful pro breastfeeding rhetoric, described in Chapter Three, in influencing some women to 'persist' or to 'persevere' with breastfeeding.

8.3 'CIVILIZING' THE INFANT BODY: PRACTICES OF FLEXIBILITY AND REGULATION

As discussed in Chapter Six, the women in this study subscribed to various aspects of the 'modern' and 'traditional' good mother. They insisted they needed to remain relaxed and calm, be flexible in their approach to childcare and in doing so, would remain 'in control' of their new role. A strong commitment to child-centred practices was evident: they would be guided by their baby's needs. Simultaneously, however, some women stressed it was important to 'show who's boss', the baby was not going to 'rule the house'. It was within the varying discourses surrounding settling and sleeping where women 'played out' their commitment to flexibility and child-centred practices. Within this discursive field, some women struggled with the commitment to flexibility, while others strove for regulation and control over their infant's behaviour. It was the infant's settling and sleeping pattern that particularly required monitoring and regulation. The now separated infant body needed to become 'civilized'.

Settling and sleeping practices, not surprisingly, formed a major part of the women's discussions. In these interviews with new parents, the women 'worried' (Walzer, 1996) about and discussed the infant's sleeping pattern far more than the men. Apart from breastfeeding, settling their baby and promoting 'civilized' sleeping patterns preoccupied women's thoughts during the first few months after the birth. This is quite

understandable. A baby that sleeps for at least some of the day allows a mother, if she is the primary caregiver, to get some rest or time to herself. Walzer (1996: 222) also suggests that mothers 'worry' about the care of their babies because 'they are expected to and because social norms make it difficult for mothers to know if they are doing the right thing for their baby'. Walzer (1998: 222) calls this 'mother worry' and believes that it is generated by the question, 'Am I being a good mother?'

During our interviews women talked often of the techniques they used to settle their babies. They described something very satisfying and appealing about a well-fed, settled and contented baby. Not only did this represent a 'good' mother, relaxed and in control, but it also appealed at a non-discursive level to feelings or personal fantasies of what it was to be nurtured. Jane illustrates this well in the following scenario. She talked of settling her baby in the evening by firstly bathing her and then feeding her. She described the clean and fed baby as *'nice and snug and cosy and warm... contented (with a) belly full of food',* giving Jane a feeling of satisfaction, an almost aesthetic sense of satisfying motherhood.

Prior to the birth of their baby all the women had imagined such contented scenes. They expressed hopes that their baby would be a settled, 'good' baby, but most entertained the idea that their baby could be, as Kylie described, 'a screamer'. A 'good' baby was variously seen as one that fed well, slept well and rarely cried. The 'good' baby is cast as 'pure' and innocent (Murcott, 1993). The women in this study made it very clear that a 'good' settled baby was related to a relaxed and calm 'good' mother.

What is most significant about the practices related to settling and sleeping are the number of confusing and conflicting accounts that the women drew upon. As Christine admitted prior to the birth, she was more unsure about where her baby should sleep than any decision related to feeding her baby. Prior to the birth, some of the women volunteered their decisions about where the baby would sleep. For example, Amanda, while having rearranged their spare room to double as a nursery and study, planned that the baby would sleep with her and her partner. Tina, Sally and Amanda were unusual in their confirmed decision to 'allow' the baby to sleep with them and were mainly influenced by friends who had advocated co-sleeping as a successful form of night time

settling and sleeping. For these women, co-sleeping represented a particular approach to mothering that would maintain some continuity between mother and baby. It would be comforting for the baby and personally satisfying for themselves and their partner. Tina, however, also believed co-sleeping was practical. She had heard from her sister that this was often the only way to get a baby to sleep.

The majority of the women, however, planned on the baby sleeping in a cradle or cot in the parents' room. A few were adamant that to gain independence the baby should sleep in its own room from the start. Drawing upon the words of her mother and mother-in-law, Linda illustrated the opposing accounts of where a baby should sleep:

> *I think my mum has the view that (the) baby (should) have its own room and that's where they should be and when they're ready to be fed they will awake, and then they're to be cuddled and kissed and, you know go crazy over, but then straight into their room again till they wake up for their next meal...She doesn't like the idea of me having him in our bed, whereas Mark's mother she says, 'Oh, don't listen to what other people say, you know I had all mine in my bed with me and maybe that's why they're all still clinging to me at 30 and 33' and she said it's a special time, you just do whatever you want to do, don't listen to other people.*

Here Linda presents the contradiction between women's desire to maintain continuity or connection with their baby and the alternative imperative, also held by important others, for a child to develop independence at an early age. Linda wanted to be free to cuddle and hold her baby whenever she wanted to or felt the baby needed it. She resented being told by her sister that she 'will have to let go of him one day'.

The Challenge of Maintaining Flexibility in Infant Care Practices

The practice of co-sleeping contradicts dominant professional and public discourse. The majority of popular parenting texts recommend that an infant sleep in its own bed. While it is often advised that the cradle or cot should be in the parent's room for the first two or three months, it is rarely advised that the infant should co-sleep with his or her parents. Some texts such as '*Babywise*' (Ezzo & Bucknan, 1995) portray co-sleeping as the easier, short-term option with detrimental or 'dangerous' long-term consequences. Other texts do not even mention co-sleeping as an option, such as Fowler and Gornall (1991) who only mention co-sleeping as a form of settling following

immunization, or Green (1988) who reassures mothers that they will not roll on or smother their baby if they drift off to sleep while feeding the baby in bed. Some sources suggest that co-sleeping is ultimately hazardous, raising the risk of Sudden Infant Death Syndrome (Ezzo & Bucknan, 1995). Books promoting co-sleeping (Sears, 1986; McKenna & Bernshaw, 1995) rarely influenced the women in this study. As mentioned previously, the three women in this study (Amanda, Sally and Tina) who decided their babies would sleep in their parents' bed, had been primarily influenced by friends and work colleagues who had also undertaken this practice.

The practices of exclusivity discussed in the previous section centred predominantly on breastfeeding and the women's desire to maintain a connected and intimate relationship with their baby. Yet it was not always just the nature of the breastfeeding relationship that maintained this exclusivity. Using the rhetoric of the 'flexible good' mother, women such as Linda, Trish and Sally settled and put their baby to sleep in ways that ensured their close proximity to their baby. These women all described times when, to settle the baby, they would cuddle up in bed alone with her/him. During the day the infant was kept close. For example, Trish placed her baby on a sheepskin on the lounge room floor. Every whimper or cry was responded to immediately. This was not done as a desperate measure to get some peace such as Kylie described. Rather it was a decision these women made about their own and their baby's needs.

Sally, in her first two weeks at home after the birth, established a night time feeding, settling and sleeping pattern that would have challenged even the most 'flexible' of professional and public accounts. She would get up to feed the baby during the night, go to a room downstairs with a couch, feed the baby, *'falling back to sleep there, waking up for another feed and having another sleep there'*. Whenever she tried to move the baby he would waken. Consequently most nights the baby was sleeping on her chest. This did not worry Sally, *'it's not too bad because I quite like having him sleep on my chest... it's alright and he likes it'*. When her baby was seven weeks old she still found this an easy and satisfying way to settle him and get some sleep during the night. Sally stated, *'Oh I don't even bother going to bed'*. By 12 weeks Sally had changed her night time feeding pattern. *'I'm starting to go back to bed with Richard and taking Henry with me now.'* However, she still found it more comfortable to get up at night to feed him and if he fell

asleep on her chest she would stay asleep on the lounge. Sally added, *'I like that, that's a nice time'.*

These women enjoyed this part of their relationship with the baby. They talked about being relaxed about their baby's sleeping pattern, of 'going with the flow' and being flexible. They stressed that they were guided by their infant's behaviour and if the baby needed to sleep, they should sleep wherever it was convenient. Trish described this approach as 'civilized'. Importantly, the practices of co-sleeping and 'presencing' (Wrigley & Hutchinson, 1990), together with the exclusive practices associated with breastfeeding, maintained the connected relationship between some women and their breastfeeding infant.

For the majority of women, however, the decision to 'allow' their baby to sleep with them was not so easy. The powerful professional and public accounts associated with settling and sleeping persuaded many women that it was important to establish bedtime routines. The infant must sleep in its own bed, have a routine to indicate bedtime and be able to put her/himself to sleep. This call to 'train' and manage the infant makes it very difficult for women to maintain flexibility or to do what 'is best for them and their baby'. Flexibility is only possible within a limited range of acceptable options. Women wanting to just be 'close' to their baby were often confused as Denise described:

> *....I don't want to set up any patterns that will cause problems for a long time... my mum and dad had to break me at 18 months of having me in bed with them and it sounded awful, they were quite brutal, they just let me scream the whole night...I don't want ever be put into a position like that and somebody who worked for Karitane said one of the things that they had a lot of people coming in for was when the baby was 8 or 9 months and trying to break them of certain habits like feeding in bed or your sleeping with them.*

Denise felt certain that the baby was better in his own bed although she found there was something very 'nice' about having the baby in bed with them and that co-sleeping may promote 'closeness'. *'I suppose I don't want to deny... the closeness with him'.* Denise decided to encourage her baby to sleep in his own bed during the night. His bed was placed right next to her side of the bed and she could pat him while lying in bed. Once the sun was up the baby was 'allowed' to lie with them as Denise had determined, *'This*

was the start of the day... while it's dark he knows that he has to be in his cradle'. She felt satisfied with this compromise reiterating, *'I don't want to keep taking what is the easy option now and then having problems'*.

For some women, co-sleeping did not reflect a pre-planned commitment to maintaining continuity with the baby. Rather, the decision to co-sleep occurred so the mother could get some rest. They were being pragmatic and argued this demonstrated their ability to be flexible. For example, Tess found her baby at four weeks was unsettled during the night, waking each time she was placed in her bassinet. Tess said, *'I was just shattered, I gave up fighting and I thought oh just sleep with me then'*. Donna was also ambivalent about her decision to co-sleep:

> *The big BUT, the middle of the night when you're tired you put him in the bed with you, because sometimes he won't settle in his cradle, he'll just whinge and cry and carry on all night and he has to have some sleep so in the end I've grabbed him a couple of times and then put him into bed with us where he usually settles a lot quicker BUT I don't want him to get into the habit of sleeping in the bed with us.*

These women generally accepted the professional and public rhetoric of the independent baby sleeping in its own bed. Like many of the other women, Donna and Tess related stories of older children they knew who still climbed into their parents' bed in the early morning. In public discourse this is generally not condoned. Susan warned if you left a baby in your room for even three to four months they had great difficulty settling in their own room. Yet these women wanted their baby close. Even Jane, who believed that lying with her baby was the absolute 'last resort', knew the baby liked the body closeness. She made a point of describing how she cuddled her baby over her left-hand side to be close to her heartbeat.

Over time some women stated with more certainty that they were not 'going by the book' in settling their baby in their own bed. Lyndall confidently said, *'I cuddle him back to sleep but I like doing it'*. Joanna was advised by the early childhood nurse not to cuddle her baby to sleep. *'I'm trying not to nurse him a lot...I've been putting him in his bassinet and just giving him his dummy... giving him a pat on the back and walking away... and that's what I've been told to do by the clinic staff.'* However, Joanna was still 'allowing'

herself one period in the day where she could cuddle her baby as he slept, '*I'll enjoy it when I do it*'.

Most of these women were accepting of their baby's sleeping patterns and tended to be more relaxed about a baby's unsettled period. Amanda described calmly bathing and cuddling her baby when he was having his evening 'tantrums'. She saw these screaming periods as a time when the baby needed to communicate with the world. Maggie believed that some mothers held high expectations of their baby's sleeping pattern:

> *Sleeping problems aren't usually sleeping problems until you make them a problem yourself when, because your so stressed about the fact that it's not sleeping the way you want it to, (you must) accept that if you've got a baby who wakes up seven times a night, as terrible as it might seem that, you know, it's probably only a phase and there's not much you can do about it... so learning to be flexible...*

In these accounts there is a strong emphasis on taking a child-centred (Newson & Newson, 1978) approach to infant care or, as more recent accounts describe, being 'sensitive' (Woollett & Phoenix, 1991; Leach, 1994a,b) to their infants. These women talked of getting to know their baby's needs, the cues the baby gave and of learning by 'trial and error' what suited their baby. In being child-centred and flexible about the care of the baby they constantly thought, read and talked about infant care and all the possible approaches. They believed, as Leach (1994a) articulates, that ultimately 'what is good for the baby is also good for the mother'. The amount of mental work or 'thinking' work (Walzer, 1996) that was needed to maintain flexibility was striking. A flexible approach requires the women to undertake 'emotion' work, remaining calm and relaxed. As Woollett and Phoenix (1991: 36) note, the sensitive mother must 'hold her own feelings in check', allowing her to make informed or 'rational' decisions about infant care based on the information she gathered.

The first few months with their newborn baby, however, often challenged the women's commitment to a flexible, relaxed and child-centred approach to infant care. While co-sleeping with their baby, whether out of choice or necessity, worked at night, some women found this settling pattern demanding and frustrating during the day or evening and wanted to somehow regulate or 'civilize' their infant's behaviour.

Developing a Focus on Regulation and Control

In Chapter Seven, women described the demands and disruptions that breastfeeding brought to their lives. For some women the breastfeeding relationship was constructed in a disconnected and antagonistic way. Mother and baby constituted two individuals with competing needs and demands. These women resented the lost sense of identity and individuality and described the breastfeeding baby as a 'leech' or an invader. Life as a mother, particularly a breastfeeding one, was disruptive, uncontrolled and chaotic. These women wanted to regain order and control over their lives. Consequently they began to focus on techniques to regulate or 'civilize' their infant's behaviour. Rejecting flexibility and a child-centred approach, they believed if they were personally happier, then this would also be better for their baby. To 'civilize' their baby they had to take control.

In Chapter Five Jane demonstrated an unrelenting concern to regulate her baby's sleeping pattern. After learning from a health worker that a baby requires 18 hours sleep in 24 hours, Jane became obsessed with the amount of sleep her baby got. While the night time sleeping pattern was never a problem (the baby slept for eight to ten hours at night), it was the day time 'catnaps' that concerned Jane. She learnt many techniques from various health workers to 'manage' the baby's sleep during the day, such as settling the baby by wrapping her tightly in a sheet. The nurses also suggested placing an extra sheet to cover the baby's head so that when the baby awoke she would not receive any stimulation from her surroundings and would presumably settle back to sleep if it was not feeding time. Jane also discovered that her baby might sleep for longer periods if there was a fan heater on in the room, providing extra warmth and a monotonous noise to encourage sleep. She remained in a quandary as to whether she should pat baby Louise to sleep or initiate controlled crying.

Ultimately Jane was extraordinarily successful in getting her baby to sleep frequently and for long periods. The routine she had established was totally predictable. In fact by five months of age her baby's pattern was so predictable Jane commented, '*I could do the day blind folded, I know exactly what she is going to do*'. In this scenario, the baby has been so well trained in a particular sleeping routine that Jane had achieved a high level of order and control in her life. Jane had persisted for the last five months in

establishing a regulated sleeping routine. Consequently Louise was now cast as the 'perfect' baby.

For some women, regaining control and managing the 'infant body' meant ceasing breastfeeding while for many others it meant regulating their infant's settling and sleeping pattern. Most of the women in this study turned at some point to professional sources of help. They visited the local early childhood nurse, used the 24-hour counselling services provided by the two mothercraft organisations, read from parenting texts or consulted their doctors.

These women learned the 'golden rule' in settling an infant. As Simone stated, *'The cot is for sleeping, the breast is for feeding'*. The majority of professional and popular discourse currently advocates that an infant must learn to sleep in its own bed. Placing an already sleeping infant in its cot or cradle is a 'bad' habit, or as Tess described, *'the fatal mistake'*. In his book on 'surviving' babies, Christopher Green, a well-known Australian paediatrician advises, '(F)eeding a baby until he drops off to sleep is a bit like rocking him off to sleep. It might all be very cosy and comforting but you might run the danger of making a rod for your own back. In time you may set up a dependence that creates a no-suck - no-sleep situation' (1988: 154).

In order for the baby to go to sleep in the cot rather than at the breast, the women learnt numerous settling techniques to 'manage' the infant body. Simone, in a lengthy discussion, described many of the techniques she had learnt. For example, after feeding and changing the baby, she was told to relax the baby by wrapping her properly and putting music on, placing the baby in her cot and then patting her. Simone stressed it was important to have the same routine each bedtime. Joanna had also learnt about routines from the early childhood nurse, who stressed the baby should follow a pattern of sleep, eat and play for a specified amount of time. Simone added that if the baby did not settle, she was to leave the baby to cry for three to five minutes, go in and pat her till she quietened and then leave the room. If the baby continued to cry she was to leave the baby for a slightly longer period each time. This technique of patting the baby and letting her cry for short periods was fairly successful for Simone. After a week the baby

settled to sleep more easily. However, these techniques were less successful by the time the baby was four months old.

Simone's description of this technique of 'training' a baby to go to sleep parallels what other women call 'controlled crying'. A number of these women used 'controlled crying' with varying commitment and success. Kylie, for example, believed that the best thing she had done was to put her baby in his cot and let him cry for half an hour. She described how he had soon learnt that the cot meant sleep and she insisted *'we're getting (him) trained'*. For many 'experts' the best way to 'train' a baby to settle and sleep is by 'controlled crying'. Advocates insist that within a couple of days the baby will learn that when in the cradle or cot it is time to sleep. Indeed Ezzo and Bucknan (1995), the authors of '*Babywise*', suggest a baby can be trained in this way to sleep for seven to eight hours at night by the time he or she is eight weeks old. In this popular account, Ezzo and Bucknan (1995) do not advocate an approach to infant care that is child-centred, rather they insist that the only approach to infant care should be parent directed. They argue that the practice of demand feeding, results in a baby who does not know a routine and who consequently will wake through the night.

Barbara also advocated 'controlled crying' as a way to 'manage' her demanding baby. She described becoming extremely frustrated by her baby's 'screaming' and said the baby would feed *'every minute of the day if she was allowed'*. Barbara and her partner had decided, without the suggestion from any 'experts', that they needed to impose some routine upon their baby:

> *I think part of the reason why I find it difficult to settle her down sometimes is because as soon as she comes to me she can smell it and... if I fed her she'd be happy. So Alistair and I have decided that she actually chucks tantrums so that she'll get fed and so we've decided that if it's not feeding time that we'll try not to feed her while she screaming, if she calms down then she might get some if she's lucky.*

Barbara and her partner were prepared to reward their daughter for 'good' behaviour. Most of the time they were in agreement about how daughter should be managed. However, there were times when Barbara believed that she knew the baby's behaviour better than Alistair did. For example, in the evening, around their dinner time Barbara

thought it was fruitless trying to get their baby to sleep, *'she will scream and scream and scream and scream... experience tells me that she's not going to go to sleep'.* Alistair, however, disagreed. Barbara stated, *'Alistair doesn't ever want to give in. So he'll sort of sit there and he'll have her in the cot and pat her, and she just screams. Eventually we have to pick her up so... you know he says 'oh she shouldn't get away with it you know, it's bad behaviour''*.

In contrast, some parenting texts that emphasise a commitment to a 'flexible' account do not advocate controlled crying as an approach to managing a baby's settling pattern (Fowler & Gornall, 1991; Green, 1988).

Some women in this study were also ambivalent about the technique of controlled crying. Donna experienced many periods where she found the baby would not settle in his bed and she often nursed him to sleep. She described this practice as 'hazardous' and did not want him to get used to it. Donna was advised by the early childhood nurse to let her baby cry for three to five minutes when trying to get him to sleep in his own bed. While this worked sometimes, she often found he just got too distressed and concluded that her baby was not too old to cuddle to sleep.

Fiona was similarly ambivalent about controlled crying. She had received the usual conflicting advice instructing her on the one hand not to pick up a crying baby as 'they expect it all the time', and on the other hand telling her 'you cannot spoil a baby until they get to about six months'. Fiona decided to take the latter approach. Despite the difficulties in getting their baby to sleep, Fiona and her partner were reluctant to let him cry himself to sleep. The Early Childhood nurse had recommended to Fiona that she try controlled crying with her baby but she was reluctant to initiate this practice until she knew what was causing his unsettled behaviour. *'I thought he may be snack feeding but then I also didn't know if he was in pain, he would just scream, and maybe he had reflux or something... while I wasn't quite sure I wasn't happy to leave him cry.'*

Drawing Upon the 'Experts'

In this discussion I have referred to a number of popular parenting texts. Contemporary parenting manuals as Marshall (1991) calls them, follow a long history of professional

advice on child rearing. Authors such as Reiger (1985, 1986) have traced the development of the infant welfare movement, highlighting the increasing number of newly specialised 'experts' such as infant welfare nurses, paediatricians, kindergarten teachers, psychologists (Reiger, 1986), and perhaps most recently, lactation consultants. The professionalisation of aspects of everyday life, such as infant care, has previously been examined in Foucauldian terms as a form of monitoring and regulating the population (Armstrong, 1983; Donzelot, 1979; Urwin, 1985). From the early 1900s the medical profession in particular began to campaign for regularity in routine and the importance of hygiene in caring for infants (Reiger, 1986). Medical experts such as Truby King and Benjamin Spock became household names and women learnt that regulated routines and flawless hygiene were not only important for the physical development of a child but crucial for emotional and social development. Reiger (1986: 41) states that it was argued 'regular discipline... should be instilled in a child right from birth to train him for society'. Citing from a 1939 edition of *'The Housewife'*, Reiger (1986: 41) writes 'irregular or unwise feeding leads to broken or restless sleep, to faulty elimination, to unsatisfactory growth of perhaps parts we cannot see - of both body and brain'. Not only the digestive system but the child's entire body was to be trained and disciplined. While many women adhered to these instructions, Reiger (1986) and Carter (1995) both demonstrate that women showed considerable resistance to the experts, with many women ignoring the imperative for routine choosing to breastfeed on demand.

Over time, the 'science' of child rearing came into disrepute and new mothers started to value experience (Reiger, 1986). The infant welfare sister was cast as a woman with experience. The 'old wife', as Reiger (1986) states, was thought to hold years of accumulated knowledge and was well respected. In her historical analysis, Reiger (1985) comments upon the development of a supportive relationship between mothers and the infant welfare sisters of the 1940s and 50s. In this current study, conducted in the 90s, all the women utilised the services provided by early childhood nurses within their local community. In contrast to the previous generations of women, however, these women were extremely sceptical of the implied need to have their baby routinely 'checked' by the early childhood nurses. Kylie for example, had referred enthusiastically

to her local nurse as 'god'. However, like many others, she also rejected the advice given if it did not match the views she already held. In many ways the relationship with the health professionals was ambivalent and this is evident in previous parts of my discussion. Tess and Jacki, for example, felt extremely irritated when they were told their babies were putting on too much weight.

Kylie visited her early childhood nurse regularly in the early weeks with her baby. She treated the nurse's advice as gospel and found her suggestions in relation to the baby's sleep to be practical. Her account later changed when Kylie decided to cease breastfeeding. She was very aware the health professionals were committed to breastfeeding and consequently made her decision to wean her baby at 12 weeks of age without any discussion with the early childhood nurse. Kylie went to her mother's place one hour north of Sydney to wean her baby. Away from the professional help she had sought often in the past weeks, and with the support of her partner and mother she felt free to wean the baby. Upon ceasing breastfeeding, Kylie found little need to visit the nurse as it was more convenient for her to weigh the baby at the local pharmacy.

Tina also visited the early childhood nurse on a weekly basis. When her baby was six weeks old, she described to the nurse a change in her baby's feeding pattern. The nurse reassured her that this was a 'growth spurt'. Tina accepted this explanation but when she told her sister and friends, they responded sceptically saying, 'they always say that'. Jacki and Joanna also spoke of their resistance to the health professionals' insistence upon a routine of sleeping and feeding. Joanna stated, *'It doesn't kind of work that way...I try not to rock him to sleep... and I try my best for a routine...I'm probably wrong but I fit into his routine'*.. Joanna believed that she would act differently if this were not her first child. *'I think if I had a few children I would like the baby to have a routine. But for my first baby I would rather enjoy him... than have a set routine. We work with each other.'*

Interestingly, while these women did not necessarily rely upon the health professionals' advice in caring for their baby, drawing upon a variety of sources, they remained committed to what Urwin (1985) describes as 'normalising apparatuses'. In the main, these women attended regular 'check-ups', particularly in the first two to three months,

and through the interviews they demonstrated their involvement in the monitoring of their child's development (Urwin, 1985).

The women were also sceptical of health professionals who did not have children themselves - personal experience was highly valued. Kylie, for example, believed that professional knowledge coming from books held little relevance for practice and personal experience. Despite this cynicism about professional and popular texts, most of the women in this study had at least one book about baby care and parenting. The most popular texts were by Australian paediatrician Christopher Green and the English psychologist Penelope Leach. Most often these books were used to follow the infant's development. Donna liked to keep her knowledge of infant development just a little ahead of her infant's present stage, to keep *'one step ahead of him'*. Interestingly two of the women had especially ordered from the United States the book *'Babywise'* by Ezzo and Bucknan (1995). Fiona described this as a book that helped you to get your baby to sleep through the night by ten weeks of age.

Urwin (1985) stresses that such parenting books do not significantly influence or shape the accounts taken up by women. Rather, she argues that it is more probable that the popularity of these books is related to fact that they appeal to fantasies or feelings the women have already experienced and were congruent with ideas that they already had. In her examination of the child care literature, Urwin (1985: 166) finds that these books and pamphlets reinforce the normative view of child development and 'provide an image of an almost totally child-centred mother'. In general these books functioned as a check for the mothers that they were doing the right thing. Urwin (1985) believes that given the strong investment that many women have in children, these books provide exactly what they want to hear on the importance of the parent's contribution to early development.

In addition to the demands of breastfeeding, a new mother is constantly involved in thinking about, worrying about and making decisions in relation to her infant's settling and sleeping pattern. Murcott (1993) in following the work of Mary Douglas, describes the infant as being at the 'margins' of society and although a human being, still has to be socialised into the adult world. The responsibility to 'civilize' or 'train' the young infant

in the ways of the adult world typically falls on the mother. Her 'success' at training her infant will bestow upon her the status of 'good' mother. The mother must manage and train the infant body, and the infant's settling and sleeping pattern provide an important example of this work.

CONCLUSION

In the first two sections of this chapter I have explored the practices used by women to ensure their identity as breastfeeding mothers. Some of the women who described breastfeeding as a connected, harmonious and intimate experience found this experience so pleasurable and satisfying that they 'worked' at maintaining an exclusive relationship with the baby. Here, despite their commitment to a 'shared parenting' rhetoric, these women constructed 'special times' with their baby and positioned themselves as 'indispensable', their baby needed them there all the time.

Alternatively, in the second section of this chapter there were women who experienced enormous difficulties with breastfeeding. These women 'persevered' with breastfeeding in order to achieve their goal as a breastfeeding mother. In persevering these women desperately wanted to experience a connected and intimate relationship with their baby.

In the final section of this chapter, I have examined the conflicting practices of flexibility and regulation in relation to infant settling and sleeping. What is particularly interesting about these two apparently opposing approaches to infant care is that both require intense 'emotional' work on the part of the mother. The flexibility account is perhaps most prominent in contemporary parenting discourse. The women in this study were frequently advised by family, friends and health professionals to do 'what suits you and your baby', 'all babies are different' and it is only by 'trial and error' that a mother will discover 'what works'. Taking a child-centred approach and being flexible were important. When uncertain about their baby's needs or pattern they believed it was imperative that they be rational in their approach and remain calm and relaxed, in other words undertake 'emotion' work on the self.

Linda reflected upon the demands of maintaining a flexible approach. In her experience as a mother she had started to see that it may not always be possible to remain calm and relaxed. *'Oh a lot of people say the baby picks up, they sense (your mood), I think that's really hard 'cause it's also very hard for you to suddenly say be relaxed... relax... relax, there's a lot of pressure to say you're relaxed.'*

The second account emphasising routine and regulation of the infant body also requires discipline and 'emotional' control on the mother's part. In this account the woman must put in an enormous effort to train or 'civilize' the infant body. Using the example of settling and sleeping, the baby is taught through repetitive measures to sleep in its own bed, to put itself to sleep rather than being rocked or breastfed to sleep and to sleep for a period of three to four hours without waking. This training of the infant takes time, energy and vigilance. It is emotionally and physically exhausting for the person implementing it. Tess seemed to be well aware of this commitment when she said she did not have the *'personal strength or resilience'* to pursue 'controlled crying' with her six-month-old baby.

This ambiguity and contradiction in the demand to be both relaxed, calm and flexible as well as in control of one's thoughts, emotions and bodily experiences when caring for an infant, is an important finding of this study. Women are required to undertake a high degree of 'emotion' work in order to achieve this relaxed state. This tension around control of the body is also seen in the practice of breastfeeding and is examined further in the following chapter.

CHAPTER NINE

BLURRING THE BOUNDARIES: CONTRADICTIONS AND UNCERTAINTY IN THE EMBODIED EXPERIENCE OF BREASTFEEDING

The previous chapters have presented the experiences of 25 Australian women as they became mothers for the first time. The representations of maternal subjectivity that developed in this group of women were diverse. For the majority of these women breastfeeding was central to their experience of motherhood. Prior to the birth of their babies, the women constructed breastfeeding as a crucial part of a maternal subjectivity, synonymous with mothering. Breastfeeding was to be a way of life. Following the birth it became clear breastfeeding was not simply a discursive construction but was also experienced non-discursively as an embodied experience. For some, this was a connected and pleasurable experience but for many others it was disruptive and distorting. In Chapter Eight, breastfeeding was described as a 'practice of the self'. Women 'worked' very hard to achieve an identity as a breastfeeding mother. They wanted to be relaxed, calm and in control. In order to accommodate the pleasurable and connected experience of breastfeeding, some women established an exclusive relationship with their baby. The promise that breastfeeding would be a pleasurable and connected experience motivated many other women to 'persevere' with breastfeeding against a variety of odds. Here perseverance, similar to Bottorff's (1990) notion of persistence, encapsulates the tenacity with which some women in contemporary western societies take on breastfeeding as a project.

In this final chapter I synthesize theories of subjectivity and the body, with the more descriptive personal accounts of motherhood and breastfeeding provided by the women who participated in this study. I explore the blurred and uncertain boundaries of breastfeeding and maternal subjectivity. Breastfeeding, in a society where rational autonomy and independence are highly valued, challenges the boundary between mother and child, self and other. Breastfeeding also challenges the dualist notions of mind and body, nature and culture, or as Grosz (1994) describes 'the inside and outside' as well as motherhood and sexuality. I also suggest that the disciplinary boundaries of Foucauldian

theory, contemporary poststructuralism and the phenomenology of Merleau-Ponty are blurred. Through the study of breastfeeding theories merge, making the distinction between poststructuralist work on the body and phenomenological understandings of the perceived and sensed body unclear or ambiguous. Breastfeeding is experienced simultaneously as a discursive construction and as an embodied or 'lived' female experience.

In Chapter Four I detailed a range of theoretical perspectives from which it was possible to analyse the experience of motherhood and breastfeeding. The writings of Schilder, Rubin and Merleau-Ponty bring the body to life as something sensed and perceived in individual and diverse ways, and as crucial to a sense of self, that is an embodied self. I have paid particular attention to the work of nurse theorist, Reva Rubin, whose work on maternal identity and experience, particularly the embodied nature of the maternal self, is insightful. Her theoretical work on maternal role attainment spawned much research and has been further developed by theorists such as Mercer (1985, 1986). Few nurses, however, have contributed substantially to the development of Rubin's work on the body-self. I contend that this thesis, which has described the embodied nature of breastfeeding, extends Rubin's work on the embodied self.

These writings on the lived body, however, do not foster an understanding of subjectivity as having a 'social core' (Holloway, 1989). The work of Foucault and Elias, and later poststructuralist ideas from Shilling, Lupton and Rose, contribute an understanding of the social and political self, constituted in relation to varying discourses and related practices. In Chapter Three I explored the various discourses of breastfeeding that construct an imperative to breastfeed. Public health and bonding discourses, as well as accounts of personal success, appeal to contemporary constructions of rational and autonomous self. Women in this study were determined to master breastfeeding. Breastfeeding became an 'identity project' (Rose, 1996).

In this chapter I explore what the experience of breastfeeding reveals about notions of an embodied maternal subjectivity. The work of feminists such as Young (1990), Grosz (1994) and Kristeva (1982) theorises the female body as 'different' from that of the masculine 'norm'. Women's corporeal existence has been constructed as dirty and

polluting, lacking containment or boundaries. These feminists argue that female embodiment challenges notions of the embodied self as contained, bounded, separate and 'civilized'. Through the analysis of the experiences of this group of women, it is apparent that breastfeeding threatens 'masculine' understandings of the boundaries of self and other, inside and outside, nature and culture and motherhood and sexuality.

Feminist debate has called for new ways to understand the female body, proposing we view the body in its connectedness and relation to others, to link the bodily flows from one being to another so that sometimes it is difficult to understand two separate individuals. The experience of breastfeeding described in this study suggests that for some women the ambiguous boundary between mother and child during pregnancy continues in the breastfeeding relationship as a connected, harmonious and intimate experience. The ambiguous and conflicting nature of the breastfeeding relationship between mother and infant is, however, difficult to reconcile within contemporary womanhood that values autonomy, independence and control.

9.1 NURSING THEORY AND THE EMBODIED EXPERIENCE OF BREASTFEEDING

Pregnancy and Breastfeeding: Similarities in the Non-Discursive Experience

One of the most important findings of this study was the non-discursive, embodied nature of breastfeeding. Breastfeeding was not purely a discursive construction situated within varying public and professional discourses and practices. Time and time again in this study there were experiences that the women could not describe. Our language, couched within patriarchy, does not provide the words to articulate many aspects of personal feminine experience. Importantly, Carter (1995) also notes the difficulty women have in finding the words to describe their experience of breastfeeding and McConville (1994: 72) quotes from a participant in her study, 'It's so wonderful, it's indescribable'. This is particularly significant in relation to Kristeva's emphasis upon devising strategies for women to articulate a female experience. Kristeva (1981: 137) states, 'In 'woman' I see something that cannot be represented, something that is not and, something above and beyond nomenclatures and ideologies'. Within patriarchal language, feminist practice can only be couched in the negative, 'at odds' with what

already exits, so that we may say 'that's not it' and 'that's still not it' (Kristeva, 1981: 137). In this study, women struggled to find words to talk about the experience of pregnancy, birth and breastfeeding. Indeed, some women struggled to describe how they felt about their babies, as Maggie claimed in describing her love for her baby, '*...I've got no choice in it and ah, you know I'm just caught up in this, it's something that you really can't describe... I feel like I had no control over it, it just is*'. Carter (1995: 150) believes the difficulty women have in describing their feelings about breastfeeding may arise because these feelings are 'an uncomfortable mixture of feelings that belong to mothering and feelings that belong to sex'. The language needed to describe this experience may challenge the strict boundaries between motherhood and sexuality.

At this point it is useful to consider breastfeeding as an experience analogous to pregnancy. Theorists and researchers from diverse disciplines have demonstrated the challenge that pregnancy brings to a woman's understanding of self (Bergum, 1990; Bibring, et al., 1961; Cosslett, 1994; Rubin, 1977, 1984; Stainton, 1985; Young, 1990). The embodied experience of pregnancy is difficult to articulate as it brings new sources of bodily sensation and perception that challenge an understanding of self and other. Feminist and cultural analyses of the experience of pregnancy have also found a similar ambiguity between what is considered women's appropriate feminine and mothering behaviour and women as sexual beings (Bergum, 1990; Martin, 1987; Young, 1990). Pregnancy challenges the boundaries of woman as mother, pure and virginal, and woman as sexually active.

Psychoanalytic accounts of the relationship between mother and fetus have often described a symbiotic 'oneness' or unity during pregnancy (Bibring, et al., 1961; Deutsch, 1944; Rubin, 1977). These accounts stress, however, such unity can only be temporary. Consequently, there is a focus on describing the 'stages' of separation between mother and fetus during pregnancy. In these accounts a women must resolve the ambiguity between self and other (fetus) before, or soon after, birth. For example, Bibring, et al. (1961) talk of a developmental 'separating-out' from the embodied infant at birth. As discussed in Chapter Two, Deutsch and Rubin also describe a psychological 'separating-out' from the embodied infant prior to birth. Related nursing and medical literature relies heavily upon the work of psychologists and psychoanalysts who advocate a series of stages in maternal-

fetal relationship, viewing the baby as a separate other by the end of pregnancy (Ballou, 1978; Cranley, 1981; Lumley, 1980, 1982).

In Chapter Four I introduced the writings of a number of feminist authors who theorise pregnancy as a dynamic experience and a challenge to notions of subjectivity. The experience of maternity, particularly the 'strange' situation of pregnancy, illustrates a lack of borders or boundaries between self and other. In contrast to the 'separation' account in early psychoanalytic and psychological work, Kristeva (1982) and Young (1990) describe pregnancy as a merging of the inside and the outside, a reconstitution of the self. In Kristeva's terms pregnancy represents the 'abject', something that is out of order, threatening borders and boundaries. The 'abject' represents the collapse of the inside and the outside. In the interview prior to the birth, the women in this study worked hard to describe the ambiguity of pregnancy. For many there was confusion of the boundary between self and fetus. The fetus for some was a substantial part of themselves, existing in harmony with the woman's bodily rhythms and patterns. For others, however, the fetus represented a significant threat to their body boundaries and routines. They experienced the 'other' as an antagonist to their known and bounded self. Importantly, none of these women described their relationship with the fetus in a series of developmental stages but as something that fluctuated throughout pregnancy.

Nursing Theories and the Imperative to Restore Certainty to Body Boundaries

In contradiction, however, to some of their own writings, Bibring, et al. (1961) and Rubin (1984) have also described a continuing unity of mother and child following birth. For example, Bibring, et al. (1961: 36) describe the ambiguous relationship between mother and baby as:

> Always having the characteristics of a freely changeable fusion, varying in degree and intensity of narcissistic and object-libidinal strivings so that the child will always remain part of herself and at the same time will always have to remain an object that is part of the outside world and part of her sexual mate.

This description of the relationship between mother and child following the birth as a 'freely changeable fusion' where the child continues as part of the mother, is important and seems consistent with the findings of this study. Bibring, et al. (1961), however, do not

locate breastfeeding in this notion of fusion and continuity. Similarly, while some of Rubin's work identifies the ambiguous relationship between a mother and her baby in the postpartum period, she does not distinguish between the woman who is breastfeeding and those who are not. In Rubin's analysis, it is not breastfeeding that prolongs or maintains a connection between mother and baby rather it is the nature of the maternal body and its recovery from childbirth.

Rubin (1977, 1984) in extending her theorising of the body-self to the post-partal period, describes the slow return of the 'normal' functioning body. Drawing upon Schilder's work, Rubin (1984) asserts that any change in the functioning of body parts, interior or exterior, is distressing. Deviations from the known bodily function of the healthy and intact self are described as a threat to self esteem and self worth and experienced in a negative way, as a loss or deprivation (Rubin, 1984). Following birth, body boundaries are not immediately restored and the body image remains distorted. Rubin (1977) describes how the presence of perineal sutures, haemorrhoids, abdominal distension and breast engorgement all represent a break in the body boundary. The uterus is perceived to be large, sometimes feeling floppy or dragging on the back, the vaginal discharge is heavy particularly as a woman moves around or passes urine (Rubin, 1977, 1984). Rubin (1977) describes how women feel as though all their inner contents will seep through the vagina. The woman moves slowly and is distressed by her body odours from perspiration or vaginal discharge (Rubin, 1977). She stresses many women feel disillusioned by their slow return to normal.

As discussed in Chapter Four, Rubin draws upon Schilder's notion of the Phantom Limb to explicate the immediate postpartum experience. Rubin (1977) stresses that for a number of weeks after the birth, a woman continues to feel as though she is pregnant, experiencing many of the sensations associated with the movement of the fetus. Physically, while involution of the uterus occurs, a woman still senses the mass and weight of pregnancy and experiences the fatigue felt in late pregnancy (Rubin, 1977). Rubin found women perceive these embodied experiences as continuous with pregnancy. Other bodily functions such as passing urine, defecating as well as lactation are often difficult and Rubin (1984: 113) argues these difficulties act to 'disorientate a woman's body image from her self image of adequacy and competence'. Importantly, Rubin (1977, 1984) also notes that if the baby has difficulties, such as grasping the nipple, sucking or burping, the

woman experiences this as a continuation of her own dysfunction. This embodied experience, characterised by broken and uncontained boundaries, is cast as particularly distressing or 'disordered', even unacceptable for women.

In drawing upon Kristeva (1982), the maternal body with its seepage of blood, milk, perspiration and the heavy feeling of the internal organs becomes the 'abject'. The post-partal maternal body threatens previously known body image and boundaries. Rubin (1984: 124) stresses, 'It takes about three to four weeks to restore body intactness'. Rubin refers to this four-week period as the neo-maternal period. At the end of the neo-maternal period, a woman will find a time to separate herself spatially from her child and free herself from the confinement of the home, in order to 'be herself, the self in good continuance with her pre-pregnant, recognisable, and predictable self' (Rubin, 1984: 124).

In her 1984 work, Rubin alludes to the shifting or fluid boundaries of the maternal body. In the early period following birth, the boundary between mother and baby remain, as in pregnancy, ambiguous. Rubin emphasises women have little tolerance for this ambiguity and they strive to restore body boundaries. This tenuous state does not sit comfortably with dominant notions of efficiency and control present even in Rubin's time of observations and writings. The women she observed strove for individuation from their infant, so that the self and other were separate and independent by the fourth postpartum week.

Women's concern to return to 'normal' as quickly as possible following pregnancy and birth is reinforced in nursing literature and parallels dominant discourses of control, management and efficiency. The minimal nursing research that focuses on the postpartum body tends to be concerned with describing the timeframe within which women return to their 'functional' status, in others words when they are able to resume previous activities (e.g. Tulman, et al., 1990).

Another interesting feature of Rubin's work on the ambiguity of the relationship between mother and baby in pregnancy and the early postpartum is its almost abrupt ending, with the 'individuation' or separation of mother and baby at the completion of the 'neo-maternal period' (Rubin, 1984). Rubin does not pursue an exploration of women's experience of breastfeeding as a continuing embodied connection between mother and baby. This cannot

be a criticism of Rubin's theoretical contribution as her work on pregnancy and the early postpartum has been enormous and perhaps it is unrealistic to think Rubin could have taken this further. Additionally, the era within which Rubin collected observation data was typically a period in North American society where few women breastfed their infants. It is clear, however, that Rubin did not believe breastfeeding represented a continuity between mother and baby. In the introduction to her 1984 work, Rubin disregards Benedek's work on the symbiotic nature of breastfeeding, stating that a 'symbiotic relationship beyond pregnancy would be a disaster to the woman, the child and the family' (1984: 5). In Rubin's work, breastfeeding appears as a cognitive aspect of maternal subjectivity rather than an embodied experience. Feeding per se, whether that be with breast milk or formula, is described by Rubin as a measure of 'goodness-of-fit of self and child in situations of action and interaction' (1984: 136). In preparation for a feed and during the feed, a woman engages intensely in cognitive processes of mimicry and role play drawing upon her knowledge of her child and making a concentrated effort to achieve 'goodness-of-fit' in each feeding encounter (Rubin, 1984). Breastfeeding is not theorised in its relationship with the maternal body and the infant body. Thus in Rubin's theorising, the notion of continuity or connectedness of mother and child beyond pregnancy and the fourth postpartum week is unacceptable. In her work, there is no space for women to re-evaluate the nature of their embodied self as a maternal self, with a powerful connection to another.

Rubin's 'tidy' developmental theory of maternal identity detailed in Chapter Two is challenged by the place afforded breastfeeding in the accounts of these 25 Australian women. In this study breastfeeding has been established as central to women's experience as new mothers and crucial in the construction of maternal subjectivity. This finding suggests it is perhaps possible to agree with Palmer's (1988: 13) statement that 'breastfeeding is at the core of identity'.

In Chapter Six I described the way in which a number of women in this study were able to articulate a connected, harmonious and intimate experience of breastfeeding. These women formed an intimate and sensual relationship with their infant that resembled the 'oneness' of pregnancy. For these women breastfeeding was exhilarating. However, not all the women in this study shared this connected, harmonious and intimate experience. Indeed it was only a minority of women who experienced such continuity and pleasure.

Many others experienced breastfeeding as disruptive and distorting of their boundaries and bodily routines and some described a disconnection between themselves and their baby.

I now argue that the experience of these women positions breastfeeding as an embodied relationship and for some, a shared continuity between mother and infant. As in pregnancy, breastfeeding blurs or challenges the boundaries between mother and child, between self and other. Breastfeeding threatens the dualist divides of inside and outside, of mind and body, of autonomy and interdependence, as well as the discursive constructions of motherhood and sexuality. Breastfeeding threatens borders, order and control. As Cosslett (1994) writes, 'The challenge to the notion of identity comes not from the ideologies and discourses of culture, but, however essentialist it may sound, from the body itself'. Breastfeeding represents the 'abject' and as such may offer the potential for women to explore a new form of femininity and sexuality. Such continuity and the challenge to known boundaries is, however, experienced in diverse ways and is not necessarily tolerated or even desired by all women.

9.2 EMBODIED CONNECTIONS: TOLERATING THE BLURRED BOUNDARY BETWEEN MOTHER AND CHILD

At differing times following the birth, women such as Trish, Linda, Amanda, Joanna and Sally spoke of a sense of connectedness, continuity or oneness between themselves and their baby. This was a powerful experience, described as 'wonderful' by these women. This finding challenges the assumption of separation of mother and baby at birth or within the first month following birth described by Deutsch (1944), Bibring, et al. (1961) and Rubin (1984). These women spoke of their feelings of interdependence, harmony and intimacy shared with their infant. Trish described herself and her baby as a '*package*', Joanna saw her baby as '*still part of me*', Linda believed she and her infant could '*read each other like a book*' and Sally explained she would feel '*alien*' if she did not breastfeed. They were comfortable with, indeed enjoyed, 'sharing' their body with their baby. In breastfeeding their infant they were gaining personal rewards greater than they had thought possible. To maintain this relationship with their baby, these women participated in subtle but powerful practices that excluded others from this relationship.

The imagery and metaphors of harmony, intimacy, giving of self and exclusivity used by the women in this study are also found in Bottorff's (1990) analysis and the work of Wrigley and Hutchinson (1990) and Leff, Gagne and Jefferis (1994). This persuasive imagery and the personal rewards received, motivated these women to keep on breastfeeding. As Bottorff (1990) notes, breastfeeding becomes effortless. Women in these studies tended to minimize the problems associated with breastfeeding, seeing them as short-lived and not detracting from the success of the breastfeeding experience (Leff, Gagne & Jefferis, 1994). Leff, Gagne and Jefferis (1994) use the term 'working in harmony' and Hewat and Ellis (1984) speak of 'reciprocity' to conceptualise the experience of women who described breastfeeding as 'successful'. Leff, Gagne and Jefferis (1994: 102) describe a 'rhythm' or a 'give and take' that involves co-operation from both mother and infant. For some this experience was 'elating, a high of sorts' (Leff, Gagne & Jefferis, 1994: 102).

In Bottorff's (1990) analysis the image of breastfeeding as 'gift giving' was seen as a motivation for many women to 'persist' with breastfeeding. In the following quote this image of reciprocity, giving part of oneself in return for the other's recognition and gratitude, is clear:

> ... the milk only becomes a gift in the giving away, the nourishing of an infant. As one's body opens outward in the spirit of the gift, an involvement which bonds mother and child begins to grow. Instinctively the infant eagerly, acceptingly suckles. The contended child returns a gift that continues the exchange. The child's eyes sparkle with delight, a smile comes to her lips... the giver also shares in this joy and leaves feeling renewed and closer to the child. (Bottorff, 1990: 205)

Here Bottorff alludes to the connected and fluid nature of a harmonious breastfeeding relationship. The flowing of breast milk in response to the infant's needs and eagerness to suckle cast images of harmony and flow, or as described in professional accounts, synchronicity. Drawing on a biological account, this sense of connectedness and flow is aided by the release of hormones that enable the mother to feel 'relaxed in her body and to gaze upon her child' (Bottorff, 1990: 205). Within this embodied closeness or intimacy, Bottorff (1990: 206) believes a woman and her baby 'become one'. This feeling of companionship and closeness makes breastfeeding easier to practise, and easier to keep going, 'it becomes almost effortless' (Bottorff, 1990: 206).

Similar theory generating work has also focused on the experience of women who continue to breastfeed past 12 months. Wrigley and Hutchinson (1990), using a grounded theory methodology, articulate two conditions necessary for long-term breastfeeding. First, in long-term breastfeeding, women participate in baby-led or demand feeding, responding to the infant's cues for feeding. The second 'condition' the authors called 'presencing', where the mother consciously decides not just to be there for the baby but to actively engage and be close at all times. Wrigley and Hutchinson (1990) describe the nature of this relationship as 'synchronised', the mother moving in pace with her child. Importantly this is constructed as a child-led relationship where the mother allows the child to set the pace. Wrigley and Hutchinson used the term 'surrendering' to describe the process whereby a mother continuously prioritises the infant's needs above her own. Yet 'surrendering', the fourth phase of synchronisation, was more than this. 'Surrendering' involved 'the relinquishing of a person's entire mental self to a power outside the self' (Wrigley & Hutchinson, 1990: 38). In pursuing a child-centered approach these mothers allowed the child to control, for example, the frequency of night-time feeding, did not push the child to give up night-time feeding and met their own sleep requirements by taking the baby to bed with them.

Wrigley and Hutchinson (1990) stress both the mother and the child benefit from the bond. The mothers in Wrigley and Hutchinson's (1990) study thought that they knew their child better than they believed other mothers know their children. Indeed in many of the cited quotes, these women implied their relationship with their child was superior in quality to those of other mothers and children they knew. In addition, Wrigley and Hutchinson (1990) identified 'reorientation' as another process that parallels 'synchronizing'. In reorientation, a mother rearranges her lifestyle and changes her priorities to focus on the child. These women did not return to work in the first year after the birth. As the child grew older, the women found there was less support for her breastfeeding and they talked proudly of breastfeeding in secret, their 'secret bond'.

For these women breastfeeding was a way of life. Influenced by the pro breastfeeding rhetoric, these women, predominantly produced child-centered accounts. While there is a romantic quality about the relationship these women describe with their infant, this is not at their personal expense. The women in Bottorff's study, the work of Wrigley and

Hutchinson and some of the women in this current Australian study 'worked' hard to achieve this relationship and gained immense personal satisfaction from the embodied relationship with their breastfeeding infant. Digman (1995) suggests women's sense of self-esteem and confidence is accentuated through the connected experience of breastfeeding. In addition, both Bottorff (1990) and Digman (1995) believe a woman's pleasure and sense of comfort in this intimacy with her infant somehow permeates to others close to her.

These accounts present a somewhat idyllic image of breastfeeding, an experience that advocates of breastfeeding desire for all mothers. I suggest that an account of rational autonomy is also present. The women in these previous studies have worked 'intensively' (Hays, 1996) at breastfeeding and feel good about achieving their personal goal. It is also important, however, to consider the material resources necessary to maintain an exclusive breastfeeding relationship. As Wrigley and Hutchinson (1990) note, it was important for these women that they did not undertake paid work, but through 'reorientation' decided to be with their child. They were privileged in not having to be in paid work. These women held traditional notions of the 'good' mother. They also believed mothers who did not breastfeed were not 'good' mothers. Cooke (1996) similarly found a group of Australian women who were prepared to criticise other women for not breastfeeding. The women in this current study, however, were loath to criticise women who did not breastfeed. Despite women's personal goals for mothering, notions of 'good' mothering in these studies continue to reflect patriarchal notions of the 'good' mother and the virtue of self sacrifice for the benefit of another.

Cosslett (1994) also explores the embodied experience of self and other in breastfeeding in her analysis of women's literary writings of childbirth. Cosslett (1994) draws upon examples of breastfeeding and mothering that celebrate the unity between a woman and her infant. In the following quote the baby is cast as an unproblematic extension of the mother:

> She supposed she should hate the baby now, hate how it had changed her life. But she didn't hate it, had never hated it. The truth was that having the baby had made her feel bolder and expansive. She was not just herself anymore. From now on she

> was herself and a baby, filling up two places in the world not one. (Gingher, 1988: 161-162 cited in Cosslett, 1994: 131)

Cosslett (1994) comments that this unity between mother and baby is constructed as an avenue for women's heightened sense of self worth and self importance. Cosslett's (1994) analysis, however, also demonstrates the ambiguous and contradictory position of women as breastfeeding mothers. In drawing upon the writings of Bowder (1983) in '*Birth Rites*', (Cosslett 1994: 125) relates how the character, Xenia, first sees her new baby as separate from her. Mother and baby lie in their separate beds, 'he was a phenomena and not linked to her by any continuing thread' (Bowder, 1983 cited in Cosslett, 1994: 125). In the next sentence, however, breastfeeding is described as a practice that re-establishes a connection between the mother (Xenia) and her baby:

> I see that I am not separate person, she thought, I am a channel of life, I simply give all that I have in order that he may grow. I didn't understand this at first. She saw the bulge of her breast, becoming his pink face, where she stopped and where he began, was not clear. (Bowder, 1983 cited in Cosslett, 1994: 125)

As Cosslett (1994) identifies, there is a contradiction here. The character Xenia recognises the connection through breastfeeding, between herself and her baby. Firstly, in this text this connection is constructed in terms of 'inequality and exploitation' (Cosslett, 1994: 125). The mother is all giving, the baby a parasite. Yet in the second part of the text, Xenia articulates a 'fluid dual identity' (Cosslett, 1994: 125), an almost transparent fluidity between mother and baby. Here the author asks, 'Where does the mother end and the baby start?' (Cosslett, 1994: 125)

This literary account highlights the way in which breastfeeding may be experienced in an embodied way and articulated in personal discourse as a sense of continuity between mother and baby. The separation that has occurred at birth may be restored by the interdependence fostered in a breastfeeding relationship. The uncertainty of the boundary between mother and child, the fluidity of self and other is emphasised here. This is a rare analysis, perhaps alluded to in the work of Bottorff (1990) and Wrigley and Hutchinson (1990) but never found in the dominant nursing accounts that persist with studies of 'satisfaction' or 'success' in breastfeeding. Medical and nursing accounts, while claiming the significance of the intimate contact between a mother and infant, predominantly frame

this connection around a biological or 'natural' account, emphasising anatomical functioning of the breasts and the production of breast milk particularly the action of hormones. Even in anthropological accounts a strong link is drawn between biology and breastfeeding (see edited volume by Stuart-Macadam & Detwyler, 1995). In the psychoanalytic work of Benedek (1959, 1970) mentioned in Chapter Two, the notion of an embodied connectedness through breastfeeding is suggested. Benedek (1970) represents breastfeeding as a symbiosis. She links the biologically determined hormonal responses with the bodily closeness and warmth of an infant breastfeeding. Benedek (1970) coined the term 'emotional symbiosis' to refer to the dependent nature of the mother and infant, the need that one has for the other to perceive themselves as 'good'. The description of emotional symbiosis used here parallels the discourse of the relaxed and sensitive mother, calm and attuned to the needs of her infant.

These accounts, including Benedek's, provide little sense of the social or cultural constructions of the body and breastfeeding nor is there much sense of the body having perceptual and sensory experiences that render its boundaries fluid or uncertain. The adherence to the biological or 'natural' poses no threat to order and certainty. The notion of intimacy, connectedness and uncertain boundaries between self and other in breastfeeding as part of a feminine subjectivity is only beginning to be explored in nursing work.

Digman (1995), in furthering understandings of the 'lived' experience of breastfeeding, explores the notion of intimacy in the breastfeeding relationship. She suggest that 'intimate encounters dissolve the boundaries between self and other' (Digman, 1995: 479). Intimacy is experienced at a personal level and is characterised by 'mutuality, reciprocity, being, joy, harmony, trust, emotional closeness and the touch of skin, all of which can be experienced through breastfeeding' (Digman, 1995: 480). She believes women are more likely than men to value such as intimate encounters.

The capacity of women to experience themselves in relation and connection to another has been explored by a number of feminists, particularly through object-relations theory. The work of Chodorow is particularly relevant here. Chodorow (1978), in her quest to explain why it is that women have a greater desire to be mothers, theorised women's identity as more fluid than men's identity. Chodorow (1978) proposes that a boy defines himself in

opposition to his mother and a girl defines herself in similarity and continuity. The mother contributes to this experience, treating the same-sex child as an extension of herself. Thus the pre-Oedipal attachment a girl has to the mother lasts longer and remains a part of her personality. The development of feminine identity is based upon the development of relatively permeable ego boundaries. The boy infant not only learns he is a different person but also a different kind of person. In doing so he sets himself apart from the feminine. Chodorow (1978) concludes that the masculine personality typically develops rigid ego boundaries. A man's sense of separate identity entails cutting off a sense of continuity and empathy with others. Similarly Gilligan (1982) theorises that female gender identity was established via embeddedness in relationship to others as opposed to masculine separation and autonomy. Gilligan (1982) attributes a moral superiority to female identity in the care of others and of the self. In this theorising women's sense of relatedness poses a threat to patriarchal notions of order.

Recent feminist writings on mother-infant relations continue to highlight the threat to order posed by the connected and intimate mother-child relationship. There is no tolerance in societies dominated by rational and autonomous thinking for ambiguity between self and other:

> In theories of mothering, whenever issues of bonding, separation, autonomy, merging, individuation or symbiosis emerge, the heterosexual male functions as a guarantor of order, a gatekeeper between public and private spheres, while women and especially mothers represent the disorderly matter that must be sorted out, assembled and disassembled, bonded and broken down. (Adams 1995: 427)

Many feminist writings have exposed the 'perverse' nature of this dominant construction of mother-child relations, emphasising instead an 'inevitable and necessary balance' between mothers and their children (Adams, 1995: 427). This connection between self and other, mother and child is central to this analysis. Nursing accounts exploring mothering, connectedness and definitions of self are problematic in that they support the notion of an authentic or true feminine self (see Digman, 1995; Hartrick, 1997). Digman (1995: 480), for example, believes women who are breastfeeding may use this intimacy as an 'identity tool' through which the self can be more fully defined. This need to know the authentic

self is given precedence over the ability to negotiate or tolerate ambiguity and uncertainty of self.

The most important analysis of breastfeeding as an experience that challenges the boundaries of the known self comes from Young (1990). In a rare phenomenological analysis of the experience of having breasts, Young (1990) seeks ways to conceptualise the female breast as having indefinite borders. Young (1990: 190) tries to seek 'a positive women's voice for breasted experience'. In this essay, Young like many other commentators establishes women's experience of their breasts as largely constructed within a male dominated society that objectifies the female breast. While many women may ignore the objectifying gaze, Young (1990) stresses they still struggle with ambiguity and uncertainty about their body. Young (1990: 190) ponders 'how women's breasts might be experienced in the absence of the objectifying male gaze'. She argues that despite the pervasiveness of the discursive construction of breasts, of the male objectifying gaze, '... our bodies are ourselves. We move and act in the flesh and these sinews, and live our pleasures and our pains in our bodies... we do not live our breasts only as the objects of male desire, but as our own, the sproutings of a specifically female desire' (Young, 1990: 192). Young talks of 'giving voice' to this specifically female desire (1990: 192) and proposes that if we 'conceptualise breasts from women's point of view, rather than breasts being solid, defined and an object, they would become blurry, mushy, indefinite, multiple and without clear identity' (Young, 1990: 192-193). In Chapter Three I introduced Young's suggestion that we should take seriously Irigaray's strategy to conceptualise a metaphysics of fluids, thinking of being as 'fluid' rather than a 'solid' substance or object.

In the absence of the discourses that simply cast the breast as either sexual or nurturing, Young (1990) argues that what matters most for women about their breasts is their feeling and sensitivity rather than how they look. Young believes that many women derive great pleasure and satisfaction from their breasts, a pleasure often unrelated to heterosexual intercourse, 'a place of independent pleasure' (1990: 195). Young (1990) goes on to suggest that without a bra, women's breasts become de-sexualised. They no longer conform to the 'official breast', high, hard and pointy. Rather, without a bra, the fluid nature of breast is more evident. As objects, breasts move and change shape and position. As Young describes, many women's breasts are more like fluids as in movement they

'sway, jiggle, bounce, ripple, even when the movement is slow' (1990:195). Young (1990) stresses this imagery of unbounded breasts is important. 'Unbound breasts show their fluid and changing shape, they do not remain the firm and stable objects that phallocentric fetishism desires. Because unbounded breasts make a mockery of the ideal of 'perfect' breasts.' The bra 'normalises' the breast. Without a bra nipples show and, adds Young (1990: 195), 'nipples are indecent'. The unbounded breast with protruding nipples is disrupting or threatening to phallocentric sexuality.

Similarly women enjoying their breasts and the sensations of their breasts outside of heterosexual activity is a threat to order and identity. Women who find breastfeeding a pleasurable and sensuous experience threaten the strict borders between motherhood and sexuality. Images of women in western society persist with the dichotomy of Madonna and Whore. Woman is either 'sensual mother or sexualised beauty' (Young, 1990: 197). As Young stresses, patriarchal relations depend on the border between motherhood and sexuality (Young, 1990: 197). This dualism is considered necessary for a number of reasons. In psychoanalytic thought, the infant, knowing the mother first and foremost as only an extension of itself, must of necessity separate from this earliest of erotic pleasures to be compatible with civilisation (Young, 1990). Subsequently we learn that attachment love is 'good' but bodily, 'fleshy' love or eroticism is 'bad'. Motherhood is associated with one type of love and sexuality with the other. For a woman to enjoy or take pleasure in her infant's body is crossing the border of motherhood and sexuality, raising stirrings of the incest taboo (Young, 1990). Again following psychoanalysis, a child must learn to repress all desire for the mother. This, it is argued, protects masculinity against the vulnerability and mortality of the human condition (Young, 1990: 198). This separation between motherhood and sexuality and denial of alternative forms of pleasure appears to secure women's dependence upon men for pleasure. If a woman was to find sexual pleasure in motherhood, then her need for the man may be lost (Young, 1990). Most importantly, Young believes without the separation of motherhood and sexuality 'there can be no image of a love that is all give and no take' (Young, 1990: 198). A mother defines herself as giver and feeder, as self-sacrificing and this must remain separate from her sexuality, her own desires. This separation of motherhood and sexuality maintains patriarchy and the place of the male. Young (1990: 199) suggests, 'This separation often splits mothers as it is in our bodies that the sacrifice that creates and sustains patriarchy is reenacted repeatedly'.

This boundary between motherhood and sexuality is played out in the experience of having breasts. Young (1990: 199) states, 'To be understood as sexual, the feeding or nurturing function must be suppressed and when the breasts are feeding they must be desexualised'. Many women in contemporary western societies express concern about breastfeeding as they believe their breasts will lose their sexual attractiveness. Young (1990) describes the immense personal pleasure that a woman can experience in breastfeeding. She proposes that celebrating breastfeeding as a sexual interaction for both mother and infant would shatter the border between motherhood and sexuality. Shattering this border would provide the opportunity for all women, not just mothers, to experience both their own personal or selfish desires and the pleasure of giving to another, a nurturance that both gives and takes.

Young's provocative thoughts are addressed within cultural feminist debates, where challenges to dominant constructions of gender and the dichotomies of self and other, mind and body, nature and culture, emphasise the search for a new language and new ways to express feminine sexuality. As mentioned in the Introduction to this study, in the mid 1970s and early 80s, a range of authors (such as Chodorow, 1978; Gilligan, 1982; Oakley, 1979, 1985; Rich, 1976; Rothman, 1989; Ruddick, 1982) insisted that we needed to know about and value women's experience of maternity and mothering. For Rich (1976: 18), pleasure could be found in the experience of mothering and also in breastfeeding as a 'physically delicious, elementally soothing experience'. Sichtermann (1983) stressed the potential to recapture the lost eroticism of the breasts and breastfeeding as a form of female sexuality. More recently, Blum (1993: 300) posits that breastfeeding, as an experience of the female body, can be a deeply satisfying interlude of intense engagement with and delight in one's child, 'in its irreducibly, 'factually given' child's body'. In these accounts breastfeeding is considered empowering for women. Van Esterik (1989: 107), for example, insists 'the vague murmurings or submerged discourse about the power to nurture' should be seized by women to reassert feminine values. Similar to the findings in this study, Van Esterik (1989) acknowledges that this is a difficult task as women have to develop the words and metaphors to express the intimate power of breastfeeding. Blum (1993) argues that for women to be able to freely choose to breastfeed and to experience the pleasurable, physical, emotional and relational aspects of breastfeeding, a transformation of the context of mothering would be necessary.

Breastfeeding is, however, a vexed feminist issue. Advocating breastfeeding not only for the health benefits for baby and mother, but also the immense pleasure and intimacy that can be gained, can be hazardous in its link to biology, essentialism and conservative arguments about women's reproductive and nurturing roles (Blum, 1993; Carter, 1995). Blum (1993: 306) warns that the attempt to privilege the sensual and relational aspects of breastfeeding is enormously challenging as in doing so it is difficult not to 'exclud(e) or dishonour those who do not or cannot and without contributing to a new moralism that is just as coercive as the old'. Sichtermann (1983) has warned that the promotion and support of breastfeeding can and has occurred previously in Nazi Germany, in a coercive manner.

Carter (1995) suggests the cultural or gynocentric debate that casts breastfeeding as an issue of empowerment for women could be seen as a reverse discourse, something similar perhaps to Foucault's (1980) analysis of homosexuality. It is a discourse, however, that could compel women to breastfeed. Incited by the desire to experience a different form of sexuality, an authentic feminine identity and a more rewarding experience of mothering, women may embark upon breastfeeding as an avenue for self-definition. Carter (1995) sees the writings of Van Esterik and others as problematic in their synthesis of a 'true' or authentic self. In other words, to experience a form of sexuality not confined by heterosexual patriarchal norms could also be damaging for women.

In this Australian study there are powerful examples of women experiencing a 'jouissance', an immense sensual pleasure from breastfeeding, which perhaps represents a new form of femininity and maternal subjectivity. Sally illustrated this well when she attempted to describe the 'physicality' of breastfeeding, indicating that she had never done anything with her body that enabled her to feel so much a part of her body. As described in Chapter Four, prominent feminist work has suggested a reconceptualisation of women's corporeality as a more fluid, permeable and changing entity, characterised by uncertain or ambiugous borders between self and other (Kristeva, 1980; Grosz, 1994; Irigaray, 1985). Others have emphasised the value of promoting women's potential for connectedness and relatedness (Chodorow, 1978; Gilligan, 1982). The experiences of these women illustrate the potential for women to transcend the boundaries of self and other, autonomy and control and take pleasure in an intimate relationship with their baby. These women were able to tolerate, even foster the fluid borders between themselves and their baby. As Kristeva (1982, 1986),

Young (1990) and Grosz (1994) describe, such experiences challenge phallocentric notions of order and control, of motherhood and sexuality. A connected, harmonious and intimate experience of breastfeeding locates breastfeeding as the 'abject'. As the 'abject', any imperative to breastfeed requires protection. Chapter Seven described in detail the exclusive practices these women participated in to ensure this connected and intimate position was maintained.

Not only were these women able to negotiate the uncertain boundary between self and other, motherhood and sexuality, they also managed to some extent to blur or disrupt the distinction between the public and private notions of the breast and breastfeeding. As already described, in western societies dominant discourses of heterosexuality give the breast a sexual function to the expense of its nurturing function. The exposure of breasts in public is only possible in certain circumstances. Breastfeeding is positioned as a private domestic function that has to be negotiated in the public arena. Stories of the unacceptability of breastfeeding in public abound. Carter (1995) found in her historical analysis, even in the privacy of their homes, many women have to negotiate a space to breastfeed. In contrast, women in this study described feeding freely at home, regardless of what they perceived as the discomfort of others. Some women spoke of feeding in cafes, shopping centres, at the airport and on public transport. While they felt quite positive about feeding in public, this took vigilance or care. The women thought about what they should wear, who they would be with and where they were going. Carter (1995) describes the work that women put into 'managing' breastfeeding in public. Women are responsible for maintaining modesty and decency and controlling the 'gaze' of others (Carter, 1995). Breastfeeding if done in public must be 'civilized'. As discussed in the following section, there should be no evidence of leaking breast milk. Some of the women in this Australian study were adamant they should be able to feed 'discreetly' in public. So determined in their project of breastfeeding, these women overcame any doubts they had about feeding in front of others. Some talked proudly of breastfeeding situations where they knew others may be uncomfortable. For example, Amanda described being at the airport sitting on a suitcase in the queue, feeding her baby. Highlighting the subtlety with which she 'managed' the situation, Amanda described how the man behind her in the queue would probably have been left wondering whether she was breastfeeding or not.

To experience breastfeeding in an intimate and sensual way and feel comfortable with the ambiguity of self and other, motherhood and sexuality is very challenging. Carter (1995) insists feminist frameworks that promote breastfeeding as a source of female empowerment and alternate subjectivity limit our understanding of difference and diversity among women. In a world where rational, autonomous behaviour is expected and rewarded, some women in this study were not able to articulate an intimate and sensual experience of breastfeeding. Rather they described breastfeeding as something that was 'working', it was convenient, their babies were healthy and content and they had a close relationship to their baby. Influenced by the pro breastfeeding rhetoric, some women were more pragmatic about breastfeeding (Cooke, 1996). For example, Kate said, *'I don't mind it, it's working okay...I don't get a buzz out of it or anything*'. Maggie added, *'I don't have any strong 'I love it feelings*'', and Jacki insisted breastfeeding was practical, while she did not 'dislike' it, she added, *'I can't say that I live for it either, in fact it's a little inconvenient to have this little child attached to you. I'm not insecure that I need to have this child need me or anything like that'*. These women were either not able to articulate an intimate and sensual experience or they resisted such understandings of breastfeeding.

This Australian study confirms Carter's (1995) warning of the inappropriateness of developing a 'meta narrative' of breastfeeding as an empowering feminine experience. There were women in this study who found the embodied experience of breastfeeding challenged their commitment to the pro breastfeeding rhetoric. From an alternative feminist perspective, breastfeeding can also be seen as an 'autonomy compromising experience' (Blum, 1993: 300).

9.3 CONTRADICTIONS AND AMBIGUITY IN EMBODIED CONNECTIONS: A LACK OF TOLERANCE FOR BLURRED BOUNDARIES

The Disrupted Body

The embodied experience of breastfeeding has become the major thread of this analysis. I have suggested that the connected and intimate experience of breastfeeding represents the 'abject'. To experience one's infant as a continuity of the self and in a way that is pleasurable and sensual is 'out of order', lacks control and poses a threat to identity. A few

of the women in this study were able to tolerate this ambiguity of self and other. Indeed, their enjoyment of this experience was challenging for others around them. In the discussion that follows, I suggest that the 'disrupting', 'distorting' and 'disconnected' experience of breastfeeding, presented in Chapter Seven, emanates from the 'abject'. This distressing experience of breastfeeding represents an inability to tolerate uncertain boundaries, an inability to tolerate the ambiguity of self and other, inside and outside, public and private. Only a few women felt completely at ease in their relationship with their breastfed baby and their life as a mother. Yet the level of personal distress associated with breastfeeding is rarely presented in professional or popular texts. Carter's (1995) generational analysis, Maclean's (1990) findings and the findings from this Australian study, demonstrate well the personal nature of breastfeeding and women's resistance to the demands of the pro breastfeeding rhetoric and the child-centred discourses of mothering.

Many of the women in this study spoke vividly of the demands breastfeeding placed upon them. The nature of the breastfeeding relationship necessitated their constant proximity to the infant. The baby was always with them and occupying their thoughts. As the person responsible for the care, particularly feeding of the baby, many women undertook a huge amount of 'worry' or 'thinking work' (Walzer, 1996). Women breastfed their infants, often feeling that despite the rhetoric there was little reward or recognition for their efforts. The women felt they were restricted from participating in activities they previously enjoyed. These demands were made upon the rational, autonomous and independent self and as such these demands were often unacceptable and 'disrupting'. Many women described a sense of loss of self, of putting their own lives 'on hold'.

As mothers, these women came to know the sharp the distinction between the private and public world. Until the birth of their child, these women were all engaged in full-time work in a range of occupations. Despite the low income that some of the women earned, they described having autonomy, independence and an enjoyment of their personal and public life. The majority of these women looked forward to being mothers, felt they were ready for this change and planned to be at home caring for their child for at least the first six to 12 months. They believed, as Beck and Beck-Gernsheim (1995) describe, that having a child would add value to their lives. Prior to the birth, they made a commitment not only to breastfeeding, but also to the child-centred discourse of 'being there', constantly

caring for their baby. At varying times, however, the women became ambivalent about this commitment to 'intensive' mothering (Hays, 1996). They started to realise how much their lives had changed, talking of being 'confined' to domesticity and the private world. They recognised that mothering and breastfeeding centred on the private world and they yearned to have time away from their baby, to be part of public life again. It is important to emphasise that in contrast to Carter's (1995) analysis these women did not feel restricted in public activities purely because they were breastfeeding. They did not demonstrate confusion over the nurturing and sexual function of the breast. Rather it was their personal bodily routines and patterns that were 'disrupted' by the demands of their breastfeeding baby and their commitment to 'intensive mothering'. They always had to be there. Balsamo, et al. (1992), in studying the experience of Italian women, found that breastfeeding on demand was often 'chaotic and dangerous' for women and the baby was portrayed as 'encroaching' on a sense of self.

Maclean (1989, 1990) in her Canadian research similarly described women's desire to 'have their old life back'. In Maclean's study, women felt strongly the division between the private life of home and family and the public world of work. They emphasised the lack of recognition or value given to the work done at home, particularly the work of breastfeeding. In rational management discourse, breastfeeding can not be evaluated in terms of effective time management or 'efficiency'. Time was a commodity to be controlled and managed (Maclean, 1989) and this rational account could not be easily transferred to breastfeeding.

The public world values rational autonomous and independent action. As Beck and Beck-Gernsheim (1995: 106) comment, '(I)n highly industrialised societies, people are always trained to behave rationally, to be efficient, fast, disciplined and successful'. The women in this current study were a part of this contemporary public life and now as mothers, particularly as breastfeeding mothers, they experienced contradictions and tensions. Popular parenting and breastfeeding texts tell mothers they can 'have it all', featuring images of breastfeeding women who look happy, feminine, attractive, by implication (hetero)sexually active. Such images are an attempt to blur the boundary between private and public, motherhood and sexuality. Yet women in this study believed their lives as mothers were not highly valued in the public world. A number of

women in this study who had chosen to remain out of the paid workforce or only to participate minimally in paid work, were constantly having to defend their position as 'stay at home' mothers as well as the decision to breastfeed for a prolonged period. They described a pressure to be part of the paid work force, part of the 'real world', having a life apart from their child. On the other hand, women who returned to work, particularly within the first six months after the birth, had to struggle with accounts of the 'good' mother, as someone who is always available to her child. A number of these women also spoke of justifying their decision to cease breastfeeding upon return to work. Despite encouraging words and often pressure from health professionals that it was possible to work and continue to breastfeed, those who were working three or more days a week found this impossible.

Blum (1993: 295) highlights the constraints of the contemporary workplaces for breastfeeding. The workplace as a public space is well controlled, tightly managed and as Blum (1993: 295) stresses, 'assumes that individual workers possess bodily integrity and autonomy'. In this study Jacki learned that in the corporate world there was no place for expressing breast milk except the toilet. In the public space, women's bodies, including sexuality, childbearing and lactation as well as emotionality, are 'out of order' (Blum, 1993: 295) and threaten identities.

The Distorted Body

The women in this study not only wanted their old life back, some described also wanting their 'body back' or as Rubin would describe, they wanted to restore their body boundaries. The experience of breastfeeding was sometimes a 'distorting' experience. Breastfeeding changed the women's breasts. Not only the size and shape of the breast changed but more importantly the bodily sensations of the breasts and nipples were different, 'strange', 'heavy' and sometimes painful, even excruciating. The known boundaries or borders of the breast changed as the heavier, larger breast would look and feel different clothed and unclothed. Unpredictably milk would leak from the inside to the outside of the breast. So distressing were these changes or indeed 'distortions' to their 'known breasted experience' (Young, 1990), that it was common for women to objectify their lactating breasts and breast milk, '*the stuff just pours out*', the breast '*deflated*', the breast milk had '*curdled*'. This alienation between self and body was more common when woman experienced

breastfeeding difficulties such as blocked ducts, mastitis or the baby appeared 'unsatisfied'. Balsamo, et al. (1992: 84) described a 'split between the speaking self and the breastfeeding self. The woman feels as though her body, particularly her breasts and the production of breast milk, is something that does not belong to her and consequently breast milk is reified as 'recalcitrant milk' (Balsamo, et al., 1992: 84). On the other hand, the searing pain in nipples and breasts experienced by women in this current study was often attributed to the 'uncivilized' behaviour of the infant. A number of the women provided vivid descriptions of the way their infant, 'the other', would bite or chew on their nipple or fight and scratch at the breast. I was shown examples of the nipple damage a number of times. Thus not only did their breasts 'distort', but there was (an)other constantly attached to the breast. Boundaries of self and other were constantly being challenged.

These women talked of their babies being constantly 'attached' to their breast. Maushart (1997: 203) speaks about women experiencing a form of 'tactile overload', 'a continual flesh to flesh contact' that in most professional and public accounts is presented as facilitating 'bonding' and the most enjoyable aspect of breastfeeding. However, it is not enjoyable for all women, at least not all of the time. Tess described how her baby was always 'at' her and Kylie could not find the words to describe what it was about breastfeeding she did not like, she *'just did not like the baby being at my breast'*.

The involuntary or uncontrolled flow of breast milk from a woman's body is a powerful symbol of the 'distortion' to known body boundaries or borders. Leaking breast milk highlights the ambiguity of inside and outside, self and other. Some of the women in this study were surprised by the amount of milk that 'leaked' from their breasts, particularly at times unrelated to feeding the baby. They described feeling sticky, messy, dirty and uncomfortable and resented having to 'pad up' and wear particular clothing that would camouflage the leaking milk. Many of the women had not realised breast milk could leak so frequently and profusely and they felt compelled to control it in some way, not to let it show. Here the leaking of breast milk is somehow seen as the woman's responsibility. She must 'manage' or 'control' any evidence of this 'dirt'. Interestingly Morse and Bottorff (1989) found the majority of texts on breastfeeding construct leaking as something that occurs because of the mother's lack of control as opposed to a 'normal' part of lactation. In

a more recent analysis, Britton (1997) observes that while professional accounts construct the 'let down reflex' and the involuntary leaking of breast milk as a necessary physiological process, the woman herself must monitor and contain the flow of milk.

One of the most difficult times for the women to accept leakage was during intercourse. Morse and Bottorff (1989: 18) comment, '... leaking during intercourse is related to the primal linkage of the sexual response to mothering'. Here the border between motherhood and sexuality is most exposed and threatened.

In professional and popular texts, the 'let down reflex' is confusingly described by some as a pleasant sensation and by others as an unpleasant 'tingling sensation', 'needle like pain', 'sharp pain' (Britton, 1997). Women in Britton's (1997) study struggled to describe the sensations associated with the let down reflex and used metaphor to illustrate this experience. Drawing upon the terminology used in popular and professional texts women talked of tightening and tingling sensations but, like Sally in this Australian study, they added 'it was like sparks going off inside you'. The initial sensations associated with let down did not always occur in the breast but may be initiated in another body part such as the feet. Britton (1997) adds that the women drew upon metaphors of mechanics and movement to describe the flow of milk from the breast, 'a plumbing model of the body' (Britton, 1997: 180).

Throughout history breast milk has been associated with excretion, something dirty and polluting (Kitzinger, 1979). Leaking breast milk is something that is out of control, women's bodily flows are unpredictable and embarrassing for the woman, or as Britton (1997: 181) describes, 'violating the norms of ‘civilized’ bodily comportment'. Britton (1997: 181) adds that these threats to bodily control 'operat(e) on the edge of human agency where medical discourses provide mothers with mixed messages about the individuality of control'. One body of literature stresses the hormonal nature of lactation operating within the autonomic nervous system. Another, particularly health education accounts, stresses enhanced personal control over bodily processes.

Paradoxically, while the leaking of breast milk is considered dirty or repulsive and disturbing to notions of female sexuality, it also symbolises the ability of women to feed

and nurture their infant. Similarly breast milk expression is also valued as evidence that they can provide for their infant (Britton, 1997; Morse & Bottroff, 1989). The experience of leaking breast milk highlights the contradiction between motherhood and sexuality.

Disconnected Bodies

The disrupting and distorting experience of breastfeeding gave some women a feeling their relationship with their baby lacked harmony, they were somehow 'separate' and working in opposition to each other. At times these women felt alienated from their baby. Marianne, Jane and Fiona for example, desperately desired and 'persevered' to develop a sense of connectedness and harmony with their infant through breastfeeding. In contrast, women such as Simone, Barbara and Kylie described a need to 'disconnect' from the infant. These women strived for separation and individuation from their baby. In describing their baby they used metaphors of intrusion and devourment, talking of being 'suck(ed) dry' and the baby as 'the rotten sucking little leech', the 'child from hell'. Simone, Kylie, Barbara, and at times Tess and Fiona, felt as though they existed only for the use of this antagonistic, 'uncivilized' creature. The demands of the 'uncivilized' infant for constant attention and proximity encroached on these women's sense of self, their autonomy and independence. This 'disruption' produced a conflict between self and the other. In contrast to Wrigley and Hutchinson's (1990) study where they describe women's ability to 'surrender' to the needs of the baby, there are many women who are not able to tolerate the blurred boundaries between themselves and their child.

The demands of the baby for constant access to the breast may 'disrupt' a woman's sense of embodied self in both her public and personal world. In addition, the discomfort and vulnerability of exposed, sore and painful breasts and nipples and the leaking of breast milk, 'distort' the image a woman has of her body and blur the boundaries between what is inside and outside of her body. For some women breastfeeding was excruciating, violent and mutilating. This 'distortion' of the known body threatens order, control and identity. The public body is well known as the contained, controlled and 'civilized' body, where boundaries between oneself and other bodies are quite distinct and the interior and exterior of bodies are separate. The public body that has integrity and is bounded is the 'male' body. Here blood and milk do not leak and emotions are controlled and contained.

The lack of tolerance for the ambiguity between the identities of mother and child and a desire for separation from the infant is also found in Cosslett's analysis of literary writings on childbirth. The tension between unity and separation of mother and baby described by Cosslett (1994) was introduced earlier in this discussion. For example, the character Xenia in Bowder's novel constructs breastfeeding as a practice that re-establishes a connection between mother and baby. However, here the baby is simultaneously constructed as a parasite, simply taking all that the mother, Xenia, has to give (Bowder, 1983 in Cosslett, 1994: 125). Cosslett (1994) finds further evidence of disconnection in Doris Lessing's novel, '*A Proper Marriage*', where any harmony achieved in pregnancy is lost following birth where mother and baby have different rhythms. The baby becomes an antagonist, the one who is in control, 'she sleeps and you do not', '(she) was born holding your heart in her hands, clutching your nerves like reins in her fists' (Lessing, 1977 in Cosslett, 1994: 128). Cosslett (1994: 128-129) describes a competition for the nourishment between mother and baby, 'your 'inner-self' has to be banished during breastfeeding'. The familiar imagery of the baby growing at the mother's expense, 'using up' the mother, violent and devouring, is prominent in Cosslett's analysis.

In these accounts of devourment, intrusion and alienation, the uncertain or blurred boundaries between a mother and her breastfeeding baby are intolerable. The demands of breastfeeding for a flow or continuity between mother and baby represents 'the abject', posing a threat to order, control and individual identity in a society that values control, autonomy and individualism. Within a rational autonomous perspective there becomes a need for women to restore certainty to their body boundaries and to 'civilize' or train the baby as an independent being.

Women approached their need to regain control and autonomy and to 'civilize' the infant body in a number of ways. In Chapter Eight, the practice of 'perseverance' and the contradictory practices of flexibility and regulation are described. The majority of women in this study were strongly committed to the pro breastfeeding rhetoric and they constructed breastfeeding as central to their identity as a mother. Consequently even when the embodied experience of breastfeeding was disruptive, distorting and disconnecting, many chose to 'persevere'. They considered breastfeeding 'worth the effort'. These women insisted, in their efforts to breastfeed, that it was essential to maintain a relaxed and calm

demeanour. To induce a relaxed state they undertook, as Hochschild (1983) describes, 'emotion' work to control their conscious and unconscious thoughts and feelings. They wanted to be simultaneously relaxed and flexible yet in control. I will return to this point of contradiction and paradox shortly.

In their efforts to 'persevere' women called upon assistance from numerous health professionals. In some instances this was helpful, as they started to learn more about the needs and diversity of babies. At other times the advice or suggestions from health professionals were unwelcome and the women went away determined to do 'their own thing'. Some women persevered for pragmatic reasons. Breastfeeding was considered to be better for the baby than feeding with formula. They learned, however, that breastfeeding could occur in a more regulated way. Some women introduced a pattern of feeding and sleeping that was more scheduled. Here they 'worked' to regulate their babies, to establish a routine that ensured them time away from the baby. For five women, the cost of breastfeeding was too great and they decided to finish breastfeeding between five days and 11 weeks after birth.

9.4 THE CONTRADICTION OF CONTROL: RELAXED, CALM AND 'GOING WITH THE FLOW' VERSUS UNCERTAINTY AND AMBIGUITY

The women in this study 'worked' at breastfeeding and at being a 'good' mother. To be 'successful' in breastfeeding and to be a 'good' mother, women were instructed to simultaneously be relaxed, calm and flexible, to 'go with the flow'. In conducting such 'emotion' work, they hoped to be sensitive and nurturing to their infant and above all, remain rational and in control of their lives. A commitment to these practices meant women worked intensively on their body, its routines, its boundaries and its emotional state. Their ultimate goal was to be contained and in control, and to 'civilize' breastfeeding.

During pregnancy, birth, breastfeeding and settling their infant, these women wanted to construct a demeanour that was relaxed, calm and in control. In pursuing this, they were determined to train, manage and 'civilize' their bodies and that of their infant. Yet this understanding of the controlled body is precarious and contradictory. While the women

desired predictability and control, they often represented their bodies, emotions and thoughts as uncontrollable, unpredictable and unreliable. They were uneasy about their ability to control and contain their body. For example, in the first interview, most of the women described the conscious, rational choice they had made to have a child, now was the time to have a baby. Yet they were hesitant in making an emotional commitment to the notion of pregnancy. They talked of not wanting to become '*caught up*' in a desire to have a child and find this was '*out of their hands*', something they had no control over. As Denise described, women did not want to be in a position of '*desperately trying to have a baby*'. This 'emotion' work was an attempt to prevent any disappointment or even to 'jinx' their efforts, '*if we start hanging on every period... we're setting ourselves up for failure*' (Denise). If one became obsessed with the idea of pregnancy, then perhaps they would not be relaxed enough to become pregnant and would be devastated if pregnancy were not possible. For some women it seemed 'safer' to construct an image of themselves as infertile. Somehow they did not 'trust' their body and cast their body as a biological object, separate from their understanding of self.

Thus, even prior to pregnancy, to achieve a state of relaxation and calmness, one needs to 'manage' any emotions, thoughts or feelings through the control of conscious and unconscious processes. Surely this construction of the 'controlled mind' mitigates against the notion of an embodied self. This contradiction appears to further split the self, to reinforce the western understanding of mind and body as separate entities. Britton (1997: 181) alludes to this as a 'paradox of control'. Cosslett (1994: 133) articulates this contradictory and confusing position in relation to the birth experience:

> ... the flowing model is the ideal of the natural childbirth movement - but it is not as simple or as unified as it seems. It is often conditional on an initial splitting of the self in which one half keeps an intellectual eye on the medical procedures, while the other 'flows' with the body or half consciously practices techniques to induce a self forgetful flowing in the other. Images of harmony or co-operation are often used, as the relationship between two selves a mind and a body or a 'civilized' and a 'primitive' woman inhabiting the same body.

Ironically the degree of control required to 'go with the flow' during birth often involves a further 'splitting' of the maternal self, a splitting of mind and body.

This is the contradictory and ambiguous point at which the discursive construction of breastfeeding merges with the embodied experience of breastfeeding. I suggest that this 'practice of the self', the intensive body work that is performed by mothers, reflects the priorities of the late 1990s to shape and control our bodies. Through pregnancy, birth and mothering, particularly breastfeeding, women are instructed to 'go with the flow', to allow the milk to 'let down', to listen and do as their body tells them or as their baby (an extension of their body) is telling them. In these accounts there is an emphasis on the body, its functioning and its sensations. By becoming aware of their bodies, women are told they will be able to 'tune in' to their baby, to be 'one' with the baby. This 'natural' discourse of birth and breastfeeding emphasises that if women follow their bodily instincts, birthing, breastfeeding or settling the baby will come easily. To assist these 'natural' instincts, however, women need to simultaneously undertake a significant amount of 'emotion' work. They need to 'manage' or be in 'control' of their mind, their thoughts and their feelings, as conscious and unconscious thought processes can interfere with the ability to listen to the body, or to 'go with the body'. This rhetoric of the unified body paradoxically maintains the dualism of mind and body. While women are attempting to be 'one' with their body and baby, they are also 'on guard', watching over the 'recalcitrant' mind.

Similar to Cosslett's (1994) illustration of the natural birth discourse, breastfeeding women are precariously split between inducing a relaxed demeanour to allow the 'let down' of milk to occur, and being vigilant in their management of their conscious and unconscious thoughts and emotions. They have to be on guard, not allowing any distractions in their endeavour to induce a relaxed state. Britton (1997) also identifies the paradox of control that exists in relation to breastfeeding, particularly the 'let down' reflex. Similar to the women in this study, the women in Britton's study talk of the need to be relaxed and calm, to control their emotions in order for the 'let down' to occur in a natural way. This was in contrast to consciously forcing the 'let down' in what Britton (1997: 181) describes as an 'instrumental, goal-orientated way'. In addition to this rhetoric surrounding the 'let down' reflex, women are told if they relax then they will be able to calmly put their baby to the breast, despite screams of hunger or the frustration of a fussing infant scratching at the breast. If a mother calmly and comfortably positions the infant, then the

infant will be aware of the mother's peaceful state and respond accordingly by taking the breast efficiently and calmly. This results in the 'perfect' breastfeeding experience.

This dualism of mind and body perpetuated through the contradictory positions of control and letting go can also be seen in the advice provided for settling a crying infant. In Chapters Five and Seven, I described women's belief that the fractious, unsettled or crying baby is frequently viewed as a product of its mother's stress and anxiety. If a woman is unable to relax, the infant will, as Jane in this study emphasised, '*pick up the vibes*' and will be an unsettled baby.

The rhetoric of the relaxed and calm 'good' mother has convinced professionals and mothers alike that through practices of relaxation and letting go, women will remain 'level headed' and in control. This position will ensure breastfeeding is successful. This relaxation account espouses a commitment to the 'embodied self' and highlights women's corporeality, yet in practice the account of relaxation and control serves to reinforce dualism, a division between mind and body.

What also stands out in this paradox of simultaneous control and the relaxed and calm good mother is that the private domestic sphere, the domain of female bodily functions, is being approached and dealt with in a similar manner to issues in the world of public affairs and paid work. Rationality, autonomy and control are becoming important features of private activities such as mothering and breastfeeding. Mothering and breastfeeding are being approached with the same tenacity as the tasks of the goal-oriented career person.

Many argue that the public world demands restraint, discretion and 'civilized' practices, particularly when it comes to breastfeeding in public. The findings of this study suggest such restraint and concern for body integrity is now increasingly a part of private life. The management, control and civilizing of private life, with increasing emphasis on autonomy, independence and the control of emotionality, seems in opposition to the warmth and intimacy that Beck and Beck-Gernsheim (1995) suggest individuals are trying to achieve from family life.

CONCLUSION

In this chapter I have synthesised the diverse personal experiences of breastfeeding with the theories of subjectivity and the body. Rubin's theoretical work on the body-self has undoubtedly made a substantial contribution to understanding the maternal body and the maternal self. Yet I suggest Rubin's work is limited as it denies the place of breastfeeding as an embodied experience that potentially maintains a continuity between mother and child following pregnancy. Further, Rubin stresses the need for women to restore body boundaries and a duality of mind and body within a given time frame following birth. In this and other nursing work there is little tolerance for ambiguity or uncertainty in maternal subjectivity. As in early psychoanalytic and psychological accounts, the separation of mother and child is paramount.

The findings from this study demonstrate that the boundary between a mother and her breastfeeding infant are, in contrast to traditional accounts, blurred and uncertain. I have described the way in which a connected, harmonious and intimate experience of breastfeeding blurs the boundaries between mother and child, challenging the duality of mind and body and the dominant accounts of motherhood and sexuality. A connected and intimate experience of breastfeeding represents the 'abject', something out of order. A woman's ability to tolerate, negotiate, and even gain personal pleasure from the ambiguity of self and other, poses a threat to phallocentric and logocentric notions of rationality, autonomy and control. This experience of breastfeeding sits more comfortably with certain feminist writings that value notions of 'difference' in understanding gender and in feminist theories, such as those described in Chapter Four which propose a new form of female sexuality.

Notions of intimacy and connectedness, however, were not described by all of the women. For some women, breastfeeding was unpleasant and distressing. Here the challenge to identity from the uncertain boundaries between mother and child, self and other, were not tolerated. Many women sought to regain control over their lives and over their bodies. For many women there was some comfort in a return to a dualist understanding of separate mind and body.

These findings demonstrate the imperative for diversity in any theorising of the breastfeeding experience. This analysis does not provide the opportunity to work towards any type of meta narrative on femininity and the experience of breastfeeding. To do so would exclude the experience of many women, and as Carter (1995) suggests, it may be a hazardous process that would further restrict or restrain women's options.

CONCLUSION

This study has focused on maternal subjectivity in the 1990s. In this study I examined the way in which 25 Australian women created a maternal subjectivity and gave meaning to their lives when they became mothers for the first time. Using a poststructuralist approach, I examined the personal, public and professional discourses these women drew upon to make sense of their lives as mothers. In an attempt to transcend the dualities of mind-body and individual-society present in most theories of maternal identity, I focused on exploring the place of the maternal body in women's experience of new motherhood. The early and important finding that breastfeeding was central to women's experience as mothers focused my research on the place of breastfeeding and the maternal body in the constitution of a maternal subjectivity in the 1990s.

This thesis has taken a dialectical approach to theorising motherhood and the experience of breastfeeding, examining the relationship between discourse and embodied experience. In a complex relationship, powerful discourses, as described by Foucault, merge with the sensed and perceived embodied experience in the work of Schilder, Rubin, and Merleau-Ponty. The series of interviews conducted with these 25 women has allowed an exploration of how mothering and breastfeeding beliefs and practices are constructed and embodied and how these change over time. The interview data highlighted the diversity, complexity and contradictions in the use of discourse and positioning of self as a mother. Within this group of 25 women, no two experiences were alike.

This thesis began by examining the way in which nurses and midwives interpret, write about and theorise maternal subjectivity. Using discourse analysis to examine maternal subjectivity in the professional literature, I argued that the approach taken in theories of maternal-infant attachment, bonding, transition and work on maternal role attainment tend to perpetuate the dualisms of individual-society and mind-body. There is a focus on mothers as individual, autonomous and independent, performing in the world in a

conscious, rational manner. Nursing and midwifery writings typically approach maternal identity as the accomplishment of a particular role. This view of subjectivity has led nurses and midwives to prioritise maternal role attainment as the central focus of nursing research, studying the cognitive stages that a woman must move through in creating an identity as a mother. However, our concern for order, stages and progress denies the experience of women in the 1990s, where subjectivity is understood to be more fluid or dynamic.

Within the nursing and midwifery literature, the work of Rubin stands apart as an attempt to recognise the self as embodied in nature, a self with sensations, perceptions and movement that are libidinally invested. Rubin's insightful theorising shows some parallels with certain feminist accounts of the embodied nature of pregnancy and the connectedness of mother and fetus. Yet within Rubin's work there remains an imperative, couched within rational and autonomous discourse, for mother and baby to separate, to 'polarize', at least by four weeks following the birth. This understanding does not allow for the experience of breastfeeding that has been described by the women participating in this Australian study. In Rubin's work, breastfeeding is positioned purely as an activity and interaction that women undertake in caring for their infant. While more recently, some nurses have attempted to theorise particular aspects of the breastfeeding relationship (e.g. Wrigley & Harrison, 1990; Bottorff, 1990; Leff, Gagne & Jeferis, 1994), the nursing and midwifery literature poorly describes breastfeeding and maternal subjectivity.

In taking a sociopolitical approach, I have argued that the experience of motherhood has been shaped, even constituted, by the powerful pro breastfeeding discourses in contemporary Australian society. Prior to the birth of their babies, all these women had intended to breastfeed. In their discussions, breastfeeding was constructed discursively through a range of professional and public discourses. For the majority of these women their commitment to breastfeeding was strong. These women showed little resistance to the discourses of breastfeeding as 'natural', crucial to relationships, best for baby and representative of the good mother. In Foucauldian terms, however, there is little evidence of 'docile' bodies positioned passively in relation to this rhetoric. These women were

active or agential in committing themselves to the rhetoric of breastfeeding. They were prepared to 'persevere' with breastfeeding to complete their identity as a breastfeeding mother. In a poststructuralist sense, the project of breastfeeding undertaken by these women was commensurate with their position as rational, autonomous individuals. Breastfeeding was, as Rose (1996) would describe, 'an identity project'. Breastfeeding was something that they wanted to achieve, to master, to get under control. Breastfeeding was constructed as a practice that women wanted to be part of their 'everyday' schedule. In taking this position, these women have resisted the common adverse accounts of breastfeeding that construct breastfeeding as socially unacceptable, compromising the sexual attractiveness of their breasts, inconvenient and a practice so problematic that it is almost impossible to achieve. Even those few who were not totally committed to breastfeeding were prepared to 'give it a go'.

This analysis not only identified the powerful discourses that currently position breastfeeding as crucial in the construction of maternal subjectivity, it also identified breastfeeding as a powerful non-discursive or embodied experience. Within this analysis, the maternal body was not simply shaped in Foucauldian terms through a range of competing discourses, but was experienced in a sensory and perceptual way. Women became aware of the 'physicality' of breastfeeding. This finding challenges Carter's statement (1995: 158) that 'we do not know whether breastfeeding has an intrinsic meaning beyond the social relations and context in which it takes place'. This study demonstrates that there is undoubtedly a place for understanding breastfeeding as a personal, embodied experience, where sensual and perceptual experience gives meaning to the practice of breastfeeding.

Embodied experience and discursive construction exist together, at times in harmony and at times in competition and contradiction. The connected, harmonious and intimate experience of breastfeeding was frequently articulated in relation to notions of 'bonding', 'breast is best', the 'good mother', the 'perfect' baby, and fulfillment accounts of motherhood. A disconnected, disrupted and distorted embodied experience of breastfeeding tended to be blurred with discourses of loss, depression, separation,

regulation and control. For some women, breastfeeding paralleled the feminist accounts of personal empowerment. However, as Carter (1995) stresses, the social and personal advantages are not always or even usually realised. In this Australian study there were few women who gained 'self reliance', a 'greater control over their bodies' or developed 'a solidarity' with other women through breastfeeding (Van Esterik, 1989: 69). Breastfeeding was not empowering for all women.

Breastfeeding challenges boundaries of self and other, inside and outside, nature and culture, motherhood and sexuality. The notion of the autonomous individual, the authentic self with clear and contained boundaries, is questioned when we consider the blurred boundaries of self and child during pregnancy, birth and the early mothering period, in particular when the infant is breastfed. As rational, autonomous, independent women, many felt overwhelmed by the 'oneness' or unity they experienced with their breastfed infant. Some found this continued connection intrusive and a persistent threat to their sense of self and autonomy. This position is indeed understandable when we consider the current demands in western society for autonomy, self-actualisation and rational behaviour. They could not tolerate the lack of defined border between themselves and their baby.

On the other hand, some women felt comfortable in the knowledge that they were sharing their body with another. They thrived on the dependence and harmony in this experience. The baby was 'theirs', not yet privileged with a separate identity. While this is contradictory to how contemporary women sees themselves, some women were able to tolerate or to transgress these uncertain boundaries. As described in Chapter Eight, some women established exclusive mothering practices in order to maintain their 'special' relationship with their baby. The intimacy they shared with their infant, particularly when they took their infant into their bed, threatens defined borders of femininity and heterosexual behaviour. Breastfeeding in bed was breaking the boundaries. It was no surprise that some partners of these women did not condone the practice of feeding in bed or co-sleeping with the baby. Similarly, I also ask whether at this time in history, it is more than coincidence that men are seeking to be actively involved in nurturing an infant.

As this study demonstrates, some women are able to articulate an intimacy and sensual pleasure from breastfeeding that defies the expected boundaries between mother and child. This may be threatening for many men. Indeed, in this study there were men who requested that their partners express breast milk so that they could feed the baby (Lupton & Barclay, 1997).

This thesis suggests that the connected, harmonious and intimate experience of breastfeeding requires tolerance of the ambiguous and uncertain borders between mother and child. The work of Wrigley and Hutchinson (1990) suggests that the maintenance of this mutually enjoyable experience calls for a 'surrendering' and 'reorientation' of self. It necessitates a total 'giving' of self, an incorporation of another identity as one's own. Yet clearly this is too much to ask of all women as they create an identity as a mother in the late 1990s.

Blum (1993: 296) comments, 'Even more than pregnancy the interdependent breastfeeding relationship heightens the contradictions of mothering promoted by late capitalist restructuring and the mean-spiritedness of our political era'. The embodied experience of breastfeeding challenges our notions of rational, autonomous and 'civilized' selves. This relationship conflicts directly with the contemporary demand for women to be autonomous and independent individuals and to have a personal life that is separate from that of their child. As women struggle with the contradictions between self and other, public and private, motherhood and sexuality, sometimes the choice to bottle feed appeals, allowing women to move from ambiguity into certainty.

IMPLICATIONS FOR MIDWIFERY AND NURSING PRACTICE

There are several important findings from this study of maternal subjectivity that have implications for the practice of midwives, nurses and lactation consultants. In this concluding section I address three particular issues: 1. the central place afforded breastfeeding in the construction of a maternal subjectivity, 2. the non-discursive or

embodied nature of breastfeeding and 3. the place of health professionals in producing and reproducing the contradictions and tensions of mothering and breastfeeding.

Breastfeeding and Mothering: Are They Synonymous?

Breastfeeding was found to be central to the experience of mothering in the early weeks and months following birth. For health professionals and groups interested in increasing breastfeeding rates in the community, this finding indicates that at least within this group of women the promotional messages about breastfeeding have been very successful. I believe, however, we have to question whether it is appropriate that women construct an identity as a mother around their practice of infant feeding.

This question reminds me of debates around the extraordinary commitment to 'natural' birth that women were making during the 1980s and early 90s. I believe an analogy can be drawn between the emphasis placed on 'natural' birth as an empowering experience for all women and the current imperative to breastfeed. During the late 70s, 80s and early 90s, a labour and birth free of intervention was heralded as best for the health of mother and baby, and importantly it represented women's autonomy from the medical control over birth. The powerful feminist rhetoric asking women to regain control over their bodies underpinned this change in practice. Yet importantly, 'natural' birth also appealed to our developing concern for personal success and autonomy. Proponents of natural birth promised women an 'exalted quality of the birth experience that represented an existential moment in women's lives' (Crouch & Manderson, 1993a: 56). Experiencing a natural birth was personally enhancing, a life experience that women coveted. Until recently, women seeking a 'natural' birth approached this goal with enormous conviction and tenacity. In the late 1990s I have a sense that women are preparing for labour and birth in a way that encompasses a variety of potential outcomes. Importantly, women are also encouraged to talk about their birth experience and are provided with the opportunity to debrief with midwives or other health professionals.

Unlike the rhetoric of 'natural' birth, however, breastfeeding is surrounded by a plethora of policies and practices that exist to ensure the protection, promotion and support of breastfeeding. So powerful are the practices surrounding the Baby Friendly Hospital Initiative (BFHI) and the 'Ten Steps to Successful Breastfeeding', that women in this study noted the atmosphere towards breastfeeding in the postnatal ward. Perceptively Marianne described, '*It was as if there was some sort of **code** about breastfeeding*'. Sally added, '*I don't know whether they would have been allowed to (not breastfeed). I don't think there is that culture at (the hospital) not to breastfeed...I don't know how they would react if somebody just said that they were not breastfeeding*'. I suggest that at times, health professionals have perhaps failed to see the coercive nature of breastfeeding policies and the influence they have on women's experience of breastfeeding.

The findings from this study also suggest that it is time to rethink the way in which breastfeeding is discussed in antenatal education. Many women and men in the 1990s are well informed of the advantages of breastfeeding. The attention in antenatal classes to describing the advantages of breastfeeding may simply be confirming the beliefs of most women, and could be considered patronising. Women and men may benefit more from discussions with a variety of new parents about the experience of breastfeeding. Hewat and Ellis suggested in 1986, and Laufer again in 1990, that women benefit most from realistic anticipatory guidance about breastfeeding and the opportunity to discuss attitudes towards breastfeeding, rather than focusing on promoting its benefits. The findings from this study suggest it is difficult to predict how a woman may feel and perceive breastfeeding and like birth, women could benefit from discussing and acknowledging this uncertainty.

The Embodied Nature of Breastfeeding

Over the past decade, health professionals have increased their knowledge about the physiology of breastfeeding and lactation. We have studied breastfeeding rates and the reasons why individuals do, or more typically do not, breastfeed. Many interventions have been tested and practices established to increase breastfeeding initiation and

duration. Finally, we also have come to acknowledge the many sociocultural factors that influence breastfeeding rates, such as the sexual division of labour, paid work and domestic work, notions of sexuality, medicalisation of child bearing and child rearing and the ever increasing advice from experts. However, health professionals have not seriously considered a woman's personal embodied experience of breastfeeding and how this influences the practice of breastfeeding. The rare attempts in professional accounts to describe breastfeeding as an embodied experience tend to privilege the positive experience of warmth and intimacy with the infant and dismiss the more distressing aspects of breastfeeding in physical terms, as problems of 'positioning' or 'attaching' the baby to the breast. Sensations associated with the let down reflex, for example, are most commonly described as a 'pleasant tingling sensation' and rarely as 'sparks' or 'electricity' going off inside you.

This study has highlighted the central importance of the non-discursive or embodied nature of the breastfeeding relationship and the difficulty in articulating this experience. We need to encourage women to articulate their embodied experience of breastfeeding. How can women and health professionals find a way to describe the connected, harmonious and intimate experience of breastfeeding that some women experience, in manner that is encouraging and not confronting for women whose experience is very 'difficult'. Women who perceive breastfeeding in a disruptive or distorted way and find the uncertainty of the boundary between themselves and their baby intolerable, must be given an opportunity to talk about their feelings. Currently, debriefing from the experience of breastfeeding is not a priority as it is for the birth experience. As Maushart (1997) describes, in certain groups of women it is almost unacceptable to relate why one stopped breastfeeding.

I suggest more effort is required for women to develop ways to describe the experience of breastfeeding. With a creative approach women may be able to find words, metaphors, symbols, or images to express their relatedness and connection to others and to find ways to tolerate uncertainty and blurred boundaries. We need to explore ways to represent the connected and intimate experience of breastfeeding as well as the experience characterised

by disruption and distortion to the known self. Women need to be able say with comfort, 'I want to be separate and somewhat independent from my baby'. Health professionals can contribute to the search for visual images, metaphors and symbols that may assist women to articulate their embodied experience of breastfeeding and to describe their relationship with their breastfeeding baby. In our practice it is important to gain some understanding of how a woman may be experiencing breastfeeding with this baby or with a previous child. It requires skill, the ability to be reflexive about one's own position, the understanding of breastfeeding as a discursive construction and sensitivity to experience which cannot be easily described. This type of practice is contrary to any practice based simply around a global strategy, such as BFHI and the 'Ten Steps to Successful Breastfeeding'. These policies intend to mould or shape women as mother in particular ways.

Within contemporary notions of the autonomous self, women expect to have control over their bodies. In this context, women who need to feel comfortable with their bodily routines and rhythms without the intrusion of breastfeeding should be respected. As Carter (1995) insists, our understanding of breastfeeding must allow for the diversity of women's personal experience. Similar to Carter (1995), I believe there is a need to consider and make available to women all possible choices in relation to reproduction and sexuality. This includes the choice to bottle feed.

Arguments by health professionals and some anthropologists that women be given full information about breastfeeding in order to make their choice are based on the assumption that there is an underlying authenticity about the pro breastfeeding information. We must recognise that women's choice to breastfeed is as much constructed within the pro breastfeeding rhetoric as it is in the discourses that discourage breastfeeding. Rather than hearing the benefits of breastfeeding time and time again, women in western society need to face the uncertainty of the breastfeeding experience. They need to be prepared, as they are for birth, that breastfeeding is not always easy, it is not always a connected, harmonious and intimate experience, nor is breastfeeding a reflection of their ability as a mother.

Contradictions and Tensions

Finally, as health professionals we must start to recognise the contradictory messages about mothering and breastfeeding that are actively produced and reproduced within the everyday practice of caring for mothers and babies.

Women's 'perseverance' with breastfeeding is constructed within an account of rational, autonomous behaviour and mirrors our contemporary concern to have control over our body and to succeed in our personal goals. In this account of breastfeeding, a woman not only wants what is best for the baby but also desires a particular identity as a mother and a certain type of relationship with the baby. The majority of women in this study were prepared to 'work' to establish a successful breastfeeding relationship. Most seemed aware that this commitment to exclusive breastfeeding necessitated their constant presence, the giving of time, a relaxed approach, patience and the ability to be flexible. This commitment was exemplified by the decision of the majority of these women not to return to work until their baby was at least six months old. This rhetoric is reinforced immediately following birth, when midwives following the 'Ten Steps to Successful Breastfeeding' encourage women to breastfeed as soon as possible after delivery, to practice demand feeding, insist that the infant be with the mother all the time (24-hour 'rooming-in'), tell the mother to avoid dummies or pacifiers, and limit the availability of formulas. I do not doubt that these practices are important in initiating and establishing breastfeeding and have been supported empirically (McIntyre, 1993). However, while the 'Ten Steps' are established in the policies of maternity units intended to guide the practices of individual midwives, the impact on women has not been evaluated. These protocols do not reflect the diversity of the personal, embodied experience of breastfeeding.

Simultaneously with the commitment to establishing breastfeeding, the rational and autonomous mother also knows she must take some time for herself, to be constantly in her infant's presence after the first month or so is not healthy. She needs adult stimulation and conversation, to re-establish aspects of her life prior to the baby's birth, and of course to make time for her partner and their relationship, as well as creating a

space for her partner and baby to enjoy time together. Thus, paradoxically, at the same time that women realise the need for constant proximity to their breastfeeding infant, they are advised of the need to leave their baby with somebody they trust, so as to have some 'time out' 'just for themselves' or with their partner. The mother must not become 'overly absorbed' by her baby (Fowler & Gornall, 1991).

Women encounter many similar contradictions in the day-to-day care of their baby. In conclusion, I suggest that it is through the current practice of breastfeeding that many of the contradictions and tensions of contemporary motherhood are played out. Here I return to the meanings that breastfeeding has in contemporary Australian society. Crouch and Manderson (1993) suggest that as it has increasingly become unacceptable for women to find total fulfillment and social status in life simply as a mother, additional events, such as birth and the bonding experience, have been given a prominent place in mothering. Securing a satisfying birth experience and a 'successful' bond with one's child requires an intensive investment of oneself for a limited period of time. Having established her identity as a mother in a short time period, a woman is free to participate in society in a variety of capacities. Similarly, the findings from this study suggest that breastfeeding has also assumed a surprisingly dominant place in the lives of these Australian mothers. The commitment to breastfeeding requires women be constantly with their child, however, like birth and the bonding experience, breastfeeding is also transient, even if it is for one or two years. Breastfeeding does not place women solely in a role relating to a child for an eternal period.

CONCLUSION

My overriding concern in this study has been to gain a greater understanding of maternal subjectivity in the 1990s. While undertaking this study I constantly asked myself, 'Why is a detailed understanding of maternal subjectivity important to midwives?' In answer to this, I suggest that possessing a greater understanding of women as they become mothers may allow midwives to make a thorough antenatal and postnatal assessment of the ease or difficulty of this transition. Such an assessment may

allow midwives to identify those at 'risk' of depression or those who may potentially abuse their child. Our work as midwives would be easy if we could identify the particular needs of women and outcomes for the first, second and third postpartum day and have clearly defined psychosocial tasks that could be 'assessed' or 'monitored' as easily as 'physical recovery' seems to be. Early childhood nurses could identify problems with breastfeeding or predict a mother's needs and concerns accurately in the third week after birth. But becoming a mother and developing a maternal subjectivity is not ordered and tidy. It is often chaotic and unpredictable. In undertaking these detailed longitudinal interviews with women, I have learnt that becoming a mother is enormously complex and different for all women, even women from the same cultural background, socioeconomic group and partnership status.

After many years of theorising and research Reva Rubin stated in a 1988 interview, 'We haven't begun to find out what is going on in the creative, experiential process of being a part of making a baby, making a mother' (Mercer, 1995: 4). Mercer adds (1995: 13), 'Despite the study of numerous variables impacting on the process, the transition to the maternal role identity continues to be elusive in its complexity'. I hope that studying maternal subjectivity as both an embodied experience and discursive construction further develops our understanding of motherhood and breastfeeding.

+-APPENDIX A

BIOGRAPHIES OF THE PARTICIPANTS

Barbara and Alistair were both in their early thirties when Rachel was born. They were married and had been in their relationship for five years. The couple owned the small two-bedroom house they were living in, located in an inner Sydney suburb. Barbara was a physiotherapist and Alistair a plumber by trade. Barbara was Australian born, of Anglo-Celtic background, and Alistair was raised in South Africa by his Scottish parents. The couple intended visiting South Africa when Rachel was about nine months old. Barbara was looking forward to returning to work part time when they returned from their trip. At six months Barbara was still breastfeeding Rachel.

Kylie, 26, and Steve, 37, were married and had been together for six years before the birth of Jackson. The couple rented a two-bedroom house in a southern Sydney suburb. They planned to move out of Sydney some time in the next two years in order to purchase their own home. Prior to Jackson's birth, Kylie had worked as an administrative assistant and did not want to return to work after the birth of her son. Steve was a sales representative. Kylie was Australian, of Anglo-Celtic parents and the youngest child in a large family. Born in Australia, Steve was adopted by Anglo-Celtic parents at three months. Kylie breastfed Jackson for three months.

Susan and Rob were married and had been in their relationship for three and a half years before the birth of their son, David. At the time of our first interview, Susan was 24 years of age and Rob was 25. The couple described themselves as 'Christians' and their church was an important part of their lives. At the start of the interviews they were living in a large rented house in a Sydney suburb but six months after the birth, they moved to another state to be nearer Susan's family. Susan had worked as a clerk in an insurance company and Rob was a storeman. Susan was still breastfeeding at six months.

Tess, 27, was born in Wales and migrated to Australia when she married Alex, 30, who is Australian born of Greek background. They had been in their relationship for four years prior to the birth of Grace. Tess had worked as a nanny and in the catering industry but had most recently worked in a plant nursery. Alex was an electrician and had worked for the same company for 12 years. The couple were living in their own semi-detached house in Sydney but hoped to move to an area where there were more children around. They travelled overseas to visit Tess's family for eight weeks when Grace was three months old. Tess breastfed for eight weeks.

Amanda was 35, and Jim, 38, when their son Josh was born. They were both of Anglo-Celtic background, but were brought up in Zimbabwe. They met in Sydney, where they had lived together for seven years prior to Josh's birth. Amanda was a teacher but commenced doctoral studies around the time of Josh's birth. Jim was a psychologist. When the study began the couple were renting a house in a semi-rural area on the outskirts of Sydney. Amanda was still breastfeeding Josh at six months and intended to continue for some time.

Tina was born in Ireland of Anglo-Celtic parents and migrated to Australia in her early twenties. Here she met Carl, who was born in Chile but had lived in Australia with most of his family for 15 years. Tina was 26 and Carl, 37, when their son Lachlan was born. The couple had been together for three years before marrying. Four months later Tina was shocked to find she was pregnant. Tina was a legal secretary and returned to work four months after their son was born. Carl worked as a researcher in the plastics industry. The couple lived in a rented two-bedroom home unit in a southern Sydney beach suburb. Both had some family living in Australia. Tina breastfed Lachlan for five months.

Denise and Colin were both in their mid thirties and had lived together for 12 years when their son Callum was born. Both were Australian born, of Anglo-Celtic parents. Denise was an accounts clerk and Colin a builder. Denise did not intend to return to work while her child was young. During the first six months after the birth, they temporarily moved house as they were in the middle of renovating their two-bedroom older style house in an inner Sydney suburb. Denise was still breastfeeding at six months and intended to continue for some time.

Jane and Jeff were married and had been together for six years prior to the birth of their daughter, Louise. Both were 31 years old, Australian born, of Anglo-Celtic parents. Prior to Louise's birth, the couple had purchased a small two-bedroom house in Sydney. Jane worked as an administrative assistant in a busy office and Jeff was a nurse. By the time Louise was six months old, Jane was considering returning to part-time work two days a week. Jane breastfed for six weeks.

Donna, 25, and Paul, 27, were married and had been in their relationship for nine years prior to the birth of their son, Alex. Both were Australian born, of Anglo-Celtic parents. They lived in a rented two-bedroom house in a southern Sydney suburb. Prior to Alex's birth, Donna had worked in an insurance company and intended to return to work part-time when her son was about 12 months old. Paul ran a sporting facility. The couple lived very near Donna's parents. She was still breastfeeding at six months.

Trish was 26 years old and married to Adrian, a 28-year-old research analyst. They were married and had been together for nine years before the birth of their son, Mitchell. The couple described themselves as 'Christians' and their church played an important part in their lives. Trish was a nurse and had a lot of experience working with babies. Adrian worked as a financial analyst for a large bank. The couple had recently purchased a three-bedroom home unit in a southern Sydney suburb. Trish and Adrian were both born in Australia, of Anglo-Celtic parents. Trish planned to return to work part-time, one or two days a week when her son was about 12 months old. Trish was still breastfeeding Mitchell at six months and intended to continue for some time.

Carmen and Jerry were married and had been in their relationship for eight years before the birth of their daughter, Ashleigh. At the time of the first interview, Carmen was 27 years old and Jerry was 30. Carmen was born in Mexico but had migrated to Australia with her South American parents when she was a young child. Jerry was Australian born, of Maltese background. The couple lived in their own three-bedroom house in south-west Sydney, in a newly developed housing estate. They ran their own small

business, although Carmen had not worked very much during the pregnancy. Carmen breastfed for six months.

Kerry, 24, and Cameron, 29, had been married for three years when their daughter, Caitlin, was born. They were living in their own three-bedroom house in a middle class suburb in Newcastle. Cameron worked as a sales representative for a large international machinery and construction company, while Kerry had worked as a secretary but planned to stay at home for a while to care for their child. Both Kerry and Cameron were Australian born, of Anglo-Celtic background. Kerry was breastfeeding at six months and intended to continue for some time.

Lyndall and Tim were in their late twenties when their son, Christopher, was born. They were married and had been together for six years. The couple lived in a middle class suburb in Newcastle and had recently purchased their three-bedroom home. Lyndall worked as a clerk for a large company and intended to work part-time when her son was about 12 months old. Tim was a sales manager. Both were Australian born, of Anglo-Celtic parents. Lyndall was breastfeeding at six months and intended to continue.

Simone, 30, was of Northern European background and had been living in Australia for 13 years. She had been with her partner, Greg, for ten years and they were married. Simone had undertaken tertiary degrees and had a position as a university lecturer. Greg, 34, was a middle manager employed by the government. He also taught two or three nights a week. The couple owned a small two-bedroom house in a southern Sydney suburb. They had also just purchased a large house in a middle class southern suburb that they currently rented out. Simone's mother was living with them. Simone was unsure about when she would return to work. She was still breastfeeding at six months and intended to continue for some time.

Fiona and Graham were both 24 years old when their son, Marcus, was born. They were married and had been in their relationship for four years. Fiona was born in South Africa but her parents were of Anglo-Celtic origin and she grew up in Australia. Graham was Australian born, of Anglo-Celtic parents. The couple lived in a rented two-bedroom unit in southern Sydney. Both Fiona and Graham were employed in private enterprise, Fiona as a management consultant and Graham as a financial analyst. Fiona was adamant that she would not return to work while her children were of pre-school age. Fiona breastfed for just under six months.

Joanna and Malcolm were in their early thirties when their son, Tristan, was born. They were married and had been together for nine years. They had experienced a number of years of infertility, when, without treatment, Joanna was surprised to find she was pregnant. They lived in their own three-bedroom home that they had built in a semi-rural area of Sydney. Joanna had worked in public relations and tourism but planned to stay home to care for their child. Malcolm had previously been a police officer but was now working in the family business. Both Joanna and Malcolm were Australian born, of Anglo-Celtic parents. Joanna was continuing to breastfeed at six months.

Anna and Neil were both 23 years old when their son Luke was born. They were married and had been in their relationship for five and a half years. During the interviews, the couple was renting a two-bedroom unit in a southern Sydney suburb.

When Luke was six months old they purchased a townhouse in an outer Sydney suburb. Anna was a high school teacher and intended to return to work full-time when her son was four months old. Neil worked as a manager in a large retail firm. Anna had been born in England to British parents, but had lived most of her life in Australia. Neil was Australian born, of Anglo-Celtic parents. Anna breastfed during her stay in hospital and for another two days, after which the baby was formula fed.

Kate and Terry were married and had been in their relationship for seven years before the birth of their daughter, Michaela. Kate, 28, had been working as a nurse. She was Australian born, of Anglo-Celtic parents. Terry, 33, was a painter by trade but was currently retraining in horticulture. and worked as a landscape gardener. He was also Australian born, of Anglo-Celtic parents. The couple lived in their own house in a middle class southern Sydney suburb. Terry's parents lived nearby. Kate breastfed Michaela for six months, stopping just prior to returning to part-time shift work.

Christine, 29, and Nalin, 34, were married and had been in their relationship for nine years before the birth of their son, Zac. Christine was Australian born, of Anglo-Celtic parents and Nalin was from Sri-Lanka. He had been living in Australia for 17 years. They owned their own three-bedroom house in a leafy middle class Sydney suburb. Christine had worked as a customer service operator for a large Sydney firm and Nalin was employed as a technical engineer and did shift work. He was also studying part-time. Christine intended to return to work part-time when her baby was a year old. She was breastfeeding at six months and intended to continue until her baby was about one year old.

Maggie and Dominic were both in their mid twenties when their son, Lloyd, was born. They were married and had been together for seven years. The couple rented a two-bedroom house in a southern Sydney suburb, close to Maggie's parents. Prior to Lloyd's birth, Maggie had been teaching at a private school and Dominic had been a full-time doctoral student. When they discovered Maggie was pregnant, Dominic decided that he would stop studying and take full-time employment, also in teaching. Both Maggie and Dominic were Australian born, of Anglo-Celtic parents. Maggie was breastfeeding at six months and intended to continue for some time. She intended to return to work part-time when Lloyd turned one.

Katrina and Brad, both 28 years old, were married and had been in their relationship for ten years before the birth of Lucy. Katrina was a speech therapist and had been working part-time during her pregnancy. Brad was a teacher. Katrina was born in New Zealand but had lived most of her life in Australia. Brad was Australian. Both Katrina and Brad's parents were of Anglo-Celtic background. The couple lived in their own two-bedroom home unit in an outer Sydney suburb, close to a National Park. Katrina was still breastfeeding at six months and intended to continue until her baby was about one year old. At the six month interview Katrina thought she would do some casual work when her daughter was close to a year old.

Marianne and Nick were both 32 when their daughter, Cassie, was born. They had been married for seven years. The couple lived in their own two-bedroom house in a southern Sydney middle-class suburb. Marianne was a nurse and had been studying for a law degree part-time. She resumed her study when the baby was three months old. Nick

worked as a sales executive. They were both Australian born, of Anglo-Celtic parents. With much effort, Marianne was still breastfeeding at six months.

Sally and Richard were both 26 years old when their son, Henry, was born. They had been in their relationship for 18 months when Sally found out she was pregnant. The couple lived with Sally's parents in a large, newly built home in a middle-class southern Sydney suburb. Prior to Henry's birth, Sally had worked as a project officer at a university and was studying part-time for a higher degree. Richard was employed as sound and lighting technician for exhibitions in museums and galleries. They were both Australian born, of Anglo-Celtic background. Sally was breastfeeding at six months and planned to continue for some time.

Jacki and Allan were married and had been together for 12 years before the birth of Jeremy. They owned their own three-bedroom house in an outer Sydney suburb, with views of a National Park. Jacki, 33, had worked most recently as a personal assistant to an executive director of a large private firm but planned to start her own consulting business in the new year. Allan, 32, worked as a sales manager. They were both Australian born, of Anglo-Celtic parents, and had family living nearby. Jacki breastfed for six weeks, stopping prior to returning to part-time work when Jeremy was ten weeks old.

Linda and Mark were both in their early thirties when their son, Todd, was born. They had been together for about 18 months when Linda found out she was pregnant. They subsequently brought their planned wedding date forward. They rented a two-bedroom home unit in a suburb in western Sydney. Prior to Todd's birth, Linda had worked as a clerical officer in a bank and Mark was employed as a supervisor in a large factory. Both were of Anglo-Celtic origin and born in Australia. Linda was still breastfeeding at six months but was gradually weaning Todd, as she had returned to part-time work.

APPENDIX B

INTERVIEW QUESTIONS AND PROMPTS

INTERVIEW ONE (late pregnancy)

What were your first thoughts when you found out that you were pregnant?

Had you always imagined or expected to be a mother?

Have your thoughts about being a mother changed during the pregnancy?

What is your baby like now?

How have you found being pregnant? Describe what it is like having a baby there, or something growing inside you?

What sort of relationship do you think you will have with your baby?

What sort of future would you like for your child?

What picture or image do you have of motherhood?

Describe a good mother? Describe a good father?

What sorts of information have you been drawing on or found helpful?

What are your plans for the birth?

Have you planned how you will feed the baby? What has influenced your decision?

Do you feel ready for the baby?

INTERVIEW TWO (in the first week to ten days after birth)

How are things going?

Describe your baby to me?

How was the birth?

Describe your response to the baby in the first few hours after the birth?

What is it like caring for your baby?

How do you feel about providing care for your baby?

What was it like when you came home? How is it different from being in hospital?

Describe your interactions with the health workers while in hospital?

Is there anything that stands out about these interactions, anything that was particularly helpful or unhelpful?

INTERVIEW THREE AND FOUR (very similar prompts were used in the interviews conducted four to six weeks and ten to 12 weeks following the birth)

How are things going?

Tell me about the baby?

What is it like providing care for your baby? Are there things that you really enjoy doing and things that you really don't like doing?

Last time we spoke you told me about the decisions that you had made in relation to feeding your baby, are you still going by these decisions or has this changed? How has this changed?

You have also described your thoughts about your baby's settling and sleeping pattern, are you still going by these decisions or has this changed? How has this changed?

Describe the way in which you and the baby communicate? Describe the relationship that you have with your baby?

Describe a good mother? Describe a good father?

Who do you go to if you need help or advice?

What else do you find helpful?

Describe your interactions with health workers?

Describe your interactions with family and friends

The first time that we spoke together, you described the picture/image that you had of motherhood, how do these images compare with your experience?

INTERVIEW FIVE (at 6 months after the birth)

How are things going?

Tell me about the baby?

Describe the activities (including the caring activities) that you participate in with your child? What do you enjoying doing most? Are any of these activities difficult or challenging?

(If the woman is still breastfeeding or has stopped breastfeeding since the last interview)
Describe your experience of breastfeeding?

Describe any particular time or times that you really felt like a mother?

Describe how you and the baby communicate? Describe the relationship that you have with your baby? What sort of relationship do you want to have with ..... as he/she gets older?

In earlier discussions you described a good mother as ..... Can you tell me any more about a good mother?

In earlier discussions you described a good father as ..... Can you tell me any more about a good father?

(If the woman has returned to paid employment)
Does your paid employment have an impact on the way that you mother?

How do you feel about taking your child to care?

Do you find there is pressure for women to return to work?

Today there is an expectation that men will be involved in the care and day to day management of the baby. In your experience, how does this work in your life?

How do you negotiate household responsibilities and has this changed in the past six months or year?

How has your relationship with your partner changed over the past year since you have become parents?

In earlier interviews you described the picture or image that you had of motherhood, compare this picture or image with what it is like?

Appendix C Data Analysis Framework

Dimensions of Discourse	Nature of Analysis	Focus of Analysis	Objective of Analysis	Questions to be asked of the Data
Discursive Practice (production, distribution and consumption of text) (Fairclough, 1992)	Interpretive Macro level	Inter-discursivity	-Identify what discourse types are drawn upon in the data	Is the sample characterised by a particular genre, eg, interview or conversation? Is there more than one genre? What activity type ie what is the relationship between participants, or what positions are taken by the subject. Is there a formal or informal style to the interaction? (Fairclough, 1992a) What discourse types are drawn upon (Fairclough, 1992a) eg. medical, technological, nursing, psychological, feminist or public? Do the discourse types vary within a participants talk or between participants? (Potter & Wetherall, 1994) Are there contradictions or points of tension in the use of discourse types?(Fairclough, 1992a). What objects or events are referred to? What types of subject is talked about or addressed? (Parker, 1992)
			-Describe how these discourse types operate	How is the text or talk structured to persuade? (Lupton, 1994a) How is one discourse type given precedence over another? How are other discourses or versions dismissed?(Potter and Wetherall, 1987) {Describe the way in which some of the features of text are employed eg choice of words, phrases, metaphor, interpretive repertoires see TEXT)
		Inter-textuality	-specify what other texts are drawn upon -describe how other texts are used to elaborate upon a discourse	Are other texts representing the discourse type drawn upon in a direct or indirect way? What is represented? How are the other texts contextualised in the represented discourse? (Fairclough, 1992a) In employing other texts is the speaker reflecting upon the use of particular terms or statements? (Parker, 1992) Are presuppositions present? What is taken for granted?(Fairclough, 1992a) Are there instances of metadiscourse/? (Fairclough, 1992a), ie. is the speaker shifting out of or above her own discourse, reflecting upon her position?
		Coherence	Examine the interpretation s that can be made of text	Could the text be interpreted differently? Does it receive resistant readings?(Fairclough) How would a discourse deal with different interpretations? (Parker, 1992)

Dimensions of Discourse	Nature of Analysis	Focus of Analysis	Objective of Analysis	Questions to be asked of the Data
Text Formal features of text (Fairclough, 1992a)	Description Micro level	Word Meaning	Examine key words	Identify key words of general or cultural significance. How do word meanings vary or change? What are the implications for this as a mode of power or a focus of struggle? (Fairclough, 1992a)
		Wording	Contrast the ways meanings are worded in this text with the wording in other texts(choice of words	Examine the choice of words, particularly in phrases or figures of speech. Why was this said and not something else? (Parker, 1992) Are there new lexical items and what cultural or ideological significance do they have? (Fairclough, 1992a)
		Grammar Cohesion Modality	Rhetorical organisation Examine how clauses and sentences are put together. the use of active or passive verbs, the degree of conviction	How are arguments put together? Demonstrate where a reason or purpose for an event or feeling is given. Is the speaker active in particular clauses or sentences, do they demonstrate agency in the event or feeling? Do they show commitment to a statement?(Fairclough, 1992a)
		Interpretative repertoires (Potter and Wetherall, 1987) (recurrently used systems of terms)	Identify recurrently used systems of terms	What interpretative repertoires are used to characterise and evaluate actions, events and other phenomena (Potter and Wetherall (1987)
		Metaphor	Characterise the metaphors used in the discourse sample.	What influences the choice of metaphor? How does the use of metaphor contrast with those used elsewhere? What are the effects of metaphor upon thinking and practice? (Fairclough, 1992a; Potter and Wetherall, 1994)
		Interactional Control	Describe properties of interactions Identify whether control is negotiated jointly by participants and interviewer	What turn-taking rules are in operation? What exchange structure is in operation? How are topics introduced , developed and established? How are agendas set and by whom?

Dimensions of Discourse	Nature of Analysis	Focus of Analysis	Objective of Analysis	Questions to be asked of the Data
Social Practice	Interpretive Macro-level	The nature of the social practice	Specify the nature of the social practice of which the discourse practice is a part and conversely specify the effects of the discourse practice upon social practice.	Identify the social practice that this discourse is a part of (Fairclough, 1992a) Identify institutions that are reinforced by such discourse and institutions that are attacked or subverted (Parker, 1992) What are the social and power relations and structures which constitute this instance of social and discursive practice? Who gains or loses from the employment of the discourse, whose voices receive attention over others. Who would want to promote or dissolve such a discourse, whose interests are served? (Parker, 1992) How does this discourse contribute to reproducing and transforming social and discursive practice? How does this instance of discursive practice relate to or refer to the discourse that it draws upon? What are the effects of reproducing or transforming such discourses? (Parker,1992; Fairclough, 1992a)

Dimensions of Discourse	Nature of Analysis	Focus of Analysis	Objective of Analysis	Questions to be asked of the Data
			Examine the ideological and political effects of discourse, looking in particular at systems of knowledge and beliefs, social relations and social identities	How does one discourse connect with another to sanction oppression? How does a discourse allow dominant groups to tell their narratives about the past in order to justify the present? What ideas, values, notions, concepts and beliefs are present in the text, and which are absent? Whose voices receive attention over others Whose interests are served by the reproduction of these ideas, values, notions, concepts and beliefs in the text?, How might audiences view of the world be summed up by the text? What stereotypes are perpetuated? (Lupton, 1992)

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APPENDIX D

DISCOURSES SURROUNDING THE EXPERIENCE OF PARENTING

INFORMATION FORM

You are invited to participate in a study that is seeking to understand the experience of women and men in their early months of parenting. Becoming a parent is a major event in the life of a woman or a man. It is a time of great excitement and enjoyment but also a time of challenge as you make changes in your lives.

Health workers, such as midwives, early childhood nurses and doctors often know very little about who or what influences the everyday experiences of the parents for whom we provide services. In addition, when planning care for mothers, fathers and babies, health workers do not always take into consideration the way in which we may influence the early days of parenting.

You have been selected as a possible participant for this study because you will soon be parents. If you decide to participate, we will involve you in a series of interviews during your first six months of parenting.

The first interview will take place a few weeks before your baby is born. Subsequent interviews will be spread over the next six months, with the first interview occurring within the first week after the birth of your baby. These interviews will be informal. We will use a few key questions to guide the discussion. You will be asked to talk freely about topics such as your expectations of parenting, the birth experience, your baby and your new role as parents.

We believe that participation in the study is likely to have some benefits for you by providing an opportunity to talk about your experience of birth and early parenting. The study is being conducted by Lesley Barclay, Professor of Family Health, University of Technology, Sydney and the Southern Sydney Area Health Service; Associate Professor Deborah Lupton, Charles Sturt University, Bathurst; and Ms Virginia Schmied, a doctoral student at the University of Technology, Sydney.

With your permission the interviews will be tape recorded to ensure accuracy. Any information obtained in connection with this study and that can identify you will remain confidential and will only be discussed with others with your permission. Your decision whether or not to participate in the study will not affect your present or future care within the Southern Sydney Area Health Service. You are free to withdraw from the study at any point in time.

If you have any questions do not hesitate to ring Ms Virginia Schmied on (02) 95195053 or Professor Lesley Barclay on (02) 93502789 at St George Hospital, Kogarah.

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HEALTH ON MOVE

AREA HEALTH SERVICE

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DISCOURSES SURROUNDING THE EXPERIENCE OF PARENTING

CONSENT FORM

I agree to participate in the study entitled 'Discourses Surrounding the Experience of Parenting' and give my consent freely. I understand that the study will be carried out as described in the information form, a copy of which I have retained. I realise that whether or not I decide to participate my decision will not affect my further care and/or treatment. I also realise that I can withdraw from the study at any time and do not have to give any reason for withdrawing. I have had all questions answered to my satisfaction.

______________________ Signature of Participant

______________________ Signature of Investigator

Date_________

Date__________

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HEALTH ON THE MOVE

APPENDIX E

TEN STEPS TO SUCCESSFUL BREASTFEEDING

A JOINT WHO/UNICEF STATEMENT

Every facility providing maternity services and care for the newborn should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff
2. Train all health care staff in skills necessary to implement this policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Help mothers initiate breastfeeding within half an hour of birth
5. Show mothers how to breastfeed, and how to maintain lactation, even if they should be separated from their infants
6. Give newborn infants no food or drink other than breast milk unless medically indicated
7. Practice rooming-in - allow mothers and infants to remain together - 24 hours a day
8. Encourage breastfeeding on demand
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

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