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## **The Politics of Infant Feeding Choices**

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### **Abstract**

By writing herself, women will return to the body which has been more than confiscated from her, which has been turned into the uncanny stranger on display - the ailing or dead figure, which so often turns out to be the nasty companion, the cause and location of inhibitions. Censor the body and you censor breath and speech at the same time. (Cixous 1976, in Weedon 1987:68).

I sat down on the sofa, my intention being to finish the final chapter of a riveting book I had been reading. Ruby spied me from her play spot in the centre of the lounge room. She made her way across the floor, her arms and legs flailing in such an uncoordinated manner, but never the less making good ground as she crawled towards me. She reached my feet and eased herself up to a standing position, wobbling momentarily as she used one of her hands to tap my knee. I put down my book, scooped her up onto my lap and began to sing to her. She listened politely for a few versus and then squirmed and wiggled, lowering herself sideways so that she was lying across my lap. Her head turned back and forth nuzzling into my jumper, not frantically, just patiently and persistently. Her tongue darted in and out, her mouth half open in readiness for my breast that was about to fill it. I lifted my jumper and within seconds she found what she wanted. It was all so automatic now, with no need to worry about the positioning of lips, tongue head and arms. It was like sneezing, our bodies just knew how to do it. With Ruby firmly attached to my breast, I reached across to pick up my book again when our eyes met and we gazed at each other for quite some time. I noticed the kaleidoscope of colours that made up her eyes, tiny jagged arches of blues, browns, greens and all the shades in between, and suddenly Ruby smiled at me. My milk was flowing rapidly now, cascading into her mouth as she gulped and swallowed, and still she could manage a smile. I smiled back and felt the weight of her relaxed body in my arms, her warmth and softness was exquisite. As I watched and felt her feeding, I couldn't help but marvel at the design of it all, Ruby and I together, mother and daughter, the feeder and the fed. We were an architecture so intricate and complex. As she fed I noticed her lips and tongue working together to form a tight seal around my breast, never spilling a drop of precious milk. I marvelled at her arms, always free and exactly the right length to reach up so that her tiny hands could play with my lips or face. My own arms, just the right length to cradle her head in the crook of my elbow while she drank. One of my own hands always free to stroke her head, tickle her foot or hold her hand. As far as I could see, there was nothing left to chance in this miraculous design. A baby feeding from her mothers breast, surely only a woman could have engineered such perfection. Ruby and I caught each others eye once again and smiled, and our hearts broke for the women and children who have had this experience taken from them (Personal

Journal February 1999).

The sharing of an extract from my personal journal, as a means to begin the critical discussion that is to follow, is an attempt to rectify what Adrienne Rich refers to as '...the absentee author, the writer who lays down speculations, theories, facts and fantasies without any personal grounding (1986:x). In offering my experiences as a breastfeeding critique of the patriarchal subjection of women and a means to demonstrate how women's bodies have come to be defined by someone other than ourselves.

As a midwife, who has worked closely with countless women at various stages along the 'motherhood trajectory', and now as a student undertaking postgraduate studies in Family and Child Health Nursing, I am privy to the stories that women share about one of the most pressing decisions facing new mothers, their 'choice' as to how to feed their baby. While countless women 'successfully' breastfeed their babies (myself included), others lament at their inadequacies as a mother, blaming themselves when they find, for whatever reason, that breastfeeding was not possible. It is my intention, in the pages that follow to look critically at the politics of breastfeeding, or perhaps more correctly, the politics of infant feeding choices. In particular, it is my concern that the medicalisation and scientisation of mothering, steeped in humanist discourses to which nursing largely subscribes, creates a situation where women who 'fail' to breastfeed see themselves, and indeed are seen by others, as victims of their own inadequacies. Rather, I will suggest, following Weedon (1987), that the range of contemporary feminisms offer different ways of seeing ourselves as women and moreover:

For a theoretical perspective to be politically useful to feminists, it should be able to recognise the importance of the *subjective* in constituting the meaning of women's lived reality...This involves understanding how particular social structures and processes create the conditions of existence which are at one and the same time both material and discursive (Weedon 1987: 20).

It is certainly not my intention to further polarise the breast/bottle dichotomy in regards to infant feeding choices, but rather to expose the patriarchal structures in society that contribute to the politics of infant feeding. As I name and claim my position to be feminist, and as I am a nurse who daily shares experiences with women as they feed their babies, it is important to digress momentarily in order to explore briefly the often troubled relationship between feminism and nursing. In doing so we can begin to see the patriarchal devices at play that not only marginalise and silence nurses within the health care system, but subjugate and render powerless childbearing women, and women who have become mothers. In doing so we can begin to imagine other ways of knowing, alternative positions from which to give voice to our experiences as women.

### ***Nursing and feminism***

Nursing has not escaped the feminist influence that has so deeply penetrated Western social, political and philosophical thought. Indeed, given the nature of nursing work that has historically, and continues to be undertaken in the main by women, feminist critiques effectively expose patriarchal structures (social, institutional and discursive), that oppress

women. Indeed, feminist thought is tantalising to those of us yearning for, '...a world view that values women and that confronts systematic injustices based on gender' (Chin and Wheeler 1985:74). Achieving a global feminist theory without totalising, without mastery however, is the possibility ever at the edge of our horizons (Wicke and Ferguson 1994:9).

Nurses (women) work in a health care system historically dominated by doctors (men) and the resulting oppression creates a situation in which nurses are disempowered, and women's knowledges marginalised. Medical dominance is pervasive and the medical profession have, Street (1992) suggests:

...been able to develop its own norms and values concerning the safe practice of medicine as the normative ones for the nursing profession and the community...The nurses (oppressed) have internalised the image of the doctors (oppressors) and develop a non critical acceptance of the medical model as normative (Street 1992:42).

Medicine's insistence on science and truth as a way of knowing, or rather, the *only* way of knowing, has secured their dominance and subjugated women's knowledges. The language with which the doctor speaks, the language of science, is a totalising modernist, 'man'-made discourse, which has been constructed in the absence of women because women have, by and large, been excluded from the academic institutions in which these discourses were produced and legitimated. Given the long-standing relationship of dominance and oppression, it is not surprising that nurses have adhered so rigorously to scientific principles in their endeavours at nursing research. This reliance continues despite cautions by nurse academics who point out that adherence to empiricism in order to generate assumptions remain dominant, rather than being exposed for critical review (Bruni 1991:181).

Science however, is indeed seductive. The quest for 'truths', for 'absolutes', for 'essences' and 'foundations' have been sanctioned by science, for science has at varying times, Turner (1992:127), notes, '...the way to true being, the way to true art, the way to true nature, the way to true God, the way to true happiness. Nurses practice within a modernist scientific framework where liberal-humanist discourses assume that we are all the self-knowing author of our lives accepting and living with the notion of freedom to choose, and that we possess a rational consciousness that we can exercise at will (Walker 1993:54). My need to establish nursing's link with feminism, and the drawing of our attention to the modernist notion of the human subject, will soon become apparent as I move my discussion toward a postmodern<sup>□</sup> rethinking of the subject and how we can come to understand women's experiences who see themselves, and indeed are often seen by others, as 'breastfeeding failures'.

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<sup>□</sup> The terms postmodernism and poststructuralism are more often than not conflated within philosophical and feminist texts and which I have invariably done within the discussion before us. Some feminist authors attempt to make distinctions between the two with Lather (1991), confessing to sometimes using the terms interchangeably but more often than not taking the term postmodern, to mean the larger cultural shifts of a post-industrial, post-colonial era and poststructuralism to mean the working out of these shifts within the areas of academic theory. Many feminists avoid attempts at definition taking postmodernism.

***Breastfeeding - The essence of womanhood?***

I saw Lisa today who had made an appointment for a six week nurse health assessment for her baby daughter Matilda. We talked for quite a while about lots of things. Lisa seemed to have a lot on her mind and many questions. Adjusting to life with a new baby had presented many challenges to both herself and her husband. We had decided to concentrate on the pressing issues concerning settling and rescheduled the nurse health assessment for a few days time. As we were talking, Matilda, who had been quietly alert began to cry. 'She's due for a feed', said Lisa glancing at her watch. 'Feel free to feed her while we talk', I said. 'She's being bottle fed so I have to heat it up', replied Lisa. 'No worries', I reassured her, and got the things she needed to warm the bottle. With the milk warmed and Matilda happily taking her bottle, Lisa and I continued talking. Lisa explained to me that she had 'tried hard to breastfeed in hospital but Matilda had, 'refused to attach to her breast'. 'Many midwives had a go at getting her on', she said, 'but in the end we just gave up'. Lisa's pregnancy had been induced and after a lengthy labour, Matilda was delivered by an emergency caesarean section for 'failure to progress'. Lisa confided in me her disappointment not only with the way her labour had ended in an emergency caesarean, for she certainly had hoped and planned for a vaginal delivery, but also at her inability to breastfeed her baby. 'I just feel so inadequate', she said. I know breastmilk is best for Matilda and my friends are all breastfeeding, I feel leftout and guilty (practice journal March 16th 2001).

Lisa's story is not uncommon. Many women begin to breastfeed their babies however, for an array of reasons provided to them by 'health professionals', family and acquaintances (i.e. inadequate milk supply, failure to thrive, bad milk), many also come to use formula as the sole means to nourish their baby. The 'Breast is Best' message is loud and clear and has become firmly entrenched in popular culture. Women's magazines, doctors surgeries, Child and Family Health Centre waiting rooms and a plethora of books advocate breastfeeding. Breastfeeding advocates (of which I am one) couch their arguments in science, relying on scientific evidence to promote the 'anti-infective properties of breastmilk, growth factors, calorific values and the ability of breastmilk to change in order to meet the specific needs of the infant (Palmer 1993:83).

Many pregnant women read breastfeeding literature and hear messages that breastfeeding is easy and should come naturally. Take for instance the opening page of a popular breastfeeding manual entitled *The Womanly Art of Breastfeeding*, which lays claim to be 'The worlds foremost authority on breastfeeding' . The book suggests:

Breastfeeding a baby - what could be more natural? Just cradle that precious newborn in your arms and offer him your breast. What could be simpler...  
Breastfeeding a baby is simple and natural. But it takes information and encouragement and some motherly know-how to breastfeed a baby...' (La Leche League International 1988:xiii).

It is little wonder that women experience feelings of guilt, inadequacy and failure when they are unable to breastfeed their babies. Breastfeeding in popular culture is promoted as the essence of womanhood and if we consider, as Weedon (1987:32) does, that subjectivity refers '...to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world', it is little wonder

that Lisa sees herself as a failure. What the proponents of breastfeeding do, is fail to critically examine the underlying social institutional and discursive factors at play that contribute to women's experiences who, for whatever reason, do not breastfeed their babies.

### ***Poststructuralist feminisms: (re)thinking subjectivity***

Modernist notions of subjectivity where the individual assumes responsibility for their thoughts, and actions arising from those thoughts, is both appealing and seductive. There is a dominant assumption within our society that experience gives access to truth and this being so:

From an early age we learn to see ourselves as unified, rational beings, able to perceive the truth of reality. We learn that as rational individuals we should be non-contradictory and in control of the meaning of our lives. This understanding of subjectivity is guaranteed by common sense and the liberal-humanist theory that underpins it (Weedon 1987:80).

Referring to the modernist elusion of the rational all-knowing subject however, Walker (2000:60) muses, '...if I were indeed the rational, logical person who wrote my own script for life, and that when I didn't get the script exactly right for the game that I found myself playing (which, when you think about it, is not such an implausible thought), then who else was there to blame for getting it wrong but myself?' It is precisely this 'victim' way of viewing the world, inherent in modernist thought, which became the very concern that led me to the critical discussion before us. Indeed until very recently, any other way of viewing the world apart than the one I had always known (one dictated by all the seductive elements of humanism and which I was to discover work insidiously at a subconscious level) would simply not have occurred to me. It was the voices of feminist writers who, through their stinging critiques of patriarchy, exposed the exclusion, omissions and erasures of women's experiences from historical and modernist discourses that attracted my attention. Feminist postmodern writers offered me a way to rethink both my own and other women's experiences.

Reading these feminist writers, my consciousness has certainly been raised. If we return our thoughts for a moment to the extract from my personal journal that began this discussion, and where I lamented in the final paragraph that my heart broke for the women begin to see how feminist postmodern positionings move us away from victim blaming arguments, and focus our attention toward definitions of a self that comes to be constructed. These anti-foundational times are indeed exciting and challenging for me, a nurse and mother working alongside other women and mothers, for oppositional thinking hints at transformation. As bell hooks (1990:15) suggests:

Even the most subjected person has hints of rage and resentment so intense that they respond, they act against. There is an inner uprising so intense that leads to rebellion, however short-lived. The space within oneself where resistance is possible remains. It is different then to talk about becoming subjects. The process emerges as one comes to understand how structures of domination work in one's own life, as one develops critical thinking and critical consciousness, as one

invents new, alternative habits of being, and resists from that marginal space of difference inwardly defined (hooks 1990:15).

Postmodernist discourses view liberal humanist assumptions of the modern subject as rational self-knowing authors of their lives incredulously. Central to poststructuralism is an anti-foundational epistemology. The poststructuralist agenda, 'focuses on the deconstruction of taken-for-granted historical structures of socio-cultural organisations within which various versions of the 'individual' have been inserted and, importantly, on the language and theoretical structures with which the individual and social have been written' (Luke and Gore 1992:5).

Let us consider for a moment the notion of language and how, in poststructuralist theory at least, language is considered the common factor in the analysis of social organisation, social meanings, power and individual consciousness (Weedon 1987:21). Weedon (1987) is particularly instructive in her analysis of discursively constructed subjectivities and it is worth quoting her at length:

Language is the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested. Yet is also the place where our sense of ourselves, our subjectivity is *constructed*. The assumption that subjectivity is constructed implies that it is not innate, not genetically determined, but socially produced. Subjectivity is produced in a whole range of discursive practices - economic, social and political - the meanings of which are a constant site of struggle over power. Language is not the expression of unique individuality: it constructs the individuals subjectivity in ways which are socially specific (Weedon 1987:21).

The discursive, social and political production of selves that Weedon refers to come to be family, the education system, the media and, as we shall come to hear shortly, the health care system. Individuals are subjected to gender differentiation from birth onwards. We know from a very young age, how girls should behave and how boys should behave, infact, gender specific ways of raising children, of what is expected from girls and boys, cuts across all social institutions. These social institutions however are patriarchal ones and ones in which a gendered sense of self comes to be constructed.

In order to illustrate the notion of gendered selves, and patriarchal institutions insistence on humanist discourses that rely on truth and common sense in order to fix their versions of reality, let us return our thoughts to Lisa, and her new baby Matilda, whom we met earlier. Lisa expresses her feelings of guilt and frustration at not being able to breastfeed her daughter. It is little wonder Lisa comes to blame herself for what she describes as her inadequacies as a mother. Whilst Lisa's sense of herself as a gendered being has come about from a range of social institutions since her own birth, more recently she has experienced the patriarchal health care system during the 'medical management' of her pregnancy, labour and postpartum experiences as a new mother. We can imagine Lisa during her medically (scientifically) managed labour, struggling to deliver her baby. The language spoken by the doctor is indeed powerful, and Lisa becomes a case who '*failed* to progress', necessitating the delivery of her baby by caesarean section. It is only natural for Lisa to search for a reason for her 'failure to progress', and perhaps she is told by the doctor

that she has an '*inadequate* pelvis', a common medical explanation given to women for their long and difficult labours. Medical language (and in particular obstetrical language) which nurses have come to appropriate, abound with terminology to describe inadequacies of women's bodies such as, *incompetent* cervix, *inability* to conceive, *incoordinate* uterine contractions, placental *insufficiency*, just to name a few. The postpartum period and her experiences of breastfeeding are remembered by Lisa as, many midwives 'having a go' at getting her own baby attached to her own breast. *Breast refusal*, the nursing diagnosis of a baby unable to feed from its mother's breast, must surely feel like the ultimate failure for Weedon (1987) provides us with a feminist critique of the patriarchal nuclear family in order to illustrate her understandings of the inadequacies experienced by new mothers, and takes our focus beyond the politics of infant feeding choices which has been my concern so far, to reveal the dilemmas, frustrations, and ambivalence experienced by new mothers in many areas of childcare. I suggest, for the reasons just described, that the patriarchal health care system contributes enormously to the feelings of inadequacy experienced by many new mothers. Weedon (1987) tells us:

The inadequacies widely felt by the new mother...who is inserted into a discourse of motherhood in which she is exposed to childcare demands structured by the social relations of the patriarchal nuclear family, may leave her feeling an unnatural or bad parent...The recognition that feelings of inadequacy or failure are common among women in similar positions, that the current organisation of childcare is the result, not of nature, but of social and historical developments in the organisation of work and procreation, and that contemporary definitions of women as mother conflict with other subject positions which we are encouraged to assume, offers the frustrated mother a new subject position from which to make sense of her situation, a position that makes her a subject rather than cause of the contradictions which she is living. As the subject of a range of conflicting discourses, she is subject to their contradictions at great emotional cost (1987:33).

If we consider Speedy's (2000:138) comment that, '...the values that dominate our health system are so pervasive and reflect the values of society at large, it is a struggle for nurses to remain aligned to the person rather than the institution', and heed her suggestion for the development of an '...alternative discourse to that constructed and dominated by orthodox scientific discourse characteristics of the medical world', then feminist postmodern positionings are indeed enticing for nurses. I do not suggest however that postmodern positionings should be taken on without some caution, and heed Probyn's advice that feminists who use postmodern arguments should do so critically, 'watching for holes that could swallow feminism' (1990:178). However, the political significance of decentering the subject and abandoning the belief in essential subjectivity, is that it opens up subjectivity to change (Weedon 1987:33). It is precisely this notion of oppositional thinking that postmodern feminist practices assert that I find so enticing. Here I offer the thoughts of Chris Weedon (1987), not only as a textual strategy to draw this discussion to a close, but as a feminist strategy that begs us to consider a beginning of sorts, as we imagine the potential within nursing, and specifically Family and Child Health Nursing for women to come together and voice their shared experiences:

The collective discussion of personal problems and conflicts, often previously understood as the result of personal inadequacies and neurosis, leads to a

recognition that what we have experienced as personal failings are socially produced conflicts and contradictions shared by many women in similar social positions. This process of discovery can lead to a rewriting of personal experience in terms which give it social, changeable causes (Weedon 1987:33).

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